RESEARCHING HEALTH AND SOCIAL CARE DEVOLUTION: LEARNING FROM GREATER MANCHESTER

Summary of Interim Findings

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RESEARCH BACKGROUND

Since October 2015, researchers at the University of Manchester have been examining Health and Social Care Devolution in Greater Manchester. We are working closely with the Greater Manchester Health and Social Care Partnership (GMHSCP) – the 37 NHS organisations and councils overseeing devolution and taking charge of the £6bn health and social care budget in Greater Manchester (GM). Our research seeks to understand the devolution process and its development, to describe and analyse changing governance, accountability and organisational forms, and to map and measure changes to services. This brief report sets out our findings from the first year of research. It draws on our analysis of relevant policy documents, observation of meetings (140 hours) and interviews with 20 senior staff members. The research is supported by the Health Foundation and the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester.

A NEW VISION FOR GREATER MANCHESTER

GMHSCP has articulated from the outset a highly ambitious and high-level vision for health and social care in GM, with a strong emphasis on differentiating devolution from past reforms and reform elsewhere. This vision was produced by a relatively small GM core team, working closely with NHS England, but it has attracted considerable engagement and support across all GM local authorities and NHS organisations. The underlying logic model of devolution – as outlined in the Strategic Plan *Taking Charge*[1] and *Implementation and Delivery Plan*[2] – relies heavily on the idea that the effectiveness and efficiency of the health and social care system requires wholesale transformation as opposed to incremental change. This entails improvements in prevention and self-care, better organised primary and community care, demand management, health and social care integration, and standardised acute, specialist and support services. These ideas reflect the wider national policy

[1] http://www.gmhsc.org.uk/the-five-year-plan/
[2] http://www.gmhsc.org.uk/assets/GM-STP-3-Implementation-Delivery-Narrative-FINAL-251116.pdf

Devolving health and social care: Learning from Greater Manchester.
This research is supported by the Health Foundation, an independent charity working to improve the quality of health and healthcare in the UK, and the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester.

agenda, particularly for delivering the *Five Year Forward View*[3], yet GMHSCP is seeking to move further and faster than elsewhere. GMHSCP positions itself as distinct from Sustainability and Transformation Plans (STPs) elsewhere citing the 'uniqueness' of working relationships between organisations in GM, emphasising local authority involvement in producing their place-based plan and the establishing of a Partnership Team. The vision for GM encompasses wider 'public service reform' and economic growth agendas, linking with the broader devolution arrangements in the city-region.

NEW DECISION-MAKING ARRANGEMENTS

A set of GM-wide supra-organisational governance structures and leadership arrangements have been established to support the delivery of the vision. These new boards, working groups and committees currently have no legal powers or statutory basis, though it is worth noting that the main Strategic Partnership Board has adopted many of the prevailing norms of statutory public bodies – for example, in meeting in public, publishing their papers, and having a website presence. While the existing organisational structures, governance arrangements and accountabilities remain, there is a clear sense that they are becoming less important and are more frangible than they might at first appear. In part this is seen in the reduced importance of organisational boundaries and the shift in the locus of decision-making from individual organisations to groups of organisations in localities and from national bodies to GM. It is also reflected in the coming together of providers and commissioners and of local authority and NHS organisations, and the shift from contractual to relational modes of interaction. There has been no explicit statement about the likely future of existing organisations. In the meantime, shared leadership arrangements – for example across LA/CCG and across health/social care provision – are developing.

MANAGING CONSENSUS

The arrangements outlined above reflect a commitment to shared decision-making across GM. This involves a ceding of some individual organisational autonomy – and changing of behaviours – by both local authorities and NHS organisations. A system of 'managed consensus' has evolved, which seeks to negotiate or broker agreement, and to raise the costs or consequences of defection from such consensus. We have observed that those involved have invested a great deal of time and effort in establishing the new arrangements and the commitment from senior leaders to attending, participating and engaging at all levels has been substantial. Indeed, it might be argued that the relationship building opportunities and networks which the new forums outlined above have provided may be making an important contribution to the development and maintenance of the 'managed consensus'. It is too early to say definitively how, or how well, these new organisational forms and accountabilities work. Arguably, these new arrangements have yet to be really tested, in dealing with issues on which there are strongly held and divergent views,

[3] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

or where there are acute political and geographic sensitivities, or where changes pose threats to organisational or professional interests.

