Local Government Association

DEVO NEXT

CHARTING PROGRESS ON THE HEALTH DEVOLUTION JOURNEY

EARLY LESSONS FROM GREATER MANCHESTER

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Public Service Transformation Network

CONTENTS

INTRODUCTION 4

A VIEW FROM NHS ENGLAND 8

GREATER MANCHESTER: THE STORY SO FAR 11

LESSONS SO FAR 16

INTRODUCTION

In 2014, a number of areas across England began to explore 'deals' with Government to devolve services and funding to a more local level.

The Greater Manchester Combined Authority (GMCA) signed their deal in November 2014, followed by further agreements in July and November 2015 and a memorandum of understanding (MoU) with NHS England and Public Health England. In September 2015 the Government issued an invitation for devolution proposals and over 30 areas in England responded. Although only a handful of formal agreements have been signed to date, conversations about devolving health services are taking place around England.

In February 2016 we brought together a group of senior leaders from health and local government in Greater Manchester with their peers from areas with aspirations for health devolution. The group discussed the early lessons emerging from Greater Manchester's experience on how to turn a successful case for health devolution into an achievable strategy. This document summarises the presentations given at the event and the discussions that followed. We hope this briefing note assists other local areas in identifying their own aspirations for health devolution and charting a clear course to a place-based plan to improve health outcomes, transform models of prevention and care, and meet our shared financial challenges.

So far only around half a dozen areas have been successful in agreeing health devolution deals, though we expect many more to be brokered in the months and years ahead.

Senior leaders in Greater Manchester share with the Local Government Association (LGA), Greater Manchester Combined Authority, NHS Greater Manchester and the Public Sector Transformation Network a strong commitment to sharing their experience of health devolution to support other areas who may be considering developing their own proposals. The characteristics of each devolution area are unique and each area will require a unique set of proposals for health devolution. However, there are broad lessons that can be learned from Greater Manchester's experience.

The national context

A full copy of the presentation is available on the LGA website.[1]

Key points

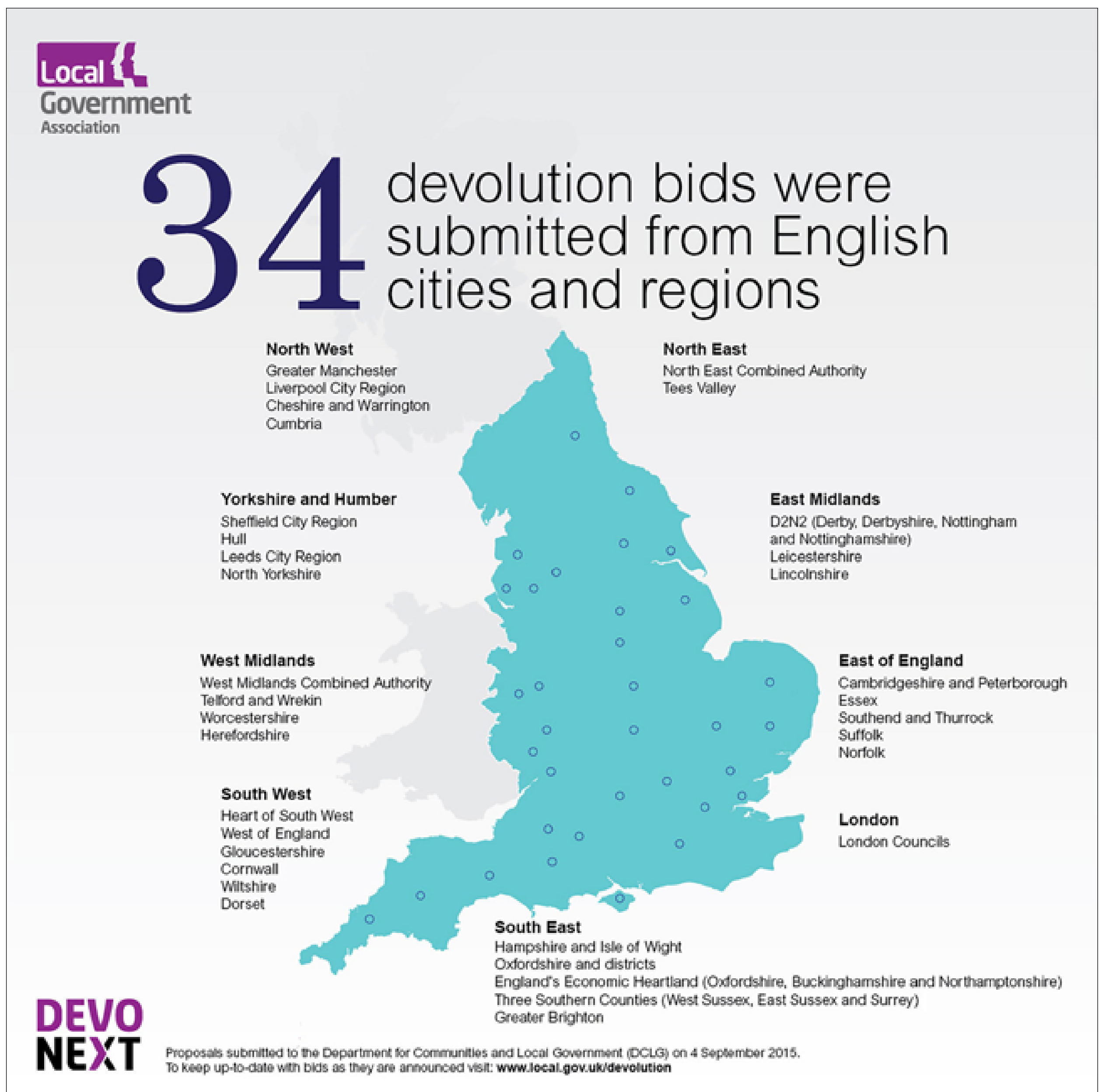
Health devolution has to be seen in the context of the wider devolution of functions, powers and resources to local government from central government and other agencies. In most areas, health and social care spend represents a significant proportion of the public sector budget. For example, in Greater Manchester health and social care spending accounts for around one third of public sector spend and health outcomes have a major impact on the potential for economic growth.

