



# Local empowerment

How to achieve a sustainable health and care service

Foreword by Stephen Dorrell, Senior Adviser to KPMG and Chair of the NHS Confederation

# About Localis

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**Joanna Killian**

Head of Local Government

KPMG in the UK

020 7311 3542

Joanna.killian@kpmg.co.uk

**Andrew Webster**

Director,

Public Sector & Healthcare

KPMG in the UK

020 7311 2707

Andrew.webster@kpmg.co.uk

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# Foreword

Debate about the balance between central and local decision making within the NHS is as old as the NHS itself; indeed, as this report points out, the Cabinet Papers demonstrate that it was the focus of intense discussion within the Attlee Government as the founding legislation was being shaped.

The argument has always involved reconciling two important principles: the first focusses on the need to deliver the aspiration of universal and equitable access to high quality services; the second emphasises the need to deliver accountable and flexible services which respond to local circumstances.

The important conclusion of this report is that, far from being in conflict, these principles in fact reinforce each other. It has always been the reality of the NHS that while it talked the language of national standards and equitable access, it in fact tolerated an unacceptable variation of standards around the country. By providing the opportunity to ensure that services respond to the needs and wishes of local people, and in particular by reintroducing democratic accountability, local decision making creates the opportunity to test local experience both against national standards and against the experience of people in similar circumstances elsewhere, both in the UK and overseas.

More local engagement provides other opportunities as well. Most importantly it provides the opportunity to end the illusion that health services are different from the rest of the public services. By creating a national silo, divorced from local decision making, we have created a structure of perverse incentives in which institutions and professionals defend their individual interests; the result is that health policy too often reflects the sum of a series of rationing decisions, and opportunities are lost to target resources towards the most effective interventions.

Furthermore the over centralised structures of the NHS are inherently conservative. At a time when good health policy requires us to change health and care services in ways which focus new technologies on the changing needs of citizens, the structures of the NHS make change more difficult. That is not usually the result of a conscious determination to resist change; more often it is the unintended consequence of multiple tiers of well-meaning "support".

This report proposes that we should respond to these challenges by creating more localised management structures. By taking the opportunity to embed the NHS more closely in the full range of local public services, and harnessing the natural impatience of voters, the report sets out an agenda which provides a key response to the health policy challenges we face.

The report is also extremely timely. At a time when it seems that discussion about the implications of Brexit borders are an obsession, it argues that local leaders need to step forward to fill the vacuum.

Civic leaders should not wait for permission. They should act quickly knowing that this is a rare opportunity to make a profound change.



A handwritten signature in black ink that reads "Stephen Dorrell". The signature is written in a cursive, slightly slanted style.

**Stephen Dorrell**

Senior Adviser to KPMG and Chair of the NHS Confederation

# Executive summary and main recommendations

Demands on the health and care services are becoming ever more complex and changing at different rates across the country. At the same time these services face serious financial constraints. Neither of these pressures will diminish – instead they will continue to grow.

How can we ensure that health and care services respond to these challenges? We believe the answer lies in loosening the long-standing central grip over the health service and providing local areas with the necessary flexibilities to drive sustainable transformation.

Giving local areas greater ownership over their provision will help them redesign services to better meet specific local demands and be tailored to individuals' needs. Providing local areas with financial flexibilities and more substantial revenue-raising powers can help achieve more integrated and sustainable local health and care services.

Devolution could give NHS management and delivery in England the shot in the arm it needs. Building on the Sustainability and Transformation planning process, it could lead to a system-wide transformation focused on people and place rather than organisations; giving local leaders the freedom they need to better manage the health and wellbeing of their local populations.

Devolving health-related powers and funding will require a great deal of political capital from the centre. The health service is rightly revered and fundamental reform is often treated with suspicion. However, we believe that as reform in Greater Manchester and other parts of the country shows dividends, it will become clear that the future of the health service is local.

The scale of transformation needed in health and care services is daunting. But we believe that the deal-based framework that we set out in this report could empower local leaders to drive reform and reshape a sustainable service. A healthier balance between central and local control is possible and practical.

## Main recommendations

### **1. Negotiate directly with Government**

Local areas should be able to negotiate health devolution deals directly with the Government. These deals should give them new powers and freedoms to enable more integrated planning and delivery between health and social care.

This will mean reviewing some regulation and performance targets, delegation of key commissioning decisions and greater local financial control.

As part of these deals, we recommend that:

- The local area's departmental health budget should be fully devolved with local leaders accountable for its control and distribution.
- Local areas should commit to full open book accounting between providers and commissioners.
- Certain national directives such as the Better Care Fund, wider NHS planning and performance targets should be advisory rather than mandatory for local areas.

## **2. Create incentives through funding**

Greater financial control would allow local areas to radically rethink how funding flows through their local health and care system. This would create a completely different set of incentives to integrate services and provide the flexibility to direct more investment into preventative measures and non hospital-based services.

To drive this rebalancing process, we recommend that:

- CCGs should be given five-year fixed budgets and balance them over the medium-term rather than annually.
- Local commissioners should move away from the centrally-prescribed tariff and towards more outcome-focused models, with a capitation basis.
- Local authorities should offer business rates discounts to companies that demonstrably improve their workforce's health and wellbeing.

## **3. Give revenue-raising autonomy**

Giving local areas more powers over revenues will help cement their control of health and care services. This will give them the incentive to raise extra funding as needed and enable better use of existing resources.

To support this, we recommend that:

- Local areas should be given the freedom to alter the social care precept level.
- Local leaders should be given the power to establish devolved health taxes.
- Local areas should rationalise all local NHS estates into one body.

## **4. Modernise staffing structures**

Local areas should be able to mutualise their NHS staff structures. This would enable local leaders to develop a more multi-disciplinary workforce via place-based contracts which empower frontline staff while not changing employees' wages or working conditions.

To support local areas, we also recommend that:

- Health Education England (HEE) and other workforce bodies develop plans to support local areas with workforce challenges for integrated care.
- The Government and NHS England should run a national campaign to create a new integrated care workforce, looking beyond traditional job title boundaries.

### **5. Give full political commitment**

Any deal would, like Greater Manchester's, need total buy-in from all local partners: acute providers, clinical commissioning groups, local authorities and other arms of the public sector.

To drive this, we recommend that:

- Strong and appropriate local governance and accountability measures should be put in place before any deal begins to take effect.
- Deals should flow from the bottom up rather than being imposed from above, perhaps along Sustainability and Transformation planning footprints.

# 1. Introduction

The National Health Service (NHS) management, commissioning and oversight structures have become more localised over the past decade. This has represented a radical shift from the vision behind the foundation of the NHS in 1948.

We believe that this localisation is positive – and that it should go further. Many of the issues within the health and care service stem from the centralised nature of the system.

A more locally empowered healthcare system with a wider distribution of authority, resource and power is much more likely to try new things and find new ways of improving healthcare delivery.<sup>1</sup> Aligning responsibility for commissioning and service delivery more closely would bring greater operational and commissioning efficiencies. It would also help avoid some of the unintentionally harmful impacts top-down policies can have.<sup>2</sup>

There is nothing new about arguing for greater local empowerment in the health service.<sup>3</sup> Nor is there a correct answer – a national health service is inevitably a mix of national and local control.

But with the changing nature of care demand, evolving patient expectations around personalisation and the rise of digital technology, we feel the localist argument needs to be made afresh, especially given financial constraints and the issues identified in the Sustainability and Transformation planning process.

In arriving at our conclusions we combined our detailed experience of the workings and issues facing the health and social services with views from those directly involved. We held roundtables and conducted individual interviews with senior representatives from the Government, NHS England, national regulators, clinical commissioning groups (CCGs), local authorities and other bodies up and down the country. We also conducted an online survey of stakeholders from CCGs and local authorities.<sup>4</sup>

This report considers what a more local approach has achieved to date – and what it could achieve in the future. In particular, we suggest that local areas be given the opportunity to negotiate deals with the Government. New powers and freedoms would be given in exchange for taking on greater financial control (including being able to raise more money locally) and implementing strong governance and accountability measures.

The research for this project includes: three roundtables held across the country; 36 wide-ranging interviews with stakeholders from the Government, NHS England, national regulators, CCGs, local authorities and other bodies; an online survey answered by 110 stakeholders from CCGs and local authorities and a review of academic studies.

1. In both the Alan Milburn (2002) and Andrew Lansley (2011) white papers give the rationale behind greater freedoms as liberating local health and care economies from central control to innovate and improve patient care.

2. For example the charity Mind found that between April 2014 and March 2015 there were 19,259 sanction decisions against people with Mental Health and Behavioural Disorders.

3. Morrison opposed the removal of local 34 authority control over hospitals. Cabinet papers, 12th October 1945

4. Details of the research are included in Appendix 2.

## 2. The case for localist reform

“If a hospital bedpan is dropped in a hospital corridor in Tredegar, the reverberations should echo around Whitehall” – Aneurin Bevan

For decades central control and intervention has been the norm in the NHS. From performance targets to planning guidance and beyond, those at the centre of the health service’s management and oversight frameworks have had control over its day-to-day operations. This desire for control is mainly driven by an understandable aim for national standards.

However, as our research has made clear, this “command and control” approach can be unhelpful and sometimes counterproductive for local health and care economies. The effect of centralised regulatory and planning structures, with its resulting lack of local accountability, creates an environment that resists change. This hampers local innovation and leadership and ultimately leaves the health service worse off.

### 2.1 Central prescriptions

Inflexibility over finances, performance management, national regulation and planning are seen as a substantial barrier to local-level transformation. Four-hour A&E targets, for instance, are widely seen to limit a hospital’s effectiveness. Hospitals are encouraged to focus on meeting their targets rather than on other important measures such as patient satisfaction and ambulance delays.<sup>5</sup> One acute director noted that frontline staff are less able to help those in greatest need: instead they have to try to see everyone within a given timeframe, no matter what the problem.<sup>6</sup>

5. Nuffield Trust (2015) – What’s behind the A&E crisis?

6. As a BMA survey showing that a third of doctors manipulated data to meet the targets suggests, the targets are not necessarily accurate. BBC News (2007) – A&E success ‘not sustainable’

### Central barriers to transformation

We asked: "In your local area, what are the biggest barriers to delivering a sustainable, better, more integrated health and social care system over the course of this parliament?" Answers were on a scale of 0-5, 0 being "not a barrier" and 5 being "a very substantial barrier". Results were:

Lack of financial flexibility	3.7
Lack of flexibility over performance management	3.0
Lack of flexibility over national regulation/oversight	3.3
Lack of flexibility over planning footprints	2.5

Guidance from central NHS bodies is not always helpful. As one CCG representative said: "We're in a constant cycle of planning and responding to top-down guidance which prevents us from just getting on with it and building relationships at the local level." A foundation trust director agreed: "Most people's time is consumed with day-to-day completion of tasks... and what fills time is completing assurance templates and telling people to do better because the minister told you to. That doesn't create an awful lot of headspace to think about transformation."

An example of this is the recent NHS Shared Planning Guidance. The guidance is positive in that it is place-based and driving the Five Year Forward View.<sup>7</sup> But many stakeholders we spoke to felt constrained by central intervention in forming their Sustainability and Transformation Plan (STP).

