

FABIAN POLICY REPORT

LOCAL AND NATIONAL

How the public wants the NHS to be both



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FOREWORD



Jon Ashworth is MP for Leicester South and shadow health secretary

The English health and social care system stands at a turning point. The NHS remains among our most cherished of institutions. As Labour's shadow health secretary it is my privilege to meet health staff who have dedicated their lives to caring for other people when they need it most. I remain in awe of those who bring so much professionalism and personal dedication to their work. And I am also lucky enough to spend time with patients across the country who tell me about their experiences as service users.

As we look now to renew health care in the 21st century we confront similar questions to those posed when Labour first set up the NHS in the 1940s. How inter-reliant are health and social care? And how well can one be maintained in isolation from the other? It is pretty obvious now that to safeguard our NHS, universal and free at the point of need, we need to address the funding challenge and the gaps in provision which have beset social care, especially since 2010.

If Labour is to protect and reinvent the NHS, then the greater involvement of local communities and better joint working across NHS and local authority boundaries are both necessary and inevitable. Neighbourhood decision-making will play a role in ensuring that services are fit for the future, but also in providing whole population care which keeps people well and out of hospital.

If you want to make any changes to the health system, perhaps the most crucial factor is to take people with you. Public opinion matters. Residents need to understand where they can receive services and what standards they can expect. Without patient support the system fails. This Fabian Society report is an important step in seeking to understand the real public attitudes to some of the changes which are currently being proposed.

Recent developments in England's NHS, including the Five Year Forward View and innovation in vanguard areas, have set out the potential for community-driven service transformation which better meets the needs of the people who live in those communities. In Manchester, in Cornwall and at borough level in London, diverse devolution plans are taking shape which have in common a desire to let neighbourhoods shape their own services around their own health and care needs.

How do we accommodate these changes within the framework of a universal national service, with national standards? Universal coverage must remain a priority. And we are still waiting to see what health devolution will mean for transparency in decision-making and for public understanding of the standards people can expect from the NHS. Too often devolution under the Cameron and May governments has meant localising blame and shifting responsibility for unpopular decisions. Accountability is key.

The sustainability and transformation plans (STPs) currently being drawn up across England have shown that health and social care leaders are prepared to be ambitious in redrawing services across sectors and across geographical boundaries, but the scale of change being proposed is not currently being matched by funding from national government. Service change at this scale requires investment and it needs to be front-loaded. It is not clear that the current government is prepared to pay for the changes local providers say are required. What's more, if STP plans are merely about filling financial holes in government spending, they will neither command nor deserve the support of patients and their families.

This report attempts to resolve some of these issues, and to help us better grasp the context in which these decisions are being made. There is clear public support for local decision-making, but also, above all, there is a desire to maintain the universal service which we have come to rely on. For the Labour party to meet these expectations, we must find ways to harness local decision-making, energy and accountability in order to drive the changes we need to keep English communities fit, healthy and well in the 21st century. **F**

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**FABIAN
SOCIETY**

A Fabian Society report
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Like all publications of the Fabian Society, this report represents not the collective views of the Society, but only the views of the individual writers. The responsibility of the Society is limited to approving its publications as worthy of consideration within the labour movement.

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INTRODUCTION

Time to transform

Andrew Harrop and Tobias Phibbs
spell out the challenges ahead
in devolving healthcare

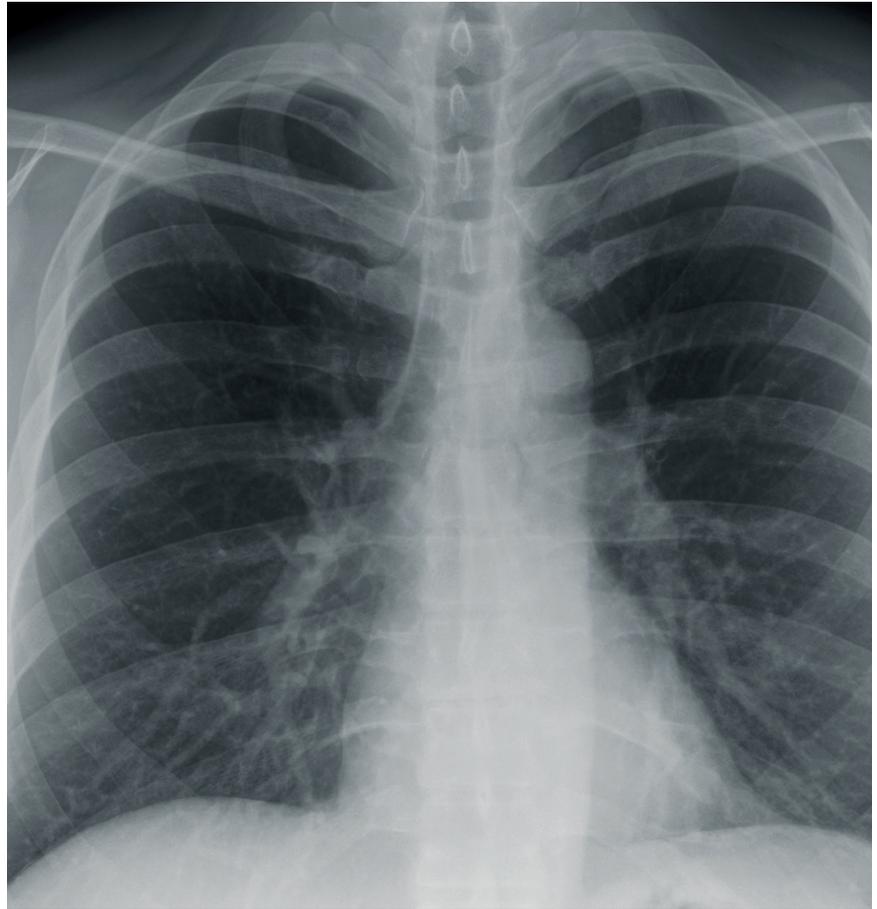
IT IS EARLY days for the devolution of health-care, but NHS localism has the potential to transform how public services are delivered in England. It offers the opportunity to make the NHS – a cherished 20th century institution – fit for the 21st century: responsive to local variation, accountable to communities and working to promote good health and wellbeing. Devolution to cities and counties also has the potential to speak to our political moment, by making manifest the public's desire to take back control.

Yet Fabian Society research conducted for this report shows that while people may have heard the term 'devolution', there is virtually no public understanding of what it entails. And while people believe that local control will improve healthcare and welcome public participation in NHS decisions, they are also deeply committed to the principle that healthcare entitlements and standards should not vary from place to place.

Perhaps all this should come as no surprise, as health devolution has so far been a technocratic exercise that has been conducted largely behind closed doors. The challenge for politicians and public service leaders is to find ways to enshrine meaningful public participation and accountability into the devolution process, so that power really is transferred to people in their localities, without the quality of service suffering.

The report begins by presenting the key findings of our research. Then Richard Vize and Jessica Studdert respond to our findings, commenting in particular on the evidence of low public awareness and understanding of NHS devolution and how people can shape local decisions.

Lord Smith and Iain Chorlton describe the progress of health devolution in



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Greater Manchester and Cornwall respectively. Smith explores the opportunities devolution presents for innovation to adapt to local situations, while Chorlton looks at the way the new settlement is enabling services to work together on preventing ill health, with the potential to transform health outcomes in rural Cornwall. Will Tuckley and Nabihah Sachedina report from London, where pilot schemes in Haringey, Hackney and elsewhere are honing in on the health issues that are most pressing locally.