The impetus for devolution has been steadily increasing over the past decade, with support for greater devolution from all political parties. In part, this is a consequence of England's high centralisation in comparison to other western economies.

1 http://www.local.gov.uk/documents/10180/7763602/20160202+PMcM+and+Damon+Palmer+GM+Health+Devo.pdf/0ee01b25-7007-45c9-8d41-8e9d89e5dcda

For example, city regions in Germany control around 75 per cent of their spend: in Greater Manchester it is only 16 per cent. There is now a recognition that the devolution of investment and relaxation of central control are imperative to stimulating growth in the regions.

The LGA's campaign to escalate the pace and scale of devolution, whilst ensuring that there is no 'one-size-fits-all' approach, reflects the overwhelming view of our member councils. The interest and aspirations for devolution from local government has been overwhelming, with 38 devolution proposals being submitted by major cities and regions to HM Treasury in advance of the 2015 Spending Review. Of these 38 proposals, over 20 included some elements of health and social care devolution. The diagram below illustrates the spread of bids throughout the UK.



The devolution deals that have been secured to date share many core characteristics and all have a strong emphasis on economic growth. It is useful to view health devolution in the context of the wider functions, powers and resources that have been devolved to local government so far:

- with the exception of Cornwall, all have agreed models with a directly elected mayor and combined authority for the devolution area (a combined authority is a legal entity bringing together a number of councils and which can take on devolved powers)
- most include a single investment fund for economic growth
- many include full devolution of the 19+ skills budget
- co-design with the Department for Work and Pensions (DWP) on future employment support for 'harder to help' claimants
- 'intermediate body status' for the European Regional Development Fund and the European Social Fund
- strategic planning of transport, including bus franchising, pooled transport funding on a multi-year settlement and introduction of smart ticketing across the devolution area
- devolved approaches to business support
- greater tailoring and engagement of the city regional UK Trade and Investment service.

Of the nine devolution deals agreed to date, six have included elements of health devolution. The nature of what has been secured varies across areas. These are summarised in Table 1 below.

Table 1: Health devolution deals agreed up to February 2016

Area	Date agreed	Summary
Greater Manchester	February 2015 MoU with NHS England and July 2015 MoU with Public Health England	Devolved budget for health and social care of £6 billion with the support of 10 councils, 12 Clinical Commissioning Groups (CCGs), 15 NHS and foundation trusts, NHS England and Public Health England
Cornwall	July 2015	Produce a business plan for the full integration of health and care services
North East Combined Authority	October 2015	Commitment to report the recommendations of a commission for health and social care integration for the North of England by summer 2016
West Midlands	November 2015	Focus on integrating mental health services
Liverpool City Region	November 2015	Commitment to further discussions on health and care devolution
London	December 2015	Five health pilots announced focusing on prevention, integration and estates

Generally speaking, with the exception of Greater Manchester, the proposals for health devolution are less likely to include a core package of devolved functions with wider devolution deals focusing on growth, employment and infrastructure. In part, this is because the deals are not sufficiently developed and are likely to require significant stakeholder engagement with the NHS and citizens to formulate concrete plans. They remain reasonably cautious in their approach, characterised predominantly by making commitments to explore more extensive integration of health and social care.

The wider health context

There are three key recent developments that have added impetus to the health devolution debate:

- The Spending Review published in November 2015 included a clear commitment to achieving full integration of health and social care by 2020. Each area must agree integration plans in 2017 giving a clear route map.
- The publication of the NHS Planning Guidance in December 2015 requires the NHS to develop sustainability and transformation plans charting how the NHS, working with its partners, will address the triple challenges of quality, sustainability and shifting to a preventative approach. The plans will be submitted in June 2016.
- Lastly, the Cities and Devolution Act 2016 paves the way for further devolution packages to combined authorities across England expanding their remit and enabling local authorities to take on and share the functions of other bodies – including health.

All areas will be required to develop plans for integration. In the case of Sustainability and Transformation Plans (STPs) this will be over a larger footprint than local authority boundaries in many areas. This convergence of the devolution and integration agendas presents a real opportunity to develop a place-based approach to planning and delivering health and wellbeing, and to align and embed plans for health integration with the wider devolution agenda.

Under the Cities and Devolution Act, health commissioning and the finance functions of any public body whose functions are relatable to the area of the combined authority, can be transferred to a combined authority by a transfer order if the Secretary of State considers that it will improve the provision of statutory services in that area.

The Secretary of State maintains his statutory responsibility for health. However, regulatory functions, such as the establishment of CCGs, the assurance of and interventions in CCGs, and guidance to CCGs cannot be transferred. Transferred health functions must still comply with the NHS Constitution, National Institute for Health and Care Excellence (NICE) guidance, NHS England commissioning guidance, national service specifications and national contract terms for Personal Medical Services and General Medical Services.

