

Health Devolution

Purpose of report

For information.

Summary

This report sets out other updates relevant to the Board, and not included elsewhere.

Recommendations

Members of the Community Wellbeing Board are asked to:

1. **Note** officers verbal update on the Joint Board Health Devolution meeting held on Thursday 26 November 2020
2. **Note** the updates contained in the report.

Action

As directed by members.

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Purpose of paper

This paper:

1. provides the context for the LGA's current policy position on devolution
2. identifies what's changed in the wider policy landscape in relation to the specific area of health devolution since 2016
3. summarises the current agreed policy messages on health devolution
4. provides a basis for the Lead Members of the City Regions, Community Wellbeing and People and Places Boards to ensure that our policy messages on health devolution and the wider devolution
5. recommends that Lead Members of the three Boards identify and agree any further action on this issue.

Background and introduction

6. The LGA Community Wellbeing Board has taken the policy lead on health devolution since 2015, when the then Government gave strong support to devolution, including health devolution, but it did not try to precisely define health devolution. The reality of the much heralded devolution of health did not match the expectations of local government in either coverage or extent of transfer of power and resources from national to local leaders.
7. The LGA is clear that health devolution is not an end in itself. It is a means of securing local freedom, responsibility and accountability to achieve improved health and wellbeing outcomes, better health and care services and better use of resources. It has also been seen as a key driver for the integration of health, social care and wellbeing care and support. The LGA has a long-standing commitment to moving the integration of health and social care from marginal activity to the main way of planning and providing services.
8. The principles that inform the LGA's approach to integration are consistent with our views on health devolution. It requires leaders to rise above organisational interests and boundaries in order to identify what will have the most beneficial impact on the health and wellbeing of individuals and populations. It also means giving people more control over health and social care resources - maintaining people's abilities, capacities and independence and working with them as equal partners to achieve the outcomes that are important to them.
9. In order to achieve this, we will ensure that integration leads to resources being shared to prevent ill health and promote physical, mental, emotional and economic wellbeing, in order to improve lives, close health inequalities and reduce the financial and social costs of illness, isolation, dependence and premature death.
10. We believe that there is no one model of health devolution and all areas should develop their own solutions. In practice though, this has led to different understandings of what health devolution is being adopted by different organisations. Some of the following arrangements have been described as devolution:

Model	Definition
Seat at the table	<p>No legal change, or organisational restructuring.</p> <p>Decisions about a function are taken by the function holder but with input from another body.</p> <p>Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).</p>
Co-commissioning or joint decision making	<p>Two or more bodies with separate functions come together to make decisions together on each other's functions.</p> <p>Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).</p>
Delegated commissioning arrangements	<p>Function is delegated to another body.</p> <p>Decision-making and budget rest with the delegate.</p> <p>Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends).</p>
Fully devolved commissioning	<p>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) e.g. under a s.105A order.</p> <p>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.</p>

11. Around half of the 38 devolution bids proposed to the HMT in 2015 included an element of health and social care devolution. The successful health devolution bids are listed below:

Greater Manchester	February 2015 MoU with NHSE and July 2015 MoU with PHE	Devolved budget for health and social care of £6 billion with the support of 10 councils, 12 CCGs, 15 NHS and foundation trusts, NHSE and PHE
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
Surrey Heartlands ICS	November 2017	Surrey CC and Surrey Heartlands CCG deal with NHSEI to improve health and wellbeing

12. The health devolution bids are a mixture of local integration, regional integration and true devolution. The experience so far suggests that bids start with enormous ambition but this is scaled back once deals are implemented. In February 2016 the LGA published a report which drew early lessons from Greater Manchester on the opportunities and challenges of health devolution:
<https://www.local.gov.uk/sites/default/files/documents/charting-progress-health--d30.pdf>
13. Since 2017, apart from GM, there has been little movement on the existing health devolution deals or any new proposals coming forward. We have learned from the experience of the 'health devo' areas and a number of reports on health devolution by IPPR and DevoConnect is that the what is called health devolution, in most areas, has simply been delegation to a more local level of some NHSE functions. Furthermore, the experience of the existing health devolution areas suggests that there has been little transfer of decision-making or resources, with NHSE ultimately retaining responsibility for key decisions.
14. There still exist substantially differing views between local government and the NHS and at national and local level on what constitutes health devolution – usually with local government wanting more power and freedom over resources and decision-making transferred to local or regional bodies than the NHS is willing to agree to. The creation of 44 STPS and the subsequent ambition of the NHS Long Term Plan that by 2021 all STPs will have developed into integrated care systems, responsible for transformation and performance, is seen by NHSEI as the main vehicle for health devolution. But it remains to be seen whether this actually constitutes devolution as local government understands it, or whether it is simply the localisation of some of the functions of NHSE, with NHSE still firmly in control.

What's changed in the wider policy landscape?

