NHS Confederation

Prevention, population health and prosperity

A new era in devolution

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About us

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

Our Health Economic Partnerships work programme supports the NHS to understand its growing role in the local economy and to develop anchor strategies at institutional, place and system level. Visit our website or contact Michael.Wood@nhsconfed.org for more information.

For more information visit www.nhsconfed.org

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Foreword

Sir Richard Leese, Chair, NHS Greater Manchester Integrated Care; Co-Chair, Greater Manchester Integrated Care Partnership.

Dr Kathy McLean, Chair, Nottingham and Nottinghamshire Integrated Care Board and Derby and Derbyshire Integrated Care Board; Chair, NHS Confederation's ICS Network.

In many ways, this current fiscal climate has similarities with, and its origins in, the immediate post-2010 years when austerity pushed local leaders for new approaches to broader public service reform. What really binds these periods is that the political and policy windows overlapped, reflecting very real challenge but also an appetite and need to do things differently.

Certainly, in our personal experiences of leading both devolution and integrated care systems, it feels like we are at an important point where the policy intersections are emerging, if not already clear, and the permissibility that comes with greater autonomy is empowering leaders to look outwards, not upwards. We heard throughout the roundtables that informed this report that health is already in all policies, and that it is already shaping practice on the ground in how we try to support communities through uniquely challenging times.

Integrated care systems (ICSs) and combined authorities work closely across large parts of the country and this coverage will only increase. We believe strengthening this broader devolution partnership and supporting constituent partners to better understand and use their collective value is a natural step. We are excited about the potential to jointly deliver outcomes that link prevention, population health and prosperity around the people we support.

Our roundtables heard about the need to help uncover those areas of alignment between health and devolution and to build on the experiences of the frontrunners already co-developing operating models that strengthen partnerships and deliver more local impact. Decentralisation is a process, not an outcome, and it is important that this report not only contributes to local action, particularly following the 2024 mayoral elections, but also stimulates a much broader ongoing conversation about how we are stronger together and what we want to collectively achieve to make our populations both better and better off.

This broader, longer-term focus is essential. There is a common danger to both devolution and to ICSs that reforms seeking to narrow decades of entrenched inequality are judged for success in months, rather than years. We believe that working together in the ways described in this report will provide the evidence base for local leadership to become the default setting in future.

Our final point is one of thanks to everyone who participated in the discussions. We were struck by the appetite to make health and devolution work and by the explicit awareness that in doing so it would likely take us into areas for which there aren't simple answers, only the need for more collaboration. This underlines just why it was a crucial opportunity for us to reinforce the thinking of bodies such as the NHS Confederation and Local Government Association around devolution and integration as we enter such an important period.

Returning to our first point about the similarities with 2010, for while politicians are open to further ideas of greater devolution of power, we should not be afraid to jointly develop and push these ideas – it may be our best hope of ensuing sustainable public services. Above all, this appetite and ambition bodes well for the coming years, and we hope this report makes those necessary and challenging conversations somewhat easier.

Key points

- There are growing parallels between local government devolution and integrated care systems, in terms of a genuine and shared interest in geography, place, role, purpose and outcomes. Leaders are now actively asking how they can work together to best serve their populations.

- In spring 2023, the NHS Confederation and Local Government Association jointly established a Health and Devolution Working Group to understand the priorities, opportunities and challenges in bringing together health and local government devolution.

- This report builds on the rich learning from the working group and sets out why ICSs and devolved administrations (referred to throughout this report as combined authorities) should work together to jointly improve health and support economic prosperity, how they can maximise their collective impact for their shared populations, and what government needs to do to support and accelerate the health and devolution agenda in future.

- Devolution in England is the delegation of powers, programmes and funding from Westminster to local government. As of November 2023, devolution deals have been agreed with 17 areas in England and this trend is set to continue and accelerate. With every part of England an ICS, we will see increasing and sustained interactions between these models.

- Even before the pandemic, there was a growing focus on fostering more inclusive forms of growth that balance economic and social development and seek to spread wealth much more evenly across places. Given the tumult of the past four years and the current state of the economy, it is rapidly becoming apparent that health, and the NHS, plays a key role in our prosperity. In recognition of this shift, health is now explicitly and implicitly part of many local devolution deal discussions.

- In many parts of the country, local devolution arrangements are already an integral part of an ICS. In all current combined authority arrangements, local authorities are statutory partners in the ICS, while the mayoral combined authority (MCA) as a body itself is often represented on system partnership boards. With these building blocks already in place, the challenge is to understand the commonality in reforms, and further develop the relationships between NHS and local government partners to better understand and use their collective value.

- It is important when seeking to understand the connections between health and devolution that leaders are firstly able to visualise, comprehend and explain what closer, more effective integrated working could feel like for colleagues on the front line and, importantly, what it would mean for local populations. This report articulates a new central vision for the shared future for health and devolution.

- While this central vision can underpin health and devolution more broadly, local leaders will be required to implement it according to their own context and nuance. We believe making this new vision for health and devolution a reality will require a phased, three-stage approach, developed through coordinated local leadership and sustained national support.

- These three steps include: focusing on people and the places where they live and work; supporting populations to improve their own health; and recognising that everything has an impact on health. For each of these steps, this report sets out the context, findings, national recommendations, local priorities and illustrative case studies.

- Delivering on these steps, and this report, will involve stretching what we can do within existing frameworks, duties and powers, before understanding what is needed to go further still; increasing and resourcing local capacity and capability; focusing on community engagement and empowerment; understanding and using soft power and system working; and above all, consistently engaging and co-developing a future of shared thinking, shared projects and shared positions.

- As the report makes clear, we believe:

  — Health, and health metrics, should be prioritised by government as a formal part of negotiations for future devolution deals, given their importance for and relevance to economic prosperity, the growing interest from system leaders and the clear commonalities in ongoing reforms.

  — The ICS-combined-authority relationship should be recognised by government and national bodies as one of equals, fostering a mature, two-way relationship and acknowledging the support needed to ensure system leaders have the capacity and capability required to best deliver on their potential.

  — While no universal operating model to align health and devolution locally exists, it is important ICSs and combined authorities create a positive vision for integration for their local populations, underpinned by a series of thematic priorities which can guide leaders on where and how best to work together.

- The timing of this report is important. There is a narrow window open in which to simultaneously look back and learn from past approaches to devolution from either a geographical or a health and care perspective, but also to look forward at what a more standardised approach to decentralisation might look like and entail, before various reforms make merging these vital areas too complex a task.

Introduction

Health and devolution: the right issue at the right time

Local government devolution has been seen as an increasingly important issue for integrated care system (ICS) leaders to understand, engage with and influence. While local and combined authority leaders already play an integral role in their ICS – including in pursuit of the core ICS purpose of helping the NHS support broader social and economic development – there appears to be much more they share in common and which needs further exploring as the two-way nature of this agenda emerges.

This agenda is developing at pace too. Both main political parties are committed to devolution, with new 'trailblazer deals' being announced changing the nature of local governance. We are also seeing greater interest in the contribution health and care services play in supporting local growth and prosperity.

With ICSs established across the country and focused on addressing long-term population health, we believe there is a pressing need to develop a joint understanding of the opportunities and challenges of local government and health devolution and to ensure our leaders are much more closely aligned during these uniquely challenging times.

Understanding our approach

The NHS Confederation and Local Government Association, through three of its boards, jointly established a Health and Devolution Working Group in March 2023. Co-chaired by Sir Richard Leese, chair of Greater Manchester Integrated Care Board and Dr Kathy McLean, chair of Nottingham and

Nottinghamshire and Derby and Derbyshire integrated care boards, the purpose of this group was to understand the priorities, opportunities and challenges for leaders in local government devolution areas and ICSs in bringing together health and local government devolution.

The working group was diverse, hosting ICS, integrated care partnership (ICP) and local government leaders along with a range of invited subject-matter experts and policy decision-makers from other sectors. Over the course of six months, the working group met a number of times, discussing a range of emerging themes which, when taken together, should help inform local practice, make national recommendations and start an ongoing, mutually beneficial conversation.

This report is an attempt to bring together the rich learning from these discussions and to support local leaders to work together to make a difference for their communities. It sets out:

- **why** ICSs and combined authorities should work together to jointly improve health and wellbeing outcomes and support growth and economic prosperity

- **how** ICSs and combined authorities can maximise their collective impact and add value to place-based partnerships – including the key priorities for local leaders to focus on and examples of good practice

- **what** national government and arm's-length bodies (ALBs), such as NHS England, need to do to align, support and accelerate the ICS and devolution agenda.

While there were gaps in the collective knowledge of those present at our roundtables about, for example, what devolution entailed or the nuance of ICS decision-making, what was particularly striking was the shared appetite and support for much closer working relationships and a better understanding of what partners could achieve together, both now and in future.

This twin approach is important given the fiscal constraints many find themselves in. Put simply, our full potential can be hard to visualise when there is so little money. Part of what we are aiming to achieve in this report is to put in place the relationships which can jointly focus on the areas that matter today and which can be transformative if, and when, there is more financial headroom in future.

The consensus from the working group was that this was the right issue to focus on and this is the right time.

Terminology

Throughout this report the term 'combined authority' (CA) is used as a collective term for all types of authorities that have been granted a devolution deal. This includes combined authorities with and without mayors, combined county authorities with and without mayors, or single county deals with and without elected leaders.

Combined authorities or combined county authorities are corporate bodies formed of two or more council areas, established with or without an elected mayor. They enable groups of local authorities to take decisions across boundaries on issues that extend beyond the interests of any individual local authority. They are legal bodies set up using secondary legislation but are locally owned and must be initiated by the councils involved.

A single county deal is where additional powers and funding are given to the upper tier county council. Depending on the level of the deal provided, the council leader may have to be elected rather than appointed by the leading party.

Merging the twin tracks of health and devolution

It is important that this focus begins with a shared understanding of both the devolution and ICS journeys, closing the knowledge gap that leaders repeatedly reported at our roundtables. In doing so, the striking parallels between these two approaches to greater decentralisation soon become clear. The question then is how, where and when do we attempt to merge these twin tracks?

Background and purpose of English devolution

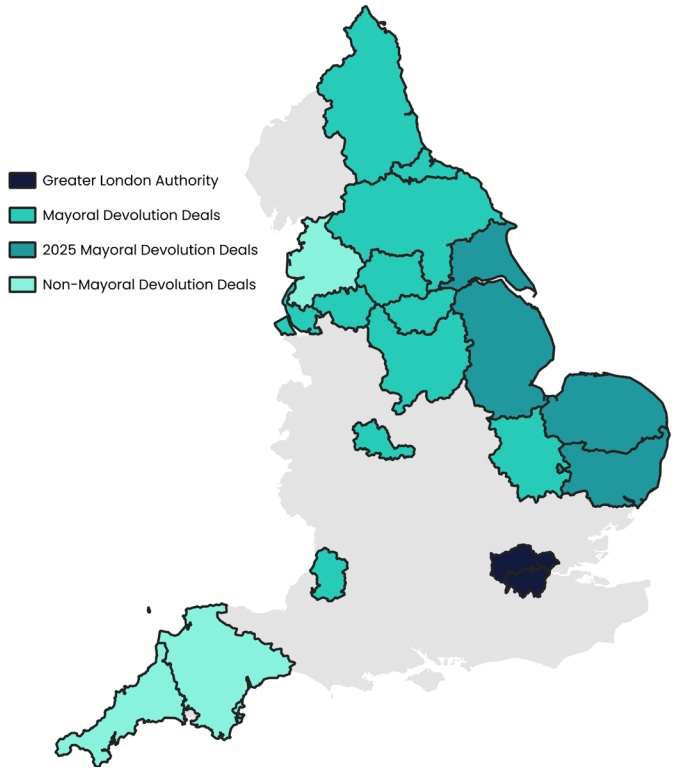
Devolution in England is the delegation of powers, programmes and funding from national government, in Westminster, to local government. While the Greater London Authority (GLA) was created back in 2000 comprising the Mayor of London and the London Assembly, the process of English devolution in the current context began in earnest in 2014 when the coalition government signed a deal with the Greater Manchester Combined Authority (GMCA).

As of November 2023, devolution deals have been agreed with 17 areas in England. This trend is set to continue and accelerate (see maps below) with, for example, three more deals announced in the 2024 Spring Budget. The 2022 levelling up white paper set out the mission that by 2030, every part of England that wants one will have a devolution deal.

For this form of devolution, powers must be transferred to a body with a leader who is directly elected by the local population, ensuring direct accountability to the local population. This will normally mean the establishment of mayoral combined authorities (MCAs) by two or more local councils, which are statutory bodies led by a locally elected mayor.

However, powers can also be transferred directly to councils with a locally elected leader, as is the case in Suffolk, Norfolk and Cornwall.

Figure 1: Devolution progress in England



Although the government has not definitively stated the key purposes of devolution, successive government policy often identifies three overarching principles:

- economic growth
- better and more integrated public services
- enhanced public engagement and accountability.

In practice, the deeply entrenched inequalities between various areas of England are an important motivating factor for the proliferation of devolution deals. Were devolution to be widened and deepened there are potentially significant benefits, with areas able to govern relatively autonomously in the best interests of their local populations, tailoring policy to local priorities and circumstances, and departing from the traditional 'one-size-fits-all' approach seen in English governance.

Typical powers

There are a number of powers and budgets that have been made available to most areas in devolution deals since 2014, with the most notable being:

- **Investment funds**: 30-year investment fund, equating annually to between £15 million and £38 million for each combined authority, that can be flexibly allocated to support local economic growth.

- **Adult Education Budget (AEB)**: Funds education and training courses for adults aged 19 and over.

- **Business support**: 'Growth hubs' which help local businesses access services such as accountancy.

- **Fiscal powers**: In addition to the power to impose a precept on council tax bills, most combined authorities retain all business rate revenues collected in their area.

