

Briefing

Devolution: what it means for health and social care in England

Devolution of powers and funds from central down to local government has emerged as one of this government's flagship policies. The notion of devolving health care was not core to the original devolution agenda, which focused on driving local economic growth. The inclusion of health and social care in the so-called 'Devo Manc' agreement announced in November last year therefore came as a surprise to many. Along with powers over housing, skills and transport, the landmark deal between the Treasury and Greater Manchester paves the way for the councils and NHS in Greater Manchester to take control of the region's £6 billion health and social care budget.

Ahead of further devolution deals expected to be announced as part of the Spending Review 2015, this briefing describes the origins of the devolution agenda and charts its progress in relation to health and social care. Before drawing some broad conclusions, the penultimate section explores some of the key policy and implementation questions that remain unresolved.

Alongside secondary research, this paper is built on insights captured at events held at The King's Fund as well as a series of conversations with representatives from various national bodies, think tanks and local areas involved in devolution, for which we are immensely grateful.

What's happening and how did we get here?

A potted history of devolution and centralisation in England

Over the past 150 years, there has been a tendency for UK governments to centralise power. The result is a UK system that is one of the most centralised of all countries belonging to the Organisation for Economic Co-operation and Development (OECD); 75 per cent of tax revenues were raised centrally in 2012 (OECD 2014), and in 2014 just under 25 per cent of public expenditure was by local government (OECD 2015).

By comparison, in Sweden (for example), almost half of revenues are spent at local government level (OECD 2014). Decentralised approaches within Europe also apply to health care; in countries including Sweden (Bidgood 2013), Denmark and Norway, for

example, decentralisation has long been an integral part of health care strategies. However, a shift back towards centralisation of health has recently been observed in a number of these countries. For those interested in the wider European experiences, Saltman and Vrangbæk (2007) provide an overview of the high-level policy lessons.

Devolution (at a national level) became a major political issue in the UK in the 1970s, with Scotland and Wales pushing for more control over their own affairs. After the 1997 election, Labour reopened discussions and held referendums that resulted in the establishment of the Scottish Parliament and the Welsh Assembly. Northern Ireland was granted its own parliament as part of the 1998 Belfast Agreement. Although each country's health system has since maintained similar values and goals and all are tax-funded with universal coverage, policies have diverged considerably. A recent comparative analysis, however, reported that while the performance gap between England and the other three nations had narrowed, no one country emerged as being consistently ahead of the pack – despite the differences in policy (Bevan *et al* 2014).

Local devolution was not really on the agenda in England during this period, with two significant exceptions: one resulting from the eight 'Core Cities', which had been working together on common interests since 1995 and successfully secured an amendment to the Localism Act 2011 to allow for bespoke decentralisation for their members (Core Cities 2011), the other being Labour's drive to create directly elected mayors, which initially floundered after only 1 of the 10 English cities to hold referendums voted to switch to the mayoral system.

Since 2010, however, there has been consensus across all the major political parties that power in England should be devolved away from the centre towards local communities on a much larger scale (Cox and Wright 2015). The coalition government sought to bring the 'first generation' of devolution (Sandford 2015) through the Localism Act 2011. It established five new combined authorities, created Local Enterprise Partnerships (LEPs), and introduced 26 bespoke 'City Deals' between 2011 and 2013 (Sandford 2015). The City Deals sought to decentralise specific policy programmes and funding streams in exchange for agreed outcomes. However, these deals have been criticised, mainly because Whitehall retains control over the majority of spend, and so local areas lack the powers they need to transform their cities.

A series of think tank reports published in 2014 (eg, Blond and Morrin 2014) called for more radical devolution of powers to local areas to help them grow their economies. It was in this context that the Chancellor, George Osborne, gave his 'northern powerhouse' speech in June 2014, in which he announced he was willing to start a conversation about 'serious devolution of powers and budgets' for any city willing to move to a new model of city government and have an elected mayor (Osborne 2014).

Soon after this, in November 2014, a landmark devolution deal between Greater Manchester and the Treasury was agreed. Then, in the autumn of 2015, the Prime Minister announced that 38 submissions for a range of devolved powers had been received. Announcements on successful bids are expected alongside the Spending Review.

Building blocks in health and social care

The NHS also has a long history of central control, encapsulated in Aneurin Bevan's famous dictum that 'when a bed-pan is dropped on a hospital floor, its noise should resound in the Palace of Westminster' (cited in Nairne 1984, p 34). Prior to the establishment of the NHS, however, all public health and infectious disease control, as well as most hospital beds, was the responsibility of local government.

Debates about where responsibility for health care should lie are not new. The Labour politician, Herbert Morrison, opposed Aneurin Bevan's proposals for a nationalised hospital service, arguing that local government should retain their health responsibilities. However, a national arrangement (the NHS) was chosen (although the Attlee government agreed that this could be revisited in future), amid concerns that local government control would perpetuate variation between different parts of the country.

... for reasons which must be obvious – because the local authorities are too small, because their financial capacities are unevenly distributed – I decided that local authorities could not be effective hospital administration units ... the only thing to do was to create an entirely new hospital service.