Support from the LGA

The LGA provides local authorities with a broad range of support for devolution, including bespoke support for areas on brokering agreements, technical advice, communications support and helping negotiate with Whitehall. There is also a Devolution Network for officers, a forum for sharing ideas, challenges and good practice, with planned regional events on devolution, which will include consideration of how health devolution aspirations can be developed and clarified at www.local.gov.uk/devolution

A VIEW FROM NHS ENGLAND

The presentation by Graham Urwin, Director of Commissioning Operation NHS England, Lancashire and Greater Manchester is available on the LGA website.[2]

Key messages

Devolution needs to be seen in the wider context of integration and place based commissioning. The Spending Review set a clear ambition for all areas to fully integrate adult social care by 2020. This means moving beyond and 'graduating' from the Better Care Fund to more ambitious and transformative shared plans. Local government and the NHS will need to determine how to deliver this. There are numerous national initiatives which aim to integrate commissioning with the provision of health and care, and all of them provide useful foundations on which to build wider and more ambitious integration plans, including health devolution.

Devolution is going to continue to be an important model to enable further integration of health and social care. The Government has ambitions for all parts of the country to adopt devolved arrangements by the end of this Parliament, though not all of them will include health. It is important to be clear about the scale of ambition that is appropriate for your area. The two slides below illustrate the spectrum from integration to devolution.

Scale of ambition: devolution vs integration

- In practice 'devolution' is a mixture of local integration, regional aggregation and true devolution.
- Learning from Greater Manchester suggests that there tends to be enormous ambition at the start, but a rowing back of ambition as the detail is worked through. We need to balance power with risk sharing appetite and ability.
- Most cost-based bids are likely to involve strengthening integration across health and local government using existing powers rather than the more radical devolution options in the Devolution Bill. In all cases, NHS England will need to be closely involved in influencing their development and applying the tests agreed by our board.
- We are using the framework below to categorise the different nature of the 'ask' contained within devolution proposals – considering the level of ambition for 'devolution' on a spectrum:

2 http://www.local.gov.uk/documents/10180/7763602/20160202+Graham+Urwin+NHSE+GM+Health+Devo+presentation.pdf/5b189655-0d9b-43db-b9d4-5b7ab83766d2

The possible different models of devolution are outlined below.

'Devolution' models – where do proposals lie?

Model	Definition
'Seat at the table'	No legal change, or organisational restructuring. Decisions about a function are taken by the function holder but with input from another body. Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).
Co-commissioning or joint decision making	Two or more bodies with separate functions come together to make decisions together on each other's functions. Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).
Delegated commissioning arrangements	Function is delegated to another body. Decision-making and budget rest with the delegate. Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).
Fully devolved commissioning	Function is taken away and given to another legal body on a permanent basis (meaning responsibility, liability, decision-making, budgets and everything else to do with that function) eg under a s.105A order. Accountability and responsibility for those functions transfers to the new 'owner' (including budgetary responsibility and funding for overspends) who will be accountable to the relevant national body for the function in question.

We are working with regional colleagues to understand where each proposal lies on this spectrum of devolution models.

From NHS England's perspective there are several key themes coming out of current discussions on devolution:

- **Multi-year budget allocations** – the Department of Health (DH) and NHS England have committed to giving local authorities and CCGs indicative budget allocations for the spending review period to aid long-term financial planning.
- **Transformation funding** – through national transformation funds from NHS England if local areas can demonstrate how they will use transformational change to deliver national policy outcomes.
- **Estates and capital** – devolution provides major potential for better use of estates and capital.
- **Tariff and payment mechanisms** – existing flexibilities for local variations to the tariff where this promotes better value for patients. In addition NHS England and NHS Improvement are developing payment approaches to support new care models by bringing together payment for multiple providers and a gain/loss sharing mechanism that allows individual organisations to benefit from actions that generate benefits to other parts of the system.
- **Health and work** – national and local initiatives to join up the health and work agenda, including joint work by DH, DWP and NHS England, to test joint commissioning and the delivery of integrated health and employment services at the local level. This has the potential for budget transfer from DWP benefits to the NHS and local government.
- **Workforce training** – scope for local areas to work with Health Education England (HEE) and local education and training boards to work more effectively within the existing arrangements.

- **Regulatory and assurance functions** – the functions of the Care Quality Commission (CQC) and NHS Improvement cannot be transferred to combined authorities but this doesn't preclude areas agreeing ways of working more closely with the regulators to ensure that that they take into account the devolved arrangements for whole health economies, rather than just focusing on individual organisations. For example, a model for modified commissioning assurance arrangements is being developed in Greater Manchester. Devolution, particularly in London, provides the opportunity and requirement for streamlined oversight between NHS England and the arms-length body partners.

The principles and criteria for health devolution, agreed by NHS England, provide a clear basis on which to build local health devolution proposals. They are summarised below.

NHS England devolution principles and criteria

Principles	Decision criteria
• all areas will remain part of the NHS and are thus bound by national standards, statutory duties, the NHS Constitution and Mandate requirements • all parties have the opportunity to work together to shape the future of the local area. • principle of subsidiarity • clear and appropriate accountability arrangements • a clear plan to support long term clinical and financial sustainability • a governance model which is simple to operate and minimises bureaucracy and overheads in the system.	• clarity of vision • a 'healthy geography' that support devolved decision- making • quality and continuity of care • impact on other populations • financial and risk management • support of local health organisations • demonstrable leadership capability and track record of collaboration between NHS bodies and local government • demonstrable track record of collaboration and engagement with patients and local communities • clear mitigation plan and exit route in the case of failure.

