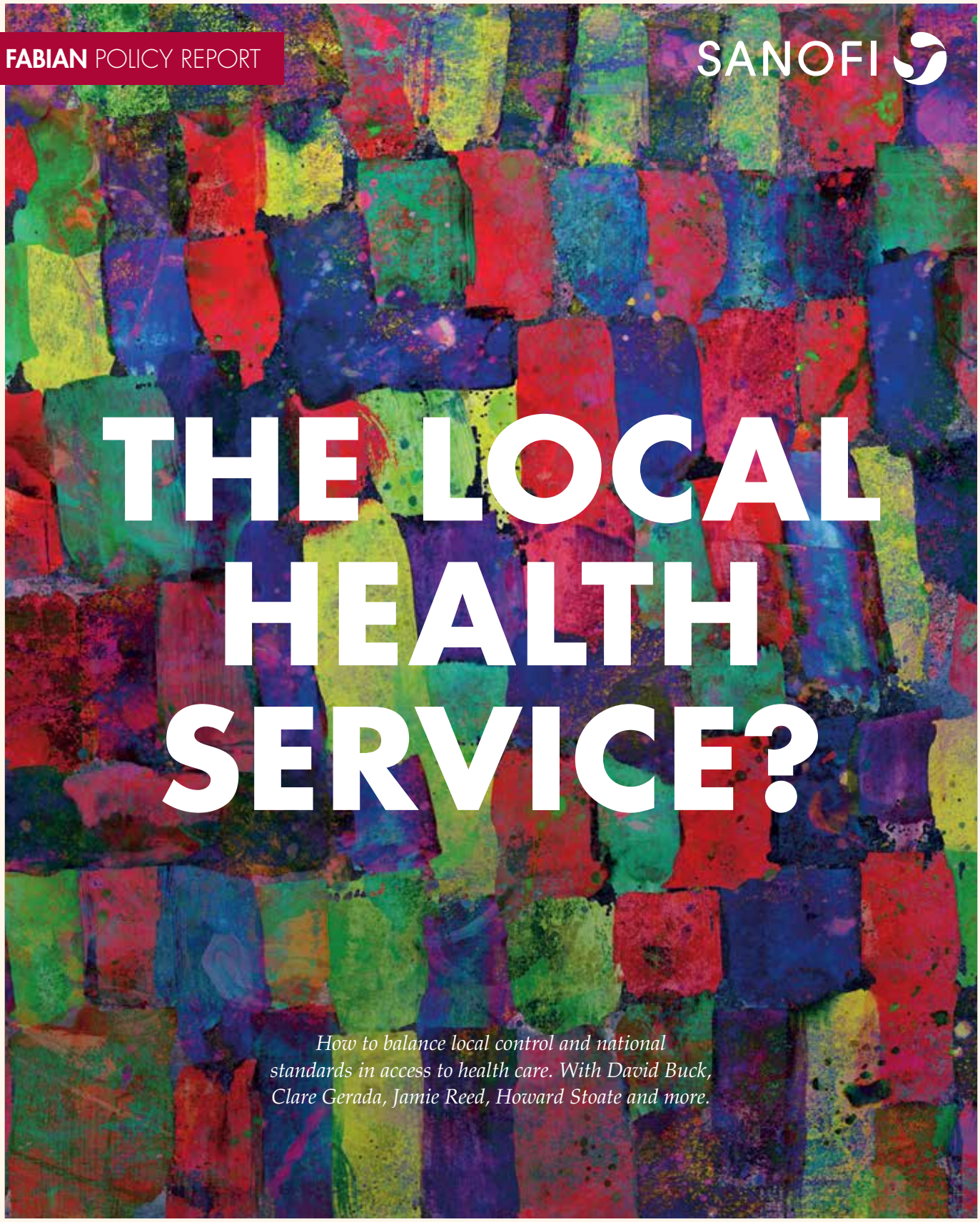
FABIAN POLICY REPORT
SANOFI
THE LOCAL HEALTH SERVICE?
How to balance local control and national standards in access to health care. With David Buck, Clare Gerada, Jamie Reed, Howard Stoate and more.

SANOFI

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FOREWORD

Jamie Reed MP is shadow health minister

The debate around localism in our healthcare provisions has been around as long as the NHS, perhaps longer. More often than not, the issue comes down to resource. How can an area with relatively little funding provide care to the same standards as wealthier areas? Current funding formulas are not up to the task of providing fair levels of funding to places with unique health challenges, such as in areas with, for example, particular geographical and demographic pressures. This is an issue that has been debated from the very inception of the NHS: in the second reading debate of the National Health Service Bill on 30th April 1946, Nye Bevan said when arguing against handing control of voluntary hospitals to local authorities:

> *"If it be our contract with the British people, if it be our intention that we should universalise the best, that we shall promise every citizen in this country the same standard of service, how can that be articulated through a rate-borne institution which means that the poor authority will not be able to carry out the same thing at all? It means that once more we shall be faced with all kinds of anomalies."*

This report sees contributions from a wide range of authors dissecting the issues at the heart of the debate and examining how high quality healthcare can be achieved at the same time as we give greater control to service users, employees and local leaders. Andrew Harrop looks at the issue of localism alongside integration and how it can work in practice. This is followed by Michael Macdonnell from NHS England looking at how national institutions will work within an increasing localism agenda. Elsewhere, Rudolf Klein considers the practical obstacles and opportunities for the NHS in providing national principles at a local level.

Over recent years, the prevalence of rationing of treatments has increased as well as the introduction of differing qualifying criteria for treatments in different areas. David Buck at The King's Fund examines in more detail the 'postcode lottery' and explains that, contrary to public fears, localism could prove the solution to health inequalities rather than the cause, if local priorities are aligned. A key theme of this debate is the extent to which national standards are applied across healthcare provision; the former chair of the Royal College of General Practitioners, Clare Gerada, examines to what extent local decisions about access to treatments should be tailored to specific circumstances. Continuing the depth of expertise in this report is a case study by Jessica Studdert of the LGA looking at the government's'Devo-Manc' proposals and its effect on healthcare in Greater Manchester, described by Simon Stevens of NHS England as"the greatest integration and devolution of care since the creation of the NHS in 1948". This clearly offers great potential to drive efficiencies and take a 'whole area' view on public health, but big practical, budgetary and democratic questions remain unanswered. Elsewhere authors consider variation in access to treatments and how far local authorities should be involved in healthcare. The report concludes with a practitioner's perspective of the debate from Dr Howard Stoate, the Chair of Bexley CCG.

The challenge of delivering national standards at a local level is an ongoing question and any debate about how services should look in the future must be open to everyone. Another five years of cost constraints, restructuring and austerity will be tough for the NHS, the staff and patients, but more people must have their say in how their local services operate.

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Where power lies

The main controversy for NHS localism is not whether to devolve power, but where to devolve it to, writes *Andrew Harrop*

Andrew Harrop is general secretary of the Fabian Society

To succeed over the next 10 years, the National Health Service must also be a local health service. A public service dedicated to the health and wellbeing of every person in England cannot be run as a bureaucratic offshoot of Whitehall. Instead, success will depend on power and trust cascading downwards to local areas, NHS institutions, teams of professionals and to citizens.

Autonomy matters because good services adapt, innovate and set their own direction, rather than just implementing instructions from elsewhere: achieving excellence is an intrinsic, internal process of learning and experimentation. And autonomy enables institutions and individuals to collaborate in co-evolving relationships and networks. This is essential when standardised top-down interventions do not lead in a linear fashion to predictable results; where conditions are ambiguous, heterogeneous and interdependent, as they so often are in healthcare.