There are significant further risks if devolution is done badly

All the 'insider' contributions recognise that devolution is no panacea, while the two most significant challenges the NHS faces are chronic underfunding

and an ageing population. And there are significant further risks if devolution is done badly. The risk is that health localism exacerbates the very divide which it should heal: in her essay, Lisa Nandy MP rightly points to the risk that devolution leads to big cities dominating to the exclusion of towns and rural areas; and city halls dominating at the expense of communities.

And Warren Escadale contrasts the formal, technocratic devolution process with the work his own organisation is doing in attempting to generate the kind of cultural shift in state-citizen relationship that would realise devolution's grander ambitions.

Together, these contributions provide a much-needed appraisal of the devolution of healthcare – where it is succeeding and where it is falling short. But above all, this collection points to how devolution might be done differently in the future, in a way that is democratic, accountable and delivers on its promise of locally responsive and better healthcare for all. **F**

FABIAN SOCIETY RESEARCH: THE FINDINGS

The Fabian Society carried out research in September and October 2016 into public attitudes towards health devolution. We carried out qualitative research on reactions to health devolution in Greater Manchester (page 5) and commissioned an England-wide poll on views on NHS localism (page 9). The research was carried out by Andrew Harrop, general secretary of the Fabian Society, and Tobias Phibbs and Tara Paterson, both researchers at the Fabian Society.

Devo Manc: the local perspective

People want local input into healthcare but not at the expense of equality, as *Andrew Harrop, Tobias Phibbs* and *Tara Paterson* explain



IT IS NOW almost a year since Greater Manchester assumed oversight of the region's £6bn health and social care budget. In September 2016, prime minister Theresa May applauded the city for having "led the way" and affirmed her commitment "to seeing [devolution] continue, giving people more control over decisions that affect them".

'Devo Manc' – as the health localism initiative is known – is at the forefront of the government's devolution agenda. But so far there has been little attempt to understand what the public thinks about it, and how it might give people more control over decisions. New Fabian Society research addresses the urgent need to understand public attitudes to Devo Manc and similar future initiatives.

We carried out three deliberative focus groups to discuss Devo Manc specifically,

as well as wider reactions to health localism and people's priorities for a locally led health service. The focus groups took place in Newcastle, central Manchester, and a suburb in Greater Manchester. We selected two very different areas of Greater Manchester in order to discuss devolution of healthcare powers to the city-region; and, by way of contrast, Newcastle where there were plans for devolution which did not include healthcare (and which have now been put on ice).

Overall, the intention behind healthcare devolution – as May put it, to "give people more control over decisions that affect them" – tapped into a strongly held sense among participants in Greater Manchester that local people, be they councillors, clinicians or residents, are in the best position to decide what their community needs. They may need strong financial oversight

from government or other 'experts' but, ultimately, the Mancunians we spoke to want someone local to be in control.

And while few Manchester participants wanted direct involvement themselves, they did want to know what's going on and to see that decision makers are held to account. Mechanisms to facilitate this type of connected, community-driven health governance have yet to be developed.

By contrast, when the participants in Newcastle were told about Devo Manc, they were much less enthusiastic about power and money for healthcare being devolved to their city. The focus groups revealed seven key insights:

1. 'Devolution' is familiar, but its meaning is not: Many participants, especially in Greater Manchester, had heard the word devolution and knew



about a new mayor but few felt that they really understood what devolution meant – and most people hadn't heard about healthcare devolution.

Despite considerable media attention, many focus group participants in Greater Manchester had not heard of the city-region's health devolution deal. Two participants in central Manchester were very aware of the initiative and some others in both Manchester groups said that media headlines about Devo Manc were slightly familiar, upon being shown them; but most said they could not remember hearing about it. "I've not read, heard or am aware that Manchester's taking control of its own share of the kitty," said a man in suburban Manchester.

A central Manchester participant said: "There's such a lot about devolution, anyway. I can't quite remember if I saw that about the NHS, or just about devolution in general." 'Devolution' was a recognised buzzword, but for many no more. "I've heard about all the devolution talk, but to be perfectly honest, I haven't a clue what it means," noted a Newcastle participant. The

main change participants tended to associate with devolution was the new elected mayor role.

2. People in Greater Manchester broadly welcome Devo Manc: However, initial impressions of Greater Manchester's health devolution varied between the groups.

Focus group participants in central Manchester were the most positive about health devolution, with one participant describing it as "quite a coup for Greater Manchester." Although some in this group were cautious ("Who's holding the purse and are they capable?"), most of the participants shared the view of the member who said that the plans were "going to be a lot better for the north, if the north can actually get the money from the government itself."

Suburban Manchester participants were slightly more sceptical, but still broadly approved. One woman in suburban Manchester summed up her initial reaction: "It sounds very good but probably won't be."

Newcastle participants were more circumspect. They wanted to 'wait and see'

how it turned out in Greater Manchester and were not particularly enthusiastic about the north east adopting the same approach. Participants thought it would "be a wise idea to see how Greater Manchester deal with it, see if they benefit from the devolution" before supporting health devolution in Newcastle or the north east.

3. Local input is seen as vital: Greater Manchester participants, in particular, believe that local perspectives were vital for effective healthcare. They believed that local actors (councillors, clinicians, managers, residents) understood the area and its needs far better than national leaders.

Broadly speaking, people felt that local residents and decision-makers understood their communities better than "some faceless bureaucrat down south", as one participant put it. One participant from suburban Manchester said: "I think we know more what we want in our community than national leaders know. For example, this [service] that's closing down, we know more, we want it to stay open."

FABIAN SOCIETY RESEARCH: THE FINDINGS

There was a sense that having decision-makers closer to home allowed for greater accountability and transparency. As a woman in the central Manchester group put it: *“People need to be accountable, don’t they, and if I can go and see somebody and make them account for why they’ve done that, it’s going to be much easier.”*

4. People don’t want locally tailored care at the expense of geographic equality: Almost all participants were concerned about equal access to top quality care, even if they also supported local decision-making.

The principle of fairness was very important to most participants across all groups; as one argued: *“Everybody should be entitled to the same level of care, and the same services, regardless.”* While participants often favoured local decisions (at least in Manchester), there was a sense in all three groups that people across England should receive equitable access to care. In a survey at the end of the discussions, 17 out of 23 participants agreed with the statement *“Healthcare should be the same across the country so nobody loses out.”* 13 also agreed that: *“Different communities have different needs so healthcare should be delivered differently in different places.”*

When people were asked to choose between local autonomy or national consistency, they tended to answer the question with reference to fairness. Some worried that devolution could worsen healthcare’s ‘postcode lottery,’ if funds or resources weren’t distributed equitably. Participants worried about patchy service quality – *“We shouldn’t have any hospital that’s poorer than another”* – and different entitlements: *“Everybody should be entitled to the same level of care, and the same services, regardless.”*

On the other hand, some also felt that localisation could mean that communities’ specific needs would be better addressed, leading to fairer outcomes. The argument was that for *“poorer areas, where the health is poorer, they need more money, don’t they? Say for Liverpool, Newcastle, areas like that, they’re going to need more money than, say, London, which is a much more affluent society.”* Even here, however, there was a

sense that there should be basic services and resources that everyone receives.

5. There is disagreement about who should shape local decisions: Our participants were not in agreement about which local actors would be the most effective in representing the community and making decisions.