GREATER MANCHESTER: THE JOURNEY SO FAR

The presentation by Steven Pleasant, Chief Executive of Tameside Council and Warren Heppolette, Strategic Director for Health and Social Care Reform, NHS Greater Manchester is available on the LGA website.[3]

Key points

The devolution of health in Greater Manchester is firmly embedded within the wider proposals for economic growth, linking health to wealth. Greater Manchester recognised that across the total public sector spending of £22 billion, over 75 per cent is controlled by central Government and much of the remaining 25 per cent was highly regulated. Greater Manchester's projected deficit for health and social care is £2 billion by 2021 and therefore presented a strong case to Government that a short-term financial fix was not sufficient. Instead, they proposed an upfront investment in system-wide reform to achieve financial sustainability, improve health outcomes and improve the conditions for economic growth.

The case for including health in the devolution proposals for Greater Manchester is compelling. Without strategic action to change the approach to health services and health outcomes, Greater Manchester will not be able to achieve its economic objectives of growth and productivity. The health and growth agenda are interdependent: low productivity is in part due to poor health.

3 http://www.local.gov.uk/documents/10180/7763602/20160203+WH+and+SP+Health+Devo+Presentation+GM+WEB.pdf/2c3e3410-5ba9-4e17-91dc-f5ead6d6f071

For example, two-thirds of all the 250,000 people out of work have mental health problems and average healthy life expectancy for men in parts of Greater Manchester is 57 years – "and yet we do not currently commission health or social care to support people to get back into work. You can't do devolution without health and social care." The poor health of citizens represents a drag on the economy which must be addressed by a radically different approach to health and wellbeing.

An equal challenge for Greater Manchester is the financial position for health and social care. The combined budget for health and social care accounts for one third of all public sector spending. The combined funding gap for health and adult social care and health by 2021 will be £2 billion. It was clear that finding more money to patch the existing system could only be a temporary measure. The only solution is a strategic redesign of the health and wellbeing system: "we had an unsustainable system with poor clinical outcomes, and the resulting bill was going to end up at the Treasury's door." The redesign is not just to put health and social care services on a sustainable footing but also to significantly improve the health of the population to support economic aspirations.

The MoU on health and social care devolution was signed in February 2015 and is supported by the 10 Greater Manchester councils (with cross-party support), 12 CCGs and 15 NHS and foundation trusts. It set in train preparations to transfer a combined budget of £6 billion for health and social care to Greater Manchester in April 2016.

This must be seen in the context of the £22 billion of public resources already discharged to Greater Manchester for other functions. Since then, there has been a huge amount of planning for devolution.

But devolution and the transfer of functions is not an end in itself and Greater Manchester has agreed ambitious outcomes by 2021:

- 1,300 fewer people dying from cancer
- 600 fewer people dying from cardiovascular disease
- 580 fewer people dying from respiratory disease
- 270 more babies attaining a healthy birth weight
- 3,250 more five year olds being socially and emotionally ready to start school
- 16,000 fewer children living in poverty because their parents have secured good work
- 2,750 fewer people having serious falls by supporting people to live well and independently at home.

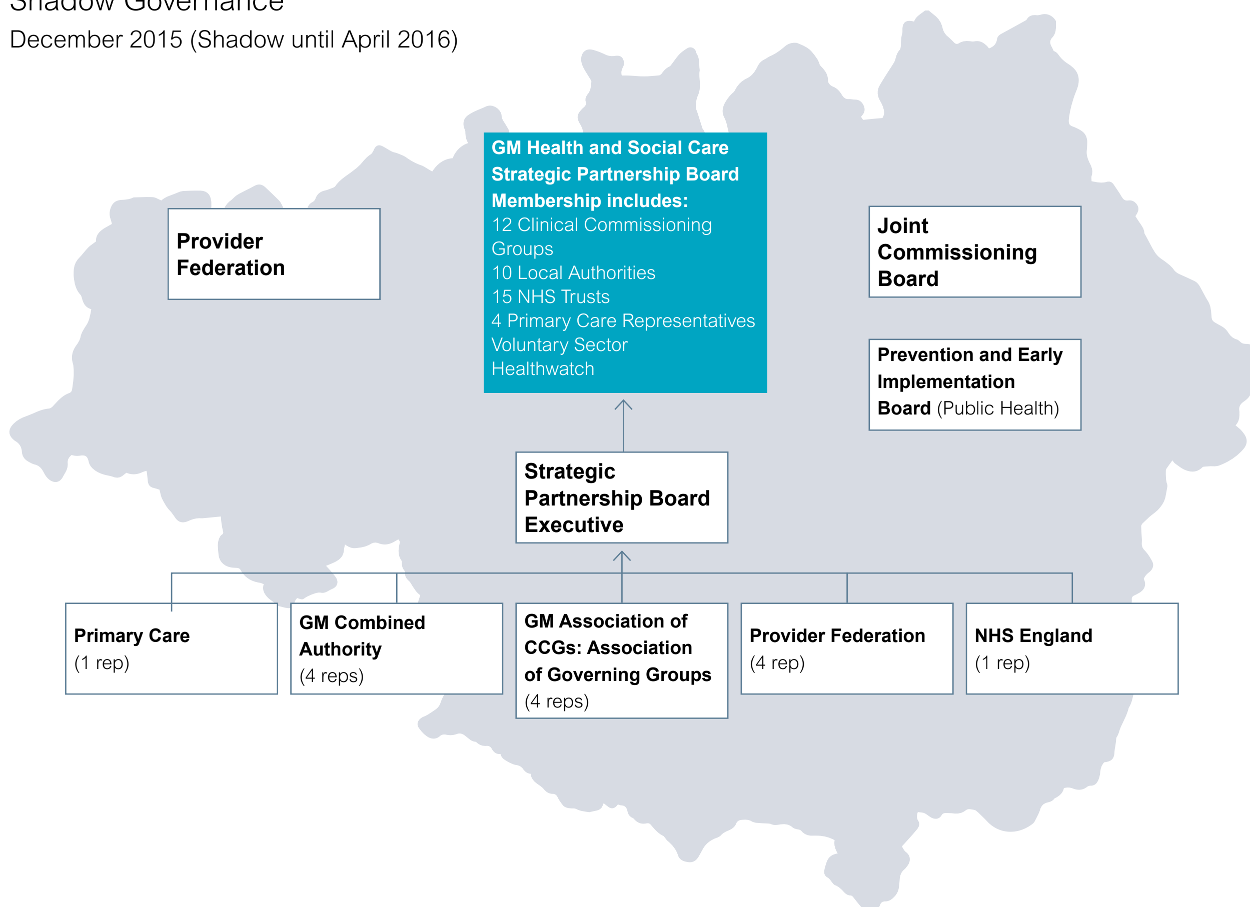
More outcomes are likely to be agreed for the whole of Greater Manchester in the months ahead.