(Aneurin Bevan, Hansard (House of Commons Debates) 1946)

The resulting NHS Act, which came into effect in 1948, saw the transfer of local authority-run hospitals to the new National Health Service. Local government remained responsible for a wide range of community health services and public health until 1974, when reorganisation saw these too transferred to the NHS. This legislation, along with the National Assistance Act, which also took effect in 1948, gave rise to the separations between health and social care that we see today – an NHS largely free at the point of use and funded through general taxation, with means-tested social care funded either privately or by local authorities, and in recent years, for those reliant on public funding increasingly available only to those with the highest need.

Devolution from national to local bodies is, of course, not new to the NHS. A succession of policy initiatives have sought to increase the level of local autonomy in health – for example, the introduction of foundation trusts and the establishment of clinical commissioning groups (CCGs). Most recently, the *NHS five year forward view* asserted that 'England is too diverse for a "one size fits all" care model to apply everywhere' (NHS England *et al* 2014). With this new offer of local flexibility comes the inherent recognition that variation can mean local services tailored to local need, and that health and social care need not look exactly the same everywhere. Despite these intentions, however, this promised autonomy has arguably not yet materialised; the centre still steps into operational matters.

The recognition that organisational boundaries often act as barriers to delivering high-quality care has led to growing attention to the concept of integrated care – between different parts of the NHS and between health and social care. Health and wellbeing boards, established as part of the Health and Social Care Act 2012, were designed to bring together local authority, NHS and other local partners to agree needs and priorities and achieve more joined-up working and, ultimately, services. In addition, a programme of 25

integrated care pioneers, first launched in May 2013, aimed to encourage bottom-up innovation, allowing sites to adopt different approaches to develop integration between health and social care services at scale in their local areas. The government's most recent mechanism for driving integration, the Better Care Fund, includes a £5.3 billion pooled budget for health and social care services to work together more closely in local areas to 'deliver better outcomes and greater efficiencies through more integrated services for older and disabled people' (HM Treasury 2013).

Alongside these moves towards greater organisational autonomy and integration, wider public sector initiatives have attempted to promote place-based approaches to funding and service configuration. The 13 Total Place pilots, launched in 2009, involved local services – including the NHS and local authorities – working together to deliver better outcomes and value for money by focusing on joint working and reducing waste and duplication. This scheme was superseded by the coalition government's Whole Place Community Budget pilots from 2011. The House of Commons Communities and Local Government Committee's inquiry into community budgets (2013) stated that the pilots were demonstrating 'the clear potential to facilitate cheaper and more integrated public services'. However, they noted that key issues remained, that savings would not be easy to realise, and that fulfilling this potential would require strong local leadership and a commitment from central government to 'facilitate local partnerships and the flexibilities needed'. The June 2013 spending round included £200 million to extend the Troubled Families programme, which came out of the community budget's work, and encouraged local authorities and partners to 'grab the nettle' and develop new ways of working centred on families with multiple problems (HM Treasury 2013). An independent evaluation is due to be completed by the end of 2015.

The transfer of public health from the NHS to upper-tier local authorities as part of the coalition government's reforms reflected the recognition that much of what keeps people healthy lies beyond the remit of the NHS. Alderwick *et al* (2015b) argue that those working in integrated care and public health need to 'join up the dots', extending efforts to integrate services beyond just those of health and social care, and shifting the focus to improving population health. The initiatives referred to above, such as Total Place and Community Budgets, along with the recently established Mayoral Health Commissions in Liverpool and London, provide some of the building blocks to support such a shift.

The terms that we are using

- **Devolution:** involves 'the transfer, concurrent exercise, or joint exercise of functional responsibilities from a public authority (which could include a government department or NHS England) to a combined or local authority' (NHS England 2015a) following an order from the Secretary of State, as set out in the Devolution Bill. This would be accompanied by a corresponding transfer of duties, accountabilities and resources
- **Delegation:** without an order, commissioning functions and financial resources could be transferred to joint commissioning boards, but with accountability arrangements unchanged (ie, existing accountabilities would be retained by NHS England and CCGs)
- **Pooled budgets:** local authorities and NHS bodies can already pool health and social care budgets at a local level through section 75 of the NHS Act 2006, which forms the basis for Better Care Fund arrangements

- **Integration:** refers to overcoming the barriers that exist between health and social care and between different parts of the NHS to ensure that the right services are provided to people in the right place and at the right time
- **Population health:** this approach looks beyond integrated care to focus on improving the broader health of local populations, including the impact of the wider determinants of health (Alderwick *et al* 2015b). Kindig and Stoddart's (2003) definition describes it as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group'
- **Place-based approaches:** focus on the services being delivered in a defined area, taking a whole community rather than individual-level view – the aim being to deliver services that meet the unique needs of people living within a given 'place'
- **Combined authority:** introduced under the Local Democracy, Economic Development and Construction Act 2009 to enable councils to integrate economic development and transport functions across a functional economic area, pooling responsibility to deliver services more effectively

The latest developments

The deal signed on 3 November 2014 between the government and leaders of Greater Manchester Combined Authority (GMCA) surprised many by including an invitation to the region to 'develop a business plan for the integration of health and social care across Greater Manchester, making best use of existing budgets and including specific targets for reducing pressure on A&E and avoidable hospital admissions' (HM Treasury and GMCA 2014).

