Health and social care devolution: a commentary

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Summary

The Greater Manchester Devolution Agreement, settled with the government in November 2014, was a significant event for local government. Following the initial deal, Greater Manchester and NHS England signed up to arrangements for local integration of NHS and social care budgets. Since then, Cornwall has agreed a devolution deal with the government which also includes health and social care and several of the devolution ‘bids’ to the Treasury in September 2015 have included proposals for some devolution of health.

At the same time the Cities and Local Government Devolution Bill is making its way through parliament, proposing an ‘enabling’ framework within which devolution deals can be negotiated.

This briefing gives a summary of what has happened so far and highlights key issues in the debates in parliament on the Bill. It looks particularly at the compatibility of the Bill with current NHS legislation and issues around governance, accountability and overview.

It will be of interest to members and officers in all councils concerned with devolution proposals and those working in health and social care where devolution is or may become an issue.

Briefing in full

The agreement announced in February 2015 by the Treasury to devolve the £6 billion NHS budget for Greater Manchester to a combined authority of the constituent
local councils followed the devolution deal announced in November 2014. The extension of the deal to health and social care was not widely expected, and meant that the devolution agreement with the Greater Manchester authorities was a step change from arrangements like city deals. Since then, Cornwall has agreed a deal including health and social care and several bids made to the Treasury for the September 2015 deadline contained proposals that included health and social care (see list below).

The Greater Manchester deal is, of course, not the only development to progress greater integration between health and local government, such as the NHS England’s Vanguard programme, and in other areas health and social care are considering different ways to bring health and services together with joint funding and joint or integrated commissioning and provision. But the Greater Manchester deal is by far the most extensive.

**Bids including health and social care:**

- Heart of South West
- Oxfordshire and Districts
- Gloucestershire
- Oxfordshire County Council
- Liverpool City Region
- Three Southern Counties
- Cumbria
- Cambridgeshire and Peterborough
- North Yorks
- Suffolk
- Lincolnshire
- Norfolk
- Worcestershire
- Hampshire and IOW

*(information from LGA devolution register)*

These ‘bids’ are varied in how detailed the proposals are – some are very much outlines of a potential combined authority whilst others are more worked through. Gloucestershire, for example, has submitted a detailed devolution proposal, including plans for integrated health and social care as part of a single vision for health and wellbeing for the county: whilst the Heart of the South West is a statement of intent.
A second major devolution deal, Sheffield City Region, published on 5 October 2015, following a more limited initial deal, has no reference to devolution proposals around health and social care in the Sheffield city region.

**Greater Manchester**

The Greater Manchester Devolution Agreement was settled with the government in November 2014. This was then followed by the agreement to bring together the budgets of the NHS and local government to plan joint services.

The ten local authorities and the NHS in Greater Manchester will have direct control of, or influence over, the £6 billion entire health and social care budget currently spent on the 2.8 million people in the combined authority area.

In February 2015, an agreement (Memorandum of Understanding) between the Government, the Greater Manchester health bodies, the local authorities and NHS England was signed.

**Memorandum of Understanding**

The Memorandum of Understanding creates a framework for achieving the delegation and ultimate devolution of health and social care responsibilities to accountable, statutory organisations in Greater Manchester (GM). It sets out the process for collaborative working in shadow form from 1st April 2015 and identifies the areas for further detailed work during the remainder of the year, leading to full devolution in April 2016. The parties to the agreement are: all local authority members of the Association of Greater Manchester Authorities (AGMA) and all Greater Manchester Clinical Commissioning Groups (CCGs) (together known as GM) and NHS England (NHSE). It is emphasised that GM will remain within the NHS and social care system.

The Memorandum sets out the objectives of the health and social care agreement, the steps needed to deliver the objectives and the five initial workstreams:

- developing a strategic plan (clinical and financial sustainability)
- establishing leadership, governance and accountability
- devolving responsibilities and resources
- partnerships, engagement and communications
- early implementation projects.