- **Transport**: Most devolution deals have included a multi-year transport investment budget. Going forward, the aim is eventually to replicate the simplified, consolidated funding settlement given to greater London.

- **Planning and land use**: Many combined authorities have the ability to create spatial plans for the use of land (for example, for infrastructure and housing) in their area.

In addition to these core powers, further 'special' powers have been offered to what is presently a limited set of combined authorities. These include powers relating to police and fire, justice, housing, and, of course, health.

Recent 'trailblazer deals' have expanded the responsibilities of some combined authorities in the areas of transport, adult education and housing (including the Affordable Homes Programme and funding for brownfield development). Importantly, these deals commit to providing

a single funding settlement in the 2025 Spending Review, akin to the method of funding of government departments. These trailblazer deals have been formalised with Greater Manchester and the West Midlands, while some other areas have been offered a 'level 4' devolution deal with enhanced powers but without a single settlement: Liverpool City Region, the North East, South Yorkshire, and West Yorkshire.

Combined authorities (and directly elected mayors in particular) also wield significant 'soft' power, due to their high-profile position and mandate from the local population. This allows them to set local priorities, even those which do not relate to powers available locally, and bring together relevant public and private sector partners.

Where does health feature?

Devolved powers relating to health are of particular interest to this report. The GMCA and GLA are the only devolved bodies currently with responsibilities for the health of their local populations. However, the recent 'trailblazer' devolution deals have mentioned health in the context of other powers, such as employment, and, importantly, the updated Levelling Up Framework (see appendix 2) now allows for an explicit public health duty for level 2, 3, and 4 deals. In devolution deal terms, health is now explicitly part of the picture, recognising the significant and growing influence that wider socioeconomic circumstances have on health, and also the importance of population health to economic growth.

Examples of health in existing 'devo deals'

Devolved health powers held by the Greater Manchester Combined Authority:

- Health responsibilities were devolved to the GMCA in 2015.
- A Greater Manchester Health and Social Care Partnership Board (GMHSPB) was established consisting of a Joint Commissioning Board (JCB) and a Provider Forum. The JCB comprised local government, clinical commissioning group (CCG) and NHS England representatives. The Provider Forum comprised service providers, such as acute trusts and ambulance trusts.
- The GMHSPB pooled the commissioning budgets of CCGs and the social care budget of local government, using section 75 of the National Health Service Act 2006 to commission integrated health and social care services in Greater Manchester.
- It is important to note that the Mayor of Greater Manchester does not have any formal role in health devolution agreements, although the mayor would be expected to have significant soft-power and influence.
- This GMHSPB has since been transformed into the Greater Manchester Integrated Care System.

Devolved health powers held by the Greater London Authority:

- Since 2007, the Mayor of London has had a statutory responsibility to produce a health inequalities strategy.
- The mayor must also consider public health when forming strategies for other policy areas: for example, the Healthy Workforce Charter in the London Economic Development Strategy.

- In 2015, further health responsibilities were devolved to the GLA, and these were subsequently expanded in 2017. Key points include:

1. The establishment of a London Estates Board, which receives all money raised from land and property sales within London, and subsequently re-invests this to support city-wide priorities

2. A place-based framework for system regulation, which is aligned with national regulatory partners

3. The establishment of a London Workforce Board to coordinate all training and workforce development within London

4. The delegation of transformation funding to a London Health and Care Strategic Partnership Board.

Public health powers held by combined authorities:

- The East Midlands Devolution Deal is one example which includes a public health duty. The proposal states that: 'To complement and support action by the Constituent Councils, the East Midlands MCCA will take on a local authority duty to take action to improve the public's health concurrent with the Constituent Councils. This will allow health to be considered throughout the East Midlands MCCA's activities as well as enable work on local issues where health plays a key role, for example tackling homelessness and rough sleeping.'

Health as part of broader public service reform:

- The North East Devolution Deal has an explicit section on public service reform, which incudes a focus on: place-based health and care, with a new ICS-devo region-wide approach to social care collaboration, the health and social care workforce, and market shaping; healthy ageing, exploring, with partners, potential for a new 'Golden Triangle' to develop stronger partnerships between the North East, Edinburgh and Glasgow; and population health

and prevention, developing a Radical Prevention Fund that will reshape existing funding away from acute services and into preventative action.

- The West Yorkshire Devolution Deal states that: 'Government commits to working in partnership across Departments and having further discussions with West Yorkshire to explore the feasibility and opportunities around an "Act Early" Health Institute, based in the region. The institute would be a whole system test bed to evaluate the long-term health and economic consequences of early life interventions and build an evidence base on long-term outcomes for children.'

Assessing the early impact on health

Measuring outcomes is a critical part of devolved working. With health still building up a role in devolution deals, the evidence base is still developing. However, early findings from Greater Manchester support the theory that, where health outcomes are embedded within place-based strategies, they can drive improved outcomes. A University of Manchester study which evaluated changes in Greater Manchester from 2016 to 2020 compared to the rest of England, was published in the journal Social Science and Medicine in March 2024, highlighting that the deal enabled public service leaders to make significant improvements in many parts of the health system. These improvements included 11.1 per cent fewer alcohol-related hospital admissions, 11.6 per cent fewer first-time offenders, 14.4 per cent fewer hospital admissions for violence, and 3.1 per cent fewer half school days missed from 2016 to 2020. More emphasis and consistency in capturing the quantifiable impact on health from devolution, and how context specific these impacts are is an essential step in realising the potential.

The ICS journey

Integrated care systems (ICSs) are partnerships of the organisations which deliver health and social care in an area, including of course local and combined authorities. These systems include primary and secondary care providers, local government, social care providers and voluntary, community, faith and social enterprise (VCSFE) organisations.

ICSs are led by an integrated care board (ICB) and integrated care partnership (ICP). The ICP is responsible for developing an integrated care strategy, which the ICB must have regard to when developing its five-year Joint Forward Plan and carrying out its work.

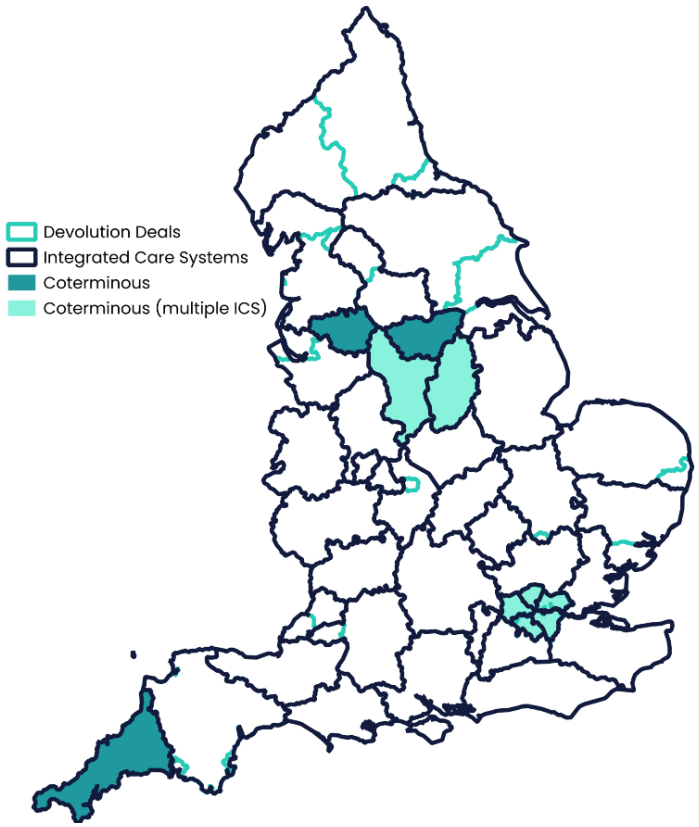
ICSs were set up in recognition of the need for more joined-up health and social care services and have been tasked by NHS England to bring organisations together and champion integrated care to achieve four key purposes:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

As work by the NHS Confederation has made clear, the fourth of these purposes is perhaps the least well understood, but is critically important to the interplay between devolution and ICSs.

The 42 ICSs in England vary enormously in terms of size, resources and population health. As shown on the map below, some are co-terminous with combined authorities or other devolution arrangements, some have a partial overlap (including multiple ICSs working with one CA and vice versa) and many have no links at present, though this will certainly change as more devolution deals are agreed.

Figure 2: Where devolution deals and integrated care systems overlap



Repositioning health, rebuilding the economy, reinvigorating communities

> "It is clear that health and prosperity are interdependent. We can't have a healthy economy without a healthy population, and vice versa."
>
> Matthew Taylor, Chief Executive, NHS Confederation

Even before the pandemic, there was a growing focus on fostering more inclusive forms of growth that balance economic and social development and seek to spread wealth much more evenly across places. Given the tumult of the past four years and the current state of the economy, it is

rapidly becoming apparent that health, and the NHS, plays a key role in the nation's prosperity. Recent analysis commissioned by the NHS Confederation demonstrated that for every £1 invested in the NHS, £4 is generated for the local community through increased economic growth. This is largely for two main reasons: the influence of population health on workforce productivity and the direct role of the NHS itself as an anchor institution.

The influence of population health on workforce productivity is significant. Chronic physical and mental health conditions lead to individuals being less productive at work or exiting the workforce altogether. Currently, in the UK over 2.5 million adults are unable to work due to long-term illness. It is important to note that chronic illnesses are most prevalent in our most deprived areas, including the many rural and coastal communities in England, meaning the impact on productivity can be felt the greatest here.

Anchor institutions are large organisations that have a significant stake and influence in their local area, and include the NHS, councils, universities, sports clubs, business and VCSE organisations. In supporting local and combined authorities to improve resilience in place and address the social determinants of health, the NHS can directly help by, for example, providing well-paid, secure work and professional development opportunities, purchasing from local suppliers, and using its buildings and spaces to support local communities.

The NHS Confederation has led on how ICSs can put economic and social development at the centre of their strategies; moving from individual organisations running isolated projects with their communities to a coordinated, system-wide view of what needs to change ('anchor systems'). The issue of stagnant productivity may date back to 2008, but the structures we have, the salience of health, and the willingness to work together to address it presents new opportunities.

Devolution and ICSs: where the tracks meet

In many parts of the country, local devolution arrangements are already an integral part of an ICS. In all current combined authority areas for example, local authorities are statutory partners in the ICS, while the mayoral combined authority (MCA) as a body itself is often represented on partnership boards. In Greater Manchester's case, this is through the mayor and MCA chief executive, while the Mayor of South Yorkshire also chairs the respective ICP. With these building blocks already in place, the challenge is to further develop the relationships between NHS and local government partners to better understand and use their collective value.

Health and devolution are both broadly underpinned by two complementary shifts. Firstly, dating back to 2007, the Sir Michael Lyons review saw the role of local government moving from one of service provider to 'place shaper'. Secondly, and more recently, in health, reflected in the creation of ICSs, there has been a shift from a focus on the role of the Department of Health and Social Care (DHSC), NHS England, the regions, trusts and target-driven primary care, to more of a social emphasis, involving joined-up national health policy, ICSs (especially ICPs), places and integrated neighbourhood working.

While service delivery will always be vital, and contains important improvement and innovation, place shaping and a social model of health improvement are what bind the NHS to partners. Local places cannot prosper, and institutions are not sustainable, just by relying on the basis of a core safety net of services.

These shifts highlight the parallels in the moves of health and care towards local autonomy and greater integration vis a vis the recent process of devolution to local government in England. This shared journey offers real and tangible opportunities, though cultural differences and challenges between these two significant public sector partners do still exist, as well as misalignments in geography. Done right, health and devolution can bring significant benefits for local communities. Misuse the opportunity though and it may inadvertently undermine this path to subsidiarity.

Strong, successful ICSs will be vital to the success of devolution, both directly and indirectly. Directly, because combined authorities in particular will begin to take on more responsibilities for the health of their local population and will need the support and engagement of the health and care sector. Indirectly, because ICSs will improve the health of these local populations, which is necessary for economic growth, and ensure the local NHS is supporting broader social and economic development.

Equally, devolution will be critical to the success of ICSs. Many of the causes of ill health lie outside the NHS's direct sphere of influence, with local economic development policies and planning decisions having measurable consequences for public health and health budgets. These costs need to be accounted for and integrated in wider health strategies. Working in close partnership with devolution deals will help ICSs more effectively shift resources towards mitigating the effects of these circumstances, ensuring improvements in population health and the long-term sustainability of the health and care system.

Devolution is certainly on the mind of ICS leaders. The State of Integrated Care Systems 2022/23, the NHS Confederation's ICS Network's annual survey of ICB and ICP leaders, reported that:

> '...while ICS leaders identify a number of areas where progress has been made, they also pinpoint areas where progress has been slower than hoped. These include their plans and commitment to supporting greater devolution. There are positive examples of devolved decision-making and provider collaboratives that ICSs will want to build on, but as place-based partnerships and provider collaboratives mature, ICS leaders recognise the need to devolve more decisions and functions to a more local level. That is their intention in the next period of their development.'

Importantly, both devolution and ICS reforms should be seen as a means to an end, not an end in themselves. They are seeking to develop a shared vision and ambition to address shared challenges for given populations. These twin tracks of devolution and ICSs are clearly running in parallel; going forward, we need to understand how and where to make them intersect.

> “The reforms face the same way, but it’s important to remember that how we got here differs. Everywhere became an ICS whilst areas have had to fight to achieve devolution. Understanding this push-pull nature helps us understand each other better.”
>
> Mayoral Combined Authority Chief Executive

Reimagining the future: where next for health and devolution?

It is important when seeking to understand the connections between health and devolution that leaders are able to visualise, comprehend and explain what closer, more effective integrated working could feel like for colleagues on the front line and would mean for local populations, whether in rural or urban settings. System leaders have a clear role in providing the intellectual scaffolding to remind people why they should want and need to keep engaging with each other during difficult, pressured times.