Governance arrangements – The diagram below illustrates the shadow governance arrangements overseeing and assuring the health and care system for Greater Manchester.

Greater Manchester (GM) Health and Social Care Devolution

Shadow Governance

December 2015 (Shadow until April 2016)



Notable elements of the governance framework are:

- Greater Manchester remains subject to the NHS Constitution or Mandate and the national regulatory framework
- the Partnership Board brings together the whole system, including councils, CCGs, providers, Healthwatch and the community and voluntary sector – system-wide commitment and ownership is crucial
- the Provider Federation – this brings together all NHS providers in a shift away from organisational sovereignty to pool responsibilities and share services across multiple sites
- the Joint Commissioning Board – co-chaired by council and CCG chief executives will commission pan- Greater Manchester specialist services but also develop common evidence-based frameworks for community and public health services if appropriate
- subsidiarity – the MoU makes a clear commitment that "all decisions about Greater Manchester will be taken with Greater Manchester"; equally, the principle of subsidiarity will mean commissioning decisions are taken at the most appropriate level – in many cases at the CCG or council level – "If this is going to work it won't just be integration at GMCA level but right down into the services where it is needed."

Analysing the financial challenge – The first step is for the system to work together to develop a clear understanding of the flow of money in the system. Only then is it possible to build a new place-based strategic framework for funding and investment. The key elements of the strategy are summarised below:

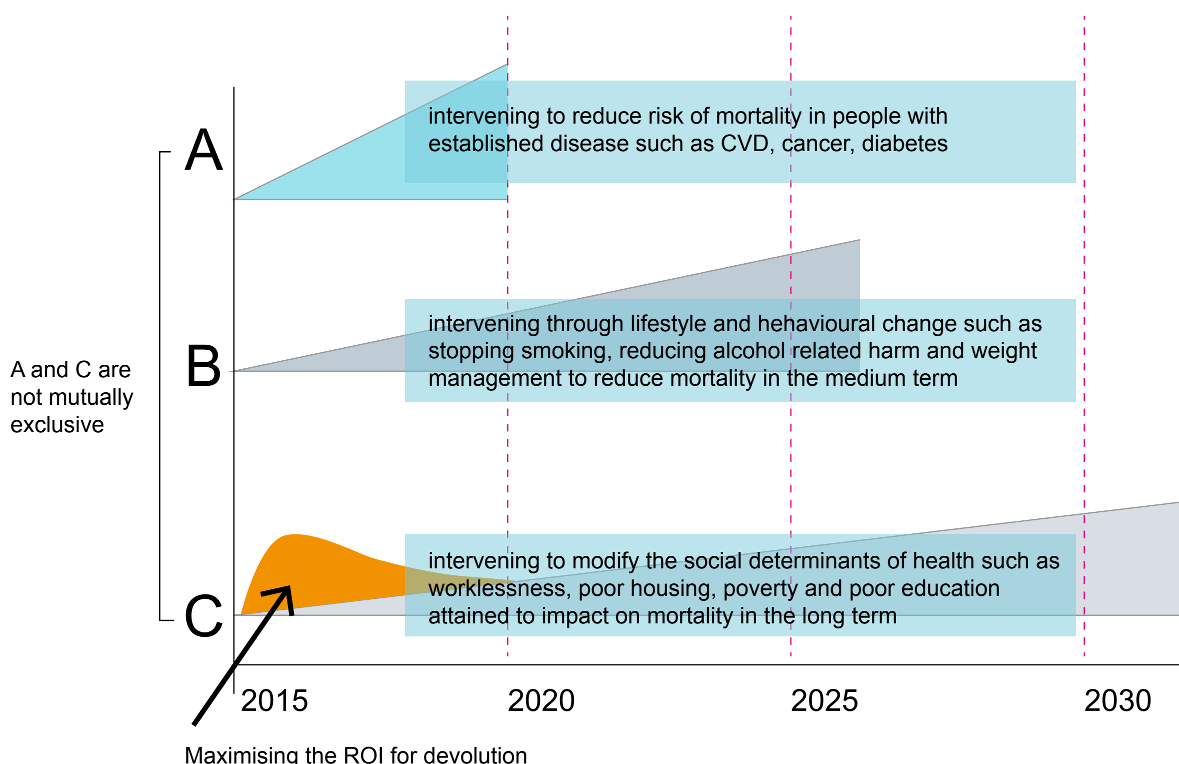
- hospital reconfiguration is vital but the most essential change needed is to reduce demand
- £450 million Transformation Fund to invest in new models to drive prevention to change demand for services through integrated pathways for mental and physical health services, proactive strategies to reduce disease, investment in primary care and community health services
- £750 million in efficiencies to be realised in standardising acute hospital care to reduce variation and a shared back office
- analysis made it clear that the Better Care Fund is nowhere significant enough to drive transformation towards prevention – its sights are still too narrowly focused on short term reductions in demand on A&E. "BCF cannot deliver what is needed to shift prevalence and productivity within the system." Greater Manchester is planning to pool around £2.7 billion, nearly 50 per cent of its health and care resources, which goes way beyond most local Better Care Fund budgets, amounting to less than 10 per cent of health and care spending.