One CCG officer felt the STP footprint had been "imposed", "started from the wrong place" and was causing the same problems as the Better Care Fund (see chapter 5).<sup>8</sup>

Central direction, management and oversight can work well. But our research suggests a current system which Dame Julie Moore describes as one where local leaders "[wait] for a command from God on high" rather than taking the initiative themselves.<sup>9</sup> Even several former health ministers – from both sides of the political divide – described to us an "empire" stretching across the Department of Health and the NHS that resists change, so much so that ministers actively seek disruption as the only way to fracture existing structures. As one acute trust director summed up: "The NHS always looks up and rarely outwards."

This culture does not help the NHS change to meet local needs. It is not always clear how local leaders should assess which initiatives are most important and how they fit together. One council cabinet member for health and social care explained that local areas respond "like shoals of fish turning this way and that in response to centrally-prescribed initiatives which change every few months."

7. NHS England (2015) – Delivering the Forward View: NHS planning guidance

8. As academic Tony Travers has written, the guidance is "'democratic centralism' in action". LGC (2016) – NHS 'local system' planning is a clear example of 'democratic centralism'

9. The Times (2016) – Incompetent bosses wrecking NHS, says troubleshooter

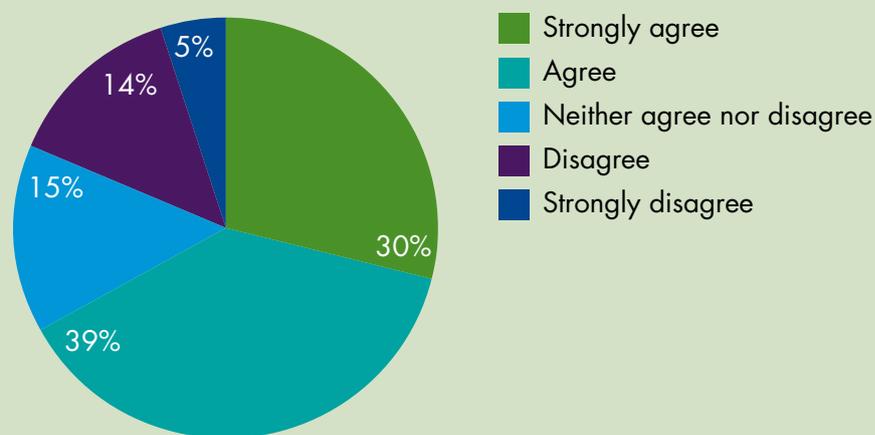
Despite this, innovation is happening: many local areas across the country are trying different approaches and models to develop better and more integrated systems. For instance, one council director for health and social care told us they encouraged innovation: “My council has had a policy of ‘don’t ask for permission; ask for forgiveness’. Try anything once; the only rule is don’t break the law.” Even Success Regime areas – perhaps the ultimate example of central oversight and intervention – innovate by “working across whole health and care economies, with providers, commissioners and local authorities, and address systemic issues as opposed to merely focusing on individual organisations.”<sup>10</sup>

Even so, local areas have to operate within a set of business rules, tendered to and overseen by the centre. These can hinder transformation and deter effective local leadership. Not every place has the same set of priorities or problems – and neither do they have uniform levels of organisational coherence and quality. National standards can have the opposite effect to that intended, given local differences.

## 2.2 Local accountability deficit

The blurring of accountability over local decision making is a problem.<sup>11</sup> Most of our survey respondents agreed that greater democratic oversight is needed in local health and care economies. This is already happening in some places. There is much stronger democratic representation in Greater Manchester following its devolution, and the establishment of Health and Wellbeing Boards (HWBs) has helped. But there is still not enough accountability at the local level. This is a problem for several reasons.

**Figure 1: To what extent do you agree that there needs to be more democratic oversight over your local health and social care system?**



10. NHS England (2015) – The Success Regime: A whole systems intervention

11. This lack of accountability has long been acknowledged. A 2009 Communities and Local Government Select Committee report notes “local... health care services remain insufficiently accountable to their local populations”. Even the founding father of the NHS, Aneurin Bevan, went onto regret this “defect” of little local democratic representation.

First, one of the main barriers to innovation is a fear of risk. If individuals at the local level are unsure to whom they are accountable, they are less likely to push for the systemic change needed. As Dame Julie Moore said recently: “We’ve created a culture of people who are terrified of making decisions because you can’t be held to account for making no decision, but you can if you make a decision.”<sup>12</sup> This defensive culture prevents what author Matthew Syed calls “black-box thinking” – learning from mistakes by examining what caused them.<sup>13</sup>

Second, in the past the health sector has not needed to explain management decisions to the public. This is not the case in local government and other parts of public services. As one council chief executive commented: “What I say to my health colleagues is that local politicians do this kind of stuff all the time – they close schools and libraries from time to time. Politicians can make those difficult decisions, and when they do they provide enormous leadership and the change happens.”

This runs into a broader conversation around public perceptions of health services, with an expectation gap between what the public think the NHS provides and what it actually does. As a practicing GP said: “The system is set up to make the population think that they are consumers with everything available to them when in fact it is rationed.” The loose connection between commissioners and the people they are meant to serve leads to services being commissioned by conventional belief rather than to meet genuine requirements. Again, this is in stark contrast to local government, which is widely accepted to be the most accountable part of the public sector.

Third, lack of local accountability deters local collaborative leadership. As one council leader put it: “Different lines of accountability pull people apart... there is no common stake.” Any system runs the risk of becoming more fragmented when relationship-building and communication are sidelined. This is a particular issue in a sector where acute providers tend to dominate.

It is vital that local partners work together. As one vanguard chief officer told us: “The one key thing I have learnt over the past few years is that if one part of the system fires off with one bright idea, it’s not going to work. If it can be a whole-system approach you have a much better chance. That’s a key lesson for anyone else trying to do this.”

### **Case study: Democracy in action in Sweden**

Sweden has substantial local democratic representation in its health and care governance. County councils provide primary care and hospitals and municipalities provide social care; both have the freedom to raise taxes. County council members, who are elected every four years, have a large say over the delivery and management of health and care – about 90% of Swedish county councils’ work relates to health and care.<sup>14</sup> The national government’s role is generally to regulate the work of municipalities and county councils.

12. The Times (2016) – Incompetent bosses wrecking NHS, says troubleshooter

13. The Times (2016) – Why the NHS must stop flying by the seat of its pants

14. Swedish government (2016) – Healthcare in Sweden

## 2.3 A new deal

Centralism and the lack of local accountability in health and care services do not fit the needs of the modern health service. Health demands have changed massively over the past few decades,<sup>15</sup> yet the service itself has not. This case for transformation is widely accepted across the political divide: health secretary Jeremy Hunt supports the principles behind the *Five Year Forward View* and his former shadow, Heidi Alexander, has said that “the NHS [should not] be preserved in aspic.”<sup>16</sup>

We believe a more locally-empowered and place-based health service is needed in England. This could foster an environment that allows local areas to do things differently and “just get on with it”, as one senior stakeholder put to us, rather than “continually bowing down to the centre knows best directives” and “being held hostage to the ‘Monday morning meeting culture’”.

### **Case study: Decentralisation in action overseas**

A number of other national health and care systems which, like the NHS, provide universal healthcare free at the point of use, have power distributed differently across national and local government and communities.

In Italy, for example, the *Servizio Sanitario Nazionale* is a comprehensive national health service financed by general taxation. Standard levels of care are determined by the state, while other powers are held by the 21 regions which control local health units and independent hospitals.

Similarly, Canada’s health system is mostly financed by general taxation and its services provided by a mix of public and private bodies. The system is highly devolved, with provinces and territories organising and running 13 essentially different systems. In New Zealand 21 district health boards are each responsible for hospitals, community and primary care services, and adult social care.

Scandinavia is very much seen as the beacon of devolved governance, but in recent years some powers have flowed back towards the centre.

In Finland, municipal reforms have merged 320 municipalities into five regions. This has involved central government taking responsibility for hospital services previously run by local government.<sup>17</sup> In Denmark 200 municipalities have become 98 and as part of the reforms, county councils, which are responsible for secondary care, have lost their fiscal powers.<sup>18</sup> These examples suggest that finding a balance between central and local control can be an evolving process.

15. In 1948, when the NHS was founded, 48% of people died before the age of 65. Today that figure is down to 14% and in 2030 there will be 51% more people aged over 65 and 101% over 85 than in 2010. The nature of diseases is also longer-term and more complex.

16. Heidi Alexander MP (2016) – speech to the Nuffield Trust

17. In Search of the Perfect Healthcare System, Mark Britnell

18. Communities and Local Government Select Committee (2009) – The Balance of Power: Central and Local Government

### 2.3.1 Devolving for disruption

In some places, such as Greater Manchester, health devolution is starting to happen. But the pace of change needs to increase.

**We believe that local areas should be able to negotiate deals that give them the power and freedom to drive disruptive innovation with the Government.**

This will mean local areas being **free of certain regulation and certain targets, acquiring greater financial control, delegating key commissioning decisions, having greater responsibilities over workforce development and being able to better engage local people in the design and delivery of their care.** It will require a clear offer from the NHS and Government to reduce bureaucracy.

In return, local areas should commit to achieving integrated financially sustainable local systems (the first step will be to agree whole-system integration and sustainability models). As in Greater Manchester, the deal should catalyse areas to “think differently and promote service and system change in ways that build on people’s views and strengthen local decision-making and accountability, to deliver significantly better outcomes.”<sup>19</sup> The deal process should also acknowledge that commissioning and provision will look different in different health and care economies.

A key feature of the deal must be that **the health budget should be held and accounted for locally. Moreover local health and care systems should have to operate under a single rationed system** to enable integrated communication and planning and delivery between health and social care.

This represents a huge shift in financial risk. We therefore suggest that it should take place over several years, with a “build-up” period (as has happened in Greater Manchester) and **a gradual shift in financial responsibility to the local area.** The timescale should be agreed between local areas and central authorities.

In the meantime, local areas still have to operate within existing guidance. Areas with Integrated Care Pioneers, such as in Leeds, would want to build on their existing integration work. **Other areas may want to their devolution to follow their STP route.**<sup>20</sup> The STP process is promising if challenging and will need new ways of managing the system, organising support structures and engaging proactive management. This deal process could offer the impetus needed, and **STPs could be precursors to future devolution.**

Over time **devolution areas should be increasingly exempt from mandatory national directives** such as the BCF, wider NHS planning and performance targets. In recognition of the different paces and directions of change in different areas, **deals should rise from the bottom-up rather than being imposed from above.**

The centre will need to accept that the process will get messy.<sup>21</sup> Local areas will need to work out how best to plan and commission a range of services. Any deal would need **total buy-in from all local partners:** acute providers, CCGs, local authorities and beyond. The centre should insist that **strong and appropriate local governance and accountability measures** are in place before any deal begins to take effect. One of the key figures in Greater Manchester told us that NHS England chief executive Simon Stevens was clear that “if he was going to devolve something, he needed to know who and what he was devolving to.”