Many of the new ICS and devolution structures being implemented across England are complex, requiring new and existing leaders to work together in different ways to unpick challenging legacy decisions around issues such as service design, provision and funding. There is a danger that inward-facing discussions around the detail of these challenges stifle the opportunity to create a new positive way of working for the future. The roundtable discussions that informed this report were clear that such a vision was the timely, first step in reimagining the ICS-devo relationship and in articulating the shared future for health and devolution.

A new vision for health and devolution

We believe a positive, reimagined national vision for health and devolution can be built, based on five core principles:

1. **Working together for our shared populations can deliver greater impact than the sum of our parts**

It is the impact on communities through which the new ICS and devolution structures will ultimately be judged. The spirit required to

bind closely these systems, and their respective leaders, must be one of 'stronger together'. In this context, aligning health and devolution enables organisations and individuals to push into the areas that matter to keep people healthy and prosperous, and where they previously may have felt 'permission' was needed to engage.

Not only should the local impact of this way of working be greater than the sum of the individual parts currently making up a local ICS and devolution arrangement, it should stimulate and test broad new thinking, reaching out to new partners and reinvigorating conversations that in many cases have been ongoing yet sub-optimal for years.

2. Aligning health and devolution can reconcile the differing national and local perspectives of the future of health and care

As the gap between the operational demands of today and the strategic needs of tomorrow widens, health and care leaders face being stretched in two different, contradictory and competing directions. National ministerial and NHS leadership will demand increased central grip and a focus on operational priorities, such as access and waiting lists, while local partners will want the NHS to help develop more resilient, thriving communities and economies which collectively look to address public service demand.

Resolving this contradiction will require deliberately open and careful local partnership working, particularly through the ICS-devo relationship, to support new approaches to place-based service planning and delivery, to advocate collectively across and within areas, to facilitate the sharing of resources and ideas, and to build trust between traditional and new partners that can challenge protectionist behaviour or failures in policy.

3. Being clear what the ICS-devo relationship can offer national government can secure our future

The UK's national political cycle often inhibits good policy development, with plans rarely lasting beyond a single parliamentary term. Ministers are, though, increasingly cognisant of the limitations of changing local practice

solely through national levers. At the core of the ICS-devo offer to national leaders should be a far richer understanding of place-based connections, the supplementary evidence and nuanced understanding of what works over a longer time period of between ten and 20 years and in different local economies, and a greater insight into the nature of the interactions between separate policy areas and government departments. This triple approach presents a compelling case for change to whomever is in power and can help formalise a future for English devolution where local is the default.

4. Modelling a new way of working which places health and care at the heart of broad strategy can help our populations and our partnerships prosper

Further calls for increased autonomy for ICSs will need a strong evidence basis on which to build. Alignment on health and devolution will enable ICS leaders to showcase the potential of this tier of administration, themselves modelling new ways of working, including peer-to-peer support and learning, and co-developing strategy that is health related and cross-Whitehall, rather than simply isolated NHS policy.

In doing this, the model of English devolution can be shifted away from its explicitly economy-based roots, making it more about promoting economic, physical and social wellbeing and resilience so that communities are self-sustaining. This will be a hugely significant development in this agenda at a point in time where many new local areas are seeking broader agreements and deals. Modelling the future, which is increasingly possible with tools to measure the causes and costs of public health, will help us move the dial from both ends.

5. Understanding the counterfactual of not aligning health and devolution will escalate the pace of change

Much of what needs to be done locally to help determine a more preventative state has already been published and championed by a succession of national and system leaders, including notably the Rt Hon Patricia Hewitt in her April 2023 independent review of ICSs. The ICS-devo

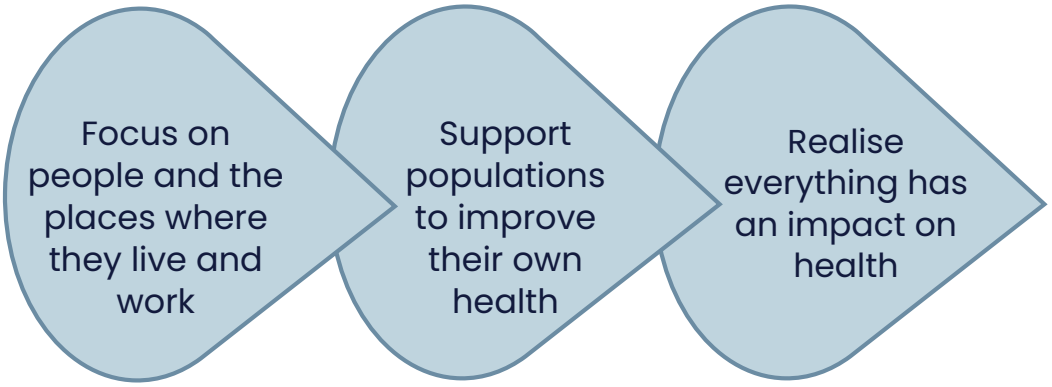
relationship is perhaps the most important lever in realising this and other reports, and in escalating the pace of change at which we all operate and through which we can truly move on prevention and population health.

This will, however, require real will and challenge from leaders, including being more vocal with each other, with local partners and with national government about the consequences of not acting to deliver this future. An empowered ICS and combined authority partnership is vital in ensuring the sustainability of our public services, but also that they engage and support communities in new, thought-provoking ways that make clear the choices involved.

While this central vision can underpin health and devolution more broadly, local leaders will be required to implement it according to their own context, recognising both the complexity of their system but also how these complexities themselves vary.

We believe making this new vision for health and devolution a reality will require a phased, three-stage approach, developed through coordinated local leadership and sustained national support. Our report proposes the following three key steps in this journey:

Figure 3: Delivering on health and devolution: three key steps



Step 1: Focus on people and the places where they live and work

The starting point for our roundtable discussions, and for the subsequent themes which emerged, was a real and sustained focus on the centrality of place and the people within. Geographies may not always be co-terminus, but there will be shared places and populations that an ICS and combined authority collectively serve and/or represent. This one constant can bind the local focus and prioritisation and unite an ambition, around which a compelling case for devolution to best support them can be made.

> "The regulatory context in which we as leaders operate may differ, our working cultures may occasionally clash, and we often perceive different value in partners, but the people we work with and for should provide a common basis on which to build a thriving, successful relationship which, in turn, supports a thriving, successful place."
>
> Working Group Co-Chair

While the challenges facing local leaders across public services are often common in nature, traditional responses can be sector-specific, place-blind and partial in impact. Whether in densely populated urban areas with extremes of need or more rural areas where the breadth makes scalability difficult, focusing on common place challenges, and developing shared ambitions for both population health and economic prosperity, can actively support those on the front line to deliver. This first step will involve maximising the respective strengths of partners and better understanding what more is needed from national leaders.

In particular, we found that:

- Local ICS and devolution leaders strongly believe there is a vital requirement to **better understand their communities and to subsequently focus their work alongside place, people and partners**, rather than from their organisational or sector perspective. In doing so, the early framing for a new sub-national approach to spatial issues such as accountability, financing and regulation may emerge.

- Devolution can bring more shared responsibility; **clarifying the roles and reach of individual partners, and being clear about how ICSs and devolution deals can add value to place-based partnerships**, including their contribution to building a long-term route-map for integrating public services and empowering citizens. It will also help understand what more is needed to accelerate local progress.

- There is a need to be **much smarter with the spatial understanding of what can best be done at which level, including supporting the development of place-based approaches that commit local partners to joint policies and ways of working**. Such a bottom-up approach to governance supports place, enables a more formal way of devolved working and is consistent with the principles of subsidiarity.

To explore this first theme, 'focus on people and the places where they live and work', we looked in detail at both people and place.

National recommendations to realise local potential

1. In the absence of a standard sub-national governance model in England, government and NHS England should **give local ICS and combined authority leaders the freedom and flexibility to determine and embed an operating approach that works for their areas**.

2. Government and NHS England should **ensure associated national targets and priorities are aligned**, supported by a forum bringing

together senior officials from departments with a shared interest in the agenda and ICS and combined authority representatives, as well as key local partners and wider stakeholders.

3. Government should **prioritise funding to support the capability and capacity of local ICS and combined authority partnerships** to deliver for their populations.

Figure 4: Focusing on people and place

Local priorities around which a renewed ICS-devolution partnership can focus

People	Place
Focus on getting the best outcomes for the shared communities you serve, rather than for your own organisation or sector.	Make place the starting point for all devolution discussions – it is meaningful to local people in ways that combined authorities and ICSs are often not.
Ensure joint community engagement is purposeful, ongoing and acknowledges the diversity of perspectives.	Develop place-based strategic approaches which commit local partners to joint policies and working.
Build on what works for local people; adding value, revising and improving only where necessary.	Be smarter with your spatial understanding and what you can collectively do, given subsidiarity is not linear.

We discuss both of these areas in more detail below.

People: the shared populations we are working with and for

It was clear from the roundtable discussions that while communities were often at the heart of both ICS and devolution strategy, there were limitations in their participatory approaches and thus how much system-level decision-making took into account their needs and their voice. For any joint approach to public service reform to be successful it will require a better, and importantly shared, understanding of the nuance, diversity and priorities of the population being served and the assets that connect and support them.

The people-related priorities that should shape future ICS and devolution working are:

1. **Focus on getting the best outcomes for the shared communities you serve, rather than for your own organisation or sector**

One of the more challenging aspects of place-based working is moving away from an institutional or sectoral perspective, particularly when practice is well ahead of policy in terms of action, accountability and assurance. There is a need for ICS and combined authority leaders to be working together to position their work alongside places, people and partners, rather than seeing one particular player locally as making a critical difference.

In the continued absence of a robust, standardised place approach to development or measurement, a focus on shared local outcomes can anchor joint discussions around strategy, priorities and delivery, and support constituent partners to be less protectionist. In doing so, systems can focus on issues that matter to local communities, engaging those with lived experience of multiple public services and changing the culture of how they themselves work. This may help define the future frameworks needed to formally support place-based working, ensuring they build on both practice and evidence.

2. Ensure joint community engagement is purposeful, ongoing and acknowledges the multitude of perspectives

The need to continuously work with and alongside communities to ensure they can actively shape, influence and evaluate decision-making is a clear priority. Community engagement has often been viewed as one-way, legalistic and lacking empathy, particularly when led by NHS organisations. Working together across ICSs and combined authorities enables new opportunities to unite around a common agreement on the people leaders are talking about when making different decisions, and when working at different levels.

Particular care and attention will be needed to ensure marginalised communities are aware of the purpose and parameters of local engagement and feel part of the ongoing debate, having a voice directly and/or through representative VCSE organisations. The new structures themselves can also suffer from a lack of public awareness. Better engagement and a stronger focus on storytelling, including through local media, can help explain to populations what devolution and integrated care means for them, bringing people on the journey and improving outcomes.

> "We need to be clear with people whether this engagement is about insight generation or whether it is about service redesign, co-commissioning or co-production, and who is doing it."
>
> ICB Director of Strategy

3. Build on what works for local people; adding value, revising and improving only where necessary

There is often a tendency when setting up new structures to 'start again', overlooking what is already working well or simply requires support, readjustment or gradual evolution. Community engagement is a good

example of a function which partners, particularly local government, have led on in different and successful forms. Whether through formal settings, such as Town Hall debates, or informal ones such as county shows, such approaches have built up trust, involved a range of local citizens and empowered better outcomes.

The role of the ICS and combined authority partnership should be to understand what forms of community engagement and involvement are already in place locally and how to add value to them; revising, expanding and/or improving only where necessary and helpful. The system perspective could itself be seen as too remote by local communities, emphasising the importance of governance, accountability and leadership, and understanding who is best placed to lead on this engagement.

Place: the starting point for discussions and the spirit of subsidiarity

Leaders at the roundtables reported that a common concern of local partners and constituent leaders was that the new structures, such as mayoral combined authorities and ICSs, will suck power upwards, away from the communities they are making decisions about and out of the hands of those institutional leaders delivering services. This is the antithesis of subsidiarity and runs the risk of disempowering and destabilising local leadership and place initiatives, making their jobs harder and limiting the collective ability to support populations. The roundtables focused on using place as the starting point for discussions about how an ICS and devolution arrangement can work effectively.

The place-related priorities that should shape future ICS and devolution working are:

1. **Make place the starting point for all devolution discussions – it is meaningful to local people in ways that combined authorities and ICSs are often not**

   While much has been made of the new statutory sub-regional structures in health and care and more broadly in devolution, place

is still where much of the actual delivery of public service provision happens and where integration, or the lack of it, is most noticeable to colleagues and communities. The very principle, and test, of subsidiarity is place by default and this should underline all policies, decisions and delivery.

The related challenge for ICS and devolution leaders is to understand how to add value to local arrangements by doing things across their larger footprint; focusing on common 'wicked' problems, spreading or scaling innovative practice and addressing unwarranted variation. This requires a continuous two-way conversation, accepting ambiguity and, importantly, the separation that often exists between accountability and delivery. While place is seen as the starting point, it should not however be used as an argument to defend practice that simply isn't effective.

> "Each local place is complex, and central government doesn't have the skills to deal with this level of complexity."
>
> University Vice-Chancellor

2. Develop place-based strategic approaches, which commit local partners to joint policies and working

The sub-regional landscape in England resembles something of a patchwork, with various devolution areas having differing degrees of local autonomy. Similarly, ICSs – although covering the whole country – are understandably taking differing approaches to their governance and partnerships. There will be common priorities that link the ICS and combined authority tier with place, and successful working will require a constant echo between the two, with place vital in both contributing to and interpreting these issues.

