Nuffield Trust Parliamentary Briefing

Cities & Local Government Devolution Bill: Report Stage

The Government has made devolution to the cities and regions of England one of its central policy reforms this Parliament. The Cities and Local Government Devolution Bill lays a framework for local areas to bring together and change their local public services.

The implications of the Bill for the English NHS and social care system are much less clear. It includes important new powers to remove functions from NHS hospitals, commissioners, and other bodies, and transfer them to local or regional authority. Areas including Manchester, Merseyside, and Gloucestershire are working on ambitious proposals to take on health care powers.

Depending on the implementation, interpretation, and limits on these powers, transfers of power like these may fundamentally reshape the health service in the years to come. There is a crucial role for scrutiny by MPs as the Bill passes through the Commons.

- The Bill contains two paths to transfer powers over health care to local and combined authorities. Schedule 4 creates a system of "delegation" where NHS bodies pool their powers. Clauses in the main body of the Bill, meanwhile, create a much more powerful process which could **provide for the transfer of almost all health care functions in England away from hospitals and NHS commissioners, to local authorities**.
- Devolution and delegation under both these systems could create historic shifts in the NHS. **We urge MPs to query how far these powers might extend**, and whether the right limits are in place on the transfer of national powers.
- There are also questions about how the system of NHS accountability and leadership could work with a complicated mixture of regional and national powers. Can **national provisions for health and social care really be enforced centrally**, as they are now, under a devolved regime?

Parliamentary briefing
December 2015

- **Will central and regional government squabble** over the responsibility for meeting population needs and making difficult decisions, such as closing hospitals or propping up overspending health care providers? What will happen to neighbouring areas?
- Deals possible under this Bill create **the possibility for NHS funding to melt into wider regional authority budgets, making ring-fencing or protecting impossible**. Given the importance of health care spending as an issue, this needs clarity and scrutiny.
- Clause 18 of the Bill now expresses clear restrictions on which goals, duties and standards can be devolved. In its current form it does **allow for the majority of standards, and several key system oversight roles, to be transferred to the regional level**. There are good arguments on both sides as to whether local or regional variation should be encouraged or opposed, but it is very important that we are clear on the limits of variation, who decides those limits, and the justification for this.
- **Devolution to combined authorities under the Bill may actually have a centralising effect for many health and social care functions**, taking power away from councils representing smaller communities, and Clinical Commissioning Groups representing clinicians. Although this might be desirable in some cases, it is also important to look at how the positive elements these bodies bring in health and social care can be preserved.

1. How will transferring NHS functions work – and are the checks and balances in place?

The Bill as amended at Committee stage includes two parallel paths to give local or combined authorities greater involvement in health service commissioning and oversight. Schedule 4 effectively creates new provisions for delegation of powers and pooling of funds, based on the 2006 NHS Act. This would support existing and developing arrangements like those in Manchester – which it is important to note do not rely on the full devolution powers used in the Bill.[1]

This highlights the question of when the more powerful tools in Clauses 6, 7, 16 and 17 of the Bill, would be needed. These provide much more extensive powers, allowing the Secretary of State to transfer NHS functions, dissolve NHS Bodies (including NHS hospital and mental health trusts, clinical commissioning groups and NHS England) and transfer their assets to combined and local authorities.[2] In doing so the Bill would create the potential for future shifts in power which would be among the most profound since the founding of the health service.

These transfers will be made through affirmative order, with relatively limited scope for MPs to debate and no option to amend. The House of Lords constitution committee described the Bill's provision as "powers which are so broadly framed that they could potentially involve the amendment of primary legislation by order, known as Henry VIII powers".[3]

MPs should make certain that the appropriate checks and balances are in place to ensure proper scrutiny of changes to the NHS and NHS bodies under this Bill. Key questions will include:

What exactly cannot be transferred under Clause 18?

Clause 18, as currently amended, places significant but limited restrictions on transfers of NHS functions. The Secretary of State responsible for the NHS must remain able to meet his duties under NHS legislation, including his duty to promote a comprehensive health service with regard to the NHS constitution. Many regulatory powers must also be kept at a national level.[4]

Three significant changes to the Clause have been made in the Commons so far. Firstly, there is far more clarity about which powers and duties are included in the list to be reserved. A restriction on the transfer of "supervisory" powers has been removed. This was not a legally meaningful term, and we welcome this change. The "core duties" of the Secretary of State, and "national service standards" are better specified.

