DAC BEACHCROFT

THINKING LOCAL:

The power of local autonomy in delivering healthcare

Health adviser

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THE POWER OF LOCAL AUTONOMY IN DELIVERING HEALTHCARE

Emerging from the command-and-control model that existed during the coronavirus pandemic, the power of local autonomy is now being realised, boosted by the Health Bill's emphasis on subsidiarity and place-based leadership. **Charlotte Burnett** explores how local and central control can be balanced for the good of all.

As the Health Bill makes clear, policymakers want to build a modern health and care system that provides better care for communities. Reducing bureaucracy, increasing accountability and promoting integration are not new concepts. Empowering local figures, and harnessing the power of local autonomy is going to be crucial in delivering on these goals within the new framework. But there is an inherent tension between centralised action and activity, versus the concept of subsidiarity. There will remain a need for coherent central strategy to avoid inconsistency and the exacerbation of health inequalities, while too much room for manoeuvre at local level would run the same risks, with high degrees of variation emerging.

> *"In my 30 years of experience, the NHS always delivers better when there is absolute clarity on what the centre does around rules and policy, but where people are liberated to work within those rules with their own local flavour,"* says Sir James Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust. *"The price of not doing that is levelling down and slowing up. We have to accept a degree of variation that comes with liberation, because the value of liberation massively outstrips the consequence of things being too standardised and centrally controlled.""*

It is clear that a delicate balancing act is taking place. The solution lies in working together to marry the respective benefits of central and local.

KYC – KNOW YOUR COMMUNITY

After a period involving lockdowns and travel restrictions, the term 'local' has never had more significance and one of the powerful positives to emerge from COVID was the community response.

> *"People wanted to help out and look after their friends, family, neighbours. That connection and energy is lost if you take away the local element,"* says Mackey. *"We're part of the community. The community is part of us. It's in all of our interests to work together."*

Working together to overcome the tension, or disconnect, between central command and frontline, locality-based principles must involve understanding and accountability. Tracey Vell, Clinical Director at Health Innovation Manchester and Medical Executive Lead for Primary Care at Greater Manchester Health & Social Care Partnership says the best way to navigate this is via a focus on 'earned autonomy'.

> *"If we get localities showing great relationships and delivery, becoming peer-based assurance vehicles, then we should have less command-and-control, and they should have earned autonomy to deliver in a bespoke way,"* says Vell.

Everything still needs to be knitted together but, to deliver truly bespoke care, central policymaking has to build in flexibility to be agile – and accountable – at a local level.

> *"You expect the NHS to deliver clarity at a national level on the big issues, whether that's elective recovery, cancer, getting ready for winter or outcomes for people with heart disease. That's the 'what'. But the 'how' has to be different to reflect local context and circumstances,"* says Mackey.

This appreciation of nuance is vital when you consider localities may cover several hundred square miles, and what works in one area may be wholly unsuitable elsewhere. Vell's Greater Manchester umbrella, for instance, covers 10 localities and the scale of 'localities' or 'neighbourhoods', 'communities' and 'Place' must also be understood.

Population density and other demographic measures are varied, so the provision of care must be, too. Some argue that an over-reliance on the 'local' breeds too much variation within the NHS, but the size, reach and unique makeup of the NHS must be taken into account.

> *"That view is understandable, but the NHS as an organisation cannot be compared to the 'Tesco's or 'Marks and Spencer's of the world,"* says Mackey.

As such, variation should not be viewed as inconsistency but, rather, as flexibility – something which the complex NHS and wider health system requires. True transformation relies on connecting with all parts of the system.

> *"As leaders, you're always looking for things to latch onto which give energy and create motivation. You have to have a local feel for those things, in order to truly connect,"* says Mackey.

This connection goes both ways. Leaders connect with communities and communities connect with their leaders. Local figures have a closer connection, meaning trust and impact are more keenly felt at this level, and even beyond.

Vell points out that 'place-based' represents local authority or Clinical Commissioning Group (CCG) constructs. She says that might be too broad, and ward- and neighbourhood-level approaches could be better harnessed. Delivering vaccination messaging via faith leaders is one example of this in practice. Local figures have the reach and trusted influence to get to the point of need.

> *"To reach certain demographics, we started vaccinating in BetFred in Wigan,"* says Vell.

Whether it's issuing prostate screening leaflets in the high street, or giving messages to the youth in McDonald's, community connection requires a smaller footprint to work on. But Vell thinks this can go further, still.

> *"Why aren't we doing lung screening programmes in benefits offices? Screening while you wait. Make every contact count,"* she asks.

Vell wants to see a culture change to leadership by influence and equity. A culture that supports trust in on-the-ground, frontline neighbourhood-level relationships, where someone knows community members' names, and can open doors (including to those perceived as 'non-health' areas).

> *"For those that sit with the frontline, our job is to connect up and down from that frontline,"* says Vell. *"The frontline is where population health comes alive and the data becomes meaningful. Inequality reporting data can be sent to PCNs, so they have a better understanding of whether it's obesity, smoking, jobs, environmental issues that a given population is dealing with."*

GOING BEYOND HEALTHCARE

When wider determinants that impact people's lives beyond healthcare are stabilised, better outcomes emerge.

This is precisely what Rupert Dunbar-Rees, Chief Executive Officer at Outcomes Based Healthcare (OBH), focuses on. OBH is a health

data analytics organisation providing insights for population health management. Dunbar-Rees welcomes the move to increase local autonomy and the scope that place-based leadership allows for looking beyond individual care settings to encompass wider factors.