15. Since the government announced the first devolution deal with Greater Manchester in 2014, 11 areas have had devolution deals confirmed, nine of which are now Mayoral Combined Authorities (MCAs). The LGA has consistently advocated for greater powers, funding and responsibilities to be transferred from central to local government, and since the announcement of a devolution white paper in 2019, work has gone into refreshing and strengthening the LGA's position and lines on devolution. The LGA's position on devolution is built around four elements: establishing an English devolution baseline; expanding the focus of devolution beyond economic growth to encompass wider priorities for public service reform; making the case for greater fiscal devolution; and, asserting the constitutional position of English councils within the context of a strengthened United Kingdom. Alongside these elements are a series of agreed principles, which will be used to shape the LGA's response to the white paper. These

are: that devolution deals should be locally led, with no one-size-fits-all approach; that devolution deals should leave nothing off the table; that devolution must be backed by adequate resources; that individual devolution deals must form part of a new push towards localisation, and that English councils must have a stronger voice on the national stage.

16. This much-anticipated white paper on devolution, has now been further delayed. Having first been expected in June 2020, it now seems unlikely that the white paper will be published until spring 2021. Early indications suggest it will continue to focus on the devolution of powers aligned to promotion of growth, within the context of local economic recovery. While this delay has resulted in less clarity around the government's current agenda for devolution, it has not entirely halted the process with plans for an East Yorkshire devolution deal worth £1.6bn proceeding.
17. This delay also gives a further opportunity for the LGA and other interested stakeholders to revisit current positions on devolution, and shape new lines on areas such as health devolution, which have thus far been less of a focus of the broader national discussions around devolution. It is also an opportunity to look at those areas that have had some responsibility for health devolved to them as part of their devolution deal, how this has worked for these areas, and to look ahead to areas that might be interested in having aspects of health devolved to them in future devolution deals.
18. The starting point for this work will be to consider how devolution can be turned 'right side up' to better focus on locally determined outcomes rather than deals driven by the priorities of Whitehall departments with councils given the powers to convene public agencies and defragment national funding streams to deliver these.
19. Some areas had expressed an interest in health devolution when agreeing their devolution deal: most notably, from Tees Valley Combined Authority to run health services for in Teesside, Darlington and Hartlepool and from the Liverpool City Region who expressed interest in developing proposals for health devolution. It is not clear if or how these ambitions will be taken forward in the absence of the devolution white paper.
20. In parallel, the NHS making swift progress on implementing its own version of devolution within the NHS and potentially extending to adult social care and public health functions. In implementing the NHS Long Term Plan, the 44 STPs and ICSs will assume responsibility for performance and transformation of the NHS organisations within their system. NHSEI and the other national NHS arms-length bodies will increasingly look to system leaders to take a practical leadership role in how the system operates, and only go directly to individual NHS organisations where necessary. As to whether this will lead to formal devolution of authority and resources akin to the Greater Manchester health devolution, there is no evidence to suggest that NHSEI supports this approach for other ICSs. However, this 'system by default' approach is also being interpreted as the NHS's main driver of health devolution (in their terms).
21. The LGA has welcomed the shift to integrated care systems as a vehicle to drive to improvements in health and care services and health and wellbeing outcomes. However, not all of the 44 ICS footprints are not co-terminus with combined authorities, which raises the question of whether health devolution can be aligned with the combined authority strategies for improving health and wellbeing and reducing health inequalities. There is a danger that approaches to health devolution and more general devolution may diverge because of the continuing delay in the devolution white paper will lead to a twin

track approach in which the NHS leads health devolution under ICS leadership and the local government leads all other devolution.

Community Wellbeing Board policy position on health devolution

22. There is no one model or governance that is right for every area, and where health and local government leaders agree that greater local freedom and flexibility is needed, it is for the area to develop its own proposals. However, there are common principles and values which need to underpin all health devolution agreements. First and foremost, decisions should be taken as close as possible to the communities they affect. Our support for subsidiarity in health and wellbeing is consistent with the LGA's wider policy on English devolution: that is, that decisions should be taken as close as possible to the communities affected by them.
23. Local government and the NHS do not always share a common understanding and narrative on health devolution. The LGA continue to work with national partners to build a common understanding of the importance of devolving real power and resources as close as is appropriate to local communities. We will also work with partners to ensure that notions of devolution within the NHS and local government are consistent with each other and have subsidiarity as a founding principle.
24. We will continue to work with NHSEI, DHSC and MHCLG to ensure ICSs fully understand the importance of local government involvement in devolved decision-making structures for health and care. Furthermore, ICSs and STPs must be accountable to local places through council overview and scrutiny and HWBs.
25. The decision to propose health devolution is one for councils to make in partnership with their health partners and in consultation with their communities. There is no one model of governance for health devolution that is right for all areas, and where greater accountability is needed, it is for council and NHS leaders to determine their own arrangements for governance.
26. There is potential for ICS's to be genuine strategic partnerships between councils, the NHS and other sectors to address common health and wellbeing challenges and a key vehicle for devolution of health. We will work with national partners and local councils to identify the vital components that all ICSs need to have in order to achieve genuine health devolution.
27. The CWB also has agreed specific policy lines on various aspects of NHS Reform that are relevant to our policy position on health devolution. They are summarised below.
28. **On ICSs** - We support a joined-up approach to improving population health, health and care services and use of resources. Many ICS leaders strongly underline our message that local government leaders need to be at the heart of ICS leadership, in order to achieve their objectives of improving health, improving health and care support, and addressing inequalities.
29. Some also fully support our message that most action and planning needs to be taken by place and led by health and wellbeing boards (HWBs) as the place-based forum where political, clinical and community leaders come together to drive local priorities for health improvement and addressing health inequalities.
30. But there is a risk that national priorities of NHSE (eg getting on track with elective care, bringing health institutions to financial balance etc) will dominate the resources and focus of ICSs. Also, some ICSs are still strongly focused on the NHS, rather than the wider