This is all increasingly recognised at the frontline, where the focus is on personalised care and control. The best way to help someone live well with complex, chronic illness is different in every case – driven by the individual's choices and circumstances – and involves many different individuals and agencies, working together in discrete ways on each occasion.

But autonomy also matters at the level of whole local healthcare systems. Adaptive, personalised frontline relationships and networks cannot be willed from the centre through direction; and nor can they come about spontaneously through market-like incentives and transactions. Healthcare networks need to be steered and nurtured by local leadership and stewardship.

The need for strong locality-wide leadership is a vital new feature in the debate on the NHS's future and this report examines, celebrates and scrutinises its gradual emergence. A previous Fabian report, *Going Public*, identified two key roles which neither individual providers nor central government have the capacity, insight or joined-up perspective to perform.

First, local leaders are best placed to drive service improvement, through a combination of commissioning, facilitation, scrutiny and intervention. Except in cases of serious failure, national agencies are simply too distant and over-stretched to do this job. As the NHS Five Year Forward View makes plain, it is localities that need to make choices on which new service models can combine quality and value, taking account of their own individual circumstances.

Second, only local leaders can set 'whole-place' strategy, looking in the round at local needs, preferences and context. This is a challenging task, even from an NHS-only perspective, given fragmentation within the service and people's natural affiliations to individual institutions when faced with change. But strong local leadership also needs to drive collaboration across all public services (and with non-profit organisations and businesses), for example to direct resources towards prevention or create seamless personalised services.

This leads to the main controversy within the debate on NHS localism, which is not the question of *whether* to devolve power, but *where* it should be devolved to – and, in particular, whether devolution should also include significant power sharing with local government. Many on the NHS side of the fence are already embracing dynamic local leadership, by clinicians and managers, but still see clear limits on the role councils should play. For a few years, perhaps this is sustainable, as the NHS concentrates on reforms that are mainly focused on remodelling the relationship between primary, community, mental health and acute care.

But over time it cannot be, because too many of the drivers of demand are the responsibility of local authorities, who are themselves on the brink of financial collapse. For example, radical leadership will be needed, by councils and the NHS together, for local public health strategies to have any measurable impact on demand. Even more urgently, over the next three years, adult social care and housing support services may simply be overwhelmed, leaving the NHS facing a rapid rise in frail older people requiring unplanned care.

The long-term solution is for health commissioners to work with local government and integration between the NHS and other services, with respect to both commissioning and provision.

UNDERSTANDING NHS LOCALISM

NHS localism is evolving along four different and potentially contradictory paths:

- **Clinical commissioning groups**, the local commissioners of community and acute healthcare, are being offered more power over the commissioning of primary and specialist care; and many are starting to actively reshape their local provider landscape, using nationally-approved models and individually-negotiated extra powers.
- **Acute health trusts** are shifting their focus from hospital-based care to community services; and in the future some will offer primary and social care. The ambition is for some acute trusts to take end-to-end responsibility for patients, as US-style 'accountable care organisations'.
- **Local government influence** is developing, through health and wellbeing boards and the Better Care Fund, which councils and the NHS spend jointly. Some councillors and elected mayors are playing an expanding role in scrutiny, system-wide leadership and integration between the NHS and other services, with respect to both commissioning and provision.
- **City regions**, starting with Greater Manchester, are being offered the opportunity to take over some national NHS responsibilities and may also pool some of the local functions of CCGs and health and wellbeing boards.

There is an important distinction between decentralisation within the NHS (increasing power and flexibility for local managers and clinicians) and models involving elected city or local authorities (which implies political accountability, 'whole-place' leadership and integration beyond the NHS).

All these models are examples of 'managed' localism, since a high degree of national prescription continues. This includes the financial and regulatory regime and – from a patient's perspective – national rights, enshrined in the NHS constitution, including the right to NICE approved treatments when recommended by a clinician.

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ment to jointly design services which are both 'whole-place' and 'whole-person', encompassing health, support and wellbeing. In all likelihood most of the money will need to come from NHS budgets, but the level of strategic and operational integration required suggests that local government will need to become ever more involved in NHS decisions. For reasons of financial sustainability, we will in effect see the creation of local health and wellbeing services, reporting to local government and NHS England on an equal footing.

The question then becomes, at what scale should this happen. Will clinical commissioning groups (CCGs) and councils jointly manage all health and care spending at local level, as NHS England has said might happen in some places? Or will new regional arrangements be introduced, above them, as is now beginning in Greater Manchester? The answers will no doubt be different in different places, as is the logic of localism.

The NHS should not see the expanding role of city or local authorities as a regrettable consequence of austerity and changing patterns of demand. Until now NHS localism has been remote and technocratic, but gradual integration with local government holds out the promise of far greater political leadership, democratic scrutiny and public involvement. This poses some risks (in the short-term NHS insiders might have to work harder to make the case for changes to popular services) but it will also inject local ownership, leadership and accountability. It may be that only high profile city-bosses will have the clout needed to drive through major institutional reforms and be the face of local services to the public.

And what of the public? Debates on localism can sound very far removed from people's daily lives and their own relationships with frontline services. But the test of local devolution must be its capacity to demonstrably improve individuals' health and wellbeing. That must mean two things together – better overall outcomes and less variability in the things that matter for patients. The second point is particularly important, because the public will not accept greater 'postcode lotteries' in overall outcomes, as the price of local autonomy over 'how' services are run.

There has always been local variation in health and healthcare outcomes, and there always will be. But for decades 'unwarranted' variation has been too high. In times past this was swept under the carpet, but now we have the evidence to map and understand it. This includes the NHS Atlas of Variation (on differences in quality, safety, activity levels, spending and outcomes), the NHS Innovation Scorecard (on the pace of adoption of new NICE-approved technologies), and data on compliance with non-compulsory NICE guidelines.

Just because there have been high levels of variability in access, quality or outcomes historically, does not mean this should be tolerated in the context of localism. National data combined with local autonomy and accountability should create the context for locally-driven adoption and innovation, with the aim of improving performance, relative to national benchmarks. Localities should be seeking to understand whether geographic variations are explicable and warranted (ie reflecting local need or consciously chosen priorities) or imply suboptimal service configuration and clinical practice, or an allocation of resources which reflects history rather than demand or value. And similar principles apply in analysing local service patterns, including seeking evidence of the 'inverse care law', where people from disadvantaged backgrounds have unjustifiably inferior experiences. To make sure these approaches are followed everywhere, NHS England should provide support, to complement the scrutiny of local stakeholders.

Localism should also provide the spur to close gaps in overall health outcomes, not just those related to the provision of care. Local leaders will be able to take health inequalities far more seriously (both within and between local areas) since more of the levers for achieving change will be at their disposal. Indeed, one of the main rationales for handing NHS powers to Greater Manchester, at city region level, is to achieve a non-siloed, whole-place approach to public health, since it is expected that the new mayor will develop complementary strategies in areas such as employment, skills, transport and policing.

There are, however, limits: neither overall national performance nor geographic inequalities will improve just through local leadership The public still expects a National Health Service across England, so devolution in healthcare must be 'managed'. In a more localist future, there must still be a core set of national standards, underpinned by strong evidence-based institutions.

This applies especially when it comes to access to services, treatments and technologies. After all, the standardisation brought about by the last Labour government's slew of entitlements, frameworks and targets had a hugely positive impact on both overall quality and levels of variability. It is easy to forget, for example, that NICE was conceived not to block the path of expensive new technologies, but to drive out postcode lotteries in the availability of treatments and, later, in clinical practice.