Overall, clinicians were the group people said should have the most say, followed closely by NHS managers. Some participants believed that local clinicians understood the community best because *“they listen to us spouting with our worries and whatever, and they get a good feeling of what the public’s all about”* or because they had the most knowledge and expertise: *“[Doctors] know best, don’t they? They are the people in healthcare; they are the top people; they’re the ones that look after you and diagnose you, and treat you, etc, so really, they’re the ones that know the most, and they are the experts in healthcare.”* But several other participants worried that doctors did not have the necessary skills – *“I would’ve put doctors last [in the ranking], to be quite honest because they’re clinicians, they’re not business people,”* – or the time – *“They haven’t got time, basically”* – or the motivation – *“doctors most probably would all look after their own interests.”*

Overall, however, healthcare professionals were more popular decision-makers than councils and councillors. Some believed that councils and councillors could coordinate care and services in the community, however others felt that councillors lacked understanding about healthcare and didn’t communicate with their constituents. Ambivalence about local government involvement in healthcare sat alongside a belief that the NHS should prioritise treatment over broader work with other agencies to prevent illness (a stronger focus on prevention and public health is one of the main reasons for bringing health and local government closer together, and hence also for health devolution). The participants all recognised the importance of prevention, but largely saw it as the responsibility of other public services. Some worried that a focus on long-term changes in behaviour would mean fewer resources for healthcare now:

“Have we got time to make those changes at the cost of what we might be taking away from the diagnosis and treating?”

In all the groups, new elected mayors were regarded as unfit to oversee healthcare. When asked: *“Who should have the most say in decisions about healthcare in your community?”* all but three participants across all the groups ranked the mayor last. It seemed that the city-region mayor lacked the appeal of both the national actors (more expertise) and local actors (more understanding). *“What does he know, really, about the health service and what we need?”* asked a participant in suburban Manchester. However, it is important to note that the focus groups took place more than six months before the new positions even existed.

6. A desire for ‘experts’ being in control, especially in budgeting and management: Participants in all the groups valued expertise. They wanted assurance that health funding was in capable hands, which some believed requires national oversight.

All three groups identified a need for expertise in health service management. This was particularly pronounced in discussions about budgets. In Greater Manchester, many participants expressed concerns about who would manage the city region’s £6bn health and care budget and whether they would be capable. There was a sense that health spending wasn’t particularly well managed now, with participants in each group criticising ‘waste’ in the health service. Some participants in the Manchester groups took this as an indication that national actors currently in charge were ineffective and that local councils or NHS managers could do a better job.

The Newcastle group largely considered national actors to be more capable and experienced in overseeing the health service, however. Newcastle participants worried that if they followed Manchester’s path and allowed local control of health spending then money could be mismanaged and *“run out.”*

Notably, those who were strongly supportive of local residents having a say on services and care, still believed that financial decisions were too important and

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complex for local residents to weigh in on without 'expert' guidance at the very least. *"I'm not educated enough to know what we should be investing our money in,"* was the perspective of a Newcastle participant.

7. People want information and transparency, if not direct decision-making:

There was little support for residents having direct control over decisions but people wanted to feel informed and empowered. In the Greater Manchester groups, several participants said that local residents deserved to be heard and worried that no one told them about local decisions or opportunities to participate.

The focus group participants said that local residents should have less influence over healthcare decisions than other more 'expert' actors we asked them about. The participants in Newcastle were unanimous in their beliefs that local residents didn't understand enough to contribute to healthcare decision-making, but some in the Manchester groups took a different view.

One woman in central Manchester argued that suitably qualified local residents should be involved: *"I think there's also something about making sure that whatever level they're deciding what's happening ... local people are represented, not just local councils, but local people somehow representing different parts of Greater Manchester, or different illnesses, or whatever, so there's people who've got really good local connections, and the skills to have some influence on that group, because I think it's quite hard to influence people if you've not got the skills."*

Participants across all groups said they felt that local residents did not currently have much power to influence the health service. Several indicated that they were not aware of ways to get involved or give feedback. As one participant in central Manchester put it: *"I've never been asked to give my opinion on anything, it's just never happened that the residents have got anything to do with the NHS. Nobody's included."* In Newcastle, the participants were even more unanimous, insisting that local residents have *"very little, if any"* power and that they *"wouldn't even know how to voice [their] opinion about it."*

There were a few cases where participants did recognise existing patient participation mechanisms, however. Feedback surveys were mentioned spontaneously in all three groups, for instance. Some expressed appreciation for the opportunity to take part: *"I got a text message recently, from my experience in hospital... they wanted to know comments and all sorts of stuff on this text message. I thought, wow, OK. I filled it all in. I thought it was quite an innovative thing to do."* But more people were sceptical about whether patient surveys made any difference, even if their intention was positive: *"It probably ends up in the bin."*

When we asked people if they would be personally interested in taking up different forms of 'people power', few participants found options to lead community initiatives or participate in health service decision-making appealing. These options were thought to be too time-consuming; they were believed to require a level of expertise that participants felt most local residents, including themselves, did not possess; and they were believed to be ineffectual. As one Newcastle participant said: *"You might get more people involved if they thought they could make a difference."* But many people did want the option of power, if not power itself. A woman in urban Manchester stated: *"People aren't stupid. Just explain to people what their options are, whether they take it or not"*.

In general, people in the focus groups

were more enthusiastic about having greater power over their own care than community-wide participation. They wanted to choose their provider, co-direct their care and give feedback, more than take part in collective initiatives. Some people spoke warmly about the power and choice they had been offered, while others were sceptical about whether personal control was feasible in an overstretched NHS.

Overall, there was a sense that communication should be improved between the health service and local residents: *"If it's about local and getting everyone involved, then you need to make sure that you are getting everyone involved, and making us aware about what's going on."* A sense that there needed to be more transparency and communication was echoed by several participants, especially in the context of health devolution. Even when participants were less interested in playing a larger role in the health service, many wanted to be made aware of decisions taken in their community and opportunities to give input.

The discussions were guided by a range of material. We started by showing media headlines about 'Devo Manc' to assess participants' familiarity with health localism in Manchester. We also showed a video produced by the University of Manchester and provided participants with a '30-second guide' about healthcare devolution from the *Manchester Evening News* to aid their understanding and evaluate their perceptions after being given more information. In addition to open discussions, participants debated contrasting statements and ranked options in order to explore trade-offs.

The Newcastle group was told about plans for Greater Manchester and asked to discuss whether they would like to see something similar in the north east. In the week we conducted the Newcastle focus group, plans for a north east devolution deal were put on hold. Interestingly, the contrast between the Manchester groups and the Newcastle group suggested largely opposing attitudes towards localisation, with Newcastle participants expressing far more scepticism towards local control. However, these small groups only provide a snapshot of opinion, which may not reflect the views of the population of each community. **F**

ABOUT THE FOCUS GROUPS

We conducted three deliberative focus groups in September 2016, each with eight participants lasting two hours. Two of the groups were held in Greater Manchester (one suburban, one city centre) and one in Newcastle. All participants had used the health service in the last 12 months. At least two participants in each group had children under 16 years of age and at least two participants in each group were over 65. Their members ranged in age from 25 to 75 years old and were in socio-economic groups B, C1 and C2.