Rather than trying to fuse two different structures roughly together, ICS and devolution leaders stated they preferred to focus on co-developing

strategic place-based approaches which better commit local partners to joint policies and working over the long term. In some cases, places are building on anchor networks local partners have established, in others using missions-based approaches. Integral to the success of these place-based methods are innovative forms of community engagement and data through which to better understand each other and the locality.

3. Be smarter with your spatial understanding and what you can collectively do, as subsidiarity is not linear

Even with a commitment to offer devolution to every local area that wants it by 2030, the sub-national governance of England will be uneven in speed, scale and subject – something government at some point must address. This does though present different opportunities to different areas at different times, placing an increasingly important emphasis on the framing of 'place' and the understanding and use of spatial policy and approaches. Starting from the bottom-up is a good way through this complexity; complementing and challenging system-wide powers, priorities and strategies with a more granular understanding of need, provision and impact at the various levels.

While some combined authorities are seeking legal responsibilities for public health, for example, this does not mean that a duty necessarily needs to be taken away from elsewhere. Combined and local authorities, public health directors and ICSs can concurrently, and successfully, hold related powers, but it is important they understand the differing spatial values involved and agree how they will best use them.

> "Co-terminosity is hugely helpful, or course, but it is not critical. Many countries face this issue and every tier of working will have some form of geographic overlaps and misalignment. Start with the population."
>
> Local Authority Director of Strategy

> "We need to simultaneously think about what we are offering to government and how we are supporting local boards."
>
> ICB Chair

Case studies: Focus on the centrality of place and the people in them

There are examples of this theme emerging across England, including:

- Shifting to prevention: using evidence to realise this shared endeavour – the North East journey
- GM Working Well: Roots to Dental
- Towards a healthy and prosperous future – reflections from the Cambridgeshire and Peterborough Metro Mayor, Dr Nik Johnson

Shifting to prevention: using evidence to realise this shared endeavour – the North East journey

It should be no surprise that there is significant impetus to focus on prevention in the North East. The region has the lowest life expectancy of any English region, the highest levels of childhood poverty and high rates of economic inactivity due to ill health or disability.

The North East Devolution Deal established the North East Combined Authority (NECA), with election of a North East Mayor on 2 May 2024. The deal brings together the local authorities of Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and County Durham. In addition to a 30-year investment fund, the deal will devolve the MCA control over the Adult Education Budget; give control to the region of over half a billion pounds to upgrade public transport; and provide immediate support to build new affordable homes

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on brownfield sites. There will also be a funding pot available to help place-based regeneration across the region.

Prevention is a thread running through the North East Devolution Deal as well as the priorities of the new North East and North Cumbria Integrated Care Board. The NECA Devolution Deal outlines the intent to establish a programme of public service reform (PSR). Example priorities are presented in the deal for consideration, including:

- place-based approaches to health;
- prevention in public safety;
- a regional approach to address public service workforce issues;
- and a dedicated radical prevention fund.

Alongside this, the ICB and agreed system strategy, Better Health and WellBeing For All, has clearly prioritised prevention, early detection and effective management of the biggest causes of premature mortality: cancer, cardiovascular and respiratory disease. This includes a commitment to invest over £13 million every year in prevention activity.

This focus on prevention builds on previous initiatives across the region, where the need to shift financial and workforce resources towards prevention has long been recognised. The 2016 North East Combined Authority (NECA) report, Health and Wealth: Closing the Gap in the North East, found that over 60 per cent of health and care funding was being spent on tackling the consequences of ill health through hospital and specialist care, over 20 times the 3 per cent devoted to public health.

More recently, the North of Tyne Combined Authority's Child Poverty Prevention Programme has sought to direct new investment towards prevention. In 2023/24 it supported 98 schools, providing a suite of poverty interventions to help to reduce disparities and raise educational attainment of disadvantaged pupils, it provided welfare advice to 500 families, and this year has funded baby boxes to support 750 vulnerable first-time parents.

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The programme also worked with employers to develop poverty prevention approaches which have impacted 9,000 employees. Another example is the £63 million, three-year Changing Futures Northumbria programme, which concluded in March 2024. A collaboration across Gateshead, Newcastle, North Tyneside, Northumberland, South Tyneside and Sunderland, the programme is being delivered by the Department for Levelling Up, Housing and Communities (DLUHC), with funding also contributed by the National Lottery Community Fund. The aim is to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system by taking a people-centred approach.

While the need to shift to a focus on prevention is well acknowledged, the barriers to moving in this direction are clearly significant, especially given the degree of demand and growing constraints on public funding. It is recognised that substantial cultural and systemic change will be required to truly make this shift with a willingness to think differently about investment, leverage funding pots across the system and move from a focus on services to a focus on people.

Another new organisation, Insights North East, is working to support the region's policy-makers in this endeavour. Insights North East has been established as a partnership between universities, local authorities and the NHS to deliver actionable, evidence-based insights based on the considerable research and expertise that the universities foster, but which has often been difficult to access. Insights North East is working with the combined authority and the ICB to draw together a range of evidence and expertise to support the public sector reform agenda. The work is placing an emphasis on taking a cross-system approach that goes beyond a focus on health and wellbeing, drawing in partners from the third-sector, police and fire services as well as schools, colleges and employers. The aim is to create a space for thinking about new approaches that draws on the significant opportunities of devolution and an integrated care system to align resources, priorities and action.

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GM Working Well: Roots to dental

Working Well, commissioned by Greater Manchester Combined Authority (GMCA), supports residents at risk of or experiencing long-term unemployment. It is grounded in the principle that 'good work is good for your health.'

Working Well data suggests unmet need in relation to oral health and employment. Many participants are living in pain and feel embarrassed about their teeth, impacting on their wellbeing and ability to move into work.

The Working Well: Work & Health Programme (WW: WHP) alone found that 15 per cent of participants (4,000) had dental issues, specifically either pain/problems in their mouth (10 per cent of all participants [2,700]) and/or problems which stop them smiling or speaking without embarrassment (10 per cent of all participants [2,700]). Over 40 per cent do not have access to a regular dentist. To date, participants have been very unlikely to have accessed a dentist or experienced an improvement in their oral health issues while on the programme which highlights the unmet need.

This issue is not exclusive to Working Well. Inequalities in access to NHS dentistry is a widely recognised national issue that was exacerbated by the pandemic.

Working Well: Roots to Dental sets out a clear ambition to address the unmet need:

1. **Health**: improve oral health outcomes and provide access to primary dental services.

2. **Skills**: assist in the training of future Greater Manchester dental professionals, in essence 'growing our own'.

3. **Employment**: achieve employment outcomes for Working Well participants whose oral health presents as a barrier to work.

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The pilot was established to provide 100 participants on WW: WHP with access to NHS dental services at the University Dental Hospital of Manchester (UDHM). It addresses a mutual need – UDHM trains future dental professionals who require experience of delivering a range of interventions, and participants on WW: WHP present with a wide array of dental issues.

Previous UDHM schemes targeting disadvantaged groups have suffered with low attendance rates, so the added value of reaching people via Working Well was that it could offer support to remove barriers such as transport, childcare and anxiety. Treatment appointment attendance has been exceptionally high to date at 99 per cent.

Participants are receiving comprehensive treatment for a range of dental issues including extractions, dentures and restorations. A number of participants are having teeth repaired that would potentially have otherwise been extracted. In the future, NHS Greater Manchester will also co-develop an online training programme to empower Working Well Key Workers to advocate for oral health improvement with participants.

Following treatment, it is anticipated that participants will experience improved quality of life and employment prospects. For those with the most severe dental issues, the impact could be transformative. Initial feedback has been positive, and the pilot partners are considering extending the scheme.

“Previously I struggled with pain when eating and sensitivity all the time. I could not drink without a straw, and this makes people look funny at you. Now I have had two root canals on my front teeth I can bite better and eat better, and it is not sore. I feel more confident to smile as my teeth are a much better colour. I cannot wait to have the rest of them done … I think it will improve my employment prospects by looking better and having less pain.”

The pilot is currently in treatment phase so there is limited data around employment outcomes at this stage. However, positive feedback from participants and UDHM is encouraging. It is widely known that good work

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supports good health, and vice versa. Working Well: Roots to Dental has provided the opportunity to remove barriers to work around oral health which should improve quality of life and employment outcomes.

This provides a notable example of the integrated approach to health, skills and employment that is adopted by Greater Manchester. The existing level of collaboration between GMCA and NHS Greater Manchester is unique in terms of its breadth and level of commitment, creating a platform for future collaboration. The joint working goes beyond engagement and strategy, reaching into investment and delivery to improve outcomes for residents.

So far Working Well: Roots to Dental has been successful in that:

1. It has achieved its target referrals and participants are receiving dental treatment that they may otherwise struggle to get.

2. Improved oral health is anticipated to have a positive effect on their quality of life and employment prospects. Emerging findings support this.

3. It has benefited UDHM students who are now treating a greater diversity of patients to develop both their technical and soft skills.

4. It has generated learning for a re-opening and expansion of the scheme, with the possible translation of the model to support other participant health issues and workforce skills development. For example, this could lead to developing a mutual relationship with local universities or training providers for health and social care to deliver physiotherapy and psychological support to Working Well participants.

The pilot partners will continue to deliver Working Well: Roots to Dental and monitor its ambitions across health, skills and employment in Greater Manchester.

Towards a healthy and prosperous future: Reflections from Cambridgeshire and Peterborough Metro Mayor, Dr Nik Johnson

"As Mayor of Cambridgeshire and Peterborough, it is my belief that we should all have every opportunity to succeed. I want to see our region made sustainably and equitably prosperous. As a doctor, I know that prosperity and health are interconnected. And, as a fan of the Marmot Review, I understand how hard it is to achieve one without the other.

"Regrettably, for lots of people, personal circumstances do not lend themselves to good health, and instead can actively degrade it. This needn't be the case. At a minimum, we should all have a place to call home, where we feel safe, able to live comfortably and with dignity; the means to provide ourselves and our loved ones with a nutritious diet; and the ability to secure and reach gainful employment, education, and training; all within and as part of an accessible and invigorating natural environment and public realm.

"Instead, there's no guarantee that any of us can go about our daily lives making and benefiting from productive contributions to the economy or wider society. As it stands, many find their ability to participate restricted, trapped in cycles of decline, unable to realise true potential, at risk of becoming dependent upon welfare support and healthcare services. While those directly affected suffer most, everyone is worse off as a result.

"While making us better is the responsibility of our National Health Service, as a mayoral combined authority, we can help people stay well in the first place. Though not a healthcare provider, we must embrace the enormous public health implications of our work. Indeed, this is why I champion integrated care systems and value enormously the insights and expertise of our world-class health partners. It's why, in pursuing the types of universal solutions central to Marmot's 'Fair Society, Healthy Lives' report, a vastly improved public transport network is perhaps my and this organisation's primary focus.

"In ensuring our interventions are proportionate to the level of disadvantage it's why I remain determined to build the best possible future

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for our unique Fens. And why I am committed to making our enviable history, heritage and culture a source of regional pride and inspiration, something available for everyone to experience and enjoy and feel able to join in, unlocking the many benefits of imagination and creativity.

"By delivering on our promise of a well-connected region in which a diverse, modern and vibrant economy is enabled and sustained by a highly-skilled, locally trained workforce, we will ensure that our increasingly resilient communities are integral to the types of good growth needed to secure Cambridgeshire and Peterborough's fairest, healthiest, most prosperous future. And, in taking such 'action across the whole of society' as Marmot recommends, we can pioneer a fuller consideration of socio-economic outcomes, public health included, in our decision-making processes. We will then play a more intentionally significant part in the design and build of that best future, where everyone feels genuinely involved, where we all have a real and lasting opportunity to thrive, and where wellbeing and quality of life are second to none."

Step 2: Support populations to improve their own health

Building on and baking in the centrality of place and people will require the partnerships and powers required to truly invert traditional ways of working. With the short-term demands on public services increasing, leaders at our roundtables felt strongly that there is a need for a renewed, collective ambition and purpose to help populations themselves to improve their own health, rather than see statutory services continue to try to do it to communities.

> "The interrelationship between health and the economy, the focus on addressing inequalities and good growth, and the ambition to better utilise greater local autonomy are mutually binding, compelling and beneficial. Having a vision that will support populations to improve their own health will bring these factors together and to life."
>
> Working Group Co-Chair

ICSs and combined authorities are aligned in many thematic areas and this partnership can set the basis for a new and long-term approach to understanding and delivering on the enablers of good health; such as transport, housing, employment and education, and skills. An increased understanding of the variables and how policies interact can drive further connectivity and better outcomes in both urban and rural areas. Such an approach will require new ways of working, and holding each other to account, but can shape places in permissive ways that encourage, connect and reward communities for their engagement and endeavour. It can also go some way to ensuring the sustainability of the individual public services citizens rely on.

This second step is about supporting and evidencing the long-term discussions about what more is needed, what powers leaders should be seeking to really make a difference and, importantly, how they would use them.

In particular, we found that:

- Emerging health and devolution policy clearly face the same direction – with **prevention, population health and prosperity now central to our collective aims and to our success**, though there is still some way to go to deliver on this. ICS and combined authority leaders believe they need to jointly focus on the mindset, skillset and toolset needed to develop plans that are long-term, evidence-based and multi-sector.

- ICSs and combined authorities need to **use existing collective powers, agency and resourcing more effectively, pooling where appropriate, and focusing on common challenges – not waiting for permission** from government or national agencies to stretch what they can already do. This is important in facilitating conversations and breaking down barriers, as well as ensuring progress on the national missions in the levelling up white paper.

- Realising this potential will require capability and capacity building at the ICS and combined authority level. The **necessary headspace (including time, capacity, skills, data and resources) required to understand community need, and then to coordinate and collaborate on the policy and implementation response, is no longer present** in many areas and this should be a priority for national and local leaders to address.