The restriction on transferring responsibility for standards has been greatly weakened. The Secretary of State now only needs to "have regard" to them in transferring powers and responsibilities. This would in theory allow local areas to be given exemptions from core NHS standards, like waiting times targets and NICE guidance.[5]

18 (2) (c) states that powers exercised by special health authorities are not to be counted as "vested in them". This would appear to exempt them from the limits on the devolution of health service regulatory functions. If so, that would imply that it would be possible to devolve functions of the NHS Trust Development Authority, NICE and Health Education England. The question of whether

[1] http://www.publications.parliament.uk/pa/bills/cbill/2015-2016/0097/cbill_2015-20160097_en_1.htm
[2] http://www.publications.parliament.uk/pa/bills/cbill/2015-2016/0064/16064.pdf
[3] http://www.publications.parliament.uk/pa/ld201516/ldselect/ldconst/9/903.htm#a1
[4] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[5] http://www.parliament.uk/documents/commons-public-bill-office/2015-16/compared-bills/Cities-and-Local-Government-bill-151118.pdf

it is appropriate for there to be local variation for major workforce, safety and guidance functions like these should be raised by MPs.

How will oversight and accountability for transferred NHS powers work after transfer?

The Devolution Bill was designed to encourage the devolution of powers currently held by Ministers to Elected Mayors as a single point of accountability – although this is no longer compulsory under the current draft. Clause 9 and Schedule 3 also set up overview and scrutiny and audit committees for combined authorities, providing some non-political oversight[6].

Delegation, as provided for in Schedule 4 and being implemented in Manchester, means that fundamental duties of NHS bodies will still remain in place. But under full devolution there would be no requirements of the sort currently attached to commissioning plans, to ensure that the combined authorities have taken and acted upon appropriate public health expertise such as aligning commissioning to population needs; taken account of inequalities in commissioning decisions; used the best evidence to inform interventions and service delivery; and identified health service and treatment priorities.

There is also an important question about whether taking NHS functions out of the health service will change the capacity of the health system to take accountability for them. How would compliance and standards on the part of local or combined authorities carrying out NHS functions be monitored under the Bill?

Finding safeguards against potential conflicts of interest has been very important for the transfer within the NHS of responsibility for commissioning GPs, to CCGs in which GPs themselves have an important presence[7]. There needs to be consideration of comparable robust and transparent arrangements where local or combined authorities control health services.

What will happen if things go wrong?

So far, the actual mechanisms by which standards and finances would be overseen are not clear. How will the Secretary of State for Health ensure that the duties and regulatory powers reserved by Clause 18 of the Bill are still enforced when he cannot control local authorities? How will NHS regulators enforce breaches? Will NHS debts and liabilities (including PFI and clinical negligence claims) be guaranteed by the Secretary of State for DCLG?

As the Bill currently stands, the capacity to transfer functions appears only to go in one direction. Whatever happens, there is no way that a power can be returned to the NHS without primary legislation. It is not clear that this asymmetry is justified or wise.

2. Should power over the use of NHS funding be limited?

Use of NHS funding currently

At present the NHS budget, held by NHS England and by Clinical Commissioning Groups, forms a clear and separate funding stream, set apart from other central government budgets and from the related budgets for public health and social care held by local authorities.

There are some existing arrangements for pooled budgets across health and local authorities. Section 75 of the NHS Act 2006 allows NHS commissioners and providers and councils, to make contributions to a common fund to be spent on pooled functions or agreed NHS or health-related

[6] http://www.publications.parliament.uk/pa/bills/cbill/2015-2016/0064/16064.pdf
[7] http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

council services, managed by the council or CCG[8]. This legislation is being used in the implementation of the Better Care Fund[9], a mandatory pooled budget across CCGs and LAs which has the aim of integrated health and social care to improve care for frail and elderly people.[10]

The Bill would significantly expand this so that a Section 75 pooled budget could also cover social care spending. This effectively combines the NHS and social care funding streams. While there are arguments in favour of this, it will also make it difficult to scrutinise how much is being spent on the NHS nationally. It will also allow NHS funding to blend more into local government funding more widely: money in the pooled fund could cover services otherwise funded from core council funding and vice versa.

Should there be limits on any transfer of funding under the Bill?

Many of the transfers of functions from the NHS to local authorities enabled under the Devolution Bill would appear to entail and require a transfer of the related funding into the local authority budget. This raises a series of important questions.

In contrast with Section 75 pooled budgets, is it the case that this would allow local authorities to move spending originally allocated to the NHS to functions which are not related to health and social care? This could lead to greatly increased variation of funding across different local areas influenced by the pressure on other local services and the scope for local taxation. It would also mean that there was no defined NHS budget which could be protected or increased by central Government decisions. The implications for the Government's ability to commit to NHS spending pledges, and for the concept of a "national health service", are potentially very wide.