Health localism: what the English public thinks

Andrew Harrop, Tobias Phibbs and Tara Paterson outline the findings of a national opinion poll for the Fabian Society

OUTSIDE OF GREATER Manchester there has been very little public debate about healthcare devolution. So how does the public in England react to the idea of NHS localism, in the absence of any significant national discussion? A Fabian Society opinion poll examined different dimensions of this question and revealed that handing power to local decision-makers could attract support, under the right conditions.

YouGov surveyed a sample of 1,405 adults living in England, with fieldwork undertaken between 13 and 14 October 2016 (the survey was carried out online and the figures have been weighted and are representative of all GB adults). There are five key findings.

1. There is significant support for the principle of local leadership of the NHS

46 per cent of people think services would be better if healthcare was managed locally, compared to only 18 per cent who think that healthcare is best when controlled nationally. When asked who should have most say in decisions about local healthcare, only 12 per cent said national government (respondents could name 1 or 2 groups).

On balance, which of these statements comes closest to your view? (%)	
<i>If healthcare was managed locally, services in my community would be better</i>	46
<i>Healthcare is best when national leaders and organisations are in control</i>	18
<i>Neither</i>	14
<i>Don't know</i>	22

2. But this support for local leadership is entirely conditional on devolution happening in a way that avoids 'postcode lotteries'

Four times as many people agreed with a statement supporting uniformity 'so nobody loses out' (71 per cent), over an alternative statement supporting diversity of provision in response to local needs (17 per cent). Some of the demographic groups that are most likely to believe that local management can make health services better are *also* the most resistant to postcode lotteries – ie women, older respondents, working-class respondents and people who voted 'leave' in the EU referendum.

On balance, which of these statements comes closest to your view? (%)	
<i>Different communities have different needs so healthcare should be different in different places</i>	17
<i>Healthcare should be the same across the country so nobody loses out</i>	71
<i>Neither</i>	4
<i>Don't know</i>	8

3. Support for the idea that health localism could improve services is explained by a strong commitment to clinical leadership and some support for local residents having more power

When asked who should have the most say in decisions about local healthcare, clinicians were by far the most popular group (named by 65 per cent). Local residents were the second most popular group (named by 24 per cent) and were particularly popular with older voters, working class respondents and 'leave' voters.

Who should have the most say in decisions about healthcare in your community? Please tick up to two. (%)	
<i>Doctors and other health professionals</i>	65
<i>Local residents</i>	24
<i>NHS managers</i>	15
<i>National government</i>	12
<i>Local councils or councillors</i>	9
<i>Someone else</i>	1
<i>Don't know</i>	15

People in these groups were also likely to agree with a statement suggesting that local residents should have more say over healthcare, compared to an alternative which stated that healthcare decisions should be left to experts. Among the whole population, slightly more people supported decision making by experts (38 per cent) than giving residents more of a say (34 per cent).

On balance, which of these statements comes closest to your view? (%)	
<i>As a local resident I should have more of a say over how healthcare is delivered in my community</i>	34
<i>Local residents don't understand enough to help make decisions about healthcare. This should be left to the experts</i>	38
<i>Neither</i>	13
<i>Don't know</i>	15

4. Support for more resident influence does not equate to support for more power for democratically elected councils – but there is a degree of support for integrating health and local government services

Only 9 per cent of people believed that councils and councillors should have the most say on local healthcare (when asked to name one or two groups). But there is a degree of support for integrating healthcare and council-run care services, which implies council involvement in healthcare decisions and is one of the main reasons for pursuing NHS devolution. Exactly the same numbers support and oppose statements on the idea of a single organisation running both health and social care (39 per cent each). The demographic groups most likely to support integration are people aged 50–65 (who may be concerned about their parent's health and care needs) and people who voted 'remain' in the EU referendum.

On balance, which of these statements comes closest to your view?	
<i>The NHS should run medical services, while local councils should be responsible for the care of older and disabled people</i>	39
<i>A single organisation should run both medical services and care for older and disabled people together</i>	39
<i>Neither</i>	5
<i>Don't know</i>	17

Only **9 per cent** of people believed that councils and councillors should have the most say on local healthcare

60 per cent would be interested in choosing between alternative services; and **30 per cent** would like to decide on their own treatment or support

People were **evenly split** over whether or not a single organisation should run both health and social care

5. When asked about the ways in which respondents would personally participate in local healthcare, low-effort and personally-relevant options were most popular

(1) *Personal choice*: 60 per cent would be interested in choosing between alternative services; and 30 per cent would like to decide on their own treatment or support. (2) *Giving back, as an individual*: 47 per cent would be interested in providing feedback on their care, and 29 per cent would consider taking part in medical research. (3) *Collective action*: 17 per cent would be interested in attending meetings to discuss services, and 8 per cent would help run a local group of people with their health problem.

There are lots of ways people can participate in local healthcare. Which of the following, if any, would you personally be interested in? Please tick up to three.	
Choosing your hospital, GP surgery or doctor	60
Taking part in a survey after a hospital visit to provide feedback on your care	47
Deciding for yourself what treatment, care and support is right for you	30
Taking part in a medical research study	29
Attending meetings about the way healthcare is delivered in your community	17
Helping run a local group for people with the same health problem as you	8
None of these	6
Don't know	10



Only **8 per cent** of people would like to run a local group for people with the same health problems as them, while **60 per cent** would like to be able to choose their hospital, GP surgery or doctor

Conclusion

Overall, the survey shows there is the *potential* for healthcare devolution to attract the support of the English public, since there is strong support for the statement: ‘if healthcare was managed locally, services in my community would be better’. However that support is likely to be conditional on the NHS being able to demonstrate that post-code lotteries can be avoided and that clinicians will shape decisions. Support for devolution could also run up against barriers with respect to civic participation, as there is little public appetite for becoming personally involved in shaping decisions and little support for elected councillors or councils playing a greater party. **F**

THE ENGLAND-WIDE POLL AND THE FOCUS GROUPS COMPARED

There is a good deal of consistency between the findings from the three focus groups and the nationally representative survey. There are however some differences, which may be explained by the deliberative qualitative technique used in the focus groups, or by the fact that focus groups are not intended to be representative of the balance of public views.

In both studies a majority of people thought more local decision making would improve healthcare, and were supportive of local clinical leadership. But most participants were also opposed to post-code lotteries, sceptical about local government involvement in the health service and unenthusiastic about personally taking part in decisions.

The most interesting contrast between the studies is the greater respect for ‘experts’ evident in the focus groups. The participants in the groups spoke up for the merits of national leadership and professional management and most were sceptical about residents having more control over decisions. In the national poll almost as many people wanted residents to have more of a say, as wanted decisions left to experts.



Winning hearts and minds

Richard Vize says health and council leaders need to work harder to get the public involved

THE NHS HAS always struggled to find the right relationship with patients and the public. Clinicians and managers know that listening to local communities and service users helps them to understand what matters and identify ways the system can be improved, but virtually all parts of the health service find it difficult to do.

The need to get this relationship right is brought into sharp focus by the move to devolve control of health services to local areas. While Greater Manchester and other places are gaining additional powers over health through devolution deals signed between ministers and groups of councils, every part of the country has a greater decision-making role in the future of their local services through the sustainability and transformation plan (STP) process.

Under this programme, the country has been divided up into 44 areas, each of which has delivered a proposal to NHS England on how it will make the local health economy clinically and financially sustainable. This means sorting out hospital deficits, and moving care from hospitals to the community to keep people with long-term conditions living independently for longer at lower cost to the state. Crucially, councils are often playing a central role in devising STP plans. Consultations on them has barely begun; excessive secrecy in the early stages predictably triggered a wave of “secret plans for NHS cuts” headlines, maximising the chances of public opposition.