19. GMCA (2016) – Taking Charge of our Health and Social Care in Greater Manchester

20. IGC (2016) – Mapped: STP footprint plans revealed

21. It already is in places. Simon Stevens’s acknowledgment that there are “shades of grey” in determining planning and joint-working arrangements is therefore encouraging. HSJ (2016) – Stevens: 44 transformation patches will cover England

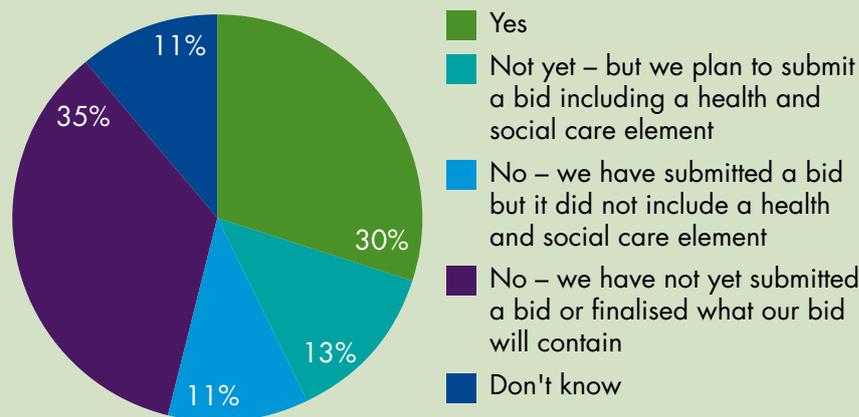
And a former minister said to us, stronger local governance would mean that “well entrenched vested interests [would] suddenly find that they’re up against a different audience and there are arguments for change coming from a different perspective.”

**Expanding the health devolution agenda**

Several areas are looking to strike similar deals to the Greater Manchester one. Five healthcare devolution pilots have been announced in London. Cornwall is putting forward a business plan to move “progressively towards integration of health and social care across Cornwall and Isles of Scilly”. And the North East Combined Authority is establishing a Health and Care Commission which will “review the scope and basis for further health and social care integration”. None, however, is as revolutionary as the Greater Manchester deal.

Our research found that while there is appetite for more powers across local health and care economies, many are holding back to see how Greater Manchester fares. As former NHS Confederation chief executive Rob Webster has written, a “complex patchwork quilt is emerging, with differing degrees of devolution.”<sup>22</sup>

**Figure 2: Has your local area put in a devolution bid that included a health and social care element?**



**2.3.2 Empowering local areas to transform services**

We believe that with the greater control that these deals would deliver, local leaders would gain a much greater and more positive influence over the healthiness and life chances of their local population. As in Greater Manchester, local areas could aim “to improve outcomes for our people, increasing independence and reducing demand on public services”.<sup>23</sup>

With the financial imperative and necessary freedoms from the centre, local leaders would be able to drive system-wide transformation focused on people and place, not local organisations. And with greater financial control, limited resources could be focused on addressing the most important local health issues.

This keeps to recent Government and NHS England policy, and reflects the lack of appetite in the sector for top-down change. These deals do not try to reinvent the wheel. Neither do they impose “postcode lotteries”.

22. LGC (2015) – Devolution must empower local leadership on health and social care

23. GMCA (2016) – Taking Charge of our Health and Social Care in Greater Manchester

But they acknowledge that health and care services can no longer be delivered nationally. Devolution would achieve a better balance between local and central control, addressing how to provide high-quality care while empowering patients, local leaders and frontline staff.

Localism is not a panacea and should not be seen as one. Health and care services face significant challenges and it will take time and resources to put new systems on a sustainable footing. Experience shows that whole-system transformation along the lines of the Greater Manchester deal is not easy. But we believe the effort will pay off: that this bold shift towards greater local control is the best way forward for the NHS.

#### ***Case study: Devolution in the Netherlands***

The Netherlands faces the challenge of establishing a financially sustainable health and care service while contending with an ageing population and tight government budgets. The country's health and care service is going through a period of major transformation which has involved the devolution of substantial powers. Recent reforms have been inspired by the Scandinavian model and follow on from similar reforms passed a decade ago. They included the devolution of the following to over 400 municipalities:

- Care for frail and elderly people with long-term conditions living at home
- Out-of-hospital care for children (0-18 years)
- Support to vulnerable populations (e.g. patients with disabilities or mental health conditions) to increase societal participation

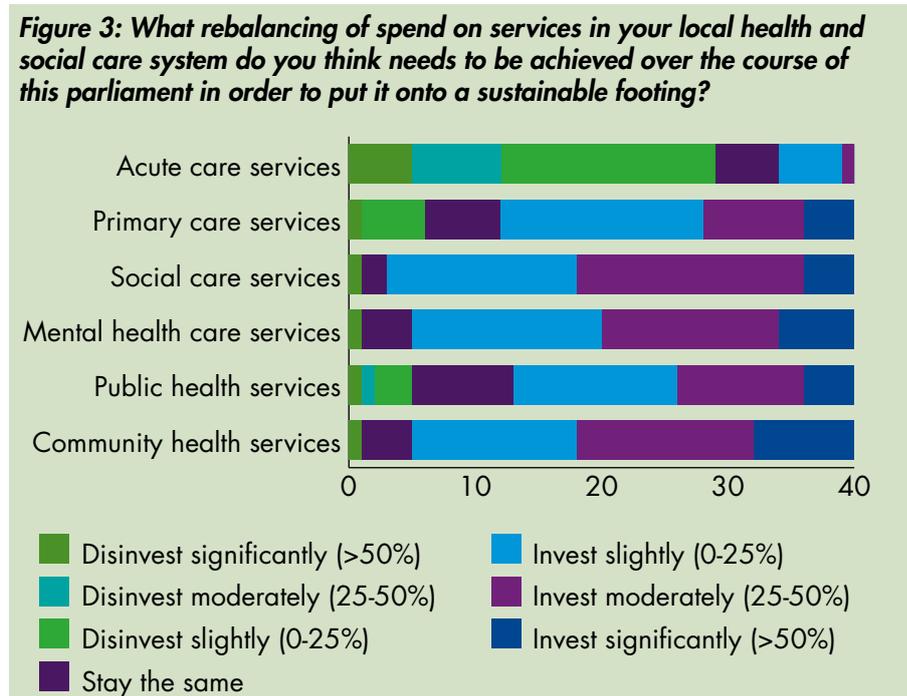
These reforms will offer a valuable case study for any healthcare service that intends to become more locally-oriented. How, for example, will municipalities develop strategies for preventing illness and support people to live in their own homes as far as possible? What strategies will municipalities take towards patients with long-term and often complex conditions? How, given overall budget cuts of up to 40%, will municipalities ensure care is organised around patient needs and not the system's needs?

### 3. Rebalancing the system

“The NHS is a social movement and not just a health care service” – Simon Stevens<sup>24</sup>

The way local health and care economies spend money needs to be fundamentally rebalanced. This is our view, and shared by the majority of survey respondents. Investment needs to shift from acute settings towards out-of-hospital care. Interviewees were clear that time and resource is not used anywhere near effectively enough in their local area. For instance just 4% of spend by the NHS is on preventative programmes.<sup>25</sup>

This imbalance has grown as local authority budgets have been squeezed. Huge short-term pressure to maintain tangible and visible services such as acute care means public health budgets have been cut.<sup>26</sup> This is short-sighted: the NHS cannot evolve along the lines of the *Five Year Forward View* without significant public health investment.



This false economy underlines the need for a more locally-empowered system, with greater flexibility over budgets, payment systems and business rates discounts. This would, as a director of public health told us, “reorient the local system to be very heavily driven by an understanding of the health issues that face the area, while at the same time proactively intervening in the inextricable demand for health services. Ultimately this should enable disinvestment in some acute services”.

24. The Guardian (2014) – Simon Stevens interview: ‘The NHS is a social movement and not just a health care service’

25. LGA (2013) – Money well spent? p8

26. And they are expected to fall by a further 20% over the next five years The MJ – Public health budgets facing further cuts

A recent study found that 40% of known ill-health is caused by potentially preventable risks.<sup>27</sup> This shows the huge opportunities in rebalancing the system. More control would enable local commissioners to invest in schemes that keep people out of hospital.

### **Case Study: Social prescribing in Rotherham<sup>28</sup>**

A social prescribing service in Rotherham has reduced A&E attendance by 17% in the past year.

The scheme allows GPs to refer people with long-term conditions to voluntary and community sector advisors. These advisors can examine non-medical needs and refer patients to non-traditional forms of care such as yoga, fitness and art classes.

Results show that 82% of service users felt better after three to four months. Researchers estimate that the scheme could save £1.1m over the next five years – a return on investment of 198%.

## **3.1 Longer-term budgets**

Health and care services commissioners are keen for more flexibility in their financial planning and strategy. Our survey respondents rate accounting constraints as one of the biggest barriers to achieving a more integrated and sustainable local health and care economy. The biggest issue is the short-term nature of NHS financing.

Almost all organisations in local health and care economies run on annual budgets. This is a problem for two reasons.

Firstly, it focuses on short-term pressures at the expense of longer-term strategic planning. The difficulties in showing a return on investment within a year makes it hard to justify a resource shift towards preventative action.

Secondly, the annual budget cycle spawns uncertainty. Interviewees lamented the effects of several government interventions on financial strategies, singling out the impact of the £200m in-year cut to public health budgets on councils' financial planning. CCGs have also complained of similar in-year cuts to their budgets, such as having to fund NHS England overspends on specialist commissioning budgets.<sup>29</sup>

Annual financial control delivers few great benefits to patients. Instead, it comes at a huge cost: tying the hands of commissioners across the country – experts who understand and can respond to the needs of their local areas better than Treasury accountants.

This is why we believe that local areas should move towards multi-year budgets. The welcome result would be longer-term planning by local commissioners and providers, and investment in real transformation.

This is not a new argument. It comes up time and again in our conversations with stakeholders across the system.

27. Public Health England (2015) – England has the potential to have the lowest disease burden in the world

28. Dayson et al. (2016) – The Rotherham Social Prescribing Service for People with Long-Term Health Conditions

29. NHSCC (2014) – Making change happen

There are signs that things are changing. We understand that Greater Manchester's healthcare reform strategy will move towards five year budgets. The Department of Health has started consultations on giving CCGs three-year budgets.<sup>30</sup>

**We support these positive steps.** However it looks as if despite them CCGs may still have to balance their budgets annually, without being able to carry over underspends. We recommend that all CCGs are given five-year fixed budgets which don't need to balance annually. **We also recommend that local areas negotiating deals seek ten-year fixed budgets.**

### 3.2 Outcomes-based payment systems

Another major barrier to rebalancing spending is the payment by results (PbR) model. This model is tariff-based and accounts for 62% of income for acute providers.<sup>31</sup> It should allow money to follow the patient, reward efficiency, reduce waiting times and encourage innovation.<sup>32</sup> But our survey respondents felt that PbR had failed on many of these counts.

Because PbR pays by activity, it encourages trusts to keep patients in hospital for as long as possible, and for them to take on more patients. This actively discourages out-of-hospital care. Most trusts' growth plans are based on treating growing numbers of patients. This is not a positive outcome. Having more people go through a hospital's doors is good for the hospital's finances – but it may not be good for the patient.