But there is also a balance to strike, because requirements must not be so prescriptive that they can only be fulfilled by squeezing out any space for experimentation, local decisions on priorities, or the possibility of sometimes going beyond the national 'offer'.

The NHS has a proud record of securing equitable access to high quality, good value healthcare. From a global standpoint the service is very successful in combining three qualities – equity, value and innovation – and this is of course underpinned by the enduring commitment to an NHS free at the point of need. But to continue to advance on all three fronts – in the context of changing health needs and service models, as well as ongoing austerity – it will take a new wave of locally-led reform. As the NHS looks towards its eighth decade, this cannot be achieved from the centre: learning to let go is the only way forward for our National Health Service. F

Building the future NHS

New commissioning flexibilities may be needed to modernise care, argues *Michael Macdonnell*

Elections produce heat and light in unequal proportions. So it was in the 2015 contest in which the NHS featured prominently. Despite appearances, the debate served to underline how solidly all mainstream political parties – and the public they represent – remain committed to a tax-funded health service, free at the point of use. But the debate also exposed an implicit clause in the contract: voters are happy to pay for a tax-funded service – and pay more for it – but in return we must bring about a future NHS that is both more attuned to modern needs and financially sustainable.

There is quite a broad consensus about what this future NHS should look like. Set out in the NHS Five Year Forward View, it will be different in three important ways. First, it will prevent ill health as well as treat it; so we need radically to upgrade our public health efforts. At NHS England we've made a start by instigating what will be the world's biggest diabetes prevention programme, and a cross-government drive on obesity will begin later this year.

Second, we need to redesign how we deliver care. People live longer now, and they live with more long-term conditions. So we need to break down traditional distinctions between mental and physical health, between family doctors and hospitals, and between health and social care. To achieve this 'triple integration' we've launched a network of 'Vanguard' sites, serving 5 million people, with the task of rewiring healthcare services.

Third, this rewired health service needs to be more productive. The Forward View argued for increasing funding by at least £8bn by the end of the decade. The government has accepted this. Now the NHS has to get on with delivering its part of the bargain, equivalent to 2-3 per cent of efficiencies across its funding base. We've outlined our programme for helping NHS organisations to do this, and they will be helping us fill in the details over the coming months.

Of course it won't be the national leadership bodies that deliver this change; it will be the doctors, nurses and managers in NHS organisations across the country. But we can help, and one important way of doing so is to provide meaningful local flexibility in how policy, regulation and other rules are applied. England is just too diverse for a one-size-fits-all model to apply everywhere.

One such flexibility is how we commission services. Traditionally we have done this down separate 'pipes' that rarely converge. Primary care and specialist hospital services are commissioned nationally, whilst local hospital and mental health services are commissioned separately by clinical commissioning groups (CCGs). Social care remains the province of local government.

These separate pipes get in the way of coordinating care around people who, after all, may need all of these services. They also get in the way of making better allocative decisions between different budgets. For example, greater investment in primary care is needed to prevent illness, diagnose it early and help people manage their conditions outside of hospital. In fact, over the last decade hospital investment has been more than double that in primary care partly because these budgets have been administered separately. Similarly, for some people with long-term conditions it may make sense to spend more on social care to keep them independent and out of hospital, which means making allocative decisions across both health and social care spend. More generally, we increasingly want to ask what return we get on total health and care expenditure in different geographies.

So we are helping areas experiment with different commissioning arrangements. A first set of experiments is to give CCGs the freedom to commission primary care. Nearly 150 will be exercising this freedom. We're doing something similar with specialised hospital services, moving towards a single place-based health budget. Second, eight 'demonstrator' sites in England are helping us develop fully integrated personal budgets for patients with complex needs, supporting these people to take control of how and where money is spent. A third set of experiments integrate health and social care budgets in specific places. A number of areas across England have pursued this type of integration in recent years.

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Greater Manchester is the most feted recent addition, where local leaders have developed radical proposals for bringing health and social care together into a £6bn pooled budget. This freedom will allow Manchester to focus on its own priorities, without compromising on the essential standards of a national health service. For Manchester, one of these priorities is to improve the health and productivity of their workforce, enabling them to compete with other leading global cities.

These experiments won't be appropriate everywhere and they won't all move at the same pace. We will have to assess them for the return they generate for patients and taxpayers alike. But if they help bring about better and more productive ways of delivering healthcare – which are simultaneously better fitted to local priorities – then they could become essential tools for building the future NHS. F

Michael Macdonnell is director of the strategy group at NHS England

The health inequality challenge

Greater localism doesn't necessarily mean greater health inequalities. With the right local leadership and central government support, localism could help address the broad range of factors that drive health inequalities in a particular area, writes *David Buck*

David Buck is senior fellow, public health and health inequalities at The King's Fund

Health inequalities are one of the most pernicious and tenacious challenges that any government, and wider society, has to address. And judged by the coalition government's own commitment "to increase the health of the poorest, fastest", there are good reasons to be critical of its track record on health inequalities.

Various institutional tweaks and changes have led to a plethora of disconnected strategies in the approach to health inequalities. New central bodies such as NHS England and Public Health England have been created, while the Department of Health has seemingly lost its strong oversight function and the public health subcommittee has been disbanded. No doubt some of these were worthy initiatives, but the King's Fund has concluded that the lack of someone holding the ring and accountability at the centre led to failure.

In this context there is obviously a very strong challenge for a more local approach to overcome. But first some myths need to be dispelled, not least about the NHS. Its principles of equal access and tax-based funding continue to mean the NHS is one of the most equitable systems in the world in terms of direct access to primary and, to a lesser extent, secondary care. Far fewer people struggle here to access health care for financial reasons than in most places in the developed world.

However, there has always been much greater variation in what people actually receive from the NHS than many realise. Indeed, one of the reasons for the last Labour administration's early focus on National Service Frameworks was to tackle the 'postcode lottery' of services and outcomes. These were accompanied with increased funding and a raft of targets. Despite this, there remains much variation in services between people in different parts of the country, as documented in the NHS Atlas of Variation Series.

So, the NHS already has some of the fears of localism embedded within its provision of services. The questions are: how much of this variation is justifiable clinically? How much is actively chosen by local patients or citizens? And how much does this contribute to inequalities in health? These are also the questions we must keep in mind when assessing the impact of 'more localism'.

Arguably, the coalition government gave more power to clinicians to influence the answer to the first of these questions, through the disbanding of most NHS targets and giving greater control to clinical commissioning groups. Latterly, however, NHS England has flexed its muscles through the NHS Five Year Forward View, including its aggressive support for a limited range of new models of care. One of the unanswered and frankly unaddressed questions is how this new policy approach of "choose amongst our options" conflicts with the strategic role of health and wellbeing boards. They are, after all, the bodies who are meant to set the overall health and wellbeing strategies for their areas. In order to tackle inequalities in health effectively, all those who sit on the health and wellbeing board need to align their strategies and actions to this end. But there is little sign that inequalities in health are at the heart of NHS England's new models of care, or more broadly the focus on integration, or that these models are subservient to local health and wellbeing board strategies. Unless this is rectified, this increased central control could end up undermining the fight against health inequalities

The challenge to the NHS and health and wellbeing boards

So there is no reason why greater localism should mean greater inequalities in health *per se*. But if localism is to be successful in reducing health inequalities, health and wellbeing boards will clearly need to up their game. They must hold the NHS to account locally in order to ensure that new models of care are aligned to achieve these aims. Health and wellbeing boards will also need to work harder on other factors that drive local health inequalities too. That means a stronger focus on the wider determinants of health and on understanding the complexity of behaviour change.