Greater Manchester worked with New Economy to develop a financial modelling tool to demonstrate the amount of taxpayers' money that can be saved by these new ways of working and the impact they can have on the quality of services enjoyed by Greater Manchester's residents. In the short-term the cost benefit analysis (CBA) work will save money, through identifying which programmes provide the greatest operational efficiencies. In the longer-term this work will drive economic growth, by focusing resources on those programmes which are proven to deliver social and economic opportunity. Details of the cost benefit analysis are available at: http://neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis

Some key challenges remain to be addressed in the spending review period. First, it is difficult to shift the pattern of investment in services without wider reform of the payment system in the NHS. The tariff continues to reward activity in the acute sector rather than prevention. Second, Greater Manchester recognises that it had underestimated the amount of capital investment needed to shift models of provision and support.

The strategic plan – Greater Manchester's strategic plan builds on the ten locality plans and identifies five priorities for system transformation:

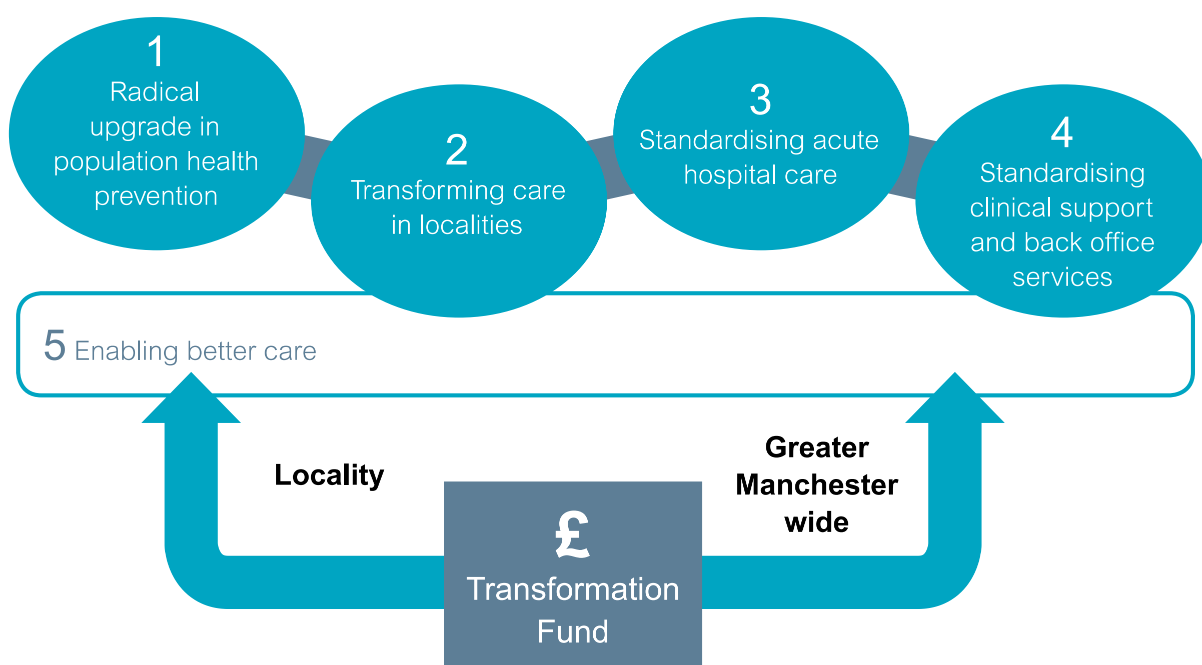
- **Prevention and population health** – focusing on community support to prevent ill-health and promote better self-management of conditions. This will have the biggest impact on demand in the long-term and takes Greater Manchester well beyond traditional public health functions reaching into housing, leisure and employment support. A preventative approach will be core to the future development of primary care in order to address the £2 billion burden of disease in Greater Manchester.
- **Transforming community based care and support** – community-based, multi-disciplinary teams to ensure people are treated as close to home as possible and hospital stays are minimised, wherever appropriate.
- **Standardising acute hospital care** – by single shared services for acute hospitals, better use of information technology and reduction in variation in care and clinical outcomes.
- **Standardising clinical support and back office services** – including support for citizens to navigate the health and care system to ensure that they are in the right place at the right time. Analysis in Greater Manchester suggests that while most of the focus of efficiency finding is here, it is probably only likely to deliver 20 per cent of the solution.
- **Enabling better care** – through new models of care, new ways of commissioning, contracting and payment design and standardised information management and technology. None of this transformational change is possible without a common data set, a unified workforce strategy and most important of all, a change in the way services are paid for.
- **Investing in transformation** – Greater Manchester developed a modelling tool to provide them with a clear understanding of scale and the timeframes for the return on investment of different prevention strategies. This enables them to justify investing in interventions that have a significant payback over the long-term. The diagram below illustrates this.