We were encouraged that 61% of our survey respondents said that partners in their local health and care economy intend to move towards new payment models. Our interviewees at regulatory bodies told us there is strong institutional support for this. Monitor and NHS England are committed to "using the full potential of the payment system to provide better support across the country for innovations in patient centred, co-ordinated care."<sup>33</sup>

The 2012 Health and Social Care Act allows payment arrangements to be determined locally. **We recommend that commissioners think about moving from the centrally-prescribed tariff towards more outcomes-focused models, such as capitation, as part of their STPs.**

About 64% of our survey respondents supported a shift towards capitation in their local health and care economies. We believe that this transition can help achieve a more vertically-integrated, rebalanced system.

#### Capitation

Capitation involves paying providers to cover most or all of the care provided to a target population across different care settings. The regular payments are calculated as a lump sum per patient.

If a provider meets the specified needs of that patient for less than the capitated payment, the local health system gains financially. This gives providers an incentive to keep patients in their target population healthy. It makes them more likely to identify risks, intervene early and arrange the right treatment for patients, at the right place and the right time to aid patients' recovery and better manage long-term conditions."<sup>34</sup>

30. LGC (2015) – DH consults on three year budgets for CCGs

31. NHS England and Department of Health – A simple guide to Payment by Results

32. Ibid.

33. Monitor and NHS England (2014) – Capitation: a potential new payment model to enable integrated care

34. Monitor and NHS England (2014) – Capitation: a potential new payment model to enable integrated care

Increasing numbers of commissioners are using capitation in different forms covering different populations. In Greater Manchester for example, capitated budgets are being piloted in Salford and Stockport: the intention is to phase out PbR across the whole city area.<sup>35</sup> Participants in the Integrated Care Pioneer and Long Term Conditions Year of Care Early Implementer programmes have developed similar models.

One of the vanguard models is the vertically integrated primary and acute care systems (PACS). This follows the capitation principle with single organisations responsible for a population's GP, hospital, mental health and community care services. In its advanced form – as in Northumbria (see box below) – this model can be genuinely radical, with PACS “tak[ing] accountability for the whole health needs of a registered list of patients, under a delegated capitated budget.”<sup>36</sup> PACS resemble accountable care organisations (ACOs), successful in some parts of Spain and in the United States.<sup>37 38</sup>

### **Case study: Vertical integration, Northumbria CCG<sup>39</sup>**

Northumbria Healthcare NHS Foundation Trust, the CCG and County Council in Northumberland are working in partnership with local GPs, mental health services, the ambulance service, Northumberland Healthwatch and the Health and Wellbeing Board to deliver an integrated primary and acute care system (PACS). Building on very strong foundations of integrated working in Northumberland, the aim of this work is to create a truly joined-up system between GP and primary care services, hospital-based care and any on-going health or social care support that people might need.

The collective vision is to create ‘one system’, with no organisational boundaries. A system which allows patients to easily access the highest possible quality of care, relevant to their own individual needs and which empowers people to stay healthy and well.

Work is now also well advanced to develop a single accountable care organisation for Northumberland which will be one of the first of its kind in the NHS becoming operational from April 2017. The ACO will have a capitated budget for the population of Northumberland and work towards shared quality objectives, drawing on services that cross different organisational boundaries to meet individual patient needs. This will make it easier for staff to work more effectively together in a joined-up way and with the same shared goals for delivering high quality patient care.

35. IGC (2015) – Devo Manc leaders request £500m 'pump prime' funding

36. NHS England (2014) – Five Year Forward View

37. King's Fund (2015) – Place-based systems of care

38. Although linked, an ACO does not necessarily require capitation. It could also, in theory, be achieved with outcomes-based block contracts.

39. HSJ (2015) – Struggling CCG may join leading NHS 'ACO' project

40. HSJ (2015) – CCGs could pick 'min' or 'max' roles under NHS England strategy

41. HM Treasury and Department of Health (2015) – London deal paves way to transform health care across the capital

NHS England has reportedly drawn up plans for CCGs to become accountable care systems, with a less defined split between providers and commissioners.<sup>40</sup> This move towards more place-based commissioning is positive. Our survey results show strong support for the ACO model, with one NHS England stakeholder commenting that the model is attractive as it shows who is in charge of a person's healthcare. Moving towards value-based commissioning would, as one council director for health and social care said, “drive value back up the value chain” because it provides the necessary incentive for providers to prevent illness in the first place.

Although the model is being piloted in some areas (Barking & Dagenham, Havering and Redbridge)<sup>41</sup> as one CCG chair noted, scale and implementation are barriers to its wider implementation. Although the model has cross-sector support, providers may get cold feet. One stakeholder told us: “Hospitals do not want to lose the money they get through the current system and GPs do not like being told that their referrals are not appropriate.”

**Case study: Alzira model**

The Alzira model is a vertically integrated care model, piloted in a small town and now replicated across Spain. Under this model, a provider receives a fixed annual sum per local inhabitant from the regional government for the duration of a contract: in return it offers free, universal access to a range of primary, acute and specialist health services to the local population.<sup>42</sup>

The model has led to providers viewing patients more holistically. Local health workers see the model as their transition from service management to health management.<sup>43</sup>

The NHS Confederation has said of the Alzira model: "Its success relies on a highly integrated clinical and business model, stretching between and across primary and secondary care. Right along the patient pathway incentives for the different providers in the system are aligned to ensure that work is carried out in the most appropriate, and therefore efficient, care setting."<sup>44</sup>

**3.3 Encouraging businesses to play a wider role in public health**

The work place is one of the priority settings for health promotion in the 21st century.<sup>45</sup> Throughout our research we heard calls for businesses to have a greater stake in the prevention of ill health. One council leader described how a company in their local area kept a doctor in their factory, to save time and to keep staff healthier. Another interviewee referred to a number of workplace initiatives that target those suffering from poor mental health. For example, a number of large US employers offer free mindfulness training courses for their employees.<sup>46</sup>

We believe there is a much wider scope for local areas to encourage employers to improve the health and wellbeing of their workforce. The devolution of business rates to local authorities by 2020 offers a golden opportunity. We believe that **local authorities should consider offering business rates discounts to companies that improve the health and wellbeing of their workforce**. This could be done in collaboration with other authorities as part of the STP process.

There is a clear economic rationale behind this. If local areas are accountable for healthcare spending, they want their local populations to be as healthy as possible. Encouraging local businesses to maintain a healthy workforce using discounted business rates as an incentive represents an investment in the hope of lower healthcare bills.

42. NHS European Office and NHS Confederation (2011) – The search for low-cost integrated healthcare

43. PWC (2014) – Lessons from Alzira: an NHS provider perspective

44. Ibid.

45. World Health Organisation (2016) – Workplace health promotion

46. Financial Times (2012) – The mind business

## 4. Incentives for personal focus

Local health and care services need to become more flexible and bespoke for patients. Giving people more authority over the care they receive delivers better outcomes for the patient and enables more effective commissioning. This is a pressing need. About 15.4m people in England have a long-term health condition and the Department of Health approximate 70-80% of them can be supported to manage it themselves.

Innovative schemes that encourage care users to be more engaged in their care are advancing across the country. In Stockport, for example, mental health service users can co-produce their care pathways (see box below). And in recent years, there has been substantial progress in delivering more personalised social care.

However the way patients receive care is still overwhelmingly driven by the needs of the delivery organisations. All too often commissioning bypasses service users altogether; with patients seen as passive recipients of treatment, rather than people who might be able – and want – to contribute to managing their own care.

A more locally-empowered health and care service would address this imbalance. As the Fabian Society has written: “Adaptive, personalised frontline relationships and networks cannot be willed from the centre through direction... [they] need to be steered and nurtured by local leadership and stewardship.”<sup>47</sup>

### **Case study: co-production in Stockport**

Mental health service users in Stockport are able to “co-create” their care pathway alongside a care coordinator.<sup>48</sup> This enables them to design their own personalised recovery pathway “towards a better future that is defined by their own goals and supported by [a] professional.”<sup>49</sup> Since the programme was launched in 2012, referrals to local mental health Single Point of Access services have fallen.<sup>50</sup>

### **Case study: “Patient hotels” in Sweden**

“Patient hotels” are a halfway house between hospital and home, offering accommodation to low dependency patients who do not need hospital care but who need a supportive environment. The hotels are mostly located in the grounds of hospitals.

47. Fabian Society (2015) – The Local Health Service?

48. Nesta (2013) – Redefining Consultations: Changing Relationships at the Heart of Health

49. Innovation Unit (2014) – 10 solutions for 21st century healthcare

50. Nesta (2013) – Redefining Consultations: Changing Relationships at the Heart of Health

Staff are all medically trained nurses; doctors are still responsible for the patients' care.<sup>51</sup> Patients are encouraged to manage some of their own care; for example, changing bandages or preparing meals.<sup>52</sup>

This service reduces pressure on acute beds and saves money, as the "hotel" costs are much lower than those of a hospital bed. Some patient hotels also generate revenues by offering accommodation to visiting relatives.

Patient hotels have been introduced across Scandinavia. The model has been considered by NHS England as a means of reducing pressure on English hospitals:<sup>53</sup> while England has some forms of intermediate care and community hospitals, they are not nearly widely used enough.

#### 4.1 Fostering personal commissioning

Giving patients a say in the care that they receive is a positive step and should be encouraged as much as possible. Patients have the biggest vested interest in receiving the most effective care for their condition. Personal commissioning is directly linked to patient need meaning the right services are more likely to be commissioned.

For example, personal health budgets have led to many patients using non-traditional forms of care that have been effective in treating their illnesses. This has encouraged a broader focus on health and wellbeing and redefined what care is. It has also encouraged innovation. One interviewee said to us: "If 20% of the population in a certain cohort are doing yoga and they are all improving, suddenly you might want to offer yoga services to the rest of the cohort."

Personal budgets have been criticised by some who have lost influence over how funding is spent. Pulse magazine, a publication aimed at GPs, has said that budgets are often used in unconventional manners.<sup>54</sup> While this may be true it misses the point. An evaluation of the personal health budget pilot programme found that it had a significant impact on well-being and quality of life.<sup>55</sup> Estimates suggest that half of the people eligible for NHS Continuing Healthcare using personalised budgets could save approximately £90 million.<sup>56</sup>

**We believe that where and when possible, local leaders should actively foster personalised budgets.** For this to happen care markets need to be as wide and deep as possible. An NHS England director and practicing GP told us that his experience was that personal budgets can suffer from a "Russian supermarket" problem: the money is there to be spent but there aren't the services to spend it on.

For personal commissioning to work, new providers must come into the market. There must also be intervention where necessary to provide and maintain a steady pool of carers.

**We believe local authorities should help set up carer network cooperatives in their areas.** These would work along similar lines as Leeds's 37 Neighbourhood Networks, where community self-help groups support more than 21,900 older people across the city.