Early reports on health and wellbeing boards were positive about the former, indicating wide support for the principles set out in Sir Michael Marmot's review on health inequalities. But statements of strategy mean nothing if not translated into reality. There are signs that some local authorities such as Blackburn with Darwen are doing this through mechanisms such as local social determinants of health funds. Other areas such as Islington, York, Wakefield, Sheffield and Liverpool have engaged the local NHS in wider debates on inequalities through health, poverty and fairness commissions. This is important: a big deficit in national policy is that the NHS's role is seen only through the narrow lens of providing treatment, and at a stretch prevention. When it has a budget of over £110bn and a staff of 1.4 million, the NHS is actually one of the largest wider determinants of health in every local community. It needs to be simultaneously valued and challenged for this contribution.

> The NHS is one of the most equitable systems in the world in terms of direct access to primary and secondary care

Local authorities have taken well to their new roles in public health after a year of transition. But as well as the challenges of working across many fronts on the wider determinants of health, they need a more nuanced approach to their work on lifestyles. National and local studies have shown that lifestyles cluster in population groups and that is storing inequalities in health up for the future. Local strategies need to factor this in if we are to address this. At the moment at least, judging from experience in London, there seems little sign this is happening.

Localism or regionalism?

One of the benefits of devolution of healthcare in Manchester is its regional approach. Looking at the common factors that affect the wellbeing of 2.7 million residents across 10 local authorities has led to a realisation that integration cannot rest at health and social care. If inequalities in health and wellbeing are to be addressed, integration needs to go much further into the economically inactive working age population, raising skills, improving health (including mental health) and focusing on families as much as individuals. This insightful, tailored approach is way ahead of the national debate on integration and could be transformative for future inequalities in health.

The LGA's database of health and wellbeing board priorities shows some clear agreement across local authorities in Greater Manchester, notably in the focus on the early years. However, there is actually more divergence than commonality overall. Already there have been concerns that devolution in Manchester has happened behind closed doors without adequate public consultation. Greater Manchester, and those that may follow in its wake, therefore need to avoid mistaking more regional control for permission to override either local priority-setting, or key national rights – particularly those related to NHS care. That means difficult decisions will need to be made regarding who is responsible and accountable at each level.

The ultimate challenge? Moving to a true population health system

So there are lots of challenges. Despite the Greater Manchester deal, the trajectory of the NHS seems to be towards more centralisation – or perhaps more accurately, a very tightly controlled range of new models of care. When the NHS budget is so squeezed this might be sensible, but it clashes with the idea of health and wellbeing boards being in the lead locally. Health and wellbeing boards could also see themselves squeezed by regionalism on the local government side too, with devolution in Manchester a case study in the making.

Furthermore, greater political participation around health is a doubled-edged sword. More localism in health and care is likely to lead to greater democratic participation as has happened in New Zealand, for example. But there is a real danger that the electorate will vote on the basis of saving the iconic hospital down the road, rather than the complexity and interplay of the factors that drive inequalities in health, which are not easily reducible to political soundbites. Avoiding this pitfall will remain one of the greatest challenges to local leadership.

At its best, localism could help lead us to a true population health system with inequalities at its heart. For me that means: inequality reduction becoming a core goal of health and social care integration locally; integration moving upstream to working age populations; local behaviour change strategies recognising and addressing the clustering of health behaviours; a local NHS playing its full role in the wider determinants of health as much as treatment and prevention; and health and wellbeing boards moving from rhetoric on inequalities in health to delivery.

If localism can deliver all this, it can deliver a reduction in inequalities in health. All this relies on strong, resilient local leadership and appropriate subsidiarity, supported by central government policy that is also subject to rigorous health impact assessment. F

Dependent variable

Daisy-Rose Srblin investigates what 'national' means in a devolved health and care system – and how much variation in access to treatment is permissible

Daisy-Rose Srblin is a research fellow at the Fabian Society

During the recent general election, the NHS featured as one of the most important political issues in the public mind. Indeed, Ipsos MORI found that it polled significantly higher than even the army or the monarchy as the institution which made people most proud to be British.[1] Clearly, it's the 'National' in the 'National Health Service' that resonates: not only is the NHS a safety net, but it's free at the point of use for all, and is available regardless of means or any other discriminatory variable.

And yet this national service has always been shaped by the judgement of clinicians and local level commissioning decisions. What is fearfully spoken of as a 'postcode lottery' has always been a feature of the NHS.[2] Growing haphazardly since 1948, both individual health authorities and powerful medical consultants have shaped local decisions on treatments and drugs. For instance, in the nineteen-nineties, GP 'fundholding' meant patients of 'budget-holding' general practices had faster access to hospital treatment than patients of non-fundholding practices, producing a clear, two-tier system.[3] In response to concerns about this inequality of access, the 1997 Labour government promised to "renew the NHS as a one nation health service",[4] establishing national service frameworks and enforcing national standards of care to "further tackle the lottery of care".[5]

However, public concern about 'post-code lotteries' in health seems stronger today than ever, due to the funding pressures the NHS faces and the process of 'rationing' being pursued by Clinical Commissioning Groups (CCGs). These processes, currently in operation across the country, restrict access to treatments in order to balance budgets, either through excluding 'low value' procedures (such as weight loss surgery) or excluding patients from surgery on grounds of lifestyle choices (such as excluding smokers from receiving hip replacements).[6] Furthermore, the government's decision to devolve health powers to Greater Manchester raises the question of how much divergence from national consistency in the NHS should be tolerated.

There are well-known examples where local variation has been deemed unpalatable. Northern, Eastern and Western Devon CCG was forced to back down on its plans to limit access to surgery for severely obese patients and smokers in the face of a public backlash.[7] However, there are also examples of variation in the NHS which might be understood as reasonable. GPs make decisions everyday based upon their individual, professional judgement of patient need. Decisions at CCG level combine an assessment of local needs and 'path dependency': the legacies of previous spending decisions.

Indeed, as NHS England has stated, "England is too diverse for 'one size fits all'",[8] so while NICE guidance and national priorities can shape decisions, there is no strict, objective way of allocating resources across different programmes of care throughout the country. In the case of health devolution in Manchester, supporters see the reform as enabling decisions to be taken much closer to the population served, mirroring the experience in Nordic countries where regional and local politicians often have a more significant role than their national counterparts in running health and care services.[9] However, leaders in Manchester have also recognised the need for adequate resources to manage this devolved responsibility. Some have called for a proportion of the rebate paid by the pharmaceutical industry to government (under the Pharmaceutical Price Regulation Scheme) to be passed downwards to help fund improved local care.[10]

There are different sorts of variation within the NHS. In many places non-statutory NICE guidelines (to be distinguished from its binding technical appraisals) are not being followed, leading to an inequality of NHS provision across the country. In the case of IVF, for example, NICE recommends three full cycles for women aged under forty who have not conceived after two years of trying. However, eighty per cent of CCGs are failing to commission three full cycles in line with these recommendations, with the Vale of York CCG failing to offer any IVF cycles at all.[11]

The potential for unfairness in these 'postcode' disparities is clear. However, while the NICE guidance on IVF is 'elective' and not mandatory, the NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals. Yet, even with these statutory appraisals, there seems to be evidence of significant variation and non-compliance, leading to inequality of provision across the country. In response to this, an 'innovation scorecard' was established in 2013 to monitor NHS compliance with NICE technology appraisal decisions, increase transparency and overcome variation.[12]