This initial announcement was followed in February 2015 by the signing of a memorandum of understanding between the GMCA (the 10 local authorities), the government, NHS England and 12 CCGs, with NHS providers also giving their formal commitment. Full details on funds, governance and the strategic plan are expected in December, with a view to having preferred governance arrangements in place and taking control over budgets from April 2016 (see box on page 8).

The Queen's Speech in May 2015 announced new legislation 'to provide for the devolution of powers to cities with elected metro mayors'. A Cities and Local Government Devolution Bill was introduced to the House of Lords on 28 May, providing a legislative framework to enable secondary legislation to be applied to different local areas to allow devolution of powers and budgets (see box on page 6).

The Chancellor used his budget speech in July 2015 to announce that the government was working towards devolution deals with the Sheffield and Liverpool City Regions, Leeds, West Yorkshire and partner authorities (Osborne 2015). The first county deal, with Cornwall, was announced in late July and included an invitation to the council and local health organisations 'to produce a business plan for the integration of health and social care services' (Cornwall Council *et al* 2015, see box on page 10). In launching the Spending Review 2015, the Chancellor invited regions wanting to agree a deal in return for a mayor (which has proved to be a sticking point for some areas (Jones 2015)) to submit 'formal, fiscally neutral proposals' to the Treasury by 4 September 2015.

Once the deadline had passed, the Prime Minister announced that 38 submissions had been received for a range of devolved powers. Around half are thought to have requested

some form of devolution over health and social care. These proposals are being reviewed; announcements on successful applications are expected alongside the Spending Review.

In October, the Chancellor unveiled plans for a 'devolution revolution', announcing what has been hailed as the biggest change to local taxation in more than a quarter of a century (HM Treasury and Osborne 2015). Mapping the path to self-sustaining and more autonomous local government, the Chancellor's announcement means that by the end of the parliament, 100 per cent of the local revenue raised from business rates will be retained by local government. Areas will have new powers to cut business rates to attract growth, while cities with elected mayors can increase rates (to a capped amount). To 'ensure the reforms are fiscally neutral', the central government grant will be simultaneously phased out.

The Cities and Local Government Devolution Bill

The Bill was introduced to the House of Lords in May 2015 as the first Bill of the 2015–16 parliamentary session. It has made a speedy journey through parliament, and was introduced into the House of Commons on 21 July 2015.

The Bill establishes an overarching framework that allows for orders to be made to: confer public authority functions on combined authorities, permit combined authorities to elect their own mayors who can then take on specified functions, and specify the requirements for the scrutiny and audit of combined authorities. Since the Bill is a broad and enabling one, it makes few references to the specific functions that could be transferred. Instead, these will be set out in future orders to parliament.

Despite the lack of detail in the Bill, health *is* mentioned – most notably in a much-debated amendment introduced by Lord Warner, proposed in response to a 'fear that... accidentally – we will end up with a piecemeal set of arrangements that basically take the "N" out of the NHS' (Hansard (House of Lords Debates) 2015). Seen as a way to preserve some of the national characteristics of the NHS, the amendment ensures that the Secretary of State retains his/her statutory duties, that regulatory and supervisory functions (the roles fulfilled by Monitor, the Care Quality Commission (CQC) and others) remain at a national level, and that national standards and accountability obligations are adhered to. When the Bill moved to the House of Commons in October 2015, the government accepted the substance of Lord Warner's clause, although laid further amendments which sought to:

- clarify that NHS England's supervisory functions over CCGs cannot be transferred
- require that provision must be made about standards and duties to be placed on any authority following the transfer of functions
- detail the national standards the Secretary of State must consider when making these provisions, including those set out in commissioning regulations, recommendations and quality standards published by the National Institute for Health and Care Excellence (NICE) and the NHS Constitution (which include national access standards)
- clarify which duties of the Secretary of State cannot be transferred – including section 1 of the 2006 Act to retain responsibility to parliament for the provision of the health service in England, and on quality, health inequalities, research, education and training, the NHS Constitution, and the NHS Mandate.

The Bill's light-touch nature leaves a number of unresolved questions, some of which are summarised later in this paper (see page 12).

Where is it happening?

Greater Manchester and Cornwall

Greater Manchester and Cornwall have led the way in health and social care devolution (see boxes on page 8 and 10). First announced in November 2014 on the basis of a mayor being elected (expected in May 2017), Greater Manchester has been offered the broadest deal to date, including powers over transport, planning and housing as well as uniting 38 different organisations as part of health and social care devolution plans. The Greater Manchester footprint covers 2.8 million residents in a monocentric city region with a compact geography, and with a number of economic and clinical interdependencies and flows.

With much of the devolution rhetoric centred on cities and the 'northern powerhouse', Cornwall was the first rural county to reach an agreement in July 2015. It includes responsibilities for apprenticeships, European Union (EU) structural funds, business support services, franchising of bus services, and a 'One Public Estate' initiative. Cornwall is the largest rural unitary authority in the country and has a considerably smaller population than Greater Manchester, at just under 550,000, greatly dispersed across the length and breadth of the region. Boundaries are coterminous, so devolution will involve a single council, CCG, health and wellbeing board, acute trust, mental health trust, community provider and GP federation.