OBH conducts population segmentation analysis, and Dunbar-Rees says this shows that the most important change in health state which people experience is when they first move from being healthy to a different health state – in other words, when they first acquire a long-term condition. The key is to keep people in the healthy state for as long as possible.

> *"The longer we can help people remain in that 'healthy / well' segment, every outcome improves, including lower overall cost of care,"* says Dunbar-Rees. *"If there is one outcome that it's vital to measure, it's the moment of leaving the healthy group. That's the outcome to rule them all."*

More local, place-based approaches allow deeper analysis of who is in the healthy group, who is leaving that group, and why.

> *"You have to acknowledge that the drivers of people leaving the 'healthy / well' segment are typically non-health factors,"* says Dunbar-Rees, adding that this can usually be linked to quality-of-life factors like income, access to green space, prevalence of crime, access to education and housing. Each of these factors is local.
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> *"Precarious housing and precarious employment are strongly associated with a person's first major health status change. Critical factors putting strain on the health system lie in solving issues like access to green space, housing and local jobs. These are difficult to impact at central level, but can be managed more effectively at local level."*

INNOVATING, LOCALLY AND NATIONALLY

Innovation holds the power to accelerate transformation, in part by smoothing the cogs between local and central control. But to maximise its potential, innovation itself must by analysed through those same two lenses.

Innovation relies on clearly defining the problem you are trying to solve, and having a mechanism or a process to surface that problem. In healthcare, the most important problems find their roots in issues related to local, frontline delivery.

> *"Local autonomy drives priorities for innovation. Then when it comes to delivering innovation, that needs to be at scale,"* explains Vell. *"Digital innovation often has massive infrastructure needs, which need to be connected. Doing things by each locality brings additional cost. There should be local discovery and identification of issues, then local participation in solutioning, but a central procurement and delivery mechanism."*
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> *"If it's all place-based, there's no at scale delivery, there's a postcode lottery for citizens, there's a lack of return on investment because its more costly,"* adds Vell. *"It's an up and down process, and the new Health Bill is forcing people to think more carefully about getting the balance right."*

THE ROLE OF DATA

The NHS Long Term Plan and Health Bill can't be delivered without timely, comprehensive data that spans organisational boundaries to complement the rise of Integrated Care Systems'. Dunbar-Rees notes that at single care setting level, data quality has improved. But individuals rarely receive care from one single setting.

> *"It's essential to think beyond and get data that extends beyond individual siloes, otherwise it is presenting a partial view of the truth and of the cost,"* says Dunbar-Rees. *"If you shine a light on the cost caused by the links between health-span and deprivation, and make the findings clear and digestible, you can create a compelling case for change and for central policy to address some of the issues. But people need the metrics to measure and understand this."*

Mackey agrees that data is a valuable instrument for managing healthcare and population health, but warns it is only useful if it influences or impacts a decision – not just for the institutions involved, but for the patient and for society as a whole.

While measurement is ever-improving, data discipline has to remain high and Mackey believes a considered, but less risk-averse approach to data – including greater public ownership – will enhance the utility of data further.

> *"We need to find a way to unleash the power of data. Maybe we need to take a few more risks in making data available,"* says Mackey. *"Customer pressure and accountability can be a useful tool. We need to take a more disruptive approach to data and allowing consumer behaviour to change our behaviour. We're only playing half the game if we don't activate the consumer."*

Local-level trust and tangibility can once again be powerful tools in activating and engaging, with Vell observing that people opt out of data-sharing less if they can see where that data is being used, and how it is impacting care in their environment.

> *"With the Greater Manchester care record permissions, people allow sharing because they see the results. It becomes more academic and less relevant if its national and people don't have line of sight on everything,"* says Vell.

For the NHS, comprehensive population coverage, a high degree of digitisation, and single patient identifier provide a strong data foundation upon which to build.

> *"Those are the 3 golden characteristics and the UK has all three in a good state,"* says Dunbar-Rees. *"This puts us on a good footing to look beyond organisational boundaries to measure outcomes and direct resources."*

Definitions and standards are a key part of driving good data quality and discipline, providing the rigour that makes data useful. During the pandemic, there was a temptation to try and compare how different jurisdictions were dealing with the virus, but without standardisation of datasets, that quickly becomes a fruitless exercise. The same is true within national boundaries.

> *"Central and local need to have good, two-way feedback mechanisms. Granular local level data is great, but ultimately it needs to be comparable out-of-area on a like for like basis, on national scale. Otherwise it's hard to know what good or bad looks like,"* says Dunbar-Rees, who knows that, for national comparability of outcomes measurement, standard definitions and criteria – such as what constitutes a 'long term condition' – must be applied.

A MOMENT FOR REALIGNMENT

Data and digital advancement and adoption have been at the forefront of dealing with the COVID-19 pandemic, but so too have healthcare's local leadership figures. The role they have played reinforces the power of a hybrid approach, and has surely provided the earned and trusted autonomy Vell describes.

The healthcare ecosystem would be wise to embrace instances of greater local autonomy flourishing, while delivering what is expected from a central policy perspective.

> *"It's really important that, whatever happens at one level also makes its way through to the other in the right way. You have to have a hybrid approach between national and local – otherwise the system will grind to a halt," says Dunbar-Rees.*

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