**Local areas should also commit to significant joint investment in out-of-hospital market development, and agree to develop a personalisation requirement as part of the development of joint market position statements.**

51. Innovation Unit (2014) – 10 solutions for 21st century healthcare

52. Ibid.

53. BBC News (2013) – NHS bosses ponder hospital hotels to ease ward pressure

54. BBC News (2015) – NHS personal health budgets spent on holidays and horse riding

55. Personal Social Services Research Unit (2012) – Evaluation of the personal health budget pilot programme

56. Department of Health (2012) – Thousands set to take control with Personal Health Budgets cash for care

**Case study: Integrated Personal Commissioning**

The Integrated Personal Commissioning (IPC) programme allows over 10,000 individuals with high and complex needs to commission their own care through personalised care planning and personal budgets.

IPC is radical because it combines health and social care at the individual level rather than population level. A CCG officer described IPC to us as “the best of the new commissioning models” because it has “captured the hearts and minds of patients”.

**4.2 Facilitating self-care**

Better self-care relies on better use of technology. Interviewees were in no doubt of the direct link between technology and better self-care. More extensive use of technology allows quicker responses to people’s needs and can reduce the need to go to surgery. We believe that if local areas have more local control and longer-term budgets, they will have the financial breathing space to invest in this technology.

## 5. Incentives to integrate

The organisations that make up local systems must be as integrated as possible in order to bring about a more balanced and sustainable health and care service that delivers bespoke care. This is better for patients, providing a more joined-up service. It is also better for governments, because resources are used more efficiently.

Integration plans are a clear objective of policymakers across the world.<sup>57</sup> The Australian state of Victoria, for example, has developed a tiered support model which provides patients with more appropriate care pathways. In Washington State, the Department of Social and Health Services uses medical, public health and social care data to model where resources need to be focused to help patients with the most complex needs.

In England there has been substantial progress in delivering more integrated care in recent years. While centrally-led initiatives such as the Better Care Fund have had mixed success, smaller-scale commissioner-led initiatives have been more effective. In Whitstable, local leaders are pioneering a new system of general practice via the local vanguard; in Kingston, integration is being driven predominantly by a change in culture rather than a new model of care.<sup>58</sup>

The advent of CCGs has driven integration in some areas. One CCG Chief Officer said they had “lassoed primary care into taking more responsibility for the system as a whole; putting primary care at the centre of how we solve this problem rather than sitting at the side sulking”. Another CCG officer noted how clinically-driven commissioning has allowed a more needs-based approach, with its GP membership “not serving across a patch but a population”.

Austerity has prompted greater cooperation across geographical and organisational boundaries. As one council chief executive and acute trust board member noted: “For the first time ever, [acute providers] are facing the prospect of completely running out of money and failing... they are now realising that the system as it is just isn’t sustainable.” This view was echoed by a CCG Chief Officer who said: “Trusts now realise that their future is entirely wound up in the rest of the system.”

57. As far back as 1997 the then Health Secretary Frank Dobson talked of his intentions to break down the ‘Berlin wall’ between health and social care BBC News (1999) – Carers caught in political cross fire

### **Case study: Delivering integrated care in Whitstable, England**

As part of the broader Encompass vanguard covering Whitstable, Faversham, Canterbury, Ash and Sandwich – serving a population of 170,000 – the multispecialty community provider site in Whitstable is pioneering a new system of general practice at scale. As part of its vanguard status, the site is redesigning the way it delivers primary care, looking to, as one of the senior partners told us, “move away from just a GP sitting in a room”.

Four aspects of the redesign have included:

- **Community paramedics delivering home care** – after reviewing all the calls the practice gets for home visits each morning, GPs decide which are the most urgent and which can be done by a community paramedic. Then, working in ‘tethered teams’ and armed with tablet computers that have the relevant patient records on and a direct line to the GP, paramedics make the visit to the home.

This delivery model is more efficient and, more importantly, hugely popular with patients – 100 per cent said that they would use the service again. As a result of this success, the initiative was rolled out across the whole vanguard in November 2015. Since the service was launched last year, over two thousand patients have received home visits with good clinical outcomes. In the Whitstable area, where the pilot has been operational since Apr 2015, there has been a 7 per cent reduction in ambulance conveyances to A&E.

- **Development of a comprehensive health and social care village** – outline planning permission has been granted for a new community hospital, teaching nursing home, and day centre and care facility, all with the intention of providing care for anyone that definitely doesn’t require acute care from a hospital. The same patient record will be used throughout the village and the land and three buildings are to be funded by an independent provider at their own risk (with no NHS money used). In time the hospital trust wants to reduce their bed stock and sees the health and social care village as an enabler.
- **Community hub operating centres (CHOCs)** will be established with a community matron leading a multi-disciplinary team made up of people from all parts of the out-of-hospital care spectrum, including social services. This will allow a quicker response to patient’s immediate needs keeping them out of hospital and in their home.
- **Mobile app development** – Encompass is supporting the development of a mobile app which allows users to know where local urgent care services are – e.g. which facility has x-ray services – and the length of the queue for the service.

Waiting times at the Whitstable Minor Injury Unit are around 45 minutes and the area has the lowest number of users per capita of A&E services in the locality (between 20-30% lower than the average). The model has also been hugely attractive to staff, with retention rates unusually high (in comparison to the rest of the NHS). It is a very rich training environment with engagement with primary and secondary care: “we train every point of the compass and people enjoy it – it’s an accidental advantage that we hadn’t planned at the time”

The Government's flagship integration initiative, the Better Care Fund (BCF), has had mixed success. In some areas CCGs see BCF requirements as a "hindrance to effective local working",<sup>59</sup> but in others BCFs are seen as being effective.

In Sheffield, the CCG and City Council have pooled health and care funds totalling £270m, going well beyond the £41m pooled budget as required by the BCF. The aim is to build an integrated budget for health and social care.<sup>60</sup>

The BCF brought in a minimum standard of integration. This works well in areas where progress had been slow. However in areas where good joint-working already exists it is seen as more of a distraction. One county council leader said that the council had "put in a lot of work into the BCF for very little output". And some stakeholders think the pooled nature of the BCF is illusory. All too often where budgets are "pooled" they in fact remain different streams within the same pool, still separate and accountable to different people.

Two recent Government announcements might change this. First, a £1bn BCF conditional performance payment has been partially scrapped.<sup>61</sup> Second, areas will be allowed to graduate from BCF to a more locally-tailored approach to integration, choosing from a number of options to suit local circumstances. (This will include setting out integration proposals in devolution bids, creating accountable care organisations locally, introducing fully integrated health and social care budgets, or sticking with the existing BCF set-up.)

**We support this hugely positive move, which we think could lead to the systematic transformation of operations at the local level. But at the same time, we believe that areas having problems with the BCFs should be able to negotiate a total exemption from the scheme. Areas that want to continue with the BCF should be able to expand its scope to include public health, mental health, disabled adults and complex adults.** This should be translated into a minimum pooled budget for these cohorts of people to be added to the local BCF.

## 5.1 Getting rid of silos

Despite the efforts of successive governments, the system seems to stay stuck in the organisational boundaries established when the NHS was created. This drives fundamental differences in the provision and management of health and social care, causing a number of problems.

- It is hard to develop appropriate care packages when most NHS spending is paid for out of general taxation and social care is either privately funded or paid out of tight local authority budgets. Uncertainty over who will foot the bill is a constant source of friction.<sup>62</sup>
- While local authorities operate within a rationed system and have to balance their books, NHS trusts operate on an activity model, often at a deficit.<sup>63</sup> The result is that trusts focus resources on immediate pressures rather than longer-term system planning. There is often little financial planning between the two systems – as shown by 80 NHS Trusts demanding a business rates rebate from local authorities.<sup>64</sup>
- Major differences in accountability arrangements between NHS bodies, local government and central government drive siloed mentalities – a substantial barrier to integration. Tensions between nationally set targets and locally delivered outcomes make integration much harder.
- Cultural differences between the health and local government sectors exacerbate these tensions. There is often a lack of mutual understanding as to what each part of the health and care service does, how it does it and why. This breeds mistrust.<sup>65</sup>

58. Kingston Council (2016) – Coordinated Care Progress Report and Next Steps

59. NHS Clinical Commissioners (2015) – A Shared Agenda

60.

61. The MJ (2016) – Health/social care integration top of council bosses' agenda

62. Commission on the Future of Health and Social Care in England (2014) – A new settlement for health and social care

63. End-of-year figures for the 2015/16 financial year published by NHS Improvement showed that providers in England had a £2.45bn deficit, three times the figure recorded for 2014/15.

64. Guardian (2016) – Cash-strapped hospitals ask for £1.5bn tax rebate

65. This is not helped by the gulf in professional separation. An HWB chair interviewed for Unblocking knew of a doctor who had never met a social worker.

These factors mean that the organisations that make up local health and care economies share little interest in a common transformation.<sup>66</sup> This prevents place-wide strategic planning.

The friction is particularly apparent between providers – in particular acute trusts – and the rest of the health and care system. Relationships are often fraught and there is a widespread view that providers operate in a world of their own. Too often acute providers are “overly reactive, rather than instigators of change” noted a senior figure at NHS England. An executive officer from an acute trust suggested that this was because his colleagues’ time is consumed with day-to-day tasks which “doesn’t create an awful lot of headspace to think about reform.”

Our research showed that the organisational structures of health and care services provide little incentive for acute providers to do things differently. As one Health and Wellbeing Board Chair summarised: “Sometimes acute providers have no idea how the community works, so there needs to be more incentives for them to take a broader view.”

## 5.2 Devolving control over local health budgets

We feel that BCF and other smaller-scale integrating initiatives offer two important lessons:

- Integration is best driven from the ground up
- Areas should be able to plan and pool resources, using a larger proportion of their budgets

As outlined in section 2.3, we believe that local areas should gain much more financial control over their local health budget. For areas that want it, control over the total local health budget should therefore be devolved and held and accounted for locally, with local areas eventually moving towards single health and care budgets and a single local commissioner of health and care services.<sup>67</sup> As part of this, local health and care systems should have to operate under a single rationed system, with financial officers across health and social care expected to balance budgets over 5-10 years. There should be full open book accounting between providers and commissioners in the local health economy.

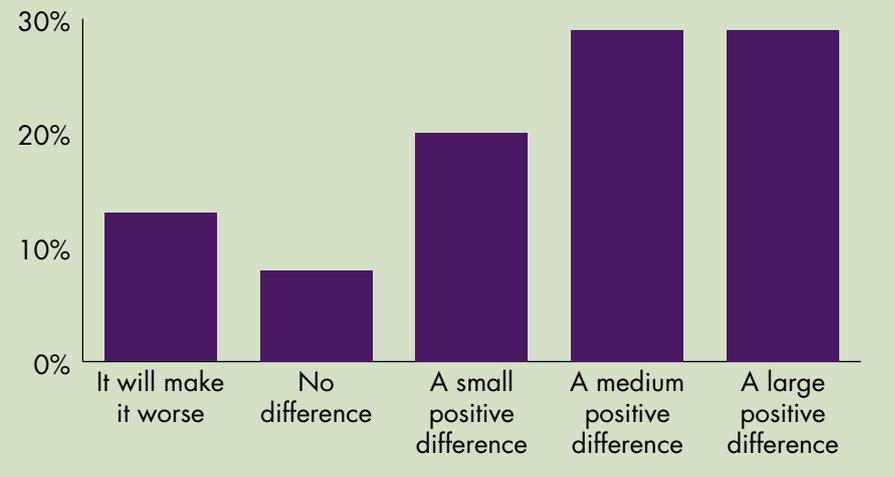
This radical rethink of the way money flows through the national health and care system would create a completely different set of incentives to integrate, fostering collaborative leadership and providing a much needed common stake in transformation. It would align incentives between local partners and devolve decision-making to a local level. This will encourage health and care funding to be seen as a single resource to improve the local population’s health.<sup>68</sup> It would also encourage long-term planning within a clearly defined budget.