Residents of both Cornwall and Greater Manchester possess strong regional identities and sense of place, and each region has its own history of campaigning for greater autonomy. Manchester's long history of collaboration and joint working is well documented; the Association of Greater Manchester Authorities (AGMA) – the voice of the 10 authorities – has been operational since 1986. Manchester became the first combined authority in April 2011 and the region is recognised to have benefited from strong, coherent and consistent leadership, notably from Sir Howard Bernstein and Sir Richard Leese. Cornwall also has a recent history of local government collaboration when, in 2009, the former county council, five district councils and borough council unified into a single unitary authority.

A track record of collaboration, integration and successfully managed change also exists in health and social care specifically. In Greater Manchester, there is an association of CCGs (previously of primary care trusts (PCTs) for 10 years), a group of acute chief executives, the Greater Manchester Public Health Network (comprising the 10 directors of public health) and an interim umbrella health and wellbeing board. There has also been strong public engagement; the consultation for the Healthier Together programme – run in partnership between and agreed by the NHS, social care, voluntary organisations and 10 local authorities – received the largest public response to a regional consultation about health services in England in the past decade (Healthier Together 2015). Cornwall became an integration pioneer in 2013 and its Living Well approach brings together local authorities, the NHS, Age UK Cornwall, community services and Volunteer Cornwall to provide bespoke, wrap-around care. The region secured public agreement to the closure

of a community hospital in 2015, which may stand it in good stead in making some of the difficult decisions that are to come.

Key facts: the Greater Manchester deal

The deal

Commenting on the historic signing of a memorandum of understanding between the GMCA, the government, NHS England and 12 CCGs (alongside letters of support from NHS providers) in February 2015, NHS England Chief Executive Simon Stevens said the agreement 'charts a path to the greatest integration and devolution of care funding since the creation of the NHS in 1948' (NHS England 2015b). With this came the announcement that £6.2 billion of health and social care budgets would be brought together. The vision is: 'to ensure the greatest and fastest possible improvement to the health and wellbeing of the people of Greater Manchester'.

A second memorandum of understanding was signed in July by Greater Manchester's public health leads, Public Health England, NHS England, CCGs, NHS providers and 'blue light' services (Greater Manchester police, ambulance, fire and rescue services), to create a 'framework by which partners will create a single unified public health leadership system'. A Director of Population Health Transformation has been appointed to lead on the role that public health plays.

In the intervening months, Manchester has submitted proposals as part of the Spending Review process, requesting additional investment to help achieve sustainability and fund a number of transformation initiatives.

Arrangements in Greater Manchester will continue to be part of the national NHS and social care system, but there will be a shift in focus towards people and place rather than individual organisations, and integration will seek to go beyond just health and social care to include other services.

What's 'in'?

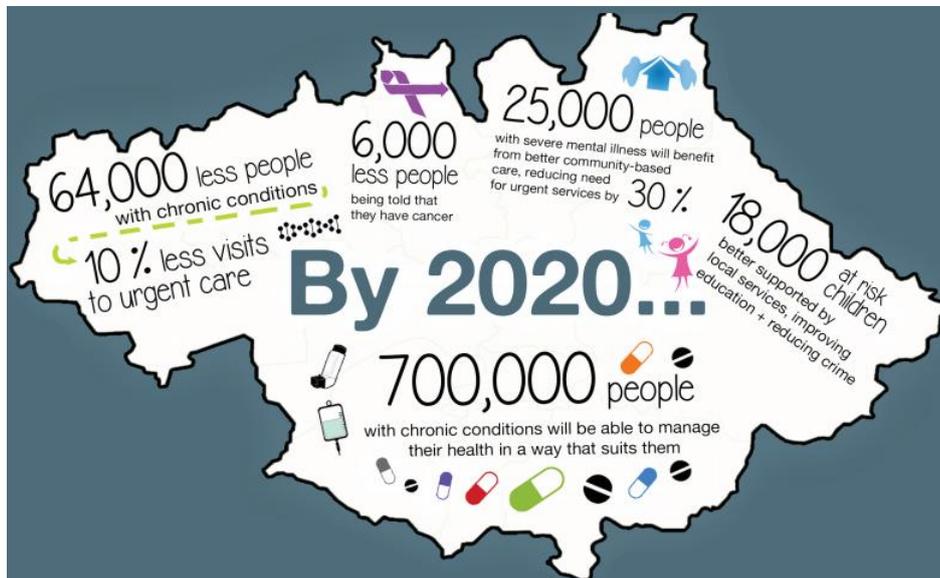
The whole system: acute (including specialised services) and primary care (including GP contracts), community and mental health services, social care, public health, and (subject to further discussions) health education and research and development.

Components of the Greater Manchester health and social care model include moving to a single estates function, single workforce transformation plan, single information governance and data sharing agreement, new hospital models, and establishing an academic health science system known as Health Innovation Manchester (HIM).

Including HIM, there are nine early implementation priorities: a public health place-based agreement and programmes; seven-day access to primary care; a dementia pilot in Salford; reaching a final decision about which hospitals will work together as single services, as set out in the Healthier Together programme; a programme to transform children and young people's mental health services; establishing workforce policy alignment; a three-year strategy to improve independence for people with learning disabilities and/or autism; and a pilot supporting people with mental health-related barriers into work.

The desired outcomes

A strategic sustainability plan (see below) was agreed as one of the deliverables in the memorandum of understanding, which will set out the expected outcomes for the Greater Manchester deal. The figure below shows some of the early outcomes agreed.