There will be a Greater Manchester Health and Social Care Partnership Board (GMHSPB), which will produce a joint health and social care strategy for Greater Manchester. The GMHSPB is running in shadow form in 2015-16, before going live in April 2016. It will have two sub-groups: a Greater Manchester Joint Commissioning Board (JCB) and an Overarching Provider Forum. Members of the former will be the 12 Clinical Commissioning Groups (CCGs) in Greater Manchester; the ten Greater Manchester boroughs; and NHS England.
Through the JCB, strategic decisions regarding commissioning of health and social care services in Greater Manchester will be agreed by NHS England, CCGs, and local political actors. The JCB will commission health and social care services across Greater Manchester on behalf of its constituent organisations, pooling the commissioning budgets of the CCGs and the social care budgets of the boroughs. At local (borough) level, Health and Wellbeing Boards, made up of representatives from CCGs and boroughs, will ensure that health and social care services are provided in a joined-up fashion, in line with the GMHSPB’s Strategic Sustainability Plan. The proposals will not lead to a wholesale transfer of functions or funds from the NHS to local authorities, or vice versa.

The proposals are to ‘be implemented with a minimum of institutional change’. The February proposals are to be implemented via section 75 of the National Health Service Act 2006, which permits agreements to share functions and budgets between NHS bodies and local authorities. Many of the November proposals are being implemented via the devolution of programmes and budgets, or the sharing of responsibility between central and local government, without changing institutional and legal structures.

The elected mayor will not have any executive or budgetary control over the integration of health and social care. The GMHSPB will appoint its own chief executive and staff team. An interim chief executive, Ian Williamson, was appointed on 14 April 2015.

A dedicated website covering new arrangements for health and social care has also been established. This states that the early priorities of the new bodies will be: seven-day access to GPs, children’s mental health, mental health and work, better care for dementia sufferers, a joint public health strategy, and aligning the workforce.

**Cornwall**

Cornwall Council is the first non metro authority to agree a devolution deal with the government. Building on the Cornwall and Isles of Scilly Growth Deal, this devolution deal ‘marks an important step in the transfer of resources, powers and accountability from central Government to Cornwall’. The deal includes developing a business plan to move progressively towards the integration of health and social care, involving NHS Kernow, Cornwall Council, the Council of the Isles of Scilly, and other local partners working with NHS England and other local partners to develop a business plan to move progressively towards the integration of health and social care.

**Scrutiny, oversight and governance**
The level of integration suggested in the Greater Manchester deal is clearly significant. Though it may not seem so radical in Wales, Northern Ireland and Scotland where they have had integrated health boards since devolution (health and social care trusts in Northern Ireland). The different administrations have their own approaches to regulation, oversight and scrutiny, and this does raise issues about how oversight will be developed where health and social care functions are devolved in England.

The Cities and Local Government Devolution Bill is a framework Bill – it provides an enabling structure to transfer functions of many public authorities, including NHS bodies, to local authorities. But we cannot know how far the powers will be used – the Bill allows for local deals with different outcomes. This raises questions about how the Bill fits with existing NHS law: the Bill is lacking detail.

We know the Bill applies to all NHS bodies – NHS trusts and foundation trusts, Care Quality Commission, NHS Litigation Authority, Monitor, clinical commissioning groups (CCGs) and NHS England – even the Department of Health. The debate in the House of Lords reflected concerns about NHS oversight (see below for debates in parliament on the Bill).