Another important question is the point at which any limitations will be applied. Should they be drawn up in each individual devolution settlement, perhaps through governance arrangements where the NHS retains accountability for money spent, as seen in Greater Manchester? If so, what assurances from the Secretary of State would be appropriate at this stage?

Or, on the other hand, are assurances about the use of NHS funding so important that provisions in the Bill itself should create limits?

3. Should powers to set goals and standards for the NHS be devolved?

Does one NHS need one set of standards?

The underlying question of whether the NHS should have one single national offer, or local variation, presents a moral and political quandary. On the one hand, it seems right that local communities should have the right to democratically decide which services they put first. Communities – rural or urban, old or young, with different ethnic mixes – may also have genuinely different needs calling for different choices.

On the other hand, universality is an NHS value; there is an argument that objective measures of cost-effectiveness should decide what is and is not prioritised; and opinion polls suggest the public value consistency.[11]

How far will the Bill allow goals and standards to vary?

[8] http://www.england.nhs.uk/wp-content/uploads/2013/12/bcf-itf-sup-pck.pdf
[9] http://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-user-guide-02.pdf.pdf
[10] http://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-user-guide-02.pdf.pdf
[11] https://www.ipsos-mori.com/_emails/sri/latestthinking/aug2010/content/5_the-nhs-public-perceptions-future-challenges.pdf

Currently, clause 18 of the Bill, inserted as an amendment in the House of Lords and amended in the Commons, would allow devolution of standards as long as the Secretary of State has had regards to those standards through the devolution process. Whether to retain, remove or change this provision will be a crucial decision for MPs.

However, even if these "national service standards" were to be kept at the centre there is still significant scope for goals and standards to vary between combined authorities responsible for healthcare. Currently, many rationing decisions are made by CCGs setting policies on what they will and will not fund for local patients. Many, for example, set limits on who is eligible for a hip replacement. Already, many CCGs work together in regional groups to develop these policies. Whether or not these are specifically among the powers transferred to a combined authority, it seems reasonable and likely that these decisions would be taken at the level of combined authority regions.[12]

Meanwhile, the existence of standards in the NHS Constitution has not stopped the Department of Health from exerting discretion over how they are interpreted, how strictly NHS providers are held to them and what sort of action is taken when they are not met. For example, last year the Department announced a "managed breach" of 18-week targets for inpatient and outpatient treatment, citing the need to focus on longer waiters.[13] This sort of discretion may play an even greater role when systemic issues are making it difficult to meet a range of targets[14], as has been seen recently, and difficult decisions about priorities need to be taken. Could these informal powers of pressure and priority effectively be transferred to combined authorities, either explicitly or through a gradual transfer of legitimacy?

4. What new powers to protect public health should be devolved?

Public health and local government

The Health and Social Care Act 2012 transferred some public health staff and funds from the NHS to the top tier of local government, placing greater emphasis on the local authority role in improving the health and wellbeing of population and tackling inequalities[15]. Some staff and functions transferred to Public Health England with some functions going to NHS England. Local Authorities retained Environmental Health functions (unitaries and districts) and Trading Standards functions (top tier authorities). This resulted in a system where public health functions can sit across four different agencies in a County, and three in a unitary authority. The opportunity to use devolution to resolve this is important.

Top tier local authorities are now responsible for using the public health funds to commission certain health services including those for sexual health and drug and alcohol problems. They also have a range of duties such as a duty to support local NHS decision making through public health advice. They also inform local health decisions more widely through the Joint Strategic Needs Assessment (an assessment of the current and future health and social care needs and assets of the local community) and Joint Health and Wellbeing Strategy[16]. Being situated within the Local Authority creates the potential for public health clinicians and staff to influence local decisions on planning, housing, transport and licensing for the benefit of the local population health. For example in order to tackle obesity local governments may regulate fast food street sales or encourage local food

[12] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/rationing_in_the_nhs_0.pdf

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447005/DH_accounts_14-15_print.pdf

[14] http://www.nuffieldtrust.org.uk/publications/access-hospital-care-nhs-target

[15] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212962/Public-health-intelligence-local-government-functions.pdf

[16] http://researchbriefings.files.parliament.uk/documents/SN06844/SN06844.pdf

initiatives, such as a sugarsmart campaign in Brighton and Hove[17], to encourage debate and change behaviours.