The scorecard's data demonstrates considerable variation across the country in the use of a range of medical technologies: for instance, in 2013-14, the Derbyshire and Nottinghamshire Area Team purchased twenty-two times fewer drugs for the prevention of thrombosis and strokes as recommended by NICE than the Area Team of Bristol, North Somerset, Somerset and South Gloucestershire.[13] While some divergence can be explained by medical need and legitimate professional judgement, slow uptake of NICE technology appraisals may also be responsible. (It should be noted that the provision of accessible data and information is a welcome step, but more must be done to make it more user-friendly and better at highlighting variation.)[14]

However, variation in terms of mode of service delivery is not necessarily always detrimental, as in the case of the devolved nations. For example, while health inequalities between the devolved nations has been well-documented, Health Foundation and Nuffield Trust research has shown that despite differences in structures, organisation, competition, patient choice and the use of non-NHS providers, there is no evidence (based upon the data available) linking these policy differences to a divergence of performance.[15]

Different sorts of variation, then, produce different degrees of divergence. Come what may, the NHS has finite resources so 'rationing' will always exist. Tie this to commissioning and policy-making to reflect local need, and variation becomes inevitable, and possibly even desirable. However, to date, the public has not been part of this conversation. Polling from 2009 for the Social Market Foundation indicated that almost three quarters of the public believe that 'treatments should only be available on the NHS if they are available to everyone and not dependent on where you live', with only a quarter agreeing that NHS treatments should be based on 'local need'.[16]

Public opinion offers an additional layer of complexity. The polling also found that people want a say on issues that affect them directly and frequently (such as GP access) or on issues where their participation was being sought (such as national health campaigns). Indeed, more recent analysis from The Patients Association has suggested the NHS should imbibe this 'no decision about me, without me' idea via CCGs, strengthening their use of patient and public engagement, and developing a clear sense of *who* should be responsible for patient engagement.[17] However, to complicate matters, the public seems to prefer health specialists taking a lead on areas where the NHS is perceived to be performing well, and where decisions need to be made using complex clinical evidence (such as in screening): for these areas, the public sees its own participation as chaotic. In these instances, the public prefers 'information' over 'involvement', with decisions made openly with transparent rationale. So, despite broad support for the principle of engaging with citizens during decision-making, a nuanced approach to local participation and involvement is needed.

It is clear that establishing a health system that avoids the extremities of either a 'one size fits all' or a 'let a thousand flowers bloom' approach, as NHS England puts it, is complicated and prone to difficulty.[18] As such, creating a truly 'national' offer in a locally and regionally devolved health and social care system generates a range of issues to consider for the future. Different local needs require different local approaches. As Nuffield Trust research has demonstrated, geographic variation in 'rationing' is now a fact within the NHS: yet, despite this, most CCGs 'muddle through' on an ad hoc basis, rather than develop a considered and transparent approach to priority setting, which is seemingly what the public would like to see.

While CCGs continue to establish how to set local priorities in the face of public disapproval of local variation, devolution of health powers must be founded upon a strong national framework. CCGs need to have the capability and resources to deliver on national frameworks and guidelines. They also need to understand fully 'what the rules are'. By the same token, national leaders must be clear in setting out what they consider to be 'acceptable variation', what the national minimum standards across the country are, and what should and should not be within CCG powers.[19]

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Greater Manchester's mission

The first devolved healthcare system in the country is a radical move. But it could be an opportunity to turn some of the worst health outcomes in the country into some of the best, writes *Jessica Studdert*

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Integration. Prevention. Personalisation. The buzzwords that indicate the reforms our health and care system needs are as widely recognised as they are overused. So too are the problematic features of current service provision: fragmentation, barriers and silos. The challenge is not one of rhetoric, but of moving beyond words to practically forge a system that works for people – and enables us all to live healthier, happier lives.

The context is a challenging one – on this there is also widespread consensus. People are living longer, and many more with long-term, complex conditions. The medical advances and increased life expectancies we can all celebrate mean that demand for services has evolved from the point when the National Health Service was first established in 1948. A hospital-based model set up to treat illness when life expectancy was 65 is now being required to tackle challenges it was not designed to cope with. Pressures are created as a consequence of this: A&E wards are struggling to cope with too many crises that could have been avoided if appropriate care was in place, and hospital beds are over-relied upon because community-based infrastructure is insufficient. The funding cuts to local government of 40 per cent over the last parliament have had an inevitable impact on social care provision: the coalition government's approach to salami-slicing Whitehall budgets without reform exacerbated the situation.

Against this backdrop, the announcement that responsibility for health and social care would be devolved to statutory organisations in Greater Manchester was certainly a bold move. The circumstances of the announcement months before the general election distracted from much of the substance of the proposed framework, which was to enable joint decision-making on integrated care to support physical, mental and social wellbeing. The intervention also exposed some of the fault lines that exist in debates over health and care reform: between centralist and localist perspectives, and between the medical profession and the local government sector.

As a consequence there are a few myths around the content and the implications of the Memorandum of Understanding which set out the terms of the devolution deal in Greater Manchester that need to be addressed, prior to a realistic appraisal of the measures. Some media coverage referred to the agreement as a local government "takeover" of the NHS. In fact, the framework was developed between Greater Manchester partners together – 12 NHS clinical commissioning groups (CCGs), 15 NHS providers and 10 local authorities – and each will retain their existing statutory responsibilities. The parties to the agreement are the Greater Manchester CCGs and local authorities (collectively known as GM), and NHS England. The mischaracterisation of the approach reflects precisely the obsession with professional hierarchies and sector-based territorialism that true integration needs to break through for new arrangements to be more than the sum of their parts.

Fears have been expressed in some quarters that the measures herald the end of the "N" in the NHS. However, the first principle of the agreement is clear that"GM will still remain part of the National Health Service and social care system, will uphold the standards set out in national guidance and will continue to meet the statutory requirements and duties, including those of the NHS Constitution and Mandate". The charge that the creation of new models of inclusive governance and decision-making would equate to the dissolution of a national system is ill-founded. The NHS has always been delivered in practice by local units such as primary care trusts, which lacked strong public accountability or visibility but worked within geographic and bureaucratic boundaries to make decisions about resource allocation and service provision. When considering the 'N' in the NHS, we need to be clear how this fits with the aspiration to craft a system suited to whole person needs, which are by definition different. What balance should be struck between national 'one-size-fits-all' rigidity on the one hand, and responsiveness to the needs of people and places, on the other? A public service reform discussion about the role of the national and the local very often quickly alights upon the phrase 'postcode lottery' in the negative – this is interestingly most often used with respect to local inputs rather than variations in outcomes nationally. The postcode lottery that people living in Greater Manchester should be most concerned about is the fact that they can currently expect to live nine years less than the average person in England. This is the motivating force behind the new framework being created by GM partners: tackling the existence of some of the worst health outcomes in the country – outcomes which have emerged and persist under a centrally-accountable national system.

The devolution agreement, while not in itself an automatic shift to positive outcomes, presents real opportunities for transformation beyond the existing baseline. Taking the starting point of making an analysis of whole population health needs across Greater Manchester, partners can work towards the twin objectives of closing the health inequalities gap – moving from having some of the worst health outcomes to having some of the best – and aligning provision to prevent ill health and promote well-being, from early age to later life.

For the first time, strong democratic accountability puts local people at the heart of the emerging new framework. Where previously decisions would be taken by remote bureaucracies or distant Whitehall departments, they will now be taken involving democratically elected representatives. This can inject a new responsiveness to the local system which will be driven by stronger direct incentives to evolve to meet people's demands: good access to high quality, joined up services which provide the right care at the right time. GM partners are already focussed on ensuring early, tangible benefits for people which also begin a shift to wider systemic reform, such as proposals to offer seven days a week GP access by the end of the year and a Greater Manchester-wide plan to join up fragmented dementia services.