66. As one CCG chief officer said: “For years I have run my organisation to only do things that will benefit the organisation itself, even if it harms other ones.”

67. See Barker Commission recommendations: Commission on the Future of Health and Social Care in England (2014) – A new settlement for health and social care

68. Nuffield Trust defines vertical integration as “focus[ing] on networks and groups at different stages of care within the health economy... [which] might involve, for instance, the drawing together of a hospital with local community services.”

**Figure 4: What degree of difference do you think devolving control of the total local health budget would have in making your local health and social care system better, more sustainable, and more integrated over the course of this parliament?**



Key stakeholders in Greater Manchester told us that financial devolution had caused vested interests to collapse. There has been a “shift in thinking of acute trusts so that they are not just focused on the needs of NHS Improvement but also whole-system transformation”. Councils and CCGs have started to integrate their commissioning functions, with many considering having one organisation with significant pooled budgeting.<sup>69</sup>

Financial devolution transfers financial risk. This takes a great deal of political capital. Local areas would take on financial control risk as well as benefit: any shortfall would need to be made up through increased local revenues (for which they should be devolved extra revenue-raising powers as we describe in chapter 8). It will also have to cover the need for more money in parts of the health and care service. In practice this would mean that local leaders would lobby the Treasury directly for more money rather than relying on the Secretary of State.<sup>70</sup>

### 5.3 Enabling better use and sharing of data

Fragmented, the lack of overlap between health and care services is not helped by problems in sharing information and the relatively low take-up of data sharing. National rules around information governance only enable organisations to share information if for the direct delivery of care, but not for commissioning care. This is a problem because it means that there is no single joined-up view about the population and high risk individuals.

We believe that a more local system would encourage local areas to try new ways of doing things. And this would mean a better use of technology. This would then loop back to better results at the local level and the spread of innovation across the system. It would also open the door for local areas to invest in IT to link up local systems .

<sup>69</sup>. HSJ (2016) – CCG and councils planning to form ‘one organisation’

<sup>70</sup>. Greater Manchester secured £450m in the 2015 Spending Review for transformational funding. This is part of a wider fund, and is arguably just the regional share, but it portrays a shifting dynamic where local leaders hold increasing sway with the Treasury. Given the geographic and current political differences between the Government and places such as Greater Manchester, we believe it is also healthier democratically.

## 6. Achieving horizontal integration

One of the key priorities of the 2015 Spending Review was greater collaboration across public service delivery.<sup>71</sup> Cross-public sector collaborative leadership and a unity of purpose are vital to the successful governance of local areas.<sup>72</sup> The full devolution of business rates to local authorities by 2020 will link their financial position to local growth. Joined-up public services will be crucial to achieving this.

Greater collaboration with the rest of the public sector is especially critical to health because so many factors, including housing and employment, link into a person's health.<sup>73</sup> This makes joint-planning between commissioners and providers of healthcare and their counterparts for other local public services crucial.<sup>74</sup>

Public sector bodies tend to follow organisational and sectoral boundaries rather than geographical ones. Separate funding streams prevent coordination. This stops a cross-sectoral response to preventing illness happening in the first place.<sup>75</sup> One CCG officer noted how some people in his local area "don't get any help with their employment or housing needs until they see their GP". This is the opposite of the prevention-based aims of the *Five Year Forward View* and directly stops people's lives improving.

This is a particular issue for individuals with complex and multiple needs who 'bump up' against multiple public services at the same time without receiving the care that they need. As one interviewee noted: "There is a group of people just bouncing around the system getting ineffective care... in some cases this is because the organisations genuinely can't deal with the complexity, in others it's because they're pushing away responsibility as they don't reach certain thresholds". Interviewees across the health and care system were aware of this issue and felt that providers were often blind to it.

71. HM Treasury (2015) – A country that lives within its means

72. Localis (2015) – Making Devolution Work

73. The King's Fund – Broader determinants of health

74. The Nuffield Trust define horizontal integration as "focus[ing] on competing or collaborating organisations, networks or groups in the health economy"

75. As discussed in chapter 3, the organisation investing in preventing illness often sees little financial return in its prevention.

76. HM Government (2011) – No health without mental health

### **Improving care for individuals with complex needs**

Often individuals with overlapping illnesses need to engage with many services at the local level. But they do not get holistic treatment. Charity coalition Making Every Adult Matter (MEAM), has pointed out that this cycling around the system comes at a huge cost to the individuals concerned – and to the public purse. "The failure to properly support this group leads to the most significant costs to public services, and they are also most likely to be unintentionally affected by the planned reductions in spending," MEAM has said.<sup>76</sup>

Central government and NHS England have acknowledged these issues, in particular relating to mental health. The Coalition Government's mental health strategy, *No health without mental health*, outlined how they "expect[ed] parity of esteem between mental and physical health services".<sup>77</sup> And in the *Five Year Forward View*, NHS England committed itself to "decisive steps" in breaking down the barriers in how care is provided between mental and physical health.

This is a global issue and occurs across the world. For example the introduction of the Affordable Care Act in the United States has extended Medicaid to an extra 11m Americans. This has made the state start to treat "super users" more holistically. Hennepin County has a pilot programme in which the social services department and local safety-net hospital have worked together to prevent illnesses happening in the first place and to stop people going into hospital unnecessarily.<sup>78</sup> The local hospital is given a per capita payment for each patient to encourage prevention. Since the pilot programme started in 2012 it is thought to have reduced medical costs for each patient on average by 11% each year.

We believe that this highlights two things:

- The need to establish local care models that are accountable for the care of all individuals whilst including all providers either in an alliance or as one organisation.<sup>79</sup>
- The need to empower local areas to rethink and reform the way they deliver care. With greater responsibility, powers and pooled funding held at the local level, there is a huge opportunity to work across silos and establish place-based strategies with regards to health, care and all other types of public service.

These points are embodied in Greater Manchester where the policy levers, and a devolution deal can establish a "healthopolis" capable of being "the UK's first devolved city region to focus on citizens' health."<sup>80</sup> These powers would also, as one of the key stakeholders in the city-region's transformational team told us, improve "the potential of Greater Manchester to be a successful place – of which getting a healthy population will be critical for its economic success." And as another key stakeholder put it, "the big opportunity of this whole process is a much clearer connection between the delivery of health and social services into the broader programmes of work and wider determinants of health".<sup>81</sup>

Our survey respondents felt that it was most important for health and care services to integrate with housing and welfare. **We also believe that local health and care economies need to involve other arms of the public sector as much as possible in developing their bids and in their Sustainability and Transformation planning.** As we noted in our report *Making Devolution Work*, too often devolution deals have not garnered the engagement – or subsequent support – of non-local authority bodies. This has been to everyone's detriment.

77. New York Times (2015) – Health Care Systems Try to Cut Costs by Aiding the Poor and Troubled

78. Community budgets, which allow local service providers to pool budgets and provide place-based budgeting, have had some success in tackling this issue. But they have not taken off as widely as needed.

79. Reform (2015) – Letting Go: How English devolution can help solve the NHS care and cash crisis

80. Importantly, integration initiatives haven't been exclusive to local government-focused devolution deals. Recent penal reform announcements, for example, included moves towards full co-commissioning between prison governors and NHS England with regards to mental health services.

81. BRE (2010) – Quantifying the cost of poor housing

## 6.1 With housing services

The effects of poor housing on health and wellbeing are well known. Problems include increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. The Building Research Establishment (BRE) estimates that poor housing costs the NHS at least £600 million per year.<sup>82</sup> Greater integration between health, care and housing services is therefore crucial. Any push towards community-based care will need appropriate care to be provided in people's homes. This issue is pressing: polling for the Papworth Trust in 2012 found that one in four disabled and older people could not get around their home safely.<sup>83</sup>

**The devolution agenda could enable better integration between public and private sector housing delivery.** Greater Manchester is developing a city-wide memorandum of understanding between 30 local housing associations and the 10 local authorities to set joint housing targets. With devolution deals invariably including powers over housing and planning more local areas will be able to integrate services.

Local areas can learn from places demonstrating best practice such as Wigan, where the council's in-house agency delivers using the Disabled Facilities Grant to provide and deliver major adaptations to private sector homes.<sup>84</sup> The council is also piloting a non-means-tested Homes Adaptations Grant service to reduce unplanned hospital admissions.

## 6.2 Welfare services

Being unemployed for significant periods can increase the risk of physical and mental ill-health.<sup>85</sup> The *Five Year Forward View* acknowledges this, noting that mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than musculoskeletal complaints do. Also the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups, just 7%.

The Government's flagship Work Programme has been criticised for its low success rate.<sup>86</sup> Despite this track record and a London Councils report which found locally-led employment schemes to be up to seven times more effective than the Work Programme,<sup>87</sup> this initiative remains firmly in the hands of central government. As the Commons CLG Committee comments, "the priorities of the Department for Work and Pensions appear particularly resistant to the arguments for devolving power to local institutions".<sup>88</sup>

We think this is wrong and so did many of our interviewees. Several alluded to the broad brush nature of the Work Programme and one arguing that health and employment can only really be joined up at the local level.

We are encouraged then to see that Greater Manchester's devolution deal includes the city becoming a joint commissioner with the Department for Work and Pensions for the next phase of the Work Programme. This is positive, but doesn't go far enough.

**We agree with the LGA's recent proposals for devolved employment support on expiry of the Work Programme and Work Choice in 2017.<sup>89</sup> We feel local areas should aim to gain these powers, perhaps under the banner of being a pilot area.**

82. Papworth Trust (2012) – Home solutions to our care crisis

83. Care & Repair (2013) – Home Adaptations for Disabled People, Good Practice Case Study: Wigan

84. UCL Institute of Health Equity (2011) – Acting on the Wider Determinants of Health

85. BBC News (2013) – Welfare-to-work scheme 'is failing'

86. London Councils (2013) – Getting London Working

87. Communities and Local Government Committee (2013) – The role of local authorities in health issue

88. LGA (2016) – Realising Talent: supporting people with multiple needs into work

89. NHS Improvement has recently said that the supply of nurses in England's hospitals is now 14,000 short of demand Financial Times (2016) – England's hospitals need 15,000 more nurses, says NHS

## 7. Reshaping the workforce

NHS workforce trends have not mirrored the growing shifts in demand for health services or the new models of care. People generally have holistic requirements and care needs to move out of hospitals. Yet in the past 15 years the number of hospital consultants has increased three times faster than GPs. The number of community-based nurses has increased by less than 1% over the past decade. And there could be huge workforce shortages across the NHS in the next few years.<sup>90</sup>

These factors are already having a significant financial effect. Spending on temporary and agency staff has increased in real-terms by 25% between 2013/14 and 2014/15 and is a one of the key underlying causes of the rising operating costs in recent years.<sup>91</sup>

### 7.1 Aligning workforce planning

To date there has been little effort to support local areas with the necessary workforce planning, training and development to shift to new, more integrated health and care models. This is a substantial barrier to transformation. A politician and practicing GP noted how “the aim of the new models of care is generally to push care into the community, but often there just aren’t enough people to do it”.