Governance arrangements

Now operating in shadow form, the Greater Manchester Health and Social Care Partnership Board will be responsible for the financial and clinical sustainability of health and social care through delivery of the strategic plan, describing how a sustainable health and social care landscape can be achieved over the next five years. Membership includes the GMCA; 10 local authorities; 12 CCGs; 15 NHS providers; NHS England; representation from primary care, patients and the third sector, the fire and rescue service, and police and crime commissioner's office. Underpinning the strategic plan will be 10 five-year locality plans, developed with each of the local health and wellbeing boards.

This board is underpinned by an overarching provider forum and joint commissioning board. Pooling of local authority and health resources will take place at locality level, with £2.7 billion already agreed across the 10 boroughs.

Next steps: The strategic plan and locality plans are to be completed by December 2015, with full devolution and final governance arrangements in place from April 2016.

Sources: Association of Greater Manchester Authorities (AGMA) *et al* 2015; Greater Manchester Combined Authority (GMCA) and NHS in Greater Manchester 2015; Public Health England *et al* 2015; Williamson 2015

Key facts: the Cornwall deal

The deal

Cornwall's deal included an invitation to the council, CCG and other local partners to work together with the government, NHS England and national partners to 'co-design a business plan to move progressively towards integration of health and social care across Cornwall and the Isles of Scilly, bringing together available local health and social care resources to improve outcomes for the people of Cornwall and including a plan to reduce pressure on Accident and Emergency and avoidable hospital admissions'. It is based on a vision that: 'People in Cornwall will live longer, happier, healthier lives and good health and wellbeing will be everyone's responsibility.' Proposals are focused on integration of health and social care, although aspects of the wider deal identify broader health and wellbeing benefits.

Cornwall is seeking: support to develop a devolved, ring-fenced, place-based health and social care budget with a minimum five-year settlement; local ownership and control of assets; delegated authority for commissioning primary care GP services (and opportunity to consider delegation of other services in future); a transformation fund of £2 million a year over the five-year period; the opportunity to develop a single outcomes framework for measuring impact on population health and wellbeing; a co-ordinated approach from national regulators.

What's 'in'?

Cornwall has proposed a phased approach over five years to bring together health and social care commissioning functions and focus them on outcomes. It plans to combine existing budgets for health, social care and welfare totalling around £2 billion into a single place-based budget. It also plans to reconfigure the provider landscape, based on the *NHS five year forward view*, and to work with local communities and the voluntary sector to implement new models of care for commissioning and provision.

The desired outcomes

- All agencies to be aligned to achieving three outcomes: helping people live longer, healthier lives; improving the quality of people's lives; fairer life chances for all.
- The population to be experiencing improved quality of health and social care by 2020.
- Organisations across health, social care and the voluntary sector working collaboratively so that people experience seamless services.
- Reduced health inequalities and improved healthy life expectancy.

Governance arrangements

Cornwall is working within the existing architecture, with the council and CCG retaining existing statutory responsibilities, overseen by the county's health and wellbeing board. Work to establish programme governance 'representing all stakeholder interests' is under way, and a monitoring board was recently established.

Next steps: Working on an outline case for integration of health and social care, with the next step being for the adult social care budget to transfer to health by April 2016.

Sources: Cornwall Council 2015; Cornwall Council *et al* 2015

As well as some similarities between the two deals, there are also a number of marked differences. For instance, Cornwall is proposing to transfer budget from adult social care to health, and is considering combining budgets for health, social care *and* welfare. Public health and a much broader focus on integration beyond health and social care form a key part of Greater Manchester's approach, while in Cornwall, the region's 'vibrant' voluntary and community sector appears to have formed a bigger part of the foundations on which these plans have been made than in Greater Manchester.

Proposals from other areas in relation to health and social care

Of the 38 bids submitted, around half are thought to have included asks relating to health and social care (see LGA nd). These submissions vary both in the level of detail provided and the number and powers requested. Asks include (among others): authority for commissioning and resources (including Public Health England, NHS England and Health Education England); place-based multi-year budgets, immunisation and screening services; control of NHS estate; support to buy out a private finance initiative (PFI) scheme; and increasing financial allocations. Some have used their submissions to initiate a longer term conversation, with a nod to possible requests in the future. For example, the North East Combined Authority – with whom a devolution deal was announced on 22 October 2015 – will, in partnership with the NHS, establish a Commission for Health and Social Care Integration (HM Treasury and North East Combined Authority 2015). The Liverpool City Region's website states that:

Clearly, health and social care, environmental protection, and our police and fire service are all vital to the economic and social outcomes of the City Region and we remain fully committed in our desire to deliver them. They require further detailed discussions around the transfer of power, legislation and delivery models than this initial eight week window offers.

(Liverpool City Region Combined Authority 2015)

London is pursuing a 'made in London' solution, and Simon Stevens has recently stated that 'for many reasons this should not take the same form as proposed in Greater Manchester' (Stevens 2015). Given London's size and complexity, the mayor recently announced that pilots would be set up as a first step – the expectation is that a deal and pilots will be agreed by the end of 2015. Considering the distinctive approach being pursued in London, and the differences between the Greater Manchester and Cornwall deals, it appears that devolution of health and social care is unlikely to take a 'one-size-fits-all' model, and will look different by area.