While the devolution deal does not bring with it any more or less funding – the £6bn package identified refers to existing resources – a more strategic approach across Greater Manchester can seek to make the best use of these by allocating them more efficiently and effectively. Full place-based commissioning and delivery can ensure public investment is committed on the basis of shared intelligence and is geared to provide the right balance between medical intervention and social support. The GM framework is an opportunity to develop a more coherent long-term strategy to ease pressure on hospitals, while building up services in the community that bring health and social care closer to people's homes. This will mean removing funding ring fences to make sure funding goes where

it is needed locally, identifying duplication caused by service silos, and strengthening formal collaboration between providers. New budgeting models such as year of care funding can be developed, which begin to engineer a system-wide shift away from a focus on single episode and crisis treatment towards longer term preventative care. This can all create space for precisely the innovation and adaptation healthcare systems need: a research, innovation and growth strategy is a major strategic thread through GM partners' joint work and they are prioritising the early implementation of an academic health science system.

Creating a preventative whole-system approach that shifts from treating illness to promoting wellness involves recognising individuals not as patients but as people. In a different relationship with statutory services, individuals have responsibility for their own health outcomes but are also given the right support. Traditionally, building-based health services like hospitals and GP practices focus on treating illness and operate largely in isolation from wider provision that impacts on good health outcomes such as employment and housing. There is now a real opportunity to align priorities across services and within communities. For example, poor health is too often a barrier to sustained employment, so another early implementation priority from the GM partners is a new programme to help people with mental health conditions get back into work.

Stakeholders in Greater Manchester are continuing to develop the relationships, trust and mutual respect between the professions and services involved. Nonetheless, there are real risks to the new approach which will need to be recognised and managed as the process evolves.

First, the funding context within which the GM partners operate is something of a burning platform. It won't be until the new Conservative government's first comprehensive spending review that partners will have confirmation of what resources they have to work with, and how long-term a settlement they can predicate their plans on. A strategic business case will be developed by the end of the year which will need to find a way to bridge financial gaps, which will be no small challenge in the context of further austerity

Second, the huge ambition set out in the early Memorandum of Understanding was matched by an extremely tight timetable for the translation of these principles and framework into action and outcomes. Partners are already part-way into a 'build-up year' ahead of full control of health and care budgets in GM by April 2016. While a roadmap and delivery plan are to be developed and agreed between the partners and wider stakeholders, governance arrangements will be agreed in parallel. A careful balance will need to be struck between moving forward where possible while also ensuring that effective system-wide leadership is forged. Governance arrangements will need to simplify accountability rather than add to complexity. They must be robust enough to realign accountability for the use of public resources sufficiently to meet the huge ambition of the framework.

A priority within all of this is to ensure constant and substantive public engagement and involvement: both in the process of devolution itself, and on an individual level in relation to health needs. There will be a new responsibility for local politicians to articulate the ambitions of the GM partnership and ensure that public dialogue focusses not simply on institutional arrangements but on health outcomes. The latter must remain a driving force for partners as well as a measure of their success. Public engagement shouldn't happen solely through democratically elected institutions but that a new transparency and accountability is created across the whole health and care system so that people have greater opportunity to become genuinely more involved and engaged in decisions which affect their lives.

GM partners are not complacent about the scale of the challenge they face. As the business case is developed they will need to identify the risks and ensure plans are in place to mitigate and overcome them. There is a shared recognition that they have a unique opportunity to move beyond traditional 'vertical' organisational silos and pioneer the development of 'horizontal' arrangements across a place which have more potential to tackle demand pressures and create more responsive services. The ultimate prize motivating all involved would be to overturn the trajectory of health inequalities which a centrally accountable system has failed to. Then words like 'integration' and 'prevention' would move from being just aspirations to standard practice. **F**

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Being fair in healthcare

Investing in the general practitioner is crucial to truly effective local healthcare, argues *Clare Gerada*

Free at the point of delivery was not the only one of Aneurin Bevan's founding principles for the NHS. More important were his views on how we organise, manage and deliver healthcare – especially how this must ensure equity and fairness such that resources are distributed according to need and not according to want or profitability.

Sadly this is not now the case. Increasingly, deprived areas are receiving less money than more affluent areas – perpetuating what we call the 'inverse care law'.

The 'inverse care law' has been most starkly elucidated in research carried out by Professor Graham Watt, who examined health and social care in what he referred to as "the deep end" practices: the 100 most deprived general practices in Scotland.

What he found was that compared to practices in the most affluent areas, GPs and other staff in the deep-end practices had to contend with shortages of staff, community resources and access to specialist care. This was against a background of high levels of multiple and social complexity in their patients and with patients less able to care for themselves, with lower health literacy, fewer personal supports and less secure accommodation or employment.

Staff in these areas not surprisingly suffered greater stress levels and high levels of sickness. This is a perfect example of the inverse care law and problems where allocation is not determined by local need.

In 1948 there were few effective treatments other than time and 'tender loving care'. Now we have an armoury of treatments and diagnostic interventions. When these interventions are applied to large populations, then they have the ability to improve the population's health. However, if not applied fairly then, by implication, the NHS itself widens inequalities in healthcare. The sheer size of the NHS makes rationing a necessary part of any healthcare system – publicly or privately funded.

Only the extraordinarily wealthy can afford all that healthcare has to offer. But for rationing to be effective it must be done fairly. The National Institute for Health and Care Excellence (NICE) is now nearly two decades old. And despite some problems it is still effective in delivering what it set out to do when first established as the National Institute of Clinical Excellence in 1999: to reduce variation in the availability and quality of NHS treatments and care. In other words, to ration fairly and reduce (if not stop) the so-called postcode lottery. This is an important function as it allows, at national level, some equity in distribution of what should be available for patients. While rationing still happens, nevertheless, NICE still has a vital function in determining the bar of what should be available to all patients.

At local level, it is the general practitioner that is pivotal to determining distribution of resource. This is not the GP as the commissioner at clinical commissioning group level, rather the GP as the 'commissioner' in the consulting room. General practitioners act as the hub in the health service. Through their interactions between different aspects of it, and in their role of patient advocate, they help to reduce unfairness in the health system and help maintain value for money. There is substantial evidence, from the UK and across the world (including the US), to show that where you have more general practitioners per head of population, health outcomes are better (at individual and population level), at lower cost and with better patient satisfaction. General practitioners' role as the gatekeeper to NHS resources, helping to determine which patients need on-going care, keeps the NHS safe and effective and in line with Bevan's principles. Sadly, as the NHS becomes more fragmented, as decisions on resource allocation are determined by market forces and not on health need, and as GPs are fast disappearing due to years of underfunding, the inverse care law will worsen.

Many clinical commissioning groups are now trying to find ways of making

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less go further. Many in the corridors of political and policy power are beginning to talk about allowing patients to top-up NHS care with treatment paid for privately. This would be a further nail in the coffin of universal health care – and move us to the chaotic system encountered in US. Patient charges will penalise the poor, the sick and old (who after all are the most frequent users of health care). Over time they will lead to a reduction of what would be provided as core part of local (and national) NHS services. Only those more expensive treatments which required top-up payments would be available, as top-up payments would ensure that financially failing Trusts could attract more resources.

The NHS is again in flux. Structural solutions are again being attempted as solutions to addressing the funding and staffing problems we face. Vanguard sites – which are attempting to integrate care across social, primary, specialist and third sector domains – are being tested. The answer, to paraphrase a famous song, 'is blowing in the wind'. We must invest in general practice, ensuring fairer distribution through resource allocation formulae that take account of deprivation. That way we can allow GPs to regain their rightful roles at the centre of healthcare delivery and rationers of care. **F**

Dr Clare Gerada is medical director of the Practitioner Health Programmer and a former chair of the Royal College of General Practitioners

DEBATE

How far should local authorities be involved in healthcare?