health and wellbeing of their populations. They will struggle to make an impact on population health improvement and addressing health inequalities unless they have a wider and more inclusive approach.

31. **On merger of CCGs** - Phase 3 of the NHS LTP restates the expectation that CCGs will merge onto the ICS footprint. This one-size-fits all approach is not appropriate for all areas. Some ICS and local government leaders support this as providing a more strategic and coherent approach to commissioning. However, many are concerned that commissioning health on this level cannot reflect the needs of specific places within a system, and will create a barrier to joining up adult social care, public health and health commissioning within place.
32. All decisions about the merger of CCGs should be taken in partnership with councils and in particular HWBs. CCGs that do merge onto a larger footprint need to ensure that they are able to maintain the good relationships and partnership working they have developed with councils in place. CCGs that merge onto a larger footprint will need to ensure that they are able to contribute to the HWB, as the only place-based partnership for political, clinical and community leadership.
33. **On NHS Reform** - We support the broad objectives of the NHS Reform Bill to remove barriers to collaborative working between NHS institutions and across the NHS and the wider system, including adult social care, public health and the voluntary and community sector. However, the reforms need to strengthen and build on the components of the NHS Act that have been successful. They need to strengthen and embed a place-based approach, led by HWBs. There is a danger that putting ICSs on a statutory footing will bypass and undermine place-based integration, led by HWBs.
34. ICSs need to be accountable and inclusive of local place-based leaders, whether or not they are put on a statutory footing. Also, having a solitary local authority representative on an ICS board is not sufficient to ensure full local authority involvement, especially in areas where the ICS footprints spans several councils.
35. The approach of 'system by default' with ICSs being responsible for the performance and transformation of health and care systems, needs to be balanced by an equal focus on place. We propose a 'place by default approach' with systems only responsible for what cannot be planned or delivered at place level.
36. **Our proposals on legal reforms** - Build on and strengthen the role of HWBs by introducing a new reciprocal "duty of collaboration to improve population health and address health inequalities" on all NHS organisations and local authorities.
37. Require ICS to ensure meaningful involvement and an equal partnership with local government, with a 'place by default' approach.
38. ICSs required to involve local government and HWBs in the development of plans. This goes further than sign off of final plans and involves early and ongoing engagement in the development of plans. Furthermore, ICS plans to devolve the development of place or locality plans to HWBs, based on JSNAs and joint health and wellbeing strategies.
39. CCGs to continue to have a strong place-based focus. In larger CCGS, for the CCG to ensure that they play a strong and proactive role in HWBs.
40. ICSs need to be accountable to their local communities. This accountability should operate through existing democratic processes – the council, the HWB and health overview and scrutiny days.
41. Give HWBs a statutory duty of 'sign off' and veto on all ICS plans. The benefit of this would be a statutory duty on ICSs to involve HWBs in the sign off process. The risk

would be that this would simply be HWBs rubber-stamping ICS plans that have been developed without their involvement. It may dominate HWB business to focus solely on ICS plans, which do not address wider health improvement and health inequalities strategies, or take a health in all policies approach. It may also mean that HWBs are subject to NHSE assurance and improvement processes. We will need to work closely with NHSE and DHSC to ensure that this statutory duty is meaningful and HWBs are properly supported to carry out this new duty.

Next steps on health devolution

42. CR, CWB and P&P Lead Members are requested to:

- 42.1. discuss the current agreed policy lines (above) on health devolution and to agree whether they need to be amended or reframed to respond to the devolution white paper.
- 42.2. ensure that our developing lines on health devolution remain aligned to our more general policy position on English devolution, and as part of the current work on the 'devolution menu'.
- 42.3. work with NHSEI, DHSC and MHCLG to ensure that as far as possible, there is alignment at national level between devolution policy for local government and the NHS
- 42.4. support any areas that have ambitions for health devolution and to identify and promote good practice on health devolution.