The remaining submissions – including Sheffield, with whom a deal was announced in October 2015 (HM Treasury and Sheffield City Region 2015) – do not appear to have included requests for health and care powers in this wave of bids. A chief officer from one of the regions not requesting devolved health powers was quoted in a recent *Health Service Journal* article as saying that he 'could not see how devolving powers would allow the health and care system to achieve anything it could not already' (West 2015).

What next? Questions still to be answered

The King's Fund sees a range of potential benefits arising from the devolution agenda – in particular, the opportunity to achieve greater integration of services, between health and social care but also with public health and other areas under local government control, so that areas can begin to focus more broadly on improving the health of the populations they serve. However, possibly because of the pace with which this agenda is moving, there are a number of outstanding questions that will need to be resolved, largely focused on resolving the tension between local and national arrangements, and the extent to which the 'national' in the NHS will be preserved.

A key point to make at the outset is that what we are currently witnessing is not devolution. The models adopted in the deals so far appear to be closer to 'delegation' than the formal 'devolution' outlined in the Cities and Local Government Devolution Bill. As we understand it, there are currently no plans to use the order-making power created through the Bill to transfer additional health functions to local authorities; any health-related orders will only be used to enable combined authorities to share the health duty that already sits with local authorities. Instead of formally transferring powers and accountabilities from NHS bodies to local authorities, we are likely to see arrangements whereby NHS functions and resources are 'delegated' to combined authorities or joint commissioning boards. These arrangements could be achieved largely through existing mechanisms (such as section 75 of the National Health Service Act 2006), except for NHS England's responsibility for commissioning specialised services, which is likely to require further legislative change.

This section focuses on the questions that we think still need to be worked through in these less formal arrangements, although we include a brief consideration (see box on page 16) of what the issues might be were a formal transfer of additional health powers enacted through an order.

How will accountability work in devolved areas?

The recently published board paper, *Devolution – proposed principles and decision criteria* (NHS England 2015a), suggests that NHS England's preference is for areas to explore arrangements that veer more on the side of delegation than of formal devolution. This preference is reflected in the deals done to date, which make clear that accountability remains with NHS England and CCGs, rather than being transferred to combined or local authorities.

This approach has its advantages, minimising organisational change, ensuring the continued involvement of CCGs and local authorities and leaving statutory accountabilities clear. However, in practice there is a lot still to play for, in particular around how big decisions will be taken about services. For example, if NHS England remains accountable, then will combined authorities need to seek 'permission' to make major changes and, ultimately, will NHS England be able to veto arrangements it does not like? Similar questions arise over the powers of other national bodies, which we discuss below.

Will local democratic involvement in health make it easier to take difficult decisions?

It is clear that the period covered by the current Spending Review will be the most challenging in the recent history of the health and social care system, requiring both services to make large-scale changes to ensure their future sustainability (Appleby *et al* 2015). In the absence of sustainable funding agreements, whoever is responsible for health during this period is likely to have to make some difficult and unpopular decisions about the configuration of local services.

The impact of greater involvement of locally elected politicians in health remains to be seen. On the one hand, difficult decisions involving the closure or redesign of local services may be easier, as local politicians become more active in making the case to their communities. On the other hand, the reverse may happen, with locally elected politicians shying away from difficult and controversial decisions for fear of losing support from their electorate. However local politicians react to these challenges, we do need to note that national politicians already have a track record of intervening in controversial local service decisions.

There may be some particular challenges for devolved decision-making; for example, if one area within a region is perceived to be losing out to other areas, or when the shared concern to improve the health and wellbeing of the region's whole population conflicts with what is in the best interests of their own areas.

How will regulatory oversight work in devolved areas?

The amendment to the Bill introduced by Lord Warner clarified that, even in areas in which functions are to be formally transferred via an order, the powers of the regulators (the CQC, Monitor and others) are to remain in place nationally. However, areas such as Greater Manchester have been clear previously that they want 'a new set of relationships' with the regulators, and Cornwall has described the current burden of information and assurance requirements on local systems from CQC, Monitor and the NHS Trust Development Authority as 'overwhelming'.

Since we can expect arrangements to vary between different areas, regulators will need to understand the local context and adapt their approach accordingly, while remaining consistent with national rules. This raises the question of whether these regulatory bodies have the capacity and resources needed to tailor their approaches to local circumstances.

If combined authorities were to introduce their own local regulatory oversight, there will also need to be consideration of how national and local arrangements fit together. 'Good-day and bad-day' scenarios will need to be worked through, making it clear where the buck stops in the event of failure. For example, were there to be a significant lapse in quality of care, would it be the CQC accounting to the Health Select Committee for its failure to spot it, or the person responsible for local regulatory oversight, or both?

The regulators have recently begun to develop approaches to regulating whole health economies (rather than individual providers). This may provide a helpful starting point for regulation in devolved areas.

Who stands behind provider deficits?

Given that the legal accountability of the Secretary of State for Health remains unchanged, the assumption is that the Department of Health would still be expected to cover the costs should a provider go into deficit. Under these arrangements, do local authorities have enough 'skin in the game' to take the difficult transformation decisions needed to put NHS services on a more sustainable footing, or will they allow current provider deficits to continue, turning to national government for help when providers overspend?

How different could a devolved area end up looking?

