Devolving Health and Social Care in Greater Manchester: Setting the Research Agenda
FINAL Summary
Tuesday 24th November 2015

1. Introduction

The aim of the roundtable meeting was to facilitate an open and constructive discussion regarding the plans and processes currently associated with Greater Manchester (GM) Health and Social Care (H&SC) devolution and to explore the contribution research could make to the devolution agenda, both locally within GM and more widely. While the aims of GM H&SC devolution are now widely agreed and accepted, there would now be much interest in the mechanisms and methods by which such aims can be achieved.

2. Health and social care devolution - key aims and pathways to impact

The meeting was timely given the impending outcome of the Comprehensive Spending Review (CSR) and forthcoming release of the strategic plan for the next three to five years. The latter will set out the 'reform agenda' concerning how GM can, and will, pursue both clinical and financial sustainability over the next five years.

The CSR submission makes the case for the non-recurrent financing of a 'transformation fund' to enable the pump-priming and double running of activities, as this will be required to support the generation and implementation of new ways of working. There is a clear sense that the government is very supportive of the 'Northern Powerhouse' and particularly of H&SC devolution, so prospects for the CSR settlement look very positive. The ultimate aim is to generate a 'sustainable system'.

There is long history of close and effective working across GM, including AGMA where councils, of various political colours, have worked in collaboration for over 10 years, particularly in relation to the delivery of infrastructure developments. The NHS also has a history of collaboration, as demonstrated through programmes such as Healthier Together and other programmes where CCGs have come together to make 'difficult decisions' for the future. It is unknown whether such collaboration is common elsewhere in the country.

The aims of H&SC devolution are very clearly stated in the Memorandum of Understanding (MOU) – to generate the greatest and fastest improvement in health and wellbeing for the people of GM, and to reduce health inequalities both within GM and between GM and the rest of the country. A sustainable future will focus on 'people and place' rather than being driven by individual organisational priorities. This, it is emphasised, is not rhetoric, but underpinned by an array of other aligned principles. Local knowledge and ability is said to produce more effective decisions than those that would be made centrally. Ultimately, decisions about GM will be made with GM and those involved will be expected to put the 'needs of the collective' ahead of the needs of individual organisations.

In discussion, it was felt that the strategic plan should start from a position of 'we have a thriving economy that needs effective services to support both this economy and the population'. For instance, in mental health, attention has traditionally been focused around the structure of specialist services. However, it is now acknowledged that the primary challenges are actually

ensuring that safe, effective and sustainable mental health services are in place to support people with mild to moderate mental health problems to gain or maintain employment. It's important that GM is still capable of delivering the specialist services, but there is a need to concurrently deliver services that support economic activity.

The content of the strategic plan moves away from the 'usual stuff'. For instance, a key focus has been on identifying what drives demand within the system and what can contribute to changing the character of this demand. 'Health potential' of the population is significant. The plan is built on an understanding that incremental local adjustments do not change the nature of demand, particularly as they are not undertaken at a scale required to generate the change required. Those present are currently trying to identify what is already known about current interventions and prevention (population health) and what the most impactful public health programmes are that could be implemented at scale. This is linked to a need to understand what the payback is in relation to such interventions and, crucially, when such a payback can be expected.

A number of areas of focus were set out:

- The need to 'get serious' about a population approach to early intervention and prevention, using data and an impactful range of Public Health (PH) programmes. Need to look for 'moments of payback'.
- CCGs have all been trying to pursue 'integrated care' in their localities, but it isn't necessarily clear what this means. Devo Manc therefore intends to create single place-based commissioners and single place-based providers, with a focus on demand reduction. They envisage those providers bringing together all of primary, acute, community provision, alongside close relationships with housing, employment, fire, the police etc. i.e. connecting to wider public service reform.
- Horizontal integration of hospitals across GM, based on existing Healthier Together programme, and going further, encouraging the formation of hospital groups which can, for example, share back office functions.
- To enable all of the above, new contractual forms are likely to be required to ensure that payment and reimbursement across the system connects people and organisations, together with metrics and information, across objectives.

To do so would require the need for 'unified provision' and 'unified commissioning'.