The £450 million Transformation Fund will front-load investment in prevention and community-based approaches and allow some 'double running' with traditional treatment services but, ultimately commissioners will need to 'switch off the traditional deficit model of health to an assets based approach'. The fund comes from a variety of sources, including council reserves in the belief that investment in prevention will reduce demand for services and improve the economy and productivity of the population. However, there is a pressing need to improve the evidence base for prevention – both to support the objectives of the Five Year Forward View and also to make the financial case for prevention with HM Treasury.

How will we pay for the changes?

- £450 million has been earmarked to fund improvements in the big areas we are focusing on – known as the Transformational Fund.
- Effective and independent management of the Transformation Fund will be crucial in ensuring the right projects are funded to deliver the agreed strategy.
- We are developing the process, but the guiding principle is that funding will be aligned to our strategic imperatives.



LESSONS SO FAR

Devolution has had a galvanising effect on the whole system with everyone committed to making it work – both at the national and local levels, and across the statutory and voluntary sector.

The positives

Governance arrangements underpin and reinforce a place based approach that includes all partners. The Greater Manchester Joint Commissioning Board and the NHS Providers Federation are a real breakthrough in moving beyond organisational boundaries to explicitly prioritise public benefit.

The devolution debate has moved beyond looking at how institutions work and is generating discussion about the relationship between the public and public services; moving from a deficit treatment model towards a community asset based approach. Central to this is having a clear understanding of the associations between prevention initiatives in early years, employment support, lifestyle change, community development and resilience and the impact on the health, wellbeing and productivity of the local population.

Ongoing challenges

There are four key challenges that Greater Manchester still need to fully address:

- **Subsidiarity and operation at the right spatial level** – getting the balance right between planning and delivery at the council locality plan level and planning and delivery at the Greater Manchester level to secure financial and health benefits at scale. This is the challenge that lies at the heart of the principle of subsidiarity – being clear about what is the most appropriate local level for decisions.
- **Making the financial case for prevention** – Greater Manchester is making a powerful case for the 'economics of prevention' and demonstrating the links between health, employment and early intervention outcomes but the evidence base needs to be strengthened to reduce the financial risk and convince sceptics that diverting resources from treatment really will result in better health outcomes.
- **Exciting the public and workforce about devolution** – Greater Manchester still needs some way to go to opening out the discussion and engagement with the public at large and 120,000 health and care staff. Its role in driving transformational, cultural and behaviour change is essential to achieving health outcomes.
- **Shifting the provider landscape** – though the NHS Provider Federation is working to deliver a radically reconfigured service, there is still a question about the willingness of providers to work on a system-wide basis when there will be winners and losers in terms of allocation of resources. In addition, the shift to a community-based prevention model will mean that more traditional models of treatment will cease.

Key themes from the roundtable discussion

The presentations prompted a wide-ranging discussion about what health and local government partners can learn from the Greater Manchester experience.

Leadership and culture change
Leadership does not reside in one particular sector or group. Political, clinical and professional leaders all have a vital role to play. The role of political leadership has been vital in Greater Manchester. In particular the support of the 10 Greater Manchester council leaders in supporting the Healthier Together consultation took a degree of political bravery and sends a clear signal that there is political ownership of the health challenges. Through CCGs, GPs' leadership role is essential to promoting and convincing NHS colleagues of the value of a preventative, system-wide approach, and the interdependence of health with the wider public sector, both for achieving better health outcomes and sustainability of the NHS. Leaders of provider organisations must move beyond their organisational interests to focus on achieving the best outcomes for the population and they need to take their workforce with them. The best strategies and plans will not achieve significant changes without a change in culture. It takes time to develop trust and the confidence that partners have common objectives.

National leadership and direction on health devolution
There have been mixed messages on health devolution. The Spending Review has a clear ambition for full integration of health and social care by 2020 with every area agreeing an integration plan by 2017. But so far, there has been no articulation of what full integration looks like, what needs to change and how to achieve this – the basis of the integration plan.

The NHS Planning Guidance requires all 'areas' to produce STPs to show how the efficiency, quality and prevention challenges facing the NHS will be addressed.

The deadline for STPs is June 2016 and there is a real danger that the timescale for agreeing plans will not allow sufficient time for local health and local government partners to develop plans for the whole system. A further concern is that the footprint for STPs may not take account of devolution footprints, making it difficult for them to join up sustainability plans for the NHS with wider devolution plans.

Risk and resource sharing
NHS England has raised concerns that the continuing funding gap for adult social care and public health represents a barrier to further devolution of health transformation and resources. Greater Manchester was able to convince the NHS that the key objective of their Five Year Forward View – reducing demand for health services – could not be achieved without working with local government and the community and voluntary sector to shift the pattern of provision to prevention. They did this by working with GPs to demonstrate that their commissioning budgets are more effectively spent on prevention.