A more devolved system would promote deeper cross sector collaboration, argues *Laura Wilkes*

The national health service is at a crossroads. Rising demand coupled with an overall gap in funding of £30bn a year by 2020 means that our current system is increasingly unsustainable and reform is required urgently.

There are two obvious ways to reform. The first is to channel additional funding towards provision to meet demand now. In the short term, this is a good fix. But if more resource is put towards the problem without changing anything else, it is likely to result in a similar crisis in future years as demand continues to rise and the overall resources needed to close the health inequality gap increases.

The second and more preferable option is to radically shift the system towards prevention and focus on wellbeing rather than ill-health. Currently, we focus too much on treatment of ill-health and too little on preventing it. As it stands, only 4 per cent of the total healthcare budget is spent on prevention, according to the NAO's 2013 *Early Action Landscape Review*.

This shift will not be easy and the health service alone won't be able to meet this challenge. It is centred too much on treatment and does not reach into all of the elements that influence the social determinants of health. Factors like the environment, housing, education, income, employment, relationships and behaviour, to name a few, all have a huge impact on our health yet cannot be addressed by the health service only.

A starting point for system reform is to agree on the principles underpinning it. Cross-sector collaboration and developing outcomes for specific places is essential. The multispecialty community providers vanguard sites, which move specialist care out of hospitals and into the community, point to an emerging model of how this can be done. They bring together a range of experts and community-based professionals to target services to those with complex, ongoing needs. We must recognise that if we are to reach into all parts of the system that keep people healthy, this must involve all stakeholders that have a share in places. Public, private and third sector services – alongside communities – all have a significant contribution to make.

Local government ought to have a substantial role in this. It is in the gift of local government to influence many of the wider determinants of health, particularly given the close connection of councils to communities. They are ideally placed to broker conversations and facilitate decisions between partners and communities about how to best use the assets that are available locally to promote wellness.

Cross-sector collaboration must look in the round at everything influencing wellness in places and identify where elements do not align. It must address the growing issue of councils scaling back on lower-level and arguably preventative discretionary community based provision in order to make savings, yet ultimately removing focus on ill-health prevention, building up costs for the future. Places must look towards what is driving demand for care and how all stakeholders can prevent and manage this.

The second principle underpinning reform must be to consider all of the resources and assets in a place that can contribute to health and wellness. Again, councils will be crucial in identifying all the social and physical resources locally which can help to support individuals and communities to promote wellness and reduce health inequalities.

The final, and perhaps most significant principle is around power. Many local public service and political leaders argue that their hands are tied; that they don't yet have the necessary powers and freedoms to make local decisions and re-focus the system on prevention and wellness. That in the absence of local powers to create real change, system shift becomes impossible.

We have seen huge strides recently in reform of power and devolution to places. Greater Manchester is set to receive substantial financial powers to enable locally-determined decisions around health and social care. Focusing on bringing together the work of health, local government, the third and private sectors and the community should maximise resources and cut duplication. But more fundamentally, it should keep care based in the community, driving down the need for acute care. Devolving the health and social care budget to local places, allowing greater determination and decision making over how money is directed locally will be a substantial enabler of system shift.

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If places are given the freedom to determine themselves how to allocate resources this will be a giant leap forward. But it needs to extend far beyond traditional providers of health and social care services. The challenge for the health sector and the myriad of new partners they will be working with in a more devolved system is to promote and develop much broader and deeper cross sector collaboration that focusses relentlessly on wellbeing. F

Laura Wilkes is head of policy and research at the New Local Government Network

We already have the structures in place to succeed, argues *Dr Steve Kell*

In 2010, the Marmot review into health inequalities in England highlighted the wide range of factors that affect people's health. In 2015, we have the structures to improve these factors, but need to focus now on working together to deliver effective change.

It is tempting to focus on structures and organisations when discussing the NHS and health outcomes. Politicians throughout the recent election campaign proposed measures such as changing responsibilities or mandatory pooling of budgets to improve health. Such changes would be damaging for the NHS, and be a dangerous distraction at a time when stability and delivery are vital.

To improve health outcomes, we must address the social, economic and healthcare factors identified in the Marmot Review. There is a clear role for local authorities and the NHS, and the introduction of health and wellbeing boards has provided an opportunity for joint working between organisations that have worked independently for too long.

On the question of how far local authorities should be involved in healthcare, I think we already have the structures in place to succeed. Health and wellbeing boards bring together local authorities, clinical commissioning groups and NHS England and are ideally placed to affect and improve population health. They provide a forum covering housing, education, social services and, of course, healthcare provision.

Critics of the current arrangements challenge their effectiveness and certainly it is difficult to prove the direct impact of the boards. But as one health and wellbeing board chair commented recently, "it's very difficult to deliver when we have spent two years agreeing what we were there for." The continued debate into their role has been part of their problem, and stability is now essential for the impact of joint working to filter through

Local authorities and the NHS have developed their relationship into one that has transcended different cultures and ways of working. Budgets have been pooled where needed locally and local priorities agreed. The challenge now is implementation of plans rather than the structures that developed the plans themselves.

The key strength of health and wellbeing boards is that they combine different roles, experience and strengths, and have the potential to create a whole greater than the sum of their parts. Given the importance of the social determinants of health and the variations in healthcare access and quality, the opportunity to combine efforts, reduce inequalities and affect change must not be missed.

This opportunity reaches much further than the much-rehearsed debates regarding social care and its interaction with the NHS. Effective social care is crucial for the NHS and patients, as we have seen this winter, but the ambition of health and wellbeing boards should be much wider and include education, employment, health access and wider public health. For example, delivering the Better Care Fund – which supports the integration of health and social care – is important but not enough to change the health of the populations we serve.

Health and wellbeing boards represent true place-based commissioning. The challenge is to identify local outcomes, be clear about responsibilities for each board member and work together to oversee local population health. This joint responsibility approach is crucial to ensure plans are implemented. In areas where health and wellbeing boards include multiple clinical commissioning groups and a dual local authority system, this focus on roles and responsibility becomes even more important.

I recently chaired a roundtable discussion, involving local authorities and clinical commissioning groups, on the future of health and wellbeing boards and there were two clear areas of agreement. Most important was the need to develop existing structures and avoid any change to legislation. The second was the need to move beyond building relationships, work together as equals and focus on key outcomes for each health and wellbeing board. If these boards are to be judged in the future, then it should be on the health of their populations rather than the workings of their structures. What happens round the table is much more important than who is round the table. Changing responsibilities or mandating rules would in fact put at risk the work already done.

Clinical commissioning groups, as clinically-led membership organisations, are ideally placed to improve healthcare provision and quality. They should now work with health and wellbeing boards to deliver wider population health benefits. The job of politicians should be to enable joint working, retain and develop clinical leadership and avoid the urge to focus on structures rather than health outcomes. F

Dr Steve Kell is co-chair NHS Clinical Commissioners, chair of NHS Bassetlaw CCG and a GP

National services, local need

Dr Howard Stoate shares his experiences of the frontline and argues that with the right safeguards, localism can lead to improved services for patients

The notion that localism can be compatible with a National Health Service is, on the face of it, absurd. By definition, localism must mean a postcode service, or what is the point of it?

The real questions, therefore, are firstly whether it matters and secondly, whether it can lead to improved services for patients. I would strongly argue that with the right safeguards, localism is not only beneficial, but essential under this criteria. That being said, how can I, a GP, former Labour MP, and a passionate believer in the NHS, make this case with any credibility?