The Devolution Bill

The Devolution Bill does not provide a framework to give authorities the most powerful tools to affect their environment to address the public's health, except for the planning powers local authorities already hold over places like betting shops and smoking areas. [18] [19] For example, the power to change drink driving limits would require more fundamental devolution of Parliamentary powers, as was given to the Scottish Government under the 2012 Scotland Act.[20] Devolution of the power to tax or prohibit products is not on the table.

Devolved areas will have a unique opportunity to tailor local solutions to local problems and use the new powers at their disposal to improve health and reduce inequalities. The agreement in Greater Manchester is poised to obtain powers over the local economy, employment supports, housing and infrastructure that are only currently available to London, [21] all of which are clearly intertwined with a social model of health. The aspirations are noble and just, although care must be taken to ensure that the regeneration and urban planning of local communities does not lead to increased inequalities and gentrification.

However, many of these opportunities could be achieved through better partnership working under the current system, rather than the need for a Bill. For example in Greater Manchester, some of the work done prior to an agreement to devolution, brought local authorities together in a health commission. This is reported to have led to success on issues such as fuel poverty, cycling, and obesity[22].

Meanwhile, MPs should consider whether fully achieving the potential of combined local leadership to improve health would require a wider range of powers to be devolved than the current bill. For example, powers to create local schemes for alcohol, other restrictions or taxation may be desired by some areas. More flexibility in devolution deals would go further to achieving the public health potential of devolution, especially the prevention agenda.

5. Can combining powers help secure cheaper or higher quality care?

Integrated and community care interventions: what works?

The Nuffield Trust has carried out more than 30 evaluations aiming to treat more people outside hospital and reduce their reliance on expensive and intrusive hospital treatment. This goal lies at the heart of current ambitions across many projects and initiatives, including devolution proposals in Manchester and Hampshire.[23] [24] [25]

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[17] http://www.brighton-hove.gov.uk/content/health/healthy-lifestyle/sugar-smart-city-what-do-you-think
[18] http://www.bbc.co.uk/news/uk-politics-27225147
[19] https://www.gov.uk/guidance/alcohol-licensing
[20] http://www.gov.scot/resource/0040/00401340.pdf
[21] http://www.reform.uk/publication/letting-go-how-english-devolution-can-help-solve-the-nhs-care-and-cash-crisis/
[22] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leading-health-care-london-report-jun13.pdf
[23] http://www3.hants.gov.uk/devolution-prospectus-september-2015.pdf
[24] http://www.nhshistory.net/mou%20(1).pdf
[25] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf

However, we found very little evidence of reductions in hospital admissions or of financial savings[26]. We speculate that any success will require at least three to five years, with constant feedback and improvement. There is a need for real caution to manage expectations on the potential for projects of this sort.

Will pooling responsibilities actually lead to better joined up care?

Joining up planning and funding at the highest level will not in itself promote better joined up working at the front line. Where services exist in different "silos" with poor communication between them, putting them into a larger organisation will in itself improve these issues. In Northern Ireland, responsibility for health and social care was combined in the 1970s, as local government lost credibility due to sectarian divisions. But this has not led to automatic progress in the two sectors working together effectively and efficiently. [27] [28]

Will this Bill help those who need it?

The lack of a regional strategic leadership position for the NHS – a "referee" body that can co-ordinate plans and thrash out disagreements between local commissioners and trusts - has been a cause for some concern since the 2013 Health and Social Care Act. The model of a combined authority seems to provide one way to address this.

However, NHS bodies have already made steps to tackle this in many areas. In North West London for example, the Whole Systems Integrated Care programme brought together health and social care commissioners and providers covering a population of over two million. Our research suggests that good local relationships are the key here.[29]

So in areas already making progress in coming together, this Bill may not be needed in order to establish strategic regional oversight. But on the other hand, if an area is still finding it hard to agree on leadership and common goals locally, it is unlikely to apply for a devolution package including health.

6. Will this mean a shift away from local control?

Losing the local scale of the CCG?

One of the main aims in the introduction of CCGs, currently in charge of most planning and funding in the NHS, was to bring decisions about how to spend the NHS budget down to a smaller scale. Although CCGs vary in population size - from the smallest CCGs who are responsible for fewer than 100k people, to the largest who are responsible for over 800k[30] - the average size of a CCG is smaller than that of their predecessors. In contrast to this, the new strategic health and social partnership being developed as part of Manchester's devolution plans, for example, will cover a population of around 3 million, across 12 CCGs and 10 Local Authorities[31].