To explore the theme of 'support populations to improve their own health', we looked in detail at both partnerships and powers.

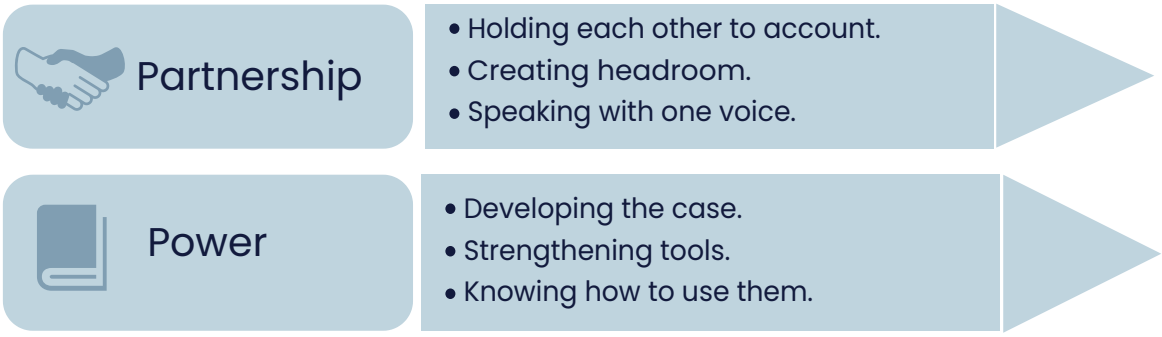
National recommendations to realise local potential

1. Government should **offer formal and coordinated support on embedding health as part of the commitment to offer all of England the opportunity to benefit from a devolution deal** by 2030.

2. Government and NHS England should work with partners such as the NHS Confederation and the Local Government Association to **build a strong evidence base to support joint ICS-devo investment in preventative models of care**. This could include building public health into the cost-benefit analysis of economic development policies.

3. Government and NHS England should **proactively engage with ICSs and combined authorities collectively when agreeing new approaches to key issues such as accountability**, including delivery of the levelling-up missions and the future role of the Office for Local Government (OFLOG).

Figure 5: Focusing on partnership and power



Local priorities around which a renewed ICS-devolution partnership can focus

Partnership	Powers
Create the capacity, resource and time necessary to fully embed community engagement, relationship building and collaboration at all levels.	Focus explicitly on both health in all policies and health policy in determining what is best needed to support and empower communities.
Be transparent about the ICS-devo partnerships and who you work with and why, including who benefits and how.	Do not wait for permission from government and NHS England to use your existing powers.
Prioritise shared data about public services and populations, not just local government and the NHS, as a key enabler to unlocking the potential.	Ensure proposals for future devolution deals involve health and build on and evolve developments that are long-term, evidence-based and multi-sector.

We discuss both these areas in more detail below.

Partnership: holding each other to account

The varying levels of awareness of the diversity and intricacies of communities is sometimes mirrored in how much, or how little, leaders know about their own local partners. Despite the overlaps, numerous ICS leaders at our roundtables expressed doubt about how combined authorities worked, and what their aims and levers were. Similarly, devolution leaders often struggled to gauge the nature of the relationship between, for example, the ICB and the ICP. For the ICS-devo partnership to fully maximise its joint potential, partners involved need the knowledge, confidence and mechanisms to challenge across traditional divides, always acting in the interests of their communities.

The partnership-related priorities that should shape future ICS-devo working are:

1. **Create the capacity, resource and time necessary to fully embed community engagement, relationship building and collaboration at different levels**

One of the most damaging consequences of over a decade of diminishing public funding is the lack of local capacity across and within a given place. No one partner has been exempt from tighter financial pressures and there is often no obvious institution locally with the resources and flexibility to lead. Allied to this, limited resources often push potential partners apart as they turn to look inwards, just as partnership working is required more than ever.

Devolved working requires new approaches to, for example, community engagement, relationship building and collaboration, and it will simply not reach its potential without dedicated local capacity, resource and time. Some of this may be derived by better local pooling of assets but more must be done by national government and agencies to support local leadership. Government can more closely align future national ICS and devolution policy, funding and timescales, but it should also have an explicit focus on funding local capability and capacity at this system level which can unlock local partnerships and secure better outcomes.

> "If we improve our relationships across the system, we improve our capacity to manage the pressures we face."
>
> ICP Chair

2. **Be transparent about the ICS-devo partnerships and who you work with and why, including who benefits and how**

ICS and combined authority leaders are perhaps unique in the combination of the macro and micro perspectives they hold. Systems are learning how to face each other but collectively they also have a key

role in empowering and supporting place-based collaborations below and in negotiating with government and national agencies above. How to hold each other to account is therefore a vital question at the heart of this new relationship, and some ICS and devolution areas are developing memorandums of understanding (as in West Yorkshire's case) or other forms of agreement.

The principles of continuous improvement, a learning culture and humility are vital, alongside transparency about who they work with and why. One area where this will be tested is with the business and investor voice, who are keen to work more with the health and care sector. Devolution leaders will be increasingly bringing ICSs into existing conversations with a range of non-traditional partners and it is important they are aware of the shared rationale behind partnerships and the mutual involvement and benefit.

> "From the VCSE perspective, the NHS and local authorities are seen as two giants, with ourselves the much more junior partner. Yet we have the trust and engagement with communities an ideas about enterprise, capital and wealth building."
>
> Voluntary, Community and Social Enterprise Chief Executive

> "Businesses are strong supporters of devolution. We want partners, including the NHS, to have the freedom and resources to express their need and take long-term investment decisions for their communities."
>
> Investor

> "From the academic sector, how can we help support policy-makers to use local levers? It is vital we get the maximum value and more inclusive impact out of academic research. Don't see the university or college role in devolution as narrow."
>
> University Vice-Chancellor

3. Prioritise shared data about public services, not just local government and the NHS, as a key enabler to unlocking potential

One of the most exciting aspects of joint ICS and combined authority working is the collective reach into the causes of issues to which leaders previously could only react. The starting point for this is a much more holistic and informed use of data, presenting a shared local picture of need, resources and challenges, including who is being impacted or missed out by existing public service provision.

There are common challenges around data, including the significant amounts of unused data, questions over how people access it and the lack of the necessary skillset. As the use of data broadens and analytical capabilities grow, there will likely be a greater appetite to break down populations to identify those most adversely affected or to target population groups to develop new policy or seek new powers around. This data is important for other reasons too.

Traditional public sector commissioning models are changing as the new structures evolve, with engagement approaches and investment priorities not as robust as they once were. Shared public service data can help drive new and more informed shared commissioning and more outcome-focused relationships with the VCSE sector.

> "A benefit of greater health devolution is that we can point to a wider range of outcomes, meaning conversations with government departments are not in isolation."
>
> Mayoral Combined Authority Director

> "Devolution allows everyone to have input to the wider social and economic determinants."
>
> ICB Chair

Powers: strengthening leaders' ability to truly make a difference to population health and economic prosperity

The passing of powers and programmes down from the centre to local leaders sits at the heart of the English devolution approach. This ethos, approach and process is a means to an end, not an end in itself, with powers, and the local autonomy to best use them, vital in equipping local leaders with the tools to do their job. While the initial range of powers and programmes sought by many combined authorities in devolution deals focused on those areas required to grow the local economy, such as skills, transport and housing, our roundtables heard how the role of health and public service reform are now rightly seen as being of huge economic value and are more prominent in discussions with government, opening up a range of new opportunities.

The powers-related priorities that should shape future ICS-devo working are:

1. **Focus explicitly on both health in all policies and health policy in determining what is best needed to support and empower communities**

All policies have a health impact, either positive or negative. The links between health and, for example, skills, transport, employment, housing and economic growth are increasingly focusing the minds of ICS and devolution leaders, highlighting the interrelations at play in both practical and strategic ways. The need is now to become much more explicit about this relationship, linking operational and policy integration and giving people agency through distributed leadership.

This will involve stress-testing current policy areas to understand how the anchor role of the NHS, for example, can support a greater impact on, and connect, communities; how differences in the implementation of policies can affect health in a positive way; and, vitally, where the gaps are for which a specific focus on devolving health policy can help. This last point will see devolution deals become much more focused on seeking additional health-related powers in future and also much earlier in discussions.

> "We need to regularly evaluate the impact that devolution has had on the health of the population. What policies have had the most impact, both health specific and otherwise?"
>
> Devolution Adviser

> "In negotiating our deal, there was a requirement for a business voice and a voice for the police and crime commissioner, but nothing in terms of health being pushed by government departments. That may simply be because we were asking for specific health powers, but it could be evidence of a disconnect between policy across government."
>
> Local Authority Director

2. Do not wait for permission from government and NHS England to use your existing powers

The four purposes of an ICS, and the role of the NHS as an anchor, have seen more health leaders joining local conversations about what makes populations healthy, rather than focusing on their services – looking at the broader determinants of health, not healthcare. Devolution can, and should, accelerate this journey considerably, ensuring a mutual commitment across partners to work together to deliver better health outcomes and a better economy.

New powers may well be needed and sought to help achieve this, but the wellbeing power and general power of competence that ICS and combined authorities already collectively hold is significant. Understanding what can be done and supporting each other to share and use this effectively is vital. This will foster a culture of asking for forgiveness, rather than permission, and lay the groundwork for further devolution of health-related powers as and when local leader determine them required.

> "We need a far better understanding of our collective powers, breathing space and resourcing. This will help us develop positive, impactful relationships and reduce duplicity."
>
> ICB Chief Executive

> "National government should model the same behaviours and approach that they expect of combined authorities and ICSs. In our own actions, we can model and demonstrate how government should work."
>
> VCSE Chief Executive

3. Ensure proposals for future devolution deals build on and evolve developments that are long-term, evidence-based and multi-sector

The 30-year timeline for many devolution deals gives some insight into the long-term nature and complexity of rebalancing local economic performance and narrowing entrenched inequalities. While the NHS has suffered from severe bouts of short-termism, ICSs need to be looking to the future, using this devolution window to advocate for much longer-term vision and focus. The real mutual benefit of devolution is focusing on addressing the long-term issues holding places back. This will require ICSs and combined authorities to focus on the evidence, agreement across multiple sectors and the collective bravery and creativity needed to keep focused on the priorities as operational and political demands rise and fall.

Importantly, as we have seen with Transport for Greater Manchester, giving local leadership greater collective control over the policy framework, the associated investment, and the service specification can derive better outcomes, including financial returns. This is a compelling argument for developing a shared purpose and can become the basis for securing more powers and change.

> "ICSs are not ends in themselves – it's about getting the best possible outcomes and having a shared focus on people who live in places, not systems."
>
> ICB Chief Executive

> "Getting everyone focused on the same ambitions takes time, hard work and a constant reminder of what you are doing and why."
>
> Local Authority Chief Executive

Case studies: supporting populations to improve their own health

There are examples of this theme emerging across England, including:

- Can ICPs offer the opportunity to move towards more locally determined solutions that better meet the needs of communities? Lessons from South Yorkshire
- The West Midlands Combined Authority focus on improving health
- The Transport for Greater Manchester story
- Promoting the role of health in driving economic and inclusive growth in the Yorkshire and Humber region (YHealth4Growth)

Can ICPs offer the opportunity to move towards more locally determined solutions that better meet the needs of communities? Lessons from South Yorkshire

When Oliver Coppard became Mayor of South Yorkshire in May 2022, one of his first decisions was to take on the chair of the new South Yorkshire Integrated Care Partnership (ICP). Oliver's stated ambition was to test whether the new ICPs could offer a sincere 'moment of change'.

South Yorkshire has worked to make the ICP a genuine public health partnership for the region, supported by the convening power of the mayor. He remains the only metro mayor to serve as ICP chair.

South Yorkshire has no shortage of great assets and examples of good practice, but there is no denying the scale of the region's challenges. As with other regions, South Yorkshire's problems are longstanding and complex, often with no obvious root cause. Rising to the challenge requires locally-led, adaptive leadership.

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ICPs offer the potential of doing things differently, to provide that leadership. They can put the individual, family and community at the centre of the design and delivery of services; ensure the voluntary and community sector are an equal partner; and that the lived experiences of our diverse communities are at the heart of the way we work.

As new structures, and by design, ICPs are permissive and collaborative spaces. They are trying to do things differently and experiment, acting as a counterbalance to sectoral, top-down targets. In doing so, they can break through institutional interests, strengthening accountability across local partners. They can improve services, by sharing learning, airing different views and brokering a consensus. And they are encouraging partners to look afresh at academic and research assets and findings.

One of the mayor's first steps as ICP chair was to commission an independent panel review into what needed to be done differently to truly tackle health inequalities. The panel brings together university, local authority, NHS, business and community groups, as well as the Health Foundation and Institute of Health Equity.

The review's starting point is that creating a health society is everybody's business. 'We need to look beyond the £3.8 billion spend on health and social care in South Yorkshire, to (at least) the £16 billion of wider public service spending.' That means reshaping wider public services – many in the control of mayoral combined authorities – such as employment support, transport and housing. The area needs to support its 72,000 strong health and care staff, making sure they have the skills and resources they need to support our communities. And it means harnessing the force of South Yorkshire's world-leading health and wellbeing economy, which adds £3.3 billion of value to the economy each year.

The benefits of this approach are apparent when looking at Barnsley Town Centre. The MCA has recently invested tens of millions of pounds to develop a new community diagnostic service at the heart of the town. By taking space in a shopping centre, the initiative takes pressure off

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the local hospital while supporting town centre assets. It has driven the uptake services such as screening in an area with historically high levels of late-stage presentation of cancers: a true partnership of Barnsley Council and the local NHS trust with support of the South Yorkshire Mayoral Combined Authority.

But no genuine public health partnership can be complete without the active engagement of central government. Many of the social levers behind good health and wellbeing sit outside of South Yorkshire's agencies. To succeed, individual ICPs need an active central government role: one built in partnership and rejecting a 'one size fits all' mindset.