The continued accountability of NHS England should ensure that existing standards and duties (such as those set out in the NHS Constitution) apply: however, there are still questions about how this will work in practice. For example:

- what happens to out-of-area patients and their right to choose? How will areas that have taken on responsibility for commissioning specialised services protect the interests of people living in other parts of the country who use the services of their providers?
- what happens if a combined authority refuses to comply with the standards demanded by NHS England?
- what happens if an area decides a national priority such as seven-day working is not a local priority?

Despite the enthusiasm behind the devolution agenda, we need to remember that while the public are broadly supportive of localism, research shows that they are concerned about local variation and the 'postcode lottery' (Ipsos MORI 2015). However, the extent of variation already evident in the NHS (as documented in the NHS Atlas of Variation series) should not be overlooked.

What are the criteria that areas must meet to achieve devolution?

Although the intention of central government has been to encourage areas to think radically and creatively, the lack of transparent criteria has resulted in areas being uncertain about what is expected of them. Although NHS England recently published a draft set of principles and criteria for assessing devolution submissions, there are a range of other national partners involved in judging bids (not least HM Treasury) and it is unclear whether all involved are working from the same criteria. In addition, there are questions as to whether the deals agreed to date would meet all of NHS England's criteria.

Can these deals deliver financially sustainable local health and social care systems?

The deals to date include a requirement that local areas deliver financially sustainable health and social care systems by 2020. Without seeing any detailed local area plans, it is hard to judge how realistic this ask may be but none can doubt the scale of the challenge it represents (just as it does for the NHS and social care nationally). We can speculate that strategies are likely to focus on the potential for savings to be realised through: community-based models of care and moving care out of hospital; shifting resources towards prevention; closer working between health and social care services to enable (for example) speedier discharge; making better use of NHS estate; and hospital and back-office efficiencies.

However, we also know that a number of these approaches improve outcomes rather than reduce costs, or do so only on the basis of upfront investment, and usually over a longer timescale than a deadline of 'the end of parliament' permits (Alderwick *et al* 2015a; Monitor 2015; Bardsley *et al* 2013). Indeed, last year, NHS England concluded that plans submitted as part of the Better Care Fund were over-optimistic, and the estimate was revised down to just £55 million of credible savings (National Audit Office 2014a).

Given the aforementioned challenges, the real question comes back to this: what is the core objective of devolution in relation to health and care? Is it reducing health inequalities, delivering locally tailored, integrated care and improving population health? Or is it a way of achieving savings and reducing spending in the future? If it is both, then this will be challenging, at least by 2020.

How will differences between local government and NHS finances be resolved?

The financial frameworks and cultures of the NHS and local government are very different, creating the potential for confusion surrounding what a devolved body *is* allowed to do – and what it is not. For example, local authorities are required to set budgets that are sustainable and balanced, with no possibility of running a deficit. NHS providers, on the other hand, do not live by the same rules, and are able – as we have seen in the current financial year – to 'plan for' and continue operating when in deficit. The rules are different again for NHS commissioners. Perhaps as a result of these differences, the two sectors have dealt with the current period of financial constraint very differently, particularly when faced with the difficult choice between balancing the books and retaining current levels of service.

Recent analysis shows that total spending on social care services (for all age groups) is over 10 per cent less in 2014/15 than in 2009/10 (including the transfer from the NHS budget). The number of people receiving services has fallen by 25 per cent between 2009/10 and 2013/14 (the authors state that 'it is important to note that there are wide variations across 152 local authorities and some of this could be explained by positive developments ... that have reduced the need for long-term care'), despite increases in demand (Humphries and Appleby 2015). In contrast, NHS providers and commissioners in financial difficulty 'have not matched pressures on funding with equivalent reductions in expenditure' (National Audit Office 2014b). At the end of 2013/14, 22 per cent of NHS

trusts and 28 per cent of foundation trusts were in deficit, many of them turning to the Department of Health for cash support. The situation this year is far worse, with 82 per cent of all NHS provider organisations overspent (by £930 million) in the first quarter.

Which set of rules will apply? And how will local authorities becoming more involved in health impact on culture and vice versa?

What happens in the event of formal devolution (whereby an order is used to transfer health functions to a local authority or combined authority)?

Accountability

Recent amendments to the Bill clarify that:

- in all cases of devolution, the Secretary of State for Health remains ultimately accountable to parliament, and is required to comply with his/her core duties (eg, to reduce inequalities and to promote the NHS Constitution)
- where NHS functions are transferred to local authorities/combined authorities, the Secretary of State will set out the standards, accountability and reporting arrangements that local authorities are expected to comply with.

The exact requirements on combined/local authorities will depend on the nature of the function being transferred, leaving it unclear as to how it will work. However, there is currently no line of accountability between the Secretary of State for Health and combined authorities – this would need to be addressed to enable the Secretary of State to fulfil his/her ongoing duties and accountability.

Are there limits to what can be devolved?

The Bill stipulates that, other than national regulatory functions and specific duties of the Secretary of State, any function currently exercised by an NHS body could be transferred through an order to a local authority/combined authority.

How different could an area look under these arrangements?

The amendments outlined above (in particular, the ongoing accountability of the Secretary of State and duty to promote the NHS Constitution) aim to ensure that core national NHS standards remain in place, thus preserving the 'national' element of the health service. But there is a question as to the capacity of national bodies to assure and enforce nationally defined standards within a devolved system. For example, would an area be able to decide to stop commissioning a service that has not been mandated in legislation or by NICE?