Sharon Lamb, a senior associate at the Nuffield Trust and a Partner at Capsticks Solicitors LLP raised a number of questions and outstanding issues about this on the Nuffield Trust website and in an article in Public Finance. She says that there are key questions that require clarification, such as whether the Bill over-rides NHS legislation, do NHS bodies have to agree and how will the Secretary of State for Health hold local authorities to account. Considering NHS legislation for example, she says that:

‘We don’t know whether the intention is to over-ride or, in fact repeal NHS law. The list of questions this raises is long – just some are:

- Do patients need to be consulted under existing NHS legislation if hospitals are closed or downgraded?
- Do NHS Constitution rules, which are legally binding on CCGs for their local areas, for example in relation to patient choice apply?
- Will NHS financial rules apply to local authorities?
- What about pricing and contracts?
- NHS ring-fencing: must local authorities spend NHS funds on NHS services or can they use the money for other services, for example adult social services?

At the heart of all of these questions is one key issue – to what extent will 'national' health service policies trump local devolved decision-making’?

Can the devolved administrations give an insight into how regulation will play out in English health and social care devolved systems? In Scotland there are still separate bodies for scrutiny of performance, finance and quality, even though Scotland has integrated health boards (The Public Bodies (Joint Working) (Scotland) Act 2014 was granted Royal Assent on 1 April 2014 and sets out the legislative framework for integrating health and social care).
According to Joy Furnival, a PhD research student at the University of Manchester, studying the regulation of healthcare in the UK, it was suggested initially that GM would develop its own oversight and regulatory system, liberating GM from national requirements. However, the finalised devolution agreement indicated that GM oversight would be in addition to existing national regulation. This could lead to more bureaucracy and complexity in an already complex system. She suggests, however, that GM will need innovative solutions ‘for future regulation, oversight and improvement in this area’.

The King’s Fund makes these points:

‘The main risks of the plans are that they will take time and effort away from work to address the growing financial challenges facing local government and the NHS, and that they will result in confused accountabilities. The worst of all outcomes would be further structural changes to the health service that distract public sector leaders from their core task of improving outcomes for the populations they serve. It will be just as important to ensure that governance arrangements help to clarify where responsibility for providing leadership of public services rests, especially as the coalition government’s reforms have left a vacuum in the NHS that needs to be filled… It will also be important to ensure the plans do not result in a further layer of decision-making being superimposed on an already complex system’.

Cities, Local Government and Devolution Bill

House of Lords third reading and report stage

The devolution of health and social care was perhaps the most contentious part of the Bill (along with the imposition of elected mayors) when it was debated in the House of Lords and now it is being debated in the House of Commons.

Although there is general support for devolving healthcare to combined authorities (and similar arrangements) there are concerns about the process and some of the potential implications for the health service nationally. What have been the main points of debate?

The Bill lacks clarity over key issues – particularly the relationship between the Secretary of State for Health, the Department of Health and the local authorities involved; the way in which this Bill relates to the powers of the Secretary of State under the Health and Social Care Act 2012; where decision-making and accountability lie; and what will actually be devolved?

It is not surprising the Bill is not clear on these issues – it is a framework Bill and it is largely a Bill that is about devolving local government functions, not health service ones.

Government ministers in the House of Lords were challenged on the ability of combined authorities to assume NHS responsibilities, claiming that the situation in Greater Manchester was that of a combined authority negotiating a deal with NHS
England enshrined in a memorandum of understanding covering a number of years. But that this means that the Secretary of State would retain all his powers in the Health and Social Care Act 2012 to overrule actions by the combined authority in accordance with the memorandum of understanding, if he disagreed with those actions. Labour Peers said that ministerial replies indicated that there will still be a good deal of central direction if the government felt it was necessary.

Opposition Peers also wanted the government to be much clearer about the relationship between NHS legislation and the Bill. They claim that the current memorandum of understanding between NHS England and the Greater Manchester Combined Authority, and the prospect of a ministerial order, are not enough to clarify how the devolved arrangements would work in practice. They also say that there is no guarantee that the same arrangements would apply to subsequent deals as they would all be bespoke negotiations.

Lord Hunt of Kings Heath summed up the central issue:

‘How do we get the advantage of local government leadership and democratic legitimacy while ensuring that we have what we would recognise as a national NHS? That is why this is such an important debate and why the Bill lacks clarity’.