> "Poor health often blights our poorest communities. It places an unsustainable burden on public services and damages our chances for economic growth. Most importantly, it ruins people's lives. One of my manifesto commitments was to make South Yorkshire the healthiest region in the country. I don't underestimate the scale of that ambition but there is nothing inevitable or insurmountable about our poor outcomes, they are a policy choice, the result of decisions that have been made locally and nationally over generations. If we are going to overcome those challenges together, we simply must do things differently."
>
> Oliver Coppard, Mayor of South Yorkshire

The West Midlands Combined Authority focus on improving health

In its mission to promote economic growth, there is recognition at West Midlands Combined Authority (WMCA) that this must be inclusive growth with improved health and wellbeing a key pillar of it. Health outcomes have thus been increasingly prioritised by the WMCA. Poor health outcomes not only affect individual quality of life but also impede regional economic

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growth through reduced productivity, increased economic inactivity and increased healthcare costs.

Evidence shows that 80 per cent of the reason people end up in hospitals is for reasons outside of immediate clinical care. As such, WMCA has made strides by leveraging its devolved responsibilities in skills, transport, housing, and the environment to improve health and aim to reduce the region's longstanding health inequalities.

The WMCA recognises the profound link between employment and wellbeing, as evidenced by its flagship Thrive programmes. These initiatives range from skills training to improve access to jobs to employer support for workforce wellbeing, aiming to reduce health inequalities by supporting specific groups into work and assisting employers in promoting their employees' wellbeing. The Thrive into Work programme, part of the nationally commissioned health-led trials, is an intensive employment support initiative integrated with the health system to support people with long-term health conditions, including mental ill health. It has also developed and launched specialised pathways designed to support neuro diverse individuals and people with mild learning disabilities in securing employment.

The significance of these programmes was further underscored by the commitment to amplify the Thrive into Work programme, extending its reach to an additional 450 people living with poor mental and physical health, focusing on those out of work and those at risk of leaving employment due to their health condition. From November 2020 to July 2022, a total of 2,566 people were supported through the programme, highlighting the WMCA's active response to the health needs of its population and the connection between health support services and employment opportunities.

Furthermore, WMCA's commitment to environmental sustainability and health is evident in its response to the climate emergency and the establishment of a vision to achieve net zero in the West Midlands by 2041. The WM2041 plan emphasises the need to consider broader social, economic, and environmental principles in achieving zero carbon,

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directly linking various aspects of these plans and programs to health inequalities and improving health outcomes. The Natural Environment Plan, launched in 2021, aims to protect, restore and enhance the region's natural environment, ensuring that everyone can enjoy its physical and mental health benefits, and strives to ensure that everyone can access high-quality green space within a 300m walk of their home.

Housing is another key determinant of health and the WMCA recognises that houses are more than mere physical structures; they are the settings for family life, social interactions and personal refuge. Quality housing conditions are shown to significantly influence both physical and mental health. The challenges faced by low-income households in accessing quality housing further highlight the connection between socio-economic factors and health.

Additionally, the design of neighbourhoods significantly impacts residents' health by influencing their ability to engage in physical activity, connect with communities, and access healthy food and public services. The WMCA's housing strategy addresses these issues head-on. The WMCA's interventions in housing go beyond addressing immediate needs; they are designed to foster long-term health improvements through the creation of safe, accessible, and supportive living environments. The additional £500 million through the trailblazer devolution deal to regenerate brownfield land, alongside more devolved responsibility for affordable housing, the WMCA housing strategy can now better respond to the region's housing needs and ensure health is a key factor within it.

Moreover, the partnership with the ICS highlights the WMCA's dedication to collaborative efforts in health improvement. By aligning with the ICS, the WMCA ensures that health considerations are seamlessly integrated into broader policy areas, thus fostering a comprehensive approach to health and wellbeing across the region. This strategic alignment is further enhanced by the WMCA's participation in ICP meetings, ensuring that health strategies are effectively coordinated and implemented across various sectors.

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More recently, the establishment of the Mayor's Health Equity Advisory Council (HEAC), chaired by the Mayor of West Midlands and reporting into the Wellbeing Board, marks a pivotal step in coordinating health efforts across the region with the ICS and the regional public health leaders. The HEAC serves as a crucial cross-reference group for aligning the WMCA's work on health, particularly focusing on system-wide alignment on health inequalities. This collaborative approach underscores the commitment to reducing health inequalities by ensuring that the broader determinants of health are addressed in a cohesive manner.

Through programmes like Thrive into Work, environmental sustainability initiatives, and a robust housing strategy, the WMCA is making substantial progress in improving health outcomes across the region. The establishment of the Health Equity Advisory Council and the partnership with the ICS further emphasise WMCA's commitment to health equity and system-wide collaboration. These efforts collectively underscore WMCA's innovative approach to leveraging its devolved powers for the betterment of the West Midlands, illustrating a comprehensive strategy to enhance health outcomes and economic prosperity.

The Transport for Greater Manchester Story

Since 2014, the UK Government has devolved powers across a range of policy areas to city regions in England. Greater Manchester has been at the forefront of this process, having negotiated its first devolution 'deal' in 2014. The series of deals conferred upon the city region new powers over a range of areas, including health and social care, housing and planning, and adult education. These deals also made provision for the creation of a new, directly elected mayoralty for Greater Manchester and for bus services in the region to be brought under local control through bus franchising.

In 2023, Greater Manchester agreed a further 'trailblazer' devolution deal with government, which agreed a single funding settlement for the city region, similar to Scotland and Wales, more influence over housing development, rail services and other new policy areas.

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Greater Manchester is already making use of these devolved responsibilities. The first Greater Manchester Mayor, Andy Burnham, was elected in May 2017 while the first phase of bus franchising began in September 2023.

Greater local control over transport, housing and health will help Greater Manchester to tailor action to meet the city region's unique challenges. Though Greater Manchester has experienced significant growth in the last two decades, nearly a quarter of residents live in some of the most deprived neighbourhoods in the country.

Unsurprisingly therefore, Greater Manchester has poor health outcomes compared to the rest of the country. Life expectancy is below the national average and one third of adults are recorded as engaging in less than 30 minutes of physical activity per week.

At present, the way to get around Greater Manchester is contributing to these poor outcomes. The number of people travelling on public transport has been in a steady decline over decades while, at the same time, personal car use is growing. Not only has this led to increasingly sedentary – and unhealthy – lifestyles, but it has also contributed to poor air quality, often concentrated in the most deprived neighbourhoods.

These challenges demonstrate that there is more that good transport can do to improve residents' quality of life and bring about inclusive economic growth. To this end, Greater Manchester is now focused on the delivery of the Bee Network, an integrated public transport and active travel system for the city region, designed to make getting around easier and more affordable.

Bus franchising forms the backbone of this ambition and will enable the region to strategically plan its transport network so that all modes (bus, tram, rail and active travel) complement one another and provide for a credible, affordable and reliable offer that will connect residents to opportunities, leisure, education and vital services.

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The NHS is an essential partner organisation in the development and delivery of the Bee Network. Through continuous engagement, elements of the Bee Network's development such as reviews of the existing transport network, cycling and walking infrastructure, and improved ticketing options, Transport for GM are working with and accommodating the unique needs of staff and patients of the NHS.

Although the full benefits of integrating the transport network are yet to be realised, there are already signs of better outcomes for Greater Manchester as a result of these changes:

- Capped bus fares contributed to an extra 1.5 million journeys being made by bus in the first three months of launch.
- Greater Manchester now has the capability to determine the specification requirement of its buses, supporting improved air quality and with the goal of establishing a fully zero emission fleet by 2032.
- Over 100km of quality active travel routes have been delivered since 2017.
- Customers can now purchase tickets granting unlimited travel covering both bus and tram travel, for 20 per cent less than the cost of buying individual tickets.

The delivery of the Bee Network will play an important role in alleviating the impacts of poor health, by making it easier to build physical movement into essential travel and providing connections to opportunities and services that improve quality of life.

As well as supporting with health access and outcomes across the city, these improvements will provide better travel for the city-region's NHS workforce, which comprises more than 150,000 staff across primary, secondary and social care.

YHealth4Growth: Promoting the role of health in driving economic and inclusive growth in the Yorkshire and Humber region

Health Innovation Yorkshire & Humber, the NHS Confederation and Yorkshire Universities formed a partnership in 2019 to tackle the increasing socio-economic inequalities and boost health outcomes in Yorkshire and the Humber by encouraging and supporting more cross-sector working. The partnership believes that health should be a key factor in all policy and economic investment and decision making at both a local and national level.

In that time, the partnership has published two reports focused on how taking collaborative action to improve health, inclusive growth and wellbeing in the region is in the best interests of all regional and national stakeholders, businesses and communities and should be a shared priority.

Levelling Up Yorkshire and Humber: Health as the New Wealth Post-COVID, published in 2020, set out a plan for how leaders could tackle the increasing socio-economic inequalities and boost health outcomes in Yorkshire and the Humber by encouraging and supporting more cross-sector working. The report Empowering local places for health and prosperity: new perspectives from Yorkshire and the Humber, published in February 2024 ahead of the Convention of the North, gauged progress made on the initial report's recommendations and looked at what more could be done to narrow the widening health and economic gap facing the region.

In relation to health and devolution, the second report concludes mayoral combined authorities are ideally placed to use their convening and commissioning powers to bring together broad-based partnerships – comprising businesses, universities, sports bodies and community-based organisations, as well as local government and the NHS, in efforts to tackle specific health and economic issues in local places.

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It also issues a rallying call not just to national, regional and local leaders but businesses, combined authorities, integrated care systems and other anchor institutions who are urged to use genuine devolution to build on existing public-private sector partnerships “ensuring businesses have a clear role, not just in developing a strong regional economy, but also in providing healthy work environments.”

Step 3: Realise everything has an impact on health

With a common view of populations and a renewed vision to better enable their health comes a much richer understanding of how working together can really deliver change. Leaders were clear they do not have to make the case for health in all policies – it is already there in strategy, in spirit and in delivery.

The challenge is to be more explicit and intentional about understanding the interactions in devolved policy, to measure and account for the health implications of all policies, and to develop collective responses to support shared populations to live healthy, prosperous lives.

> "If devolution is predominantly about giving local leaders the tools to fully collaborate and make a collective difference, then this new form of system working pushes the ICS reforms further, formalising engagement structures and asking leaders to be judged together rather than individually. This is natural; the NHS is not a curtained off segment of public services after all."
>
> Working Group Co-Chair

The roundtables agreed the need to give local leaders in ICSs and devolution areas the formal freedom and flexibility to develop their own models and priorities, rather than through the top-down national direction that many are used to. There is a challenge for local leaders to adapt to this and to share learning and work in new and expansive ways, especially during times of acute financial pressure, yet this is certainly also a challenge for Whitehall to enable this.

This third step is about the pragmatism required to make health and devolution work; understanding the added value, helping local leaders deliver services that are high quality, responsive and preventative, and pushing them into new areas of discussion where innovative solutions can be found and tested.

In particular, we found that:

- **There is no one standard operating model that can fit every emerging devolution and ICS integration arrangement**. We believe local leaders are best placed to determine their own approach, using a common underlying focus on strategic partner alignment and complementarity across the tiers based on mission, vision, behaviours and values.

- **The need to continuously gather evidence of why local leadership best serves communities is crucial**, including aligning local data and intelligence capacity with a focus on evaluation, measuring shared outcomes and the impact of health in all policies across areas with devolution deals. There are now tools available to financially quantify the public health impacts of various policy interventions.

- **Securing and aligning local leadership control and accountability over the three areas of policy, investment and service specification has been seen in other sectors to result in better outcomes**, including financial returns. This is a real learning point for ICS and combined authority leaders in seeking to best use their joint agency to improve population health and prosperity.

To explore the theme of 'realising everything has an impact on health', we looked in detail at both productivity and process.

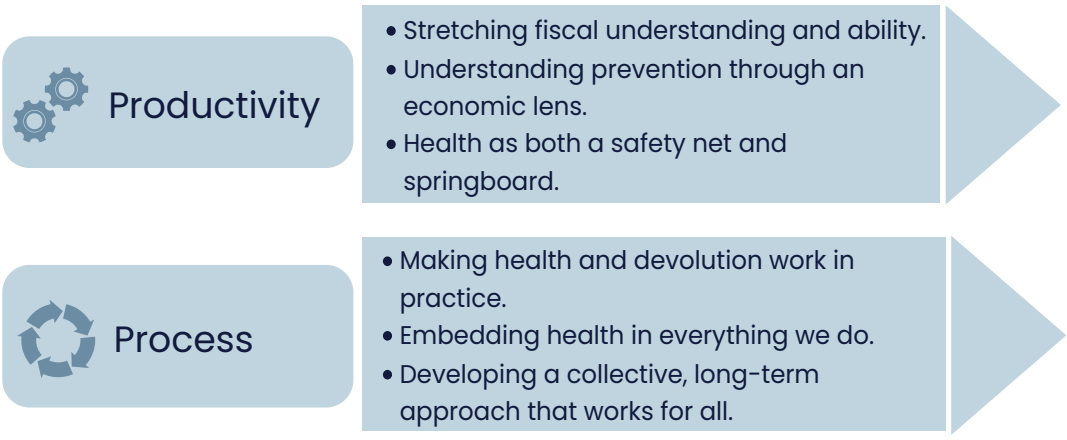
National recommendations to realise local potential

1. Government and NHS England should seek to **rationalise and reduce national targets and priorities**, empowering ICSs and combined authorities to identify their own through facilitating better data collection and sharing across public services.

2. Government should **ensure the business case and appraisal processes used by departments and national agencies supports new ways of working** and embeds the financial health costs and benefits, and the wider return on investment in everyday practice.