Will the NHS lose its budget protection?

In the event that functions are transferred to a combined authority, it is likely that budgets will be too. Does this mean the end of the financial protection of the NHS as we know it? If an area were able to meet the core standards as set out in the NHS Constitution using less NHS funds than it was allocated, would it be able to divert the surplus to other areas of local authority spend, beyond health? If the answer is yes, then much stronger accountability for outcomes would be required.

Conclusion

In exchange for a greater say over their own futures, areas such as Greater Manchester and Cornwall are promising to deliver changes to health and care services that we and many others have long been calling for.

In its final report, the Commission on the Future of Health and Social Care in England (2014) called for an end to the historic division between health and social care, suggesting that local authorities and NHS partners integrate their budgets and create a single commissioning function. The work in Greater Manchester and Cornwall is bringing this vision to life, enabling genuine integration across health and social care.

Local partners in Greater Manchester and Cornwall have also committed to look beyond the fragmentation within the NHS and social care system to the broader health of local populations and the impact of the wider determinants of health by combining their resources to enable place-based approaches. In doing so, they have recognised that the current focus on treating rather than preventing ill health limits the health gains that can be achieved for communities, and that only by considering all of the elements that influence health (eg, housing, education, employment, etc) can inequalities in health and wellbeing be properly addressed.

It is important to note that many of these prizes are not dependent on 'devolution'. Genuine devolution, as enabled through the Cities and Local Government Devolution Bill, would see health functions transferred to local or combined authorities via parliamentary orders, potentially resulting in very significant change to the NHS. However, there are currently no plans to use the Bill's powers in this way. Instead, the deals that have been agreed in Cornwall and Greater Manchester are more akin to 'delegation' than 'devolution'. The promises of integration and a greater focus on population health are to be delivered largely within existing legislation, with formal accountabilities remaining with NHS bodies.

But just because this is not strictly devolution does not mean it's 'business as usual'. In Manchester and Cornwall, health has been caught up in the wider devolution agenda, creating a potentially 'unstoppable momentum' that has brought NHS and local authority leaders together to think about how services could be transformed to better meet the needs of their populations and overcome longstanding local barriers to change:

I have never seen such unprecedented change as we've had over the last few months with Greater Manchester devolution. It has caught not just the imagination but it is absolutely being seen by us in Greater Manchester as the only way forward to make sustainable the level of care changes and outcomes that we need for our population.

Ann Barnes, Chief Executive, Stockport NHS Foundation Trust (Barnes 2015)

It remains to be seen whether this will happen elsewhere. There are, of course, questions still to be resolved if this agenda is to succeed, some of which we have outlined in this briefing. There are also risks. A key concern is whether the NHS can deliver on this agenda at the same time as it attempts to tackle mounting financial and operational pressures and progress the new care models being pioneered by the vanguards.

The pace at which this agenda is progressing is impressive. While this sense of urgency may have contributed to the energy and excitement we are seeing in local communities, it is important that areas think carefully about taking on new responsibilities at a time when public services are experiencing unprecedented pressures. The arrangements in Manchester and Cornwall have not come out of nowhere – they are the culmination of years of building strong relationships and collaborating and cannot necessarily be replicated quickly and easily. Strong leadership, such as that displayed by Sir Howard Bernstein and Sir Richard Leese in Greater Manchester, has been a prerequisite for bringing people together at both the local and national levels. We note that many of the areas that have submitted bids so far appear to have recognised this, and have been prudent in setting up commissions to explore the idea of devolution of the health budget rather than requesting it straight away. This may also be politically shrewd – shifting responsibility for difficult decisions at a time of financial pressure could be considered a way of shifting blame from Whitehall to town hall.

However, the current arrangements, which avoid making use of the far-reaching powers set out in the Bill, mean that the visions for change in Cornwall and Greater Manchester are to some extent dependent on good will, discretion and strong relationships, rather than legislation. In practice, there is little formally stopping NHS England or other national bodies from seizing back (or simply retaining) control. This could be a risk if over time national bodies choose to pursue other priorities and override local decision-making, and this could include, of course, any determined central action to bring down the rising deficits in NHS providers.

Finally, people should be realistic about the benefits devolution can bring – it is in no way a silver bullet and any savings will take time to deliver and are likely to require significant ‘upfront investment’ (Chartered Institute of Public Finance and Accountancy 2015). As Simon Stevens (2014) has pointed out in relation to bringing health and social care budgets together ‘no-one should pretend that just combining two financially leaky buckets will magically create a watertight funding solution’.

Despite the concerns outlined above, we are cautiously optimistic about the changes that are taking place. We believe the current energy associated with wider devolution has the potential to act as a game-changer in health and social care, bringing about genuine integration and a more effective focus on improving population health. In particular, we believe that the fact the plans in Greater Manchester and Cornwall have been locally driven rather than centrally imposed may make them more likely to result in sustainable improvements (Ham 2014). We hope that areas continue to move quickly to take advantage of this current window of opportunity. However, given the huge pressures facing the NHS and local government, it is essential that devolution is taken forward in a way that supports leaders in dealing with these pressures and does not become a distraction.

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