‘Devo deals’ and the STP process are driven both by a recognition of the harm caused by years of excessive central control of the NHS, fettering the ability of

managers, local politicians and the public to shape local health priorities, as well as the growing respect for local government as effective leaders of communities and managers of services. For the first time, place and community are central to health service planning.

But the Fabian Society polling and focus groups reveal how little the public understands the term ‘devolution’. This May’s elections for ‘metro mayors’ in places such as Greater Manchester, Liverpool City Region and West Midlands may encourage wider understanding, but with a mixture of mayors, combined authorities, councils and health service structures involved, it is hardly surprising that few people have a clear idea what it all means.

The research also highlights ambivalence over who should exercise local control, and a conservative view of how much latitude they should have to make changes.

Inevitably the ‘postcode lottery’ comes into play, with a strong desire for uniformity rather than responding to the varied needs of different communities. With a handful of clinical commissioning groups now pushing the legal boundaries of their powers to restrict access to some services, simply to save money, pressures around this issue will only grow.

The public prefers health decisions to be guided by evidence rather than politics

The overwhelming support in the polling for clinicians – as opposed to managers – making decisions about local health services exposes one of the major weaknesses in attempts to involve the public, namely the lack of trust in those running the services.

This is often exacerbated by the use of opaque, patronising language in consultation documents which fail to spell out exactly what services are going to be delivered and how. Trust is further undermined by a lack of openness around issues such as the need to save money.

Michael Gove will be disappointed that support for ‘experts’ remains, with 38 per cent backing the statement that “local

residents don’t understand enough to help make decisions about healthcare. This should be left to experts”. Around 34 per cent wanted local residents to have more say. In the focus groups support for experts was stronger still.

The government’s decision not to give metro mayors powers over health is supported by the research; all the focus groups regarded mayors as unfit to oversee healthcare. Support for giving power to councillors was weak. Coupled with the support for experts, these results indicate that the public prefers health decisions to be guided by evidence rather than politics.

There are tough messages in the research for health and local government leaders about how they involve the public in healthcare.

They need to work far harder at explaining what devolution means for local people and how they can get involved in consultations and decision-making.

Careful thought is required on what exactly the public are consulted on and how it is done. People need to be involved in discussions that matter to them, such as services they are likely to use, rather than broad, vague policy questions.

Involvement needs to be early, open and influential. Almost invariably, consultations over changes to health services come at the end of the process, when the public is confronted with a proposal which is unlikely to be changed. Public involvement from the beginning allows valuable insights to shape the ideas at the heart of the project.

Early involvement is also far more likely to engender trust in what service leaders are trying to achieve; as endless attempts at changing hospital services have proved, springing a plan on people – particularly one which looks like a cut – risks being swiftly mired in stubborn opposition.

However, the research also reveals the limits of public involvement in health devolution. People insist on transparency and openness and an opportunity to have their say, but only a minority will ever get involved. **F**

Richard Vize is a columnist for the Guardian Healthcare Network, contributes to the British Medical Journal and has worked with a range of organisations across health and local government over the last 25 years



Building real people power

Honest local dialogue will allow for a better focus on prevention, as *Jessica Studdert* explains

THE NHS, UNIVERSALLY accessible and free at the point of use, is one of Britain's most dearly loved institutions, the vast majority of us having literally been born into it. As a consequence, it is deeply embedded in the British psyche and commands consistently high levels of public support.

This is a commendable achievement, but it makes reform difficult. Our national political debate adds further complications, tending as it does to focus on the dichotomies of 'public versus private' or spending versus cuts', rather than the nuance of necessary reform.

And practical change has never been more urgently needed. Our 20th century model of healthcare is struggling to cope with the demands of our 21st century ageing population and lifestyles. Simply spending more might help in the short term, but it is not sustainable in the longer term over which the challenge is to shift the centre of gravity of the system away from crisis and acute provision towards integrated, community-based care.

The Fabian Society's research findings highlight some important dimensions of public attitudes to healthcare, which devolution has the potential to address as part of a route to sustainability. People support the principle of local decision-making, and there is evidence they appreciate the reform imperative to move away from a hospital-led model. The focus groups overwhelmingly preferred a more distant specialist service to a closer generalist hospital. They broadly sympathise with the need to shift investment away from treatment towards prevention, although not when treatment

and prevention are presented as zero-sum. Some participants understood the need for our health to become a wider responsibility of services other than hospitals, such as education and planning. Embedding this responsibility is crucial if the wider determinants of health outcomes, those non-clinical social, environmental and personal factors identified by Sir Michael Marmot, are to be systematically addressed.

This latent sympathy for the aims of reform needs to be activated by local leadership and deeper engagement as part of a more devolved approach. The research uncovers an 'influence deficit' in the current nationally directed system, with focus groups identifying a strong desire for more information and transparency. New devolved models of healthcare will need to move beyond rudimentary and reactive patient feedback mechanisms and instead create effective engagement, co-design and feedback loops with people. To rebuild faith in the system, the combination of directly accountable politicians and more trusted clinical leadership will have to work in tandem. There are lessons for the wider, NHS England-led sustainability and transformation plan process, which is reconfiguring services but with little or no transparency or public engagement.

Making the case for reform will take a huge degree of political courage

Effective leadership will need to build people's confidence in the system and how it is best aligned to tackle our healthcare needs, but it will also need to challenge some false assumptions. The evidence of an aversion to postcode lotteries, with strong support for uniformity over variability, is perhaps unsurprising given people's deeply held expectation of equitable access to NHS provision, a key founding principle. Yet the survey question related to outputs – services – rather than actual *outcomes*. One of the most concerning postcode lotteries that exists under the current national model is the lottery of life expectancy. Indeed, tackling life expectancies in the area that are below the national average is a key motivating factor galvanising partners across Greater Manchester.

There is an opportunity for devolution to shift the focus of local public discourse on healthcare from the protection of standardised outputs to making the case for better and more equitable outcomes. At present, the most active engagement on healthcare comes from local campaigns against a proposed local hospital closure. Given the evidence that people are open to the underlying need to realign provision away from more generalist services towards fewer specialist services, we desperately need a more constructive local democratic dialogue focused on desired ends so creating space for necessary reform, which will involve service realignment.

At present, the systematic lack of empowerment under the national model appears to foster a sense of people being buffeted by decisions rather than being involved in them. But as one participant noted: "People aren't stupid, just explain to them what their options are." Making the case for reform will take a huge degree of political courage, but the discussion is a necessary one, and one that must be led locally so that people understand the trade-offs.

Finally, some of the evidence indicates that people have a tendency to outsource decisions over their healthcare to experts. It is not clear if people's lack of trust in their own judgement and instinct over their personal health and care needs is related to the endurance of a dominant institution like the NHS which has traditionally done it for us. But for services to be sustainable they must be more geared to caring 'with' rather than 'for' people, with far greater levels of personal awareness, responsibility and autonomy.