One CCG chief officer noted: “As the integration agenda grows, we will need very different people from the ones that we currently employ. They’re going to need very different training and education.” Another stakeholder, deeply involved in the Greater Manchester plans agreed: “Thinking about how we deliver services in a different way makes us think about workforce in a different way. Developing new roles to deliver these new service delivery models is undoubtedly a challenge”.

This is fully accepted by NHS England, which notes in the *Five Year Forward View* that “we can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver.”<sup>92</sup>

90. Health Foundation (2015) – Health Foundation Representation to the 2015 Comprehensive Spending Review

91. NHS England (2014) – Five Year Forward View

92. CASS (2010) – Employee-owned businesses

A key driver for change is in how clinicians are trained. Currently the training tail wags the provider dog. One CCG chair noted how, “the current shape of service is driven as much by the training needs of junior doctors as much as the needs of the population and whatever care model is used. This stranglehold that medical training has had on services creates a shape of hospital services that is unsustainable and has got to come to an end”. New care models will demand a more multi-disciplinary approach to training with professional roles seen less rigidly.

This is starting to happen. One vanguard chief officer told us: “Over much of my career there has been a tendency to say ‘only a doctor can do it’ ... well the last five years have proved that wrong – there are a lot of other people that can do what GPs can do.”

**We therefore recommend that:**

- **Health Education England (HEE) and other workforce bodies rationalise resources and develop plans to support local areas with workforce challenges for integrated care**
- **The Government and NHS England have a national campaign to drive the creation of a new integrated care workforce, looking beyond traditional job title boundaries**

Planning and achieving a workforce better suited to needs will be a huge challenge. Many professions feel they have won their hospital status and value the prestige that comes with it. It will not be easy to convince them to, say, move to a community hospital. One CCG officer told us: “We’ve tried to set up community-based care for services such as dermatology, but both times it has been absolutely stymied by the hospital consultants not wanting to move away”. There’s some indication that the system has reached a tipping point, with consultants possibly seeing that their self-interest lies in a new provider model. But this idea of hospital status holds not just for doctors but for nurses too – and any shift towards community-oriented care will depend on them.

## 7.2 Mutualising staff structures

We believe the overarching management structures should be fundamentally reformed. As one senior figure from a central NHS body said, the health and care services “need to look at their workforce in a different way, working across boundaries and organisations.” The workforce needs to feel more engaged with the NHS as a whole rather than rules and regulations.

We think that frontline staff should collectively have much more control over the way their local organisations are run. This would mean entrusting professional people to get on with their job whilst making them more accountable.

To achieve this we believe that **local areas should be able to mutualise their NHS staff structures**. This would bring no changes to any employee’s wages or conditions. But it would give staff more freedom to manage frontline work while no longer being held back by the system. Local health economies should be able to set their own place-based contracts which would allow staff to move more freely between organisations. This could help break down barriers to shifting care out of hospital and provide incentives for multi-disciplinary skillsets. Local organisations would be able to pool back office staff, reducing administrative costs.

Importantly this aligns with government policy – a key plank of the Coalition Government’s public service reform programme was the enabling more public sector employees to take control of their workplaces via mutualisation. As we noted in our 2013 report *Catalyst Councils*, mutuals bring a number of benefits namely, as described by Charlie Mayfield, Chairman of the John Lewis Partnership, “a happier workforce, more accountable management, a closer alignment of risk and reward, a fairer distribution of profit – [this] can help engender a culture of responsibility and trust in the workplace and beyond.”<sup>93</sup>

**Case study: Staff autonomy at Buurtzorg<sup>94</sup>**

Buurtzorg, a home care provider in the Netherlands, gives its staff of 8000 nurses and 50 back-office staff significant autonomy. Nurses are able to use their training and expertise to respond to the needs of their care users without being micro-managed. Buurtzorg’s staff tend to be expensive as they are highly experienced. But since interactions have become more effective, staff now spend about half the amount of time with users than they did before the new care model was brought in. Patient satisfaction ratings are 30% above the national average and staff satisfaction is said to have improved: the provider was Dutch employer of the year in 2011

93. *In Search of the Perfect Health System*, Mark Britnell

94. Though ring-fenced, health spending has, according to the IFS, faced what equates to a 9.7% real-terms cut between 2010-11 and 2015-16. At the same time local government funding has seen major reform, with large reductions in central funding since 2010. The 2015 ADASS Budget Survey found that, since 2010, adult social care has seen £4.6bn of budget reductions – equivalent to 31% of the 2010/11 net Adult Social Care budget.

## 8. Finding financial sustainability

Health and care services face significant financial pressures: these include changing demographics, higher operating costs, introduction of the National Living Wage, a drop in social care funding and a real-terms drop in health care funding.<sup>95</sup>

NHS providers's financial position is particularly weak, with deficits totalling £2.45bn 2015/16.<sup>96</sup> The Department of Health needed an emergency bailout and to shift £950m from its capital to its revenue budget to balance its books.<sup>97</sup>

The care sector faces similar financial stress. Although the recent social care precept was welcomed by health and local government leaders, many note that it will not plug the financial hole councils already face in social care,<sup>98</sup> or resolve the "catastrophic collapse" that care homes face across the UK.<sup>99</sup>

These are huge worries for our interviewees across all parts of the health and care services. Many are concerned that their local areas are a long way from financial sustainability. Transformational schemes such as new models of care are expected to deliver some savings, but frontline staff and commissioners are unsure whether these savings can be delivered quickly enough or whether the models are scalable and replicable. As one CCG member working on the frontline of a vanguard said: "What we need to do to achieve some operational and financial sufficiency is huge... we have a good collaborative approach, but it is a huge ask. There is still huge scaling up needed to effectively respond to the challenges that we have got. I do wonder how we're going to ramp up the pace at that rate over the next few years – it keeps me awake at night".

Many interviewees accepted it was unlikely that there would be more funding to address these concerns. But when asked how to bridge the finance gap, our survey respondents mostly chose traditional funding models such as raising general taxation and specific health taxes. Both are unattractive options for the Government.

95. NAO (2015) – Sustainability and financial performance of acute hospital trusts

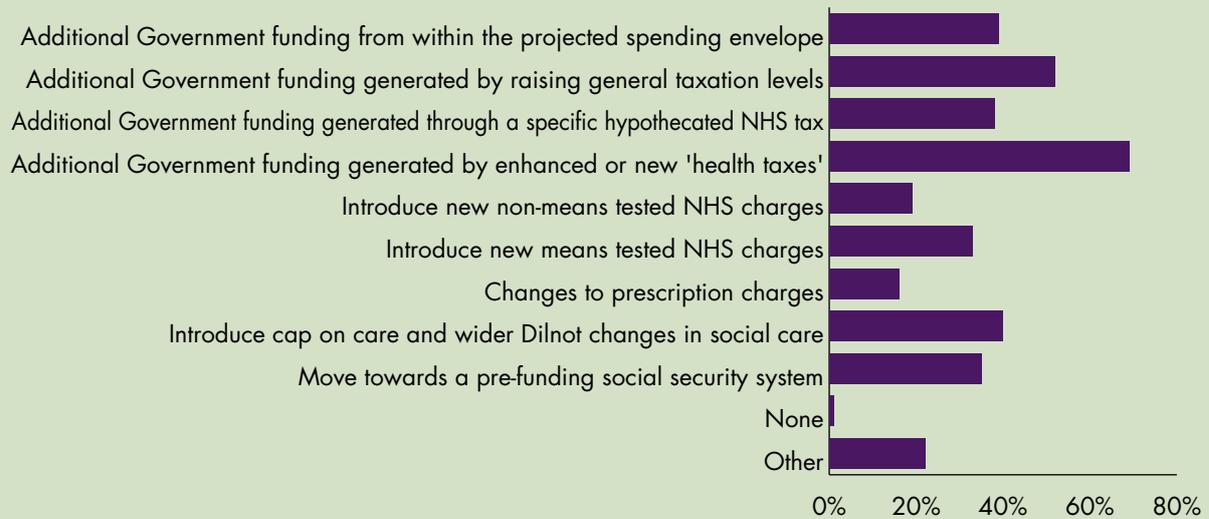
96. The Guardian (2016) – Department of Health receives £205m emergency bailout

97. The precept is expected to raise £2bn by 2019/20 but the gap across the sector by then is expected to be £6bn according to the Health Foundation.

98. The four largest care home owners in the UK, mostly focused on the state-funded market, have warned that there is a risk of "catastrophic collapse" in the care sector. Financial Times (2015) -Bupa readies sale of 200 UK care homes

99. Though in 2006, fiscal powers were taken away from Danish county councils who are responsible for secondary healthcare.

**Figure 5: What radical options for future funding of health and care services, if any, should the Government explore**



**We think it is important that local areas are able to raise much more revenue themselves.** If local areas hold more financial risk, then they should also be able to make up shortfalls and raise the funds needed to invest in prevention. **A raft of measures should be used to support local areas in finding financial sustainability: these can be measures to raise extra funding or to enable better use of existing resources.** Some of these measures can also be considered in Sustainability and Transformation planning.

#### **Case study: Achieving a central-local funding balance**

Where local government is responsible managing health and care systems, revenue tends to be mostly raised through local taxation. This is particularly true in Scandinavia. In Denmark 60% of local government revenue is raised through local taxation;<sup>100</sup> in Sweden the figure is 70%.<sup>101</sup>

Each country is committed to equalisation so additional funding is transferred to the less affluent areas where tax bases are smaller. Sweden achieves this central government grants to county councils and the transfer of municipal income tax.<sup>102</sup> Finland operates a state subsidy system which aims for equality of opportunity for equal need.

Both systems empower local areas to deliver a standard level of healthcare provision. Local leaders are able to adjust the local taxation levels according to the demands in their local health and care economies.<sup>103</sup>

100. Communities and Local Government Select Committee (2009) – The Balance of Power: Central and Local Government

101. Anell (2012) – The health system in Sweden

102. Anell (2012) – The health system in Sweden

103. The ongoing review of the business rates redistribution formula might offer lessons or a framework for implementing a similar scheme within England.

## 8.1 Fewer limits on social care precept

The introduction of the 2% levy on council tax for social care could mark a fundamental change in the culture of health and care services. As a former minister noted to us, the levy “opens up a source of funding for a joined up health and care system and is a huge step forward in reintroducing local place voice into the health service”. The amount the precept raises for local authorities varies substantially (and not all authorities have chosen to implement the levy). But the precept could develop into a substantial stream of money. This could mark several real changes:

- Councillors’ roles will change as they will be increasingly held to account for the health and wellbeing of the population.
- The culture within local authorities will shift further towards thinking about health and wellbeing.
- Local leaders might begin to lobby for the precept to rise to a higher percentage level and/or the 2% cap on council tax increases to be dropped.