3. Government and NHS England should **prioritise place-based approaches to policy, leadership development and funding**, building up the joint capabilities of local ICS and Devo leaders to maximise their greater autonomy.

Figure 6: Focusing on productivity and process



Local priorities around which a renewed ICS-devo partnership can focus

Productivity	Process
Support a better shared understanding of the strategic financing and funding of place.	Make mission, values and behaviours the critical local building blocks and learn from one another.
Change the nature of the local fiscal conversation to increase opportunities to locally attract and direct funding.	See devolution as providing the roadmap to deliver truly preventative services, linking various strategies with operational delivery.
Reframe the approach taken to business case appraisals and guidance development to assess the impact on health outcomes.	Collectively articulate why local decision-making is best for the health of communities and wealth of the national economy.

We discuss both these areas in more detail below.

Productivity: how we stretch the money matters

Many ICSs and devolution arrangements have been born into something of a storm. Successively tighter fiscal windows have limited their ability to address both the immediate operational issues but also to strategically plan for the future. How leaders and organisations pool their finite yet still significant resources to best affect is a vital part of working more closely, but the ICS and combined authority relationship has the opportunity to stretch its thinking way beyond.

Leaders at our roundtables repeatedly spoke of their desire to change the nature of the local fiscal conversation, challenging and supporting each other to develop and share persuasive investment propositions that could reshape their communities and their service models. This should be supported in parallel by clearer attempts from government to improve the quantity, flexibility and stability of budgets.

The productivity-related priorities that should shape future ICS and devolution working are:

1. **Support a better understanding of the strategic financing and funding of place**

With national financial allocations becoming smaller, more discrete and increasingly competitive, a priority for ICS and devolution leaders should be to understand better the collective strategic financing options open to them, the nature and circumstances connecting public services in urban and rural economies, and the local funding routes that can help unlock parts of the system.

Knowledge of local money flows within and between sectors is often limited, which in turn significantly reduces the ability to best use and influence the finite resources across a place; challenge existing thinking and spending where it is not fully effective; and bring in external finance partners through new whole-system plans. There has been a renewed focus on place-based public service budgets based on past programmes such as Total Place recently. Complementing a better understanding of existing financial flows should be an improved awareness of the funding pots open to places from the full range of sources, including national government, research organisations, charities and investors, and coordination and support for constituent partners in accessing and using them.

> "Areas are clearly capital constrained but also revenue constrained. It's not just about buildings and capital, it's also about people. We do need to work on defining what an investable proposition could look like."
>
> Director of Public Health

> "Funding is typically distributed in pre-determined ways, which then operate in silos. Devolution should allow us to develop broader, shared outcomes which will naturally challenge existing money flows and enable much more effective use of them."
>
> ICP Chair

2. Change the nature of the local fiscal conversation to increase opportunities to locally attract and direct funding

With a better understanding of local financing and funding comes the increased confidence to reframe the nature of the local fiscal conversation – stretching ICSs and combined authorities into a joint space where they understand better the externalities of their own investment and can co-develop shared objectives and outcomes. This is about having a shared business case for change, as well as shared policy and understanding, bringing an explicit focus on creating health value and maximising the economic and social return on investment from the range of health and care budgets, including not only the value that can be created elsewhere within the sector but crucially in the wider local economy.

The relationship between combined authorities and investors, for example, is an area of growing focus, and support from an ICS can be critical in helping develop investible local propositions in the population health space that will be of significant interest to private finance. This could focus on place-based investment opportunities in developing new models of care, linking local regeneration planning around housing, skills and transport with the growing prevention agenda.

> "Business doesn't want to invest where government money would be most effective. We are now much more interested in social outcomes, not just financial ones but we need to find the right type of money to meet societal need."
>
> Investor

> "We need to stretch ICS and devo leaders into a joint space where they understand the externalities of their investment, can share, hold or reallocate resources and co-develop shared outcomes."
>
> ICB Director of Strategy

3. Reframe the approach to business case appraisals and guidance development to assess the impact on health outcomes

To embed this new way of working with private finance and partners, there is a need to accelerate the shift to value-based funding, with formal, technical business cases for investment becoming a more standardised part of developing and appraising local policy and outcomes, and thus delivering change. Further moves in HM Treasury's Green Book to magnify the importance of social value will be important. There is a clear role for national government and agencies such as NHS England and the Office for Health Disparities (OHID) to support this, in both the government's, and their own, development and use of broader appraisals process and guidance, but also in how they can support local partners to develop the skill set and the tools to act differently.

Given its prominence, health should be made explicitly part of future government funding, impact evaluations and policy support programmes. The data exists to make this happen, with health economic valuation tools being accepted into DLUHC appraisal processes (such as the HAUS model referenced below). What is needed is greater implementation and leadership from HM Treasury.

> "Health can be a key player in new regeneration plans and developments but we need to open up and put our cards on the table."
>
> Local Authority Chief Executive

> "A better understanding of money flows, more collaborative focus on return on investment when making decisions, and new investment offers that are place-based, will likely excite and test local appetite and ambition."
>
> ICS Chair

Process: making this work

The formalising nature of devolution means process is important if ICSs and devolution arrangements are to reach their potential. Leaders at our roundtables agreed they will need to invest time and resource in understanding each other better, sharing learning and determining a model for working that reflects the key themes outlined in this report. There remain questions about how an ICS and combined authority can really work together, what value they bring to local partners, what their asks of, and offer to, government is, and what they should be prioritising. Making this work will require pragmatism and a continuous focus on both form and function.

The process-related priorities that should shape future ICS and devolution working are:

1. **Make mission, values and behaviours the critical building blocks and learn from one another**

While there are commonalities within and across ICS and devolution working, the complexities of local areas mean there is no current standard 'off the shelf' approach to developing an operating model. From emerging local examples, the three key distinguishing characteristics that can underpin an approach are mission, values and behaviours.

Discussion and agreement on these are critical in building an operating model that can function in the long term, through challenging times and

during the uncertainty of seeking current or future formal devolution deals. Cementing these plans needs careful debate and accord across a range of partners, including local and combined authorities, the constituent parts of an ICS, the VCSE sector and others such as universities and business.

ICSs and combined authorities should also be looking at what others are doing and learning together on this journey. Developing the model will take time and a consistent, constant and concerted effort to get there and will draw heavily on the experience of those 'translators' in local positions who work across sectoral boundaries.

> "We need to unlock the value of local 'translators' who work across boundaries – find them, use them, help them, value them!"
>
> ICS and MCA Director of Public Health

> "There is a natural tension between devolution and how some national bodies, including NHS England, are organised and how their activity is delivered. This tension will not be resolved in the short term or through more central decision-making."
>
> ICP Chair

2. See devolution as providing the roadmap to deliver truly preventative services, linking various strategies with operational delivery

There is a growing sense that one of the core strengths of ICS and devolution joint working is the ability to set out plans to determine more preventative places and services, truly delivering on recent reports such as the Hewitt and Fuller reviews, shifting resources upstream and closer to home.

Going further, this relationship can also simplify the institutional landscape and enable greater clarity on the specific role that, for example, the ICS, NHS, MCA, CCA, local authorities and partners can and should all play in this shared yet complex journey, understanding each other and mapping it out. There will need to be distinctions between the approaches taken in rural and urban areas, and between scale and spread, and how leaders collectively deal with variation to understand the distinct opportunities each brings will be important. The prize for both is clear – this can help ICSs realise their full potential and ensure devolution delivers better outcomes.

> "ICSs are at differing stages in trying to understand the relationship between what is generated from the bottom up and how much is done at the ICS. Systems, including the ICP, should work with combined authorities to grasp the local balance needed between autonomy, innovation, creativity and tailoring."
>
> ICB Chair

> "We need to be about doing, as opposed to asking about what we might do. Having a sufficient body of evidence about what we are doing rather than just what we have done is important."
>
> ICP Chair

3. Collectively articulate why local decision-making is best for the health of communities and wealth of the national economy

A test of this relationship will be the ability of partners to speak upwards towards government with one voice, setting out local requirements and expectations to become more successful and being bolder in articulating the offer that closer local working will present national leaders. In the early stages of devolution in England this articulation of the strengths of local

decision-making, and the difference it can make for communities, is vital in persuading others this form of sub-national governance is here to stay.

Different areas will face different challenges and bringing this distinction to the fore will help evidence the need to test policy in different settings – highlighting the importance of capacity and capability funding. The relationship between the centre and local can ebb and flow, and leaders should look to reflect on who they need to influence and make every contact count when talking to government. This may prove vital in forthcoming discussions about the role of organisations such as the Office for Local Government (OFLOG).

> "Who else do we need to influence together and bring into this conversation? For example, DWP can sometimes be seen as remote from devolution though their role is vital, while HMT and DHSC matter hugely."
>
> Local Authority Director of Strategy

> "We need to keep asking questions of each other. This is a way of working, not a defined end point."
>
> Joint ICS and MCA Director of Public Health

> "The process of devolving powers is inherently iterative and dependent on government departments themselves communicating more closely, but also understanding that better public service outcomes and a more balanced economy depend on such an approach."
>
> ICP Chair

Case studies: realising health in everything we do

There are examples of this theme emerging across England, including:

- Partnership working in action – the West Yorkshire Health and Care Partnership and West Yorkshire Combined Authority journey
- The TRUUD Health Appraisal of Economic Systems (HAUS) tool – measuring health impacts to improve value for money
- The NHS Confederation-Carnall Farrar 'Value in Health' series

Partnership working in action: the West Yorkshire Health and Care Partnership and West Yorkshire Combined Authority journey

There's a strong recognition in West Yorkshire Health and Care Partnership and the West Yorkshire Combined Authority that around 80 per cent of the things that generate and sustain good health, are things outside of healthcare. Local leaders recognise that the contribution of combined authorities and local authorities are hugely influential in the health of the population, and any powers and resources that are within the control of these institutions should be looking at ways of positively maximising their impact on the population's health. That's why partnership and voice matter so much in West Yorkshire.

The commitment is that leaders will always focus on the differences they are making and in putting as much of the power as close to the problem to be solved as possible. The places, provider collaboratives, primary care networks, organisations and local people are the vehicles for change. This is explicit in the values which state that 'this is a true partnership' and 'subsidiarity applies in all we do'.

Local authorities in West Yorkshire are further supported to deliver this impact through the statutory role of the director of public health and team. The West Yorkshire ICB is supported through the Improving

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Population Health Team, and the West Yorkshire Combined Authority is now supported through the recent appointments of inclusivity champion and associate director for improving population health (joint appointments with the ICB). The work programme of this team is complementary, but discrete and add value to the existing work of partners and teams to demonstrate the population health system working that is necessary to address the challenges outlined.

In June 2023, the combined authority received a partnership agreement and report on determinants and inclusion partnership working. In September 2023, the Partnership Agreement was signed between WYCA and WYICB, as partners committed to improving the physical, mental, economic and social wellbeing of people in West Yorkshire. The West Yorkshire Combined Authority and WYICB Partnership Agreement sets out a set of shared commitments to working together on the factors that affect population health as follows:

- **Fair economic growth**: ensuring the maximum benefits of health and wealth for the population.

- **Climate emergency**: mitigating the health impacts of the climate emergency and maximise the region's contributions to tackling climate change.

- **Tackling inequality**: tackling discrimination and removing structural inequality in joint work.

- **Determinants of health**: using the principles of this agreement, ensuring that every joint endeavour meets subsidiarity, is value for money and adds value to respective work.

The agreement also sets out reciprocal governance arrangements, with the West Yorkshire Health and Care Partnership Board having extended its membership to include the mayor and chief executive of the combined authority. The combined authority will seek to review opportunities for ICB colleagues to take up ex-officio roles on combined authority committees. In the first instances, the Place and Regeneration Committee will extend

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an ex-officio role to the chair of the ICB (or delegated representative) and the director of strategy of the integrated care board an ex-officio role on the Climate, Energy and Environment Committee.

This agreement is supported by a work plan covering: embedding a 'health in all policies' approach in the combined authority; programme delivery on work and health and creative health; and development of future ambition for the region.

One example of this work has been the establishment of a West Yorkshire Work and Health Partnership Group. The partnership brings together local authority and combined authority leads from skills and public health alongside colleagues from the ICB, DWP/local Job Centre Plus, and voluntary, charity and social enterprise sector.

The partnership defines its aims as the following:

- defining current challenges facing West Yorkshire on health and work, including key drivers and community insights
- identifying key areas for intervention
- mapping existing work to describe learning from best practice
- setting out areas for greater collaboration or future investment.

Partnerships of this nature will be influential in feeding community-level findings and strategies up to the West Yorkshire level.

The TRUUD Health Appraisal of Economic Systems (HAUS) tool: measuring health impacts to improve value for money

As ICS and combined authority (CA) spending is directed towards more cost-effective interventions, it becomes increasingly important to understand the wider costs and benefits of every policy intervention. A growing body of evidence on the wider determinants of health shows that health outcomes are impacted by a wide range of policy interventions in areas like transport, housing, and urban planning. Often policies that might have a clear economic benefit may also come with a public health cost.

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This in turn can manifest as a potentially much higher financial price to pay further down the line.

It is therefore crucial for ICSs and CAs to build health considerations into the full range of their policy decisions. By quantifying health impacts, the Health Appraisal of Economic Systems (HAUS) tool offers a new method for modelling the longer-term financial implications of urban development policies.

1. HAUS shows the relationship between different features of the urban environment (such as noise, heat, light) and the impact on public health.

2. Grounded in systematic reviews of 8,000 medical studies and 14,000 valuation studies, the HAUS tool identifies the causal pathways that increase the risk and severity of a variety of diseases.

3. The tool identifies the unit costs for 70 health outcomes, including heart disease and diabetes (collectively known as 'non-communicable diseases', which are responsible for 89 per cent of deaths in England).