The opposition moved an amendment at report stage to clarify the transfer of responsibilities:

After Clause 17, insert the following new Clause—

“Devolving health service functions
Notwithstanding the provisions in sections 8, 16 and 17 enabling the Secretary of State to transfer health service functions to combined authorities or other public bodies, the Secretary of State responsible for the health service—

(a) must remain able to fulfil all statutory duties placed on him under health service legislation in force at the time of transfer;

(b) must not transfer health service regulatory or supervisory functions vested in national bodies responsible for such functions; and

(c) must ensure that authorities or bodies to whom health service functions are transferred adhere to the national service standards and the national information and accountability obligations placed on all health service bodies responsible for functions of the kind being transferred.”

This was passed, despite the Minister, Baroness Williams of Trafford, stating she did not think the amendment was necessary. The Minister had said that there is no intention to remove or undermine the core duties of the Secretary of State, or to dismantle accountabilities for health services as agreed with a particular local area. The opposition wanted to see these commitments put onto the face of the Bill.

House of Commons second reading
The discussion of health and social care was taken up at second reading in the House of Commons. Again the lack of clarity in the Bill concerned members, as in this comment by the Conservative MP, Anne Marie Morris (Newton Abbot):

‘The Government, quite rightly, are looking to integrate NHS and social care, but will that be more complicated across a diverse range of authorities? Does it mean—I hope not—that we will have to unpick and put together again new deals between the NHS and the local authorities? Will the NHS play ball? Should clinical commissioning groups be required to be part of that? They are part of some bids for devolution, but not all of them.

On devolution of health, my one concern is this: who is ultimately accountable for the NHS in Greater Manchester? It is not clear from the memorandum of understanding signed between the Association of Greater Manchester Authorities and the Government. The mayor seems not to be part of that memorandum at this stage and I hope very much that that is reviewed. If I were an NHS provider in Greater Manchester, to whom do I look to make the decisions? Is it NHS England, the combined authority, the mayor, or am I looking in all directions? That lack of clarity really needs to be sorted out, so we have clear levels of responsibility’.

And this:

Mike Kane (Wythenshawe and Sale East) (Lab): We are in favour of the devolution package, and the interim mayor, Tony Lloyd, will have powers over transport, business rates, skills retention and spatial planning. However, the problem as it stands is that the people of Greater Manchester do not know where the health portfolio is going to sit. Who will be accountable? At the moment, it will be one of the 10 local leaders. The devolution deal, as currently put forward by the Government, is not joined up.

Second reading continued 22 October

A series of government amendments took on board the debate in the House of Lords regarding the core responsibilities of the NHS. The Minister, Alistair Burt stressed that the accountability of the Secretary of State remains and that ‘the regulatory powers of organisations such as the Care Quality Commission, Monitor and others will also remain in place to ensure that none of the national quality standards we expect from the NHS will be deviated from… ‘Clause 19 provides that the regulatory functions of national bodies held in respect of health services will not be available for transfer to a combined or local authority’.

and
‘As amended, clause 19 provides further clarity about the role of the Secretary of State for Health and what will and will not be included in any future transfer order giving local organisations devolved responsibility for health services. This clear statement in legislation, making provision for the protection of the integrity of the NHS, is intended to provide further confidence for future devolution deals. In essence, they will be underpinned by the basic core duties of the NHS, and that cannot be shifted’.

and

‘Following discussions with Greater Manchester and other local areas, we are now taking the opportunity to make available further options in legislation for combined authorities and local authorities to work together with clinical commissioning groups and NHS England across a wider area—such as Greater Manchester—to improve the integration of services. Those options will sit alongside the powers provided by the Bill to devolve a range of powers and functions that are currently exercised by Whitehall departments or bodies such as NHS England to a combined authority or a local authority. Crucially, wherever responsibility for NHS functions is delegated or shared in this way, accountability will remain with the original function holder, whether that is NHS England or a CCG. The original NHS function holder will continue to be accountable via the existing mechanisms for oversight, which ultimately go to the Secretary of State, who retains ministerial responsibility to Parliament for the provision of the health service’.