However, Greater Manchester acknowledged that the failure to address the £14 million funding gap in adult social care is a serious challenge. The ability to levy a 2 per cent precept on council tax to support adult social care in Tameside will raise only £1.4 million – just 10 per cent of what is needed. Greater Manchester's Transformation Fund is needed to create an investment pool that will support social care and other preventative services until the additional Better Care Fund money comes on stream from 2017/18 onwards. However, this still means significant medium-term pressures for adult social care.

Investing in prevention
Some of the participants had been enthusiastic investors in community approaches such as social prescribing but are now concerned that funding pressures in local government may mean public health budgets are used to shore up other council services: "I want to work with the council but there are suspicions that they will use pooled budgets to plug funding gaps."

This is a concern but it should not be a barrier to joint initiatives on prevention and the recognition that: "unless the NHS embraces the wider public service reform it will go bust." There is also a concern from NHS England that the failure of the Spending Review to address funding gaps in adult social care and public health will place undue pressure on health resources.

We also need to promote innovative approaches that are making a difference. For example, a pilot running in three GP practices in Tameside to provide welfare benefits advice to patients has resulted in households getting an additional £1,500 each, which has resulted in health benefits, and reduced their use of GP and A&E services. It was acknowledged that investing in prevention strategies that have a payback beyond a five year timescale – such as support for early years and school readiness – is challenging. Individual examples are useful but there is a pressing need for a more robust local and national evidence base for return on investment in prevention.

CCGs want to invest in long-term prevention but it is difficult for them to see beyond the annual planning process. STPs will be a positive step in supporting CCGs to plan long-term but will need to take a broader prevention approach if they are to be relevant to the wider public sector. Greater Manchester will use its strategic plan as the basis of its STP in order to maintain the focus on the wider prevention agenda.

Building on existing plans
Plans for health and social care devolution need to build existing plans of providers and commissioners and align them. The first step in many areas will be to build BCF plans towards more ambitious integration. The key message is that local commissioners and providers need to discuss and agree joint or aligned plans before they are discussed with NHS England and NHS Improvement. It is easier to achieve this if areas have a unified planning team and a single budget overseen by a joint finance director but there was recognition that not all areas are so far advanced.

Regulation and performance management
NHS England and NHS Improvement are developing place-based approaches to regulation and performance management so that regulators support integration rather than becoming a barrier.

Greater Manchester is currently working with NHS Improvement and CQC to develop supplementary MoUs on how it will work to support an increasingly integrated system. However, the good intent and understanding at senior level must be reflected in the attitudes and behaviour throughout all levels of the system.

It is important to recognise that local government and the NHS have very different regulatory frameworks and attitudes towards national regulation. As a general rule the NHS expects regulation while local government recognises that it has an individual and collective responsibility for continuous improvement.

Regulation is inextricably linked to accountability; accountability in the NHS runs upwards to NHS England and to the Secretary of State, whereas local government accountability runs outwards to its citizens and electorate.

Local government participants supported the view that 'regulation moves in when accountability moves out', so it is vital that there is clear local accountability for health devolution. This entails a clear ambition with tangible outcomes and regular engagement with local citizens to report and discuss progress. However, in the meantime there is still a need to develop more place-sensitive approaches to regulation.

Local government has a well-established sector-led approach to performance management and improvement, with a focus on constructive peer challenge and the dissemination of best practice. The NHS is becoming interested in a sector-led approach but there is still some way to go to establishing a cross-sector approach to improvement.

Wider engagement in the devolution debate

The Government's approach to negotiating individual and unique deals with each devolution area is a welcome recognition that there is no single blueprint for devolution. However, doing individual deals with Whitehall makes it difficult to have transparent engagement with our communities about what devolution will mean for them. The Healthier Together consultation in Greater Manchester was the beginning of an ongoing discussion with communities about the services they want and deserve.

It is important that devolution is seen not as an end in itself but as a means of securing local responsibility and accountability for improving health outcomes and health services. The Healthier Together consultation aimed to raise public expectations of services and to be clear that the primary purpose of the reconfiguration proposals is to save 500 lives a year, as well as put services on a sustainable footing.

Support from national bodies

Participants valued the opportunity to hear from Greater Manchester about its experiences so far in turning a successful devolution deal into an achievable plan with tangible health, finance and service transformation outcomes. They identified three areas of further support that would help them progress with their plans for health devolution:

- A standard modelling tool or template for building a robust economic case for investing in prevention.
- The LGA to work with NHS England to ensure that STPs provide a useful milestone in areas moving to full integration and to ensure that STPs plan for the whole system to improve health outcomes and financial sustainability.
- Forums for senior politicians in aspirant health devolution areas to give them the space and time to discuss their role as key leaders and champions of health devolution.

Conclusion

"Devolution isn't rocket science. It involves hard work and single-mindedness by system leaders. Senior politicians and clinical leaders need to be brave, see beyond the boundaries of their institutions and focus on what's best for their citizens. We all recognise that the system is broken and providing extra money to carry on as we are is a temporary fix. The only answer is pump-priming prevention and adopting a community assets based approach."

The circumstances that led to the Greater Manchester health devolution deal are unique. The 10 local authorities that make up Greater Manchester have a long established track record of working strategically, as have the 12 CCGs and more recently the NHS provider sector. They face common health challenges and have a provider footprint that largely aligns with GMCA boundaries. They also had a strong shared commitment and a shared vision from political and clinical leaders that takes time to develop. However, this does not mean that other aspirant health devolution areas cannot learn from their experience. The fundamental elements of their devolution strategy are likely to be key elements common to all effective integration and devolution plans.

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