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[26] http://www.nuffieldtrust.org.uk/publications/evaluating-integrated-and-community-based-care-how-do-we-know-what-works

[27] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140411_four_countries_health_systems_summary_report.pdf

[28] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf

[29] http://www.nuffieldtrust.org.uk/publications/integrated-care-north-west-london-experience

[30] http://www.ons.gov.uk/ons/rel/sape/clinical-commissioning-group-population-estimates/mid-2011--census-based-/stb---clinical-commissioning-groups---mid-2011.html

[31] http://www.hsj.co.uk/news/finance/updated-6bn-manchester-devolution-deal-is-signed/5082806.article#.VhKgGaNwaUk

Does the current model of health care devolution represent a shift away from local decision-making? If so, is this right?

On the local government side, the scope under Clause 7 of the Bill to move responsibility for social care and public health from county councils up to combined authorities raises a similar risk that local priorities will get lost. It may prove challenging to ensure that decisions at larger scale combined authorities address the population needs of local communities. .

Will input from clinicians remain important?

A second important element of the design of CCGs was to strengthen the clinical voice in decision-making: GPs make up their membership, and there are guaranteed places for other clinicians on their boards. This was based on the idea that doctors and nurses have particular understanding of local needs, and that their buy-in is vital for reforms or changes.

Research conducted by the Nuffield Trust and The King's Fund found that as a result of their design, clinicians were more engaged in the work of CCGs in comparison to previous commissioning structures, and that the larger the CCG, the less likely GPs were to agree that the CCG is 'owned by its members and feels like "our organisation"' [32].

In our research, we noted the complex system in which CCGs already operate, with some already having built joint working arrangements with neighbouring CCGs and LAs, risked making decisions more complex and distant from front line professionals. In addition, complexities can also occur when accountability arrangements across multiple bodies conflict with one another in terms of their priorities[33].

Will new combined authorities with a role in health retain the front-line involvement CCGs have built up? If so, how?

7. How will the politics of new regions work?

Accountability and scrutiny

Devolution will tend to increase the level of local political influence in commissioning decisions, and there need to be sufficient mechanisms in place to protect against the risks associated with this. These include the victory of political over clinical priorities, and the scope for wrangling over finances or hospital sites as discussed below.

At present local government overview and scrutiny committees[34] have come under criticism for lack of effectiveness[35]. The scrutiny mechanism needs to be addressed as a priority in the Devolution Bill.

Meanwhile, the Department of Health and NHS England will face the difficult task of learning to hold to account a much wider range of health care commissioners, with different motivations and capabilities. The Secretary of State will still hold the duty to deliver a national health service, but he will increasingly have to do this through organisations where he has no direct control or sovereignty is shared. His mandate, and those of central government bodies, may clash with local leaders and local politics. Are they ready for this, and have they thought about how it will work?

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[32] http://www.nuffieldtrust.org.uk/publications/risk-or-reward-CCGs

[33] http://www.prucomm.ac.uk/assets/files/exploring-ongoing-development.pdf

[34] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

[35] http://www.publicfinance.co.uk/news/2015/02/scrutiny-arrangements-%E2%80%98not-kept-pace-local-government-change%E2%80%99

Service closures and downgrades

Decisions to close or move NHS services are often some of the most controversial in any local area. An important question will be whether combined authorities, with strong local visibility and accountability, will be able to give people more faith that these decisions are made fairly, and assure them that overall provision within the city or county will still be maintained or improved.

This seems possible in some cases, especially where an area is politically united, and may help local areas to move through difficult decisions more quickly. In other cases, though, there is a risk of unhelpful division along political lines, or majority decisions pushed through leaving a disaffected minority.

Financial pressure and deficits

As important lesson from the examples of Wales and Scotland is that where a devolved authority relies on funding from a central authority, there is increased scope to squabble over who takes the blame for a financial squeeze. The Scottish and Welsh governments have blamed cuts to Westminster's block grant for pressure on their health services.[36] London leaders have argued that the devolved nations made their own choices about how to prioritise scarce resources.[37]
With fiscal consolidation set to continue for several years, it is easy to see how this could be replicated at a regional level in England. There is the risk that the public and MPs find it difficult to hold any level of government to account.

Meanwhile, NHS hospitals and other trusts continue to run up large deficits, spending more than they earn in an attempt to keep up with demand and quality requirements. Currently, the Department of Health implicitly backs them, ensuring that they will be able to cover wages and costs. It is important to know how this would be dealt with in devolved areas. Would this continue to be seen as the responsibility of the Department of Health, linked to the duty of the Secretary of State to secure the health service? Or would there be political wrangling over who picked up the bill to keep hospitals functioning?

[36] http://www.snp.org/media-centre/news/2015/mar/murphy-admits-westminster-threat-scottish-nhs
[37] http://www.bbc.co.uk/news/election-2015-wales-32590024

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