We believe that there is a pressing case for this last point. Despite the introduction of the precept, the social care funding Gap will still total between £2bn – £2.7bn in 2019/2020.<sup>104</sup> As such we recommend that when negotiating deals with the Government, **local areas should seek the freedom to alter the levy on council tax for social care. The level that the levy is set at should then be strictly tied to local need, increasing or decreasing as necessary.** Though councils will need to take political considerations into account, there is high support for adult and children services to be protected from any cuts.<sup>105</sup>

## 8.2 Devolved health taxes

Calls for health taxes such as a sugar tax have been discussed at length recently, resulting in the introduction of a soft drinks industry level tax. We believe there is a good case for these calls to be made at the local level. **If a region is particularly affected by a particular disease, local leaders should be able to bring in the relevant health tax to raise revenue and provide disincentives behaviours that cause the problem.** It will be hard to implement a tax on consumption at the regional level. But we think it should be part of the public discourse in the same way that devolving income tax and the social care precept are.

## 8.3 New local body for estate management

The NHS estate is vast but used inefficiently. A case in point is the 28,000m<sup>2</sup> East Dulwich Hospital site. Despite outline planning permission for reconfigured services being granted in May 2003 and a planning brief published as early as July 2005, the site has laid unused since the hospital was closed ten years ago.

Poor management of the public realm is changing through schemes such as One Public Estate,<sup>106</sup> but not quickly enough. Not only does it cost money – the direct running costs of the NHS estate are its third biggest cost at £7.3bn<sup>107</sup> – but it also hampers local transformation. New models of care rely upon more appropriate infrastructure. This is particularly true for the primary care estate. As one politician and practicing GP said: “To push patients into the community, capacity needs to be created within that community to care for them.”

104. Nuffield Trust, The Health Foundation and The King’s Fund (2015) – The Spending Review: what does it mean for health and social care?

105. BBC News (2016) – Social care ‘at breaking point’ despite council tax rises

106. One Public Estate is a joint programme between the Cabinet Office-led Government Property Unit, the Local Government Association and local authority partners which aims to ‘unblock’ any barriers between asset holders which prevent a more integrated approach to asset disposal.

107. Department of Health (2014) – Hospital Estates and Facilities Statistics 2013-14

Better management of the NHS estate also offers revenue-raising opportunities for local health and care economies. Public land that is not needed now or in the future can raise significant amounts of money, through one-off capital receipts or by redeveloping estate assets and deriving long-term income streams.<sup>108</sup> Monitor estimates the value of the NHS estate to be £31.2bn.<sup>109</sup> This makes better estate management a priority both for local health and care economies in their Sustainability and Transformation planning and for any local areas negotiating deals along the lines described in this report.

Pilot projects are happening in London's healthcare devolution. Five north London boroughs have agreed to collaborate in their estate strategy. In practice this will mean sharing buildings and facilities and collaborative asset disposal/redevelopment. Similarly the Greater Manchester devolution agreement has allowed a city-wide reform of estates strategy which has led on to a reconfiguring of NHS assets. An NHS Estates GM Delivery Team has been set up to work closely with colleagues from across the public sector to deliver a "one public estate" approach to property management while a GM Strategic Estates Planning Board will be responsible for translating strategic requirements into a set of GM estates targets, ensuring it meets local health and social care needs.<sup>110</sup>

We believe that this collaborative approach with local government is positive as it allows capital programmes to be aligned while removing barriers to best use the NHS estate. We think the approach needs to be applied more widely across the NHS.<sup>111</sup>

With this in mind, we therefore recommend that local areas **should consider rationalising all local NHS estates into one body**. As in Sweden – and similarly to Crown Estates– this could be transferred to a holding company structure that is arm's length of the state, which then works alongside local authorities and one or more private sector partners. Alternatively it could be led by a network of providers and local authorities working across a sub-regional geography, as is the case in north London.

## 8.4 Buy out PFI loans

Some NHS organisations who are under significant budgetary pressures are currently finding it difficult to meet the annual payments on hospitals brokered via private finance initiatives. While the payments due under the private finance initiative have enabled outdated buildings to be improved or replaced, the ongoing cost commitments can weigh heavily on the health sector.

It may be that there are some deals (or parts of deals) that no longer represent value for money. And, given that, Trusts need to look at options for saving money. That might include refinancing debt or renegotiating deals, perhaps with government support, but it should be noted that the terms of some of these agreements may make renegotiation difficult.

108. Though we note that The Health Foundation estimate that selling current surplus NHS-owned land as a one-off receipt would only raise £700m, so would strongly recommend local areas focus on redevelopment. The Health Foundation (2015) – Representation to the 2015 Comprehensive Spending Review

109. Monitor (2013) – Closing the NHS funding gap: how to get better value health care for patients

110. GMCA (2016) – Taking Charge of our Health and Social Care in Greater Manchester

111. As a senior NHS England figure told us, NHS finance directors generally have neither the capacity nor the expertise to develop comprehensive estate management and capital investment strategies; often these need to be done over wider geographies than many are used to operating within.

### 8.5 Tapping into local government entrepreneurialism

As we documented in our report *Commercial Councils*, over the past few years there has been a big shift in local government towards thinking entrepreneurially about the services it provides and how it does so. For instance in our report we found that 58% of local authorities own a trading company and 57% operate a joint venture with the private sector, as well as almost every authority sharing some services with another. Driven by falling budgets, eight out of ten councils say they would have to cut services and raise taxes without these entrepreneurial activities.

For the most part this boom in municipal enterprise hasn't happened in the NHS. As one CCG chair said, "some finance directors are thinking more commercially about factors such as estates, but it this outlook is limited". We believe that as the health service moves towards being more place-based as we envisage in this report, it will benefit from the commercial nous and expertise that local authorities have built up in the past few years.

# Appendix 1

## Recent policy initiatives

### **Health and Social Care Act**

Much of the landscape by which health and social care services are managed, commissioned and overseen in England was fixed by the 2012 Health and Social Care Act. These legislative reforms restructured both the commissioning and oversight frameworks of the health and social care system to be more locally-focused, establishing Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBs). The former are GP-led, ensuring that the services provided in their local footprint meet local need and control £69.5bn of funding.<sup>112</sup> The latter are forums where key local stakeholders from local health and social care communities set health and wellbeing strategies.

Both CCGs and HWBs are mandated to support integration but by most accounts, relationships between the two – and in effect between CCGs, health providers and local authorities – are seen to be variable in nature and balance. For many of our interviewees, this is a reflection of the long-standing cultural chasm between the NHS and local government; financial pressures; the relative immaturity of CCGs; and sometimes lack of ‘co-terminosity’ between health and local government.

### **Care Act**

In the biggest overhaul of social care legislation since 1948, the 2014 Care Act modernised the framework by which care is delivered by promoting more person-oriented care. Underpinned by a statutory principle of individual wellbeing, the Act clarified the role of the user, carer, provider and local authority in the delivery of care. The second part of the Act, currently on hold, allows for a statutory cap on the cost of care that people will have to pay in their lifetime at £72,000, thereby going some way to address the ‘all or nothing’ nature of state funding for social care.

### **Five Year Forward View**

The *Five Year Forward View* outlines NHS England’s vision for the health service up to the end of this parliament. It projects that the NHS will face close to a £30bn funding shortfall in 2020/21 as demand expectedly rises, and outlines how this gap can be closed by a combination of efficiency savings and extra funding. Specifically acknowledging that England is too diverse a country for a ‘one size fits all’ care model, the Five Year Forward View reflected a step-change in central thinking on what the NHS does and how it should do it.

<sup>112</sup> The Guardian (2016) – How does money flow through the health service in England?

As well as new care models – which include, amongst others, the joining up of GP, hospital, community and mental health services (primary and acute care systems) and the moving of hospital care into the community (multi-specialty community providers) – the *Five Year Forward View* outlined a commitment to investing in prevention and the introduction of new initiatives such as Integrated Personal Commissioning (IPC).

### **Vanguard sites**

To pilot the new models of care outlined in the Five Year Forward View, NHS England established the ‘vanguard’ programme in early 2015 in which fifty sites across England have been given flexibilities and funding to develop and test the models further. As put by NHS England, “[e]ach vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.”<sup>113</sup> Currently around 25% of the English population is covered by a vanguard; which illustrates that the programme “is not just fiddling around the edges like previous initiatives did”, as one CCG Chief Officer put it.

### **Better Care Fund**

The Better Care Fund pools funding from existing NHS and local government budgets and aims to deliver more joined-up local services for elderly and disabled people, focused in particular on keeping them out of hospital. The £3.8bn pooled budget came into full operation in April 2015, and in a positive sign, many local authorities and CCGs have committed additional resources to their local schemes, so making the total of pooled budgets £5.3bn in 2015/16.<sup>114</sup> The programme has been extended until at least 2017 by Ministers.

### **Devolution Revolution**

In perhaps the most radical step in recent NHS history, Greater Manchester was devolved the entire £6bn local health budget in April 2016 after a build-up year to prepare. Following 2014’s Greater Manchester Agreement – when it was announced that the city region would be devolved substantial powers (over housing, transport, skills etc.) in return for accepting a directly-elected mayor – this significant transfer of power is the high water mark of healthcare devolution in England to date.

The extent to which Greater Manchester’s budget has been truly devolved is contested, with some of our interviewees arguing that it is instead delegation, with much of what has been agreed and achieved to date possible without the deal. But as argued by one Greater Manchester stakeholder to us, the deal “provided the impetus, focus and expectation for change and joint-working”. Given the process is still very much in its early stages, it remains to be seen how great an effect devolution will have on Greater Manchester’s health and care economy.

### **Sustainability and Transformation Plans**

As part of the NHS shared planning guidance between 2016/17 and 2020/21, every health and care system in England is obliged to produce a Sustainability and Transformation Plan (STP) outlining how they will transform in the next five years to “deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.”<sup>115</sup> There will be 44 STP footprints each covering 300,000 to 3 million people. They are expected to be led by CCG chief officers, local authority chief executives, NHS provider chief executives and people “independent” to the role.<sup>116</sup>

113. NHS England (2015) – New Care Models

114. NAO (2014) – Planning for the Better Care Fund

115. NHS England (2015) – NHS Shared Planning Guidance

116. HSJ (2016) – Stevens: 44 transformation patches will cover England

# Appendix 2

## Research and results

The research for this project included:

- Three roundtables held across the country attended by a range of people including health ministers, former health ministers, senior civil servants, senior NHS England representatives, senior Monitor representatives, council leaders, council chief executives, council cabinet members for health and social care, council directors for health and social care, CCG chairs and CCG chief officers.
- 36 wide-ranging interviews with stakeholders including former health ministers and shadow health ministers, senior NHS England representatives, senior Monitor representatives, senior NHS Confederation representatives, council leaders, council chief executives, council cabinet members for health and social care, council directors for health and social care, CCG chairs and CCG chief officers.
- An online survey answered by 110 stakeholders from CCGs, NHS Trusts and local authorities (including CCG chairs, CCG chief officers, NHS Trust board members, NHS Trust officers, council leaders, council chief executives, council cabinet members for health and social care and council directors of health and social care) and review of academic studies.



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