Comment

The rewards of greater integration at the local level have been well argued – improving services that meet the particular needs of local areas, using the resources of local authorities to ‘go beyond integration of care to focus on population health’ – as aptly put by the King’s Fund.

The potential impact on health and social care services from the Cities, Local Government and Devolution Bill is extremely significant. Already Greater Manchester shows that local authorities and the government mean business.

However the extent of change, for example, to NHS structures and bodies, if devolution were to become widespread, is not yet clear. The Bill provides the framework but not too many details of how it can work. Yet the Bill does imply many functions could be devolved (or dissolved) from public service bodies, including the NHS. Because the Bill wants to put in place flexible, negotiated deals, it contained wide powers but little detail. The ambiguities around NHS legislation were the result. This has been partly addressed by the government amendments during the second reading of the Bill, although the nature of the Bill means there is not going to be a great deal of detail on the face of the Bill.
There are bound to be tensions – between ensuring the NHS core principles are adhered to whilst providing for flexibility and innovation at the local level. Maybe ultimately how effective devolution works in this area will be less about the legislative framework and more about the strength of relationships locally?

How accountability works is also not straightforward. The Minister at the second reading talked about a breakdown or failure in a service – if there was, for example, a dispute between two constituent areas of a combined authority, one of which claimed that there was some inequity between the service that it was receiving and the service being received by the other, ‘the buck would stop with those who were making the decisions locally, and that is the combined authority’. The matter would not go anywhere near the Secretary of State. What the Secretary of State retains responsibility for is the standards and whether or not there has been a breach of NHS duties in relation to anything that falls within his own overall responsibility. So the buck still stops with the constituent authority that is delivering the service’.

Although this is logical it could still cause some confusion locally. However, accountability and responsibility are not necessarily easy to work out in our current system when something goes very wrong. There also needs to be clarity around issues such as closure of hospitals or facilities.

This kind of issue highlights that devolving health and social care is probably the area of devolution that local people would be most interested in and concerned about. There is concern that there has not been enough community involvement in developing and negotiating devolution deals generally. And that health professionals and social care and health providers have not been fully involved.

All of this is happening, of course, at the same time as the NHS and social care are under growing financial pressures. Further integration is not a panacea. Chris Ham, the CEO of the King’s Fund commented in March:

‘With financial pressures on public services set to continue, there needs to be clarity on how overspending of NHS budgets will be handled, especially after the build-up year. This includes the scope for local authorities to switch funding from the NHS to other services. The Commission on the Future of Health and Social Care in England showed that the case for a single health and social care budget is compelling but only if sufficient funding is provided. Merging two leaky buckets does not create a watertight solution, as Simon Stevens has observed, and devolution in a time of austerity risks shifting blame for unpopular decisions from Whitehall to town hall in the absence of sustainable funding agreements’.

So far it is not clear how overspends will be dealt with and there is unlikely to be additional funding or what happens about NHS debts and liabilities, including private finance initiatives and clinical negligence claims. And devolution highlights the issue again of how the boundary between free healthcare and means-tested social care can be negotiated.

There are also clearly many technical and practical questions not yet fully answered, but the key question is perhaps more philosophical – how can a national health
service be reconciled with a system that allows for local variations; how can we define ‘national’ in this context and can genuinely flexible and local solutions safeguard the principles which underpin the NHS?

The Bill and the deal in Greater Manchester do not fully answer that question. Answers will be shaped by what happens in Greater Manchester in the build up to full devolution in 2016, by the response of residents and communities, by how local areas and the NHS develop working arrangements, and by politics. The prize is certainly worth fighting for – winning it may well be tough going.

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