The irony of our present situation is that we have a National Health Service, but we need a model which emphasises the opposite on all three counts: local wellbeing systems. This would involve everyone – people, professionals, other public services and employers – all playing a much more active role in prevention. At the heart of this shift, devolution needs to foster an honest local dialogue that involves people in decision-making, promotes responsibility and articulates a positive shared future, so that our health and care system is fit for purpose. **F**

Jessica Studdert is deputy director of the New Local Government Network



Seizing the opportunity

Strong partnerships are at the heart of Greater Manchester's approach, writes *Peter Smith*

AS CHAIR OF the Greater Manchester Health Partnership, I am sometimes asked why Greater Manchester local authorities ever get involved with health. Apart from health's obvious complexity and the enormous £6bn budget, the more sceptical simply believe we are delivering government health policy and giving it more credibility. While we recognise there are major challenges in health devolution, we believe that the opportunities outweigh them, particularly the benefits of closer integration of health and social care.

Our work on devolution and in particular public service reform has shown us the importance of integration and the need to challenge established arrangements to achieve our objective of a healthier – and wealthier – population in Greater Manchester. Many of those trapped without employment have health and other social issues and we need a holistic approach if we are to be successful. Health devolution has given us the chance to work in

place-based ways to tackle these deep-seated problems. Our health plans include, in addition to the expected health objectives, employment and child school readiness targets.

For all its great achievements in its 69 years of existence, the NHS has suffered from unnecessary and debilitating centralisation. From day one, what Bevan described as the “bedpan” approach allowed the centre to interfere in relatively trivial areas and discouraged innovation. One of the consequences has been that, although overall levels of health have improved, health inequalities remain as stark as ever and nowhere more so than in Greater Manchester. It took a long time for the NHS and Department of Health to recognise that health outcomes were not simply dependent on health inputs. Instead, as Sir Michael Marmot showed in his books *Status Syndrome* and *The Health Gap*, lifestyle and social factors influence health outcomes. The only way these can be effectively overcome is for health care to take a place-based approach working with appropriate local partners including the voluntary and community sector. This is one of the great opportunities devolution presents.

Greater Manchester is not immune from the two key pressures that are placing strain on the NHS: ageing and funding. Our ageing population has an impact on all aspects of health, from GP services to acute hospitals. We can't wait until there is a national solution to the funding crisis in social care. In Greater Manchester, we have the ability to integrate more effectively through our partnerships. Many of the problems with winter pres-

ures in acute hospitals result from delayed discharges and performance is currently unacceptably varied. So we can learn from best practice.

Funding remains a serious issue and, although the government has put in additional resources, the demographic pressures and demands to achieve more – such as 24/7 working – mean that the system is creaking at the seams and problems in one part of the system are soon felt across the piece. There does need to be an injection of more cash but there also need to be new ways of delivering health care with a greater emphasis both on keeping people healthy and keeping them out of hospital for as long as possible. The first will be achieved by a bold and ambitious population health strategy and the second by initial investment in primary and social care. Part of the Greater Manchester devolution deal was a transformation fund of £450m and already we have invested in local care organisations in four localities – with the rest to follow. We hope that these will support the growing older population to remain in their own homes as long as possible.

In Greater Manchester we are using our unique partnership to up our game across a range of key health issues. We have a number of world-class hospitals, such as The Christie, and we intend to build on that strength to raise our performance in delivering better cancer services. Our Dementia United programme engages across a range of partners to provide a more joined-up service for both patients and carers. In each of these exercises we are tapping into the considerable experience and expertise found in voluntary groups.

Health matters in Greater Manchester and we intend to seize the opportunities created by devolution to make our 2.8 million residents healthier, wealthier and hopefully happier. Our plans outlined at both locality and Greater Manchester level are publicly available and transparent and are fully supported by our partners and, after a consultation, by the public. We now have to deliver. **F**

Lord Smith of Leigh is leader of Wigan Council and chair of the Greater Manchester Health and Social Care Partnership





Owning our communities

As the pressures on services mount, we need a new model of participation, writes *Warren Escadale*

AT VOLUNTARY SECTOR North West, where I am chief executive, we are convinced of the importance of public voice and participation in devolution. For us, creating a new model of participation is about broadening ownership of the future of our communities and changing how we work together, rather than merely establishing a new local framework. Simply shifting power from Whitehall is not enough.

At VSNW, we see major potential for devolution to address inequality and tackle entrenched disadvantage. This could be achieved through: social change driven by communities, sparked by voluntary, community and social enterprise sector (VCSE) trust and energy; growth strategies that are responsive to the challenges facing communities in everyday life; a re-energisation of democracy that connects citizens to service design, delivery and accountability; and reimagining the role of VCSE groups in communities and across emerging geographies.

It would be a mistake to be naïve or complacent about devolution, though. As John Diamond from the Edge Hill University Business School wrote in our 2014 publication, *Devolution, Our Devolution: "The city region provides an organisational framework to introduce Austerity 2.0"*. This is the chilling threat that devolution poses. But there are opportunities too.

There is a chance to move beyond a merely reactive response and to begin to create new social, economic and political models with a different understanding of what participation could mean.

Pressures on public services are mount-

ing and it looks unlikely that we will be able to spend our way out of trouble. Age UK's recent report on social care, which showed we are running out of time to save the social care system for older people, is the latest sign that we're getting nearer to the critical point. Less funding, with more to do, will require a fundamental shift to avoid a fundamental snap.

The World Bank's classic model of national policy development circumscribes a large, virtuous 'policy loop': central policy development reacting to national need, implemented locally and modified nationally based on implementation feedback. Local reality, in effect, secondary to policy creation; something to be dealt with at the point of implementation. Besides mapping out a hierarchy of intelligence (and democracy), this vision of policy creation and implementation limited the possibilities of what participation could be and could achieve. Currently, local reality and participation can shape very little.

In Greater Manchester, through the Voluntary, Community and Social Enterprise Devolution Reference Group, we pushed for an acknowledgement of the role of VCSE groups in brokering engagement with communities. Our offer was welcomed. And so, in support of the health devolution strategy, *Taking Charge*, members of the reference group held conversations with 1,387 people from marginalised communities. The messages we heard about the barriers to taking charge of your own health went beyond personal motivation and the health and social care system. They included basic, structural barriers such as lack of access to: affordable, good quality food; safe green spaces; transport links; and employment and training opportunities leading to good jobs and careers.

These messages have led me to think that we could develop a very different kind of policy loop. One that hothouses participation and citizen intelligence, and starts with an understanding of how localities work and don't work: honing place and community, not just policy ideas. Significantly, these messages also suggest – and partners in Greater Manchester certainly do not need convincing of this – that health devolution alone cannot address the fundamental barriers.

And this leads me to a second set of

conversations that we have been holding with VCSE groups across the north west. Developed in parallel, these conversations are imbued with Greater Manchester's central ethos of 'place before institution' that sits at the heart of the cultural shift in their devolution and leadership thinking. The conversations consist of three basic questions: What's the dream for your community in 20 years? What are the barriers to that vision? And what could your organisation contribute to making that vision happen?

These conversations get to the fundamental nature of voluntary and community action, an intelligent appreciation of what is happening in our communities (why they work and why they don't), and the beginnings of a clearer understanding of our collective mission as a sector linked to the future of communities. A vision where communities are linked to driving change.

In Greater Manchester, the VCSE reference group framed its mission as: "to eradicate inequality in a generation's time... through citizen-led social movements". It may be unachievable but it is a laudable ambition, which sits at the heart of a collective identity and captures some of the positive spirit of devolution. You can't rethink state-citizen relationships if you aren't willing to be ambitious.