NEW LOCAL CARE ORGANISATIONS AND SHIFTS TOWARDS PREVENTION

Achieving GMHSCP's vision requires a shift towards new place-based working within localities (i.e. local authorities areas). Locality Plans are a new mechanism for planning, forging closer relationships between local health and social care organisations. Locality Plans, which require local Health and Wellbeing Board sign up, articulate how 'transformation' will improve health outcomes as well how financial savings will be achieved. Changes are underway in all localities, where Locality Plan objectives have been agreed. These plans encompass some form of 'Local Care Organisation' model. These new accountable care vehicles are responsible for the management of health and wellbeing for a defined population. Their form can vary from a virtual alliance of providers through to a prime provider such as a Foundation Trust (FT) holding a single contract for health and care services. This requires a complex remapping of services whose commissioning and provision are fragmented across CCGs, local authorities, NHS trusts and FTs, and a variety of third sector, private and voluntary service organisations. It involves in many cases the transfer of staff and services between providers (in healthcare and between health and social care). GPs are at the heart of plans to co-ordinate and deliver local care, alongside an emphasis upon health management and prevention. By bringing together health, social and public health within a 'community-based' setting, there is an expectation that these new ways of working and will lead to an improvement in health outcomes and a reduction in demand for hospital-based care. With some 'front-runners' in GM formalising these changes, new arrangements will be in place across all 10 localities by 2017, at the earliest.

TRANSFORMING ACUTE AND SPECIALISED SERVICES

Discussion surrounding changes in acute care are prominent and high profile within GM as a consequence of emerging circumstances as well as intentional priority. These organisational changes in acute care are increasingly dominating the change agenda for GMHSCP. Over the course of five years these are intended to transform service delivery and this transformation will involve some centralisation and 'rationalisation' of acute care services through formal collaboration between providers. Such changes will be contentious especially if they are seen to 'downgrade' individual hospital sites or to withdraw or reduce certain services, such as accident and emergency provision. There is a risk that this work may consume an inordinate share of GMHSCP leadership capacity at a cost to other service transformation work packages.

TRANSFORMATION FUNDING

A £450m Transformation Fund (TF) provides a mechanism for facilitating service transformation within the health and social care system to achieve clinical and financial sustainability by 2021. This fund is not intended for reducing financial

deficits within the GM health and social care system. It is therefore distinct from money available for Sustainability and Transformation Funding elsewhere in England which can be used in this way. Criteria for judging proposals have been established, aimed at ensuring that proposals deliver the GM vision, enable transformational change, consolidate resources, secure value for money and facilitate learning across the rest of the system. Rather than a bidding or 'fair shares' process for new money, localities must produce plans which demonstrate how TF money will be used 'to achieve strategic plan outcomes, based on robust locality implementation and transformation themes'. Following evaluation of transformation proposals by an independent 'oversight group', the first allocations of money have now been agreed with certain localities. Extensive investment agreements will operate as significant mechanisms monitoring performance, binding localities to ambitious targets in their proposals. With funding phased over the five years, there is an expectation that all localities will have been supported to submit proposals by end of 2016/17. The TF is also open to proposals from the transformation themes, with the first submissions expected in early 2017.

OPPORTUNITIES AND CHALLENGES AHEAD

GM's context and history are distinctive, and the expressed scale of the ambition in GMHSCP's plan *Taking Charge* is possibly unprecedented. However, the realisation of that plan and its implementation bears many similarities to and holds some lessons for wider reforms in the NHS. An emphasis on what is unique and distinctive may risk less being learned from such prior experience than could be the case. There is an intuitive appeal to GMHSCP's ideas, but their implementation requires wide ranging and complex changes across the health and social care system. There is extensive evidence from elsewhere that suggests such changes are difficult to enact and that savings or improvements are often challenging to realise in practice.

The aligning and timing of change is crucial to ensuring synergy between and within each of the different 'transformation theme' work packages. Achieving such substantive changes is all the more challenging whilst ensuring that day-to-day running of services is maintained in a health and social care system under considerable pressure. Therefore, there will be substantial testing of system leadership and the strength of relationships between organisations in the months and years ahead.

NEXT STEPS

Our research to date has largely focused on relatively high level meetings and stakeholders. The next phase will seek to understand how and to what extent the decisions taken in the meetings we observed impact at the level of GM localities. We will do this by focusing on a small number of localities. We will also use mental health as a 'tracer' to help us understand change and continuity in locality settings.