4. These pathways lead from 30 characteristics of the urban environment, such as building design, transport and green space.

5. It also identifies where in the system these costs land – often on the NHS and local authority care budgets.

6. The model also identifies where the costs of ill health associated with the urban environment land in the wider system, including costs to households, employers and other parts of the public sector such as education and criminal justice services.

The HAUS tool allows policymakers to clearly see the societal cost of urban development policies in terms of their impact on public health. This has the immediate benefits of being able to avoid those policies that may seem economically viable but on closer inspection will actually be more costly in the long term due to their impact on public health. For example,

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there might be economic benefits to squeezing more housing units into a new development, but the lack of inside space and the lack of green space will both lead to higher health and social spending in the longer term. Equally, some development policies may make little economic sense until we are able to clearly see the economic benefits that come from a healthier population.

Given that ill health among the working-age population costs £150 billion a year, the potential benefits of using the HAUS tool in development policy are clear. But there is also another potential advantage. Shared strategies between ICSs and CAs could be easier to form and simpler to implement when they integrate public health outcomes into local economic development spending. Apparent tensions between growth and wellbeing begin to fade if the costs of public ill health are understood, measured and accounted for.

This research, and the HAUS tool itself, have been produced by an interdisciplinary team of academics from the 'TRUUD project', which considers how we should Tackle the Root causes of Unhealthy Urban Development. Further information is available at https://truud.ac.uk/ and in these policy briefings:

- Revealing the health costs of the urban planning policy environment
- Valuing the 'external' social costs of unhealthy urban development
- How value is considered and used in urban development with implications for the levelling up agenda

The NHS Confederation and Carnall Farrar 'Value in Health' series

The Value in Health programme is a research-orientated partnership between the NHS Confederation and Carnall Farrar, focused on leading and shaping national and local discussions around investing in health and care. Through a dedicated suite of products, this partnership is helping leaders understand, analyse and narrate the evidence for undertaking the much-needed shift in strategy and resourcing to truly embed prevention.

Their complementary analysis and reports have already shown that:

- When it comes to quantifying the return on investment of spending on healthcare, every pound invested in the NHS results in around £4 back to the economy through increased gross valued added, (GVA), including through gains in productivity and workforce participation. This economic value is above and beyond the range of physical services and the intrinsic personal, societal and moral value that people receive from being able to access healthcare.

- There is a statistically significant association between NHS spending increases and GVA growth. In particular changes in primary, community and acute spend in England have been associated with significant growth in economic GVA between 2015 and 2019. Those areas that increased NHS spend by the most experienced far higher GVA growth than those that increased spend by the least.

- Building on this, if funding patterns among areas that increased spending the least had matched those that increased spending the most, every additional £1 spent on primary or community care could have increased economic output by £14, were a direct relationship assumed. Higher increases in acute care had lower but still significant impact, with every additional £1 spent potentially increasing GVA by an extra £11.

- Increasing spending in line with those high increase areas could have delivered average benefits of a higher GVA for a typical-sized

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integrated care system of £1.7 billion from the primary care spend, £1.2 billion from the community care spend and £1.1 billion from the acute care spend. This is a significant economic impact, which some places in England have missed out on.

- Despite the increased focus on creating better health value and unlocking system productivity, there is currently no relationship between the amount invested by NHS organisations in community care and their population community care needs. The sheer variation in spend perhaps highlights a wider lack of understanding and prioritisation in community care and a lack of awareness of the broader impact on the economy.

Conclusion

This report provides a comprehensive framework for how leaders on the front line of public services can collectively realise the benefits of health devolution. It is rich in both detail and in nuance, mirroring the depth of the roundtable discussions we held, and offers numerous examples of how this working can and does look in practice. From these discussions, and building on this report, we strongly believe that:

- **health, and health metrics, should be prioritised by government as a formal part of negotiations for future devolution deals**, given its importance for and relevance to economic prosperity, the growing interest from system leaders and the clear commonalities in ongoing reforms

- **the ICS-combined-authority relationship should be recognised by government and national bodies as one of equals**, fostering a mature, two-way relationship and acknowledging the support needed to ensure system leaders have the capacity and capability required to best deliver on their potential

- while no universal operating model to align health and devolution locally exists, **it is important ICSs and combined authorities create a positive vision for integration for their local populations**, underpinned by a series of thematic priorities which can guide leaders on where and how best to work together.

The timing of this report is important for many reasons. There is presently a narrow window open in which to simultaneously look back at how leaders have approached devolution from either a geographical or a health and care perspective, but also forward at what a more standardised approach to decentralisation might look like and entail, before the reforms make merging too complex a task.

Turning this vision for health and devolution into a reality will not be easy, but the roundtables revealed a willingness to push traditional views of, and approaches to, integration beyond where many previously felt comfortable. This will involve stretching what can be done within existing frameworks, duties and powers, before understanding what is needed to go further still; increasing and resourcing local capacity and capability; focusing on community engagement and empowerment; understanding and using soft power and system working; and above all, consistently engaging and co-developing a future of shared thinking, shared projects and shared positions. This will take time, particularly with the asymmetrical nature of devolution meaning different parts of the country will be at different stages at different periods.

The process of devolution is exactly that, a process. Iterative in nature and, depending on various factors, moving quickly at times, more slowly at others. While we do not know exactly what lies in store for this agenda, it will remain one of interest and importance for national and local politicians and cross-sector leaders, for think tanks and policymakers, but also hopefully for communities experiencing positive local change.

In this regard, future deals may well have an increasing focus on rurality, building on the proposed Greater Lincolnshire Devolution Deal or the recent approaches to county combined authorities, and scrutiny, which poses interesting questions about how elected and non-elected leaders, including ICS and health leaders, are collectively held to account.

Similarly, there has been growing talk of fiscal devolution, with local areas retaining more of the local economic growth they themselves generate. With the NHS playing a more important role in local economies and its ability to help raise, for example, business rates, this should provide a good basis for broader conversations on the redesign of funding systems and the greater flexibility to redistribute local taxation to support more inclusive growth. We believe the vision for health and devolution in this report, and the underpinning themes and priorities, are as relevant for the country's rural and coastal areas as for the city regions, which have traditionally dominated the English devolution agenda.

This is not an issue of English exceptionalism either. We lag behind the vast majority of OECD countries when it comes to decentralisation more broadly, but also in regard to the functioning of our healthcare system. The mayors of the major US cities, for example, through City Charters, wield significant power over many of the determinants of health of the population and have established local departments of health. In Denmark, the five regions all hold primary responsibilities for public services such as healthcare, social services and specialised education, but also for regional growth and development. This suite of portfolios enables broad dialogue and cohesive policymaking involving a diverse range of citizens, politicians, institutions, businesses and the national government. We can and should learn from these and other approaches being taken.

Oversight of progress on this issue will be important. The Department of Health and Social Care, NHS England, Local Government Association and the NHS Confederation's ICS Network have been working to develop a national ICP forum which they will run jointly. Given the proposed role of the group is to provide the opportunity for a two-way exchange between ICS leaders and the relevant government departments and agencies to identify how government policy could be better aligned to support ICPs as partnerships, we believe health and devolution should feature strongly in this forum's focus.

Finally, we would like to thank sincerely the co-chairs and members of the working group for their time, but also their openness, honesty and challenge. These are complex issues which were evolving almost in parallel to the discussions we held. As the national membership organisations in positions to both influence nationally and support locally, we are committed to working together to jointly on behalf of our members to champion, challenge and curate the health and devolution journey.

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Appendix 1: Further reading

There are many thought leaders involved in the health and devolution landscape and much for those keen to learn more to read. Below is a list of related publications and websites we would recommend:

- Mark Sandford, Senior Researcher, House of Commons Library – Devolution to local government in England, Eighteen deals and counting: finding meanings in England's devolution deals and The 2024 metro-mayor elections.

- Centre for Cities: everything you need to know about Metro Mayors – Everything you need to know about metro mayors | Centre for Cities

- Health Devolution Commission – https://healthdevolution.org.uk/resources

- Health Foundation: Improving health and reducing inequalities Combined Authority programme – https://www.health.org.uk/funding-and-partnerships/programmes/improving-health-and-reducing-inequalities-combined-authorities-programme

- Institute for Government – https://www.instituteforgovernment.org.uk/our-work/topics/devolution

- Reform: Close enough to care: A new structure for the English health and care system – https://reform.uk/publications/close-enough-to-care-a-new-structure-for-the-english-health-and-care-system

- Tackling the root causes upstream of unhealthy urban development (TRUUD) – 2019-2024, £6.7m. This research project is funded by the UK Prevention Research Partnership, under Grant MR/S037586/1 – https://truud.ac.uk

Appendix 2: The Devolution Framework

The Devolution Framework, as of November 2023

As part of the publication of the levelling up white paper (LUWP) the government released a 'devolution framework'. This detailed the types of powers and functions that would be considered as part of a devolution deal. Some powers may only be available to certain authorities or geographies. The framework continues to be designed to be dynamic so that it can evolve and be informed by devolution deal discussions over the coming years. The updated version, alongside Level 4 powers and functions, can be found below.

Level 4 – Deeper devolution for an established single institution or county council with a directly elected leader (DEL) in post who can meet specific eligibility and accountability criteria.

Level 3 – A single institution or county council with a DEL, across a Functional Economic Area (FEA) or whole county area.

Level 2 – A single institution or county council without a DEL, across a FEA or whole county area.

Level 1 – Local authorities working together across a FEA or whole county area, for example through a joint committee.

Strategic role in delivering services

Detail	L1	L2	L3	L4
Host for government functions best delivered at a strategic level involving more than one local authority e.g. Local Nature Recovery Strategies.	X	X	X	X
Opportunity to pool services at a strategic level.	X	X	X	X
Opportunity to adopt innovative local proposals to deliver action on climate change.	X	X	X	X
A strategic role on net zero in collaboration with government.		X	X	X
Opportunity for devolution of retrofit funding subject to the outcome of the existing pilots in Greater Manchester and the West Midlands.				X

Supporting local businesses

Detail	L1	L2	L3	L4
LEP functions including hosting strategic business voice.	X	X	X	X
Opportunity to access a Strategic Productivity Partnership to support local business growth.				X
Opportunity to articulate research and development priorities.^				X

(^) refers to functions which are only applicable to mayoral combined authorities.

Transport

Detail	L1	L2	L3	L4
Become the strategic transport body for the area and take on all associated Local Transport Authority and public transport functions. This includes responsibility for an area-wide local transport plan, bus Enhanced Partnerships, support for public transport services, and concessionary fares.*		X	X	X
Defined and coordinated, Key Route Network, with a mayoral power of direction over the exercise of local highway and traffic authority powers on the Key Route Network.*			X	X
Priority for new rail partnerships with Great British Railways – influencing local rail offer, e.g. services and stations.			X	X
Have automatic access to franchising powers to independently introduce bus franchising in line with current guidance.*			X	X
Consolidation of local transport funding settlement in line with the principles set out in the Levelling Up White Paper and Funding Simplification Doctrine. The quantum of funding and the number/remit of individual funding lines will be agreed through the next Spending Review Process.			X	
Single local transport funding settlement in line with the principles set out in the Levelling Up White Paper and Funding Simplification Doctrine. The quantum of funding and the number/remit of individual funding lines will be agreed through the next Spending Review Process.				X
Responsibility for administering payment of Bus Service Operators Grant.			X	X
Leadership in improving consistency and efficiency in taxi and private hire vehicle licensing.				X
Government commitment, subject to delivery of the Pay As You Go rail ticketing pilots in Greater Manchester and West Midlands, to build on these pilots to inform and support regional ambitions for integrated multi-modal ticketing.				X

Detail	L1	L2	L3	L4
Leadership in developing a consistent approach to pavement parking in the area.				X

(*) refers to functions which are only applicable to combined authorities as opposed to county councils.

Investment spending

Detail	L1	L2	L3	L4
UKSPF planning and delivery at a strategic level		X	X	X
Long-term investment fund, with an agreed annual allocation.			X	X
Consolidation and simplification of local growth & place and housing & regeneration funding, including a pathway to a single department-style financial settlement.				X
Removal of gateway review, subject to meeting certain criteria.				X

Giving adults the skills for the labour market

Detail	L1	L2	L3	L4
Devolution of Adult Education functions and the core Adult Education Budget.		X	X	X
Providing support and refinement for Local Skills Improvement Plans.		X	X	X
Role in designing and delivering future contracted employment programmes.			X	X
Ringfenced funding for Free Courses for Jobs.		X	X	X
Ability to work with DfE to commission a local programme of Skills Bootcamps, to be informed by future spending agreements.	X	X	X	X

Detail	L1	L2	L3	L4
Work with local stakeholders to align careers provision with devolved AEB activities.		X	X	X
Full devolution of Free Courses for Jobs funding.				X
Full flexibility over Skills Bootcamps funding.				X
Central convening of careers provision.				X
New regional Labour Market Partnership Board.				X

Housing and infrastructure

Detail	L1	L2	L3	L4
Ability to establish Mayoral Development Corporations (with consent of host local planning authority).			X	X
Devolution of locally-led brownfield funding.			X	X
Homes England compulsory purchase powers (held concurrently).		X	X	X
Strategic control in any future Affordable Homes Programme (from 2026).				X

Keeping the public safe and healthy

Detail	L1	L2	L3	L4
Mayoral control of Police and Crime Commissioner (PCC) functions where boundaries align.^			X	X
Mayoral control of Fire and Rescue Authority (FRA) functions where boundaries align.^			X	X
Clear defined role in local resilience.*		X	X	X
Where desired, offer MCAs a duty for improving the public's health (concurrently with local authorities).		X	X	X

(*) refers to functions which are only applicable to combined authorities as opposed to county councils.

(^) refers to functions which are only applicable to mayoral combined authorities.

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