This is a point of disappointment for me in how health devolution in Greater Manchester, the model for sustainability and transformation plans, has been translated elsewhere. The spirit of possibility, partnership and participation, with a genuine chance to drive change, requires a shift in working culture. Devolution increases the range of what is permissible and this includes a consideration of public ownership of health, but there is a danger that this cultural aspect – reshaping the state-citizen relationship and expanding ownership – will be lost amidst a formal drive to transfer power.

Devolution provides an opportunity to create new city and county-region systems, with very different partnerships and state-citizen relationships. At the heart of this must be a fundamental conversation about participation. So, yes, 'place before institution', but also: 'people before place'. ■

Warren Escadale is chief executive of Voluntary Sector North West

Democracy at the core

Devolution must not be allowed to fail – and that means better involving the people, writes *Lisa Nandy*



Lisa Nandy is MP for Wigan

IN A FEW months' time, Greater Manchester will make history, when it chooses its first directly elected mayor. The devolution of power – in a country that for too long has clung on to an outdated model that centralises power and concentrates decision making hundreds of miles from the communities affected – is without question one of the most significant developments in British politics for decades.

For the first time since the NHS was founded in 1948, the devolution of health and social care allows local authorities to undertake a fundamental review of the way services are provided. Not just the physical geography of where and how services are available, but a reassessment of priorities based on the needs of those who use them.

Handing powers over transport, homes, policing, skills and the NHS to an elected mayor could profoundly reshape our public services for good, putting people and communities in the driving seat when it comes to choices that affect their lives, not just in Greater Manchester but across the country. As the UK moves to a more federal structure, the model that is pursued will help to determine who holds power in the UK for decades to come.

But more than two years after the devolution deal was announced in Whitehall and signed behind closed doors in Manchester town hall, the people remain largely shut out of the conversation.

The public consultation on these sweeping changes was not properly publicised, ran for just three weeks and received only 12 responses – 10 of them from the same council leaders that signed the deal in the

first place. It didn't even mention the NHS. When the deal was announced by press release from Whitehall, MPs, councillors and the public had little idea what it was. And as legislation was passed to enable the transfer of powers, it wasn't even clear who in government was accountable for it.

From the outset, a major concern has been that decision-making will not be pushed down to the people, but levelled up from local communities to Manchester town hall. It comes just months after a major redesign of health services in Manchester – 'Healthier Together' – disrupted the collaboration that was already taking place between local areas, taking little account of the reality of people's lives. It pursued hospital closures and a centralisation of services that ignored the needs of families wanting to care for their loved ones, asking people to travel long distances on non-existent transport networks when they already struggled to afford fares on low incomes. It was defeated, but must not be repeated.

Greater Manchester is an ideal testing ground to pioneer these radical reforms, in part because of the good working relationships between local leaders, built over decades. The transfer of health and social care brought a new challenge on an unprecedented scale, bringing together 37 organisations who often saw their interests as in direct competition. It has been a significant achievement to get them to work together.

But Greater Manchester is a diverse area, facing varied and complex health challenges. From my borough in Wigan with a legacy of chronic ill health from

the mining industry, to the challenges of a younger, urban, diverse population in central Manchester, the needs of our populations vary. How will those diverse needs be met? The risk is that decisions are made in central Manchester for the benefit of central Manchester with towns and rural areas just an afterthought.

In the wake of Brexit, where communities in towns and villages across the country demanded a right to be heard, this would not just be wrong, but politically catastrophic. Those areas must be given a voice, and most importantly, the ability to hold the mayor to account.

But currently just two officials are accountable for the £6bn health budget – neither of them elected or accountable to the public. The transfer of power from one unaccountable group of officials in Whitehall to another in Manchester town hall does not look or feel like progress. These major health reforms, the most radical and risky to be proposed since the NHS was founded, have been subject to just one public consultation that ran online and through 10 public meetings across the whole of Greater Manchester. The vast majority of the public are unaware that the consultation 'Taking Charge Together' ever happened, and only 6,000 people in a population of 2.8 million have responded.

All of this has been overseen by an interim mayor who was appointed, not elected, after a decision to impose a mayor was taken from Whitehall less than two years after the City of Manchester voted to reject one. He is accountable only to the 10 people who put him into the job, who also



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make up his cabinet and are jointly responsible for delivering his agenda. The minutes of their meetings are not published and regional journalists have had to resort to the Freedom of Information Act to discover who is making decisions about critical matters such as the redesign of mental health services across Greater Manchester.

Although elected council leaders retain some oversight and decision-making powers, even this is problematic. Last year a report by the Fawcett Society concluded that “so far the experience of the northern powerhouse...risks handing power to male-dominated structures and shutting women out of the decision making process.” Only 21 per cent of council leaders, one in seven chairs of combined authorities, and 28 per cent of senior leaders in the northern powerhouse are women. Only one of the 10 council leaders in Greater Manchester is female.

This was described by one campaign group, whose 2015 survey discovered that 88 per cent of people questioned had never heard of Devo Manc, as treating people with “contempt”. It is not sustainable.

Devolution is necessary, long overdue, and cannot be allowed to fail. The pressures in the NHS cannot be solved from

Whitehall or Westminster. They can only be solved by people closest to these problems taking charge of their own lives. The challenges in Greater Manchester are great. A&Es are under unsustainable pressure from cuts to social care. Cancer diagnosis is exceptionally poor. There is a desperate lack of support, both financially and structurally, for mental health. And under the terms of the devolution deal, there is a £2bn funding gap. It will take every bit of energy and creativity to solve this, and it must start with the best asset we have – people.

A model that does not have the will and support of the people will not survive

That means a cultural shift in the way this process has operated so far. Resources made available to local communities to get involved in this process and help to shape it. Documents must be cleared of jargon and written in a language that most of us can understand. Challenges to the system

must be welcomed and embraced, and formalised through a forum that publicly holds the mayor to account. Just as select committees are properly resourced and supported, councillors should be given the skills, time and resources to scrutinise decision making and highlight where decisions are failing us. Their ability to do this must not be dependent on the patronage of the council leaders who are implementing the mayor’s agenda.

Greater Manchester is dominated by Labour representation, but it is essential in a healthy democracy that an individual as powerful as the mayor is scrutinised on a cross-party basis both to ensure challenge, and to give a voice to people who hold different views. Civil society has not been involved or even consulted. And so far, there are no plans to change this.

A model that does not have the will and support of the people will not succeed. The UK is inevitably shifting towards a federal model and getting this process right is critical. That can only mean a mayor who is accountable to and directed by the needs and lived experiences of the people they represent. Real devolution comes from public consent. Democracy cannot be an afterthought. **F**



Capital values

Will Tuckley and Nabihah Sachedina explain how health devolution is progressing in London

LONDON ASPIRES TO be the healthiest major global city. But for this to become a reality, we need to work better together – within health and care and beyond – and ensure that the diverse needs of Londoners are clearly understood and met.

Over recent years, London's health and care leaders have been working ever more closely and have developed a clear vision of better health and care, built on the views of Londoners. In October 2014, the London Health Commission published *Better Health for London*, a review of London's health and healthcare. This was informed by unprecedented engagement, reaching approximately 15,000 Londoners through public roadshows, evidence submissions, polls and deliberative events. Engagement underpinned the entire report, and proposals – such as limiting the spiraling number of unhealthy fast food outlets near schools – came directly from Londoners.