I currently Chair NHS Bexley Clinical Commissioning Group. We have a budget of around £250 million to purchase acute, community and mental health services for 230,000 people. This boils down to just over £1000 per head – in other words, not a lot. We have an elderly population, with amongst the highest rates of obesity, diabetes, and dementia in London. Because of this demographic, demand for services increases by around 5 per cent a year, but in real terms, resources have remained static over the last five years.

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We constantly strive to improve patient services and outcomes by making the money go further each year. However, it is fairly obvious that expecting providers to deliver the same service to 5 per cent more patients each year for the same resource in real terms can only lead to disaster; many argue this is already upon us.

Let us not mince words. None of the political parties are promising anything like enough resource to fund the NHS if it continues as it is. The only solution is not to demand the same service for less, but to design a different one. Before alarm sets in, this does not need to be as disastrous as it appears. Many services are not fit for purpose, are not evidence based, and frankly, do not deliver good patient outcomes. We should not therefore be apologetic about de-commissioning them. There is nothing noble about throwing public money at a poor service. This wastes resources, and does no one any favours.

The trick is to redesign the services to maximize the use of scarce resources to give the best possible outcomes to patients. Can this be done on a national basis? Of course not. We can make national decisions about how much resource we devote to health, and what new drugs the NHS should provide, but not how a service is delivered. To make any sense of it, this must be done locally.

Let me give you an example from Bexley. We had completely separate services for orthopaedics, rheumatology, physiotherapy, and chronic pain management, despite the fact that these all cover the same group of patients – those with musculoskeletal problems. Waiting times for physio were 24 weeks. Patients were referred between services, with even more delay. The costs were horrendous, the patient service very poor.

Some of our clinical lead GPs, working with our commissioning experts, redesigned the whole service into one pathway and awarded the contract to Kings College Hospital to manage the whole service. Waiting time is now four weeks for routine cases, and two weeks for urgent cases. Patient and staff satisfaction is extremely high, while the service is significantly cheaper, freeing up resource for other services.

But where do the patients feature in this new world of clinical leadership? In Bexley, we have set up a patient council, an umbrella organisation representing dozens of patient groups. Two of their members sit on our governing body and take part in all of our decisions. We also ensure that patients sit on every pathway redesign group and are genuinely involved in providing a user perspective.

We are also in the process of significantly improving two local hospitals which had failed financially and needed significant investment. We transferred ownership to an NHS Foundation Trust, which is able to invest £30 million over 3 years, to allow us to commission completely different services. We are constructing a new kidney treatment centre, and a world class cancer centre which will remove the need of patients requiring radiotherapy to travel. Each of the two hospitals now has an Urgent Care Centre which for a majority of patients obviates the need to go to A+E. They are run by GPs and expert nurses, waiting times are very short and patient satisfaction very high. We have also completely redesigned cardiology, and are in the process of significant improvement in children's services.

There is much more we could achieve at local level. However, the obsession of this government on cutting running costs means we are starved of the number of commissioning experts we need to really transform patient care. By forcing us to save thousands on running costs, we waste the opportunity to save millions by radically changing how we deliver care.

Let us not be under any illusion. The NHS cannot survive without more resources, and it will not improve outcomes without transforming what it does. This transformation must be led by clinicians and patients working as partners, designing services based on local need. F

Dr Howard Stoate is the chair of Bexley CCG and also chair of the south east London Area Prescribing Committee. He was Labour MP for Dartford from 1997 to 2010.

Bevan and beyond

History suggests we are moving towards a constrained localism rather than total regional autonomy, argues *Rudolf Klein*

From its very beginnings, there has always been an ambiguity about the precise relationship between centre and periphery in the National Health Service. Even Aneurin Bevan, its founder, spoke with a forked tongue. On the one hand, there was the Bevan who insisted that his aim of "universalising the best" required planning on "a broad national scale". The logic of both equity and parliamentary accountability for public money led to the much quoted bedpan doctrine: "When a bedpan is dropped in a hospital, I want the noise to reverberate through the corridors of Westminster". Yet there was another Bevan, the lesser-know localist who was in favour of "maximum decentralisation to local bodies", with substantial executive powers delegated to Regional Health Boards and hospital management boards.

The language of localism never died out, even as the NHS evolved over the decades to become the most centralised health care system in the Western world. For while central control was indeed the logic of the NHS's original design, it was not achieved in Bevan's day and for some time thereafter. For the first half or so of the NHS's existence, the centre simply lacked the administrative capacity to exercise tight control over what was in many respects a loose federation of local boards. As Richard Crossman, reflecting on his experience as secretary of state in the early 1970s, put it: "You have a number of powerful, semi-autonomous boards whose relation to me was much more like the relations of a Persian satrap to a weak Persian Emperor. If the Emperor tried to enforce his authority too far he lost his throne..."

Subsequently, however, the screws of central control were tightened decade by decade, and the various intermediary bodies axed – even while successive secretaries of state, Labour and Conservative, proclaimed faith in devolving power. So here's the puzzle. Why has the recurrent rhetoric of localism never been translated into effective policy? Why, over time, has change been in the opposite direction?

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The short answer is that technology allowed the logic of Bevan's bedpan doctrine to be put into effect. IT transformed the capacity of the Department of Health to know what was going on in the NHS in real time. Whereas previously information about the local activities of the NHS had been both inadequate and out of date, the challenge increasingly became how to interpret the cacophony of information alongside changing governments and their policy objectives. The long answer would, of course, be that this was all part of a sea change in the managerial style of public services with the emphasis on targets, performance indicators and regulatory bodies.

We now have a centre (whether the Department of Health or NHS England) which has the capacity to hold the periphery to account for achieving an ever-expanding list of policy targets; from waiting times to infection rates, from reducing inequality to keeping people out of A+E departments. And we are back to the twin foundations of Bevan's bedpan doctrine. On the one hand, there is the centre's accountability to parliament for the way NHS funds are spent, with an increasingly assertive Health Committee demanding answers about policy implementation. On the other, there are the claims of equity: even if the '"best'" cannot be universalised, surely equity demands that the Department of Health must strive to ensure that the same services and the same standards apply across the NHS?

So this is the key question that faces any move towards greater localism. How much local autonomy is compatible with being answerable for the way the money is spent? How much deviation from national standards in the name of local priorities is acceptable? How does the setting of local priorities in order to cater for local needs and preferences (something to be encouraged) differ from postcode rationing (something to be condemned)? And would any secretary of state resist media and public pressure to intervene in local affairs – which has been the pattern until now, despite the introduction of NHS England, which is supposed to insulate the service from political pressure – whenever there is any hint of scandal?

Like successive secretaries of state, both public and expert opinion probably favours localism in the abstract and sees the centre as smothering innovation. However, the activities of intense, organised lobbies point in a different direction from the diffuse consensus in favour of localism. Public opinion mobilises not in favour of localism, but in defence of the status quo whenever a hospital or service is threatened with closure, often appealing to the secretary of state to intervene.

So it is best to be cautious about the depth of active political support for localism in the NHS. The decision to devolve the NHS budget to Manchester offers hope. But local decision makers there will have to work within the same framework of national standards, targets, inspectorial regimes and regulatory rules and under the same statistical microscope as the rest of the NHS.

Most likely, local decision making will mean greater freedom to determine *how* national policies are implemented – and the balance between health and social care services – rather than discretion about the policies themselves. It will be a constrained form of localism. Manchester bedpans will still reverberate in the corridors of Westminster, but at least the Manchester experiment marks a significant first step towards translating rhetoric into policy. F

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