We have heard that Londoners want to be supported to be as healthy as possible for as long as possible by making healthy choices easy choices. Citizens also want high quality, accessible and joined-up health and care services. There is, therefore, a clear opportunity for greater partnership working between the NHS and local and London government to deliver what Londoners expect.

Local areas are best placed to understand the needs of their citizens. This is true for London as a whole – a city with different health challenges, population characteristics, health and care service challenges and opportunities than the rest of the country – but also at the

level of individual London boroughs, given the diversity of populations and their needs.

Over the past few years, our health and care system has made significant strides to organise services around the changing needs of our city's growing and diverse population. In December 2015, London local authorities, clinical commissioning groups, NHS England and the mayor of London committed to work more closely together to support those who live and work in London to lead healthier independent lives, prevent ill-health, and to make the best use of health and care assets. Central government and national bodies backed this vision and invited London to explore the transfer of powers, decision-making and resources closer to local populations. Many decisions about health service planning and budgets are taken at national level. This can sometimes create unintended barriers to delivering the connected and tailored local services that Londoners want. London has already made significant progress in integration and collaboration within the current system. Devolution allows us to go even further by enabling health and care decisions to be made for London, in London.

The pilots have worked together to develop and test emerging proposals

The London Health and Care Devolution Programme is underpinned by the principle that devolution proposals must be co-developed locally by pilots, grounded in the needs of our local populations and shaped through collaboration with national and London partners. Given the size and complexity of London's health and care system, our approach has been to explore how devolution could work in practice through five pilots. These pilots have focused on three priorities that emerged from *Better Health for London* – prevention, health and care integration, and making best use of health and care buildings and land.

Over the past year, the pilots have been working to make rapid improvements to health and care with existing powers and

exploring how more local powers, resources and decision-making could accelerate the improvements that Londoners want to see at the most appropriate and local level.

This local variation has manifested in different ways. In Haringey, local partners have a history of close collaboration on health promotion and prevention. The Haringey pilot has therefore focused on prevention and prioritised issues that have a major health impact locally, such as tobacco and alcohol. In other areas, the circumstances of an area – such as land values in inner London and the move from large institutions to primary and community care – have driven the focus on estates that we have seen in the North Central London and Hackney pilots.

The pilots have wide partnerships including local authorities, clinical commissioning groups, providers of health and care services, clinical leaders, the voluntary sector and wider public sector partners. To enable greater collaboration and prepare for the joint decision-making and accountability that devolution would require, many pilots have strengthened their joint governance arrangements, often building on the established health and wellbeing boards.

The pilots, along with London and national partners, have worked together to develop and test emerging proposals and take steps towards devolution, delegation or sharing of functions, powers and resources currently exercised by national partners where there is a clear case that this will assist, enable or accelerate improvements. Public and wider partner participation – at local, sub-regional and London levels – will continue to be critical as these proposals are further developed and implemented.

By *unifying* partners to deliver the best possible outcomes for Londoners; *empowering* local leaders to take control of their assets, services, and budgets; *simplifying* the decision-making processes within a complex health and care system; and *accelerating* transformation plans to gain time, money, and momentum; London is taking significant strides to becoming the healthiest major global city. **F**

Will Tuckley is chief executive of Tower Hamlets Council and chair of the Devolution Programme Board.

Nabihah Sachedina is director of the London Health and Care Devolution Programme



A unique experience

Iain Chorlton reflects on Cornwall's road to healthcare devolution

IN JULY 2015, Cornwall was the first rural authority to sign a devolution deal. So what has happened in the subsequent 18 months? Have our ambitions been realised? And does devolution remain a key enabler for the future of health and social care in Cornwall? Every place has a claim to being unique, and this is often the driver for devolution. Such a sentiment is felt no less strongly in Cornwall where we gain from Cornish national minority status and from significant European Regional Development Fund investment, based on European classifications of identity and economic need respectively. Our geography provides advantages as well as challenges. Rurally isolated, we have little opportunity for resilience: our 1,000 km coastline is the longest of any region outside of Wales and Scotland and we have just one county boundary, with Devon.

An outsider might think that because we ostensibly have 'one of everything' when it comes to organisational bodies that deliver health and social care, their integration must be straightforward. One clinical commissioning group (CCG). One unitary authority (although the Isles of Scilly have their own local authority and we must not forget the additional unique challenge of providing services to an isolated island community). One acute health trust (but 20 per cent of our 550,000 population look over the border for hospital services in Plymouth and North Devon). While this organisational coterminosity may provide opportunities for alignment, our communities are characterised by dispersed settlement patterns. There is

no defined central conurbation and it will surprise many that our largest settlement is Falmouth, with a population of 22,000. Our communities reflect Cornwall's fierce independence and those living in the remote Lizard peninsula do not necessarily have much in common with those in Bude in the north, or the 'gateway to Cornwall' in the south east of the county. While we may have organisational alignment, communities even within a defined region are complex, and diffuse. One size certainly doesn't fit all.

The financial challenges too are significant for Cornwall. The CCG has a deficit approaching £50m and the five-year sustainability and transformation plan sets out a position in five years of a system-wide deficit of more than £260m (the total annual health and social care budget is £1.1bn).

A secure home, job, stable finances and supportive communities are the true aspiration

Funding and allocation arguments aside, our analysis describes a system – over-reliant on a bed-based model of care and an overstretched care market – ready for change. Underpinning our lack of resilience is our ageing population, with almost full employment, in a low-wage economy. We also face challenges due to the seasonal variation of the labour market in Cornwall; which means it is easier to recruit carers in the winter, as we have a workforce that quickly moves to tourist employment in the summer months.

How, then, does devolution aim to tackle these challenges? The original devolution document for Cornwall refers to health and social care in just a few paragraphs, providing a business case for the devolution of health and social care. The advantages, opportunities and benefits are laid out in the wider document and its aspirations. Alignment of a single public estate, an integrated transport network, economic growth and the integration of national and local business support have more to offer to the health and wellbeing of our population than simply integrating a health and social care system.

The wider determinants of health are of more significance than direct medical interventions. Put simply, a secure home, job, stable finances and being part of a supportive community are the true aspirations of our devolution deal and they are what will ultimately result in our sustainable future. Devolution in Cornwall offers an opportunity to bring all of these wider determinants together to deliver better public health outcomes in an integrated way that will ultimately support the prevention agenda that is so important in reduce the pressures on our health system.

We have had very little trouble in seeking local opinion on any changes to services. Most of our towns have their own small community hospital, held dear to local hearts. Any perceived threat to their continued existence raises the emotional temperature. In 2009, when the West Cornwall Hospital was under threat more than 27,000 people marched in protest – a higher number than live in our most populated town. Our opportunity now is to use that energy and opinion. Community responsibility for health and wellbeing can be achieved through local devolution, and our statutory organisations are supporting that through integrated projects reviewing our public estate, developing our workforce and bringing our commissioning functions together.

So, has devolution made a difference? It has brought all our partners in health, care, other public services and economic development together; it has strengthened relationships around a set of common aims for our population, and has promoted discussion about where devolution for the local system could go next. Devolution has produced what is perhaps an unintended consequence – a binding force that has created a framework within which local partners can work together to deliver on common goals. Time will tell whether our ambition is realised. But there is no other binding or transformational vehicle that understands, or has the motivation to develop and build, Cornwall. It is in the uniqueness of our place, like the uniqueness of every place, that the potential to make relevant decisions locally, retaining what is most important and defining our own future, rests. **F**

Iain Chorlton is chair of NHS Kernow