At the centre of the strategic plans is a strong commitment to health outcomes (driving improvement) with the aim to re-orientate the system towards prevention in its broadest sense (e.g. work, health, a productive economy) from which other benefits will 'flow'. A programme of work is being built which focuses upon early years and changing the people-service relationship so that people feel like supported and empowered 'users' within communities.

While relationships and permissions with HM Treasury were important, relationships at a local level would be crucial for a single approach and conversation. This will not necessarily translate into a single way of doing things across GM, but will ensure coherence across the board, with a 'local coalition' working together.

There are three elements of the GM H&SC devolution programme that are a source of potential: (a) the governance and leadership that exists across GM, in terms of individuals, organisational forms and new infrastructure, (b) the development of a coherent reform programme and (c) the

presence of a transformation fund, which will be an indication of national support and will provide GM with the ability to boost confidence and put the strategic plan into practice.

In terms of national oversight and regulation, it was confirmed that Monitor/TDA, CQC, Public Health England and Health Education England are non-voting members of the GM H&SC Strategic Partnership Board and there is widespread support for the concept of 'no decisions about GM without GM'. It is unlikely there will be changes in primary legislation or existing national accountabilities particularly within the short to medium term, but was indicated that the regulators have actually started to see their role within GM devolution as supporting and enabling GM to understand national regulation, particularly that around competition, where it was felt that there has been a 'sea change' on views towards competition in relation to integrated organisational forms.

Some practical measures are being put in place to signal that all organisations will be bound together in some way at a GM level. Foundation Trusts, engaging with Monitor, are doing some work around formation of a provider federation. Work is taking place looking at the licenses of Foundation Trusts and whether it's possible to promote such ways of working further by writing it in to the individual organisations' licenses that there is an expectation that they will be part of the GM-wide governance systems.

The GM devolution team were currently focusing on working and generating policy within the existing legal and financial framework (e.g. with regards to tariffs), but are working on the basis that in the longer term, there is potential for changes in these arrangements. Therefore, the team continue to work closely with Monitor in relation to tariff systems, but the priority is identifying different ways of driving or supporting changes. Commissioners are working flexibly within the requirements, and it is considered important that providers are also involved in any discussions regarding changes to tariffs to contribute to the system view.

Those present are currently reading and learning from existing evidence and best practice concerning payment systems, both nationally and internationally, and the team are of the view that movement towards a capitation-based system is desirable. However, how this will occur, and within what timeframes, is currently unknown.

In the social care area, it was acknowledged that provider sustainability and viability was part of the 'bundle of problems', something that all social care organisations need to understand. Current arrangements have tended to drive risk in social care markets. One advantage GM has over other places in the country is that 98% of the population receive the vast majority of their health and social care services within GM, with the number of specialist services which patients are required to travel for being limited. They are keen to make the best use of existing opportunities within current legislative framework, looking at both speed and innovation.

There is a real opportunity for the research agenda to be closely aligned with H&SC devolution, to learn from researchers' observations, both within GM and beyond, with interactive and real-time feedback.

3. Researching health and social care devolution: key themes and concepts

The GM H&SC devolution research study funded by The Health Foundation and NIHR CLAHRC GM team is keen to ensure that the research is of practical value and is able to make a real contribution to the devolution process by way of a formative and constructive dialogue. The team have a wealth of experience in relation to the conduct of mixed-methods research which

combines both qualitative (what are the mechanisms?) and quantitative (what are the outcomes?) data collection and analysis. The unique nature of GM H&SC devolution presents an exciting opportunity, not only to generate empirical results but also to develop new methods. This must be attentive to: the timing of costs and benefits, something that is often overlooked in traditional evaluations; the importance of effective incentive and reimbursement strategies aligned to strategic initiatives and programmes; a focus on demand and trying to save costs (developing our understanding of how responsive costs are to demand).

Researchers noted that the devolution programme was not only looking to reshape demand, but was also looking to reform supply, as experience shows that it's not possible to solve problems by focusing on just one side of the equation, as available capacity will always find new demand. The difference here, within the devolution programme, is that this is taking place at scale.

Whether integrated care saves money was discussed and it was argued that past evaluations have often related to the same interventions being implemented at the same time point but by different agencies – not really testing real integration and service redesign. However, if you shift alertness of vulnerability and risk, and you do at scale, what does this do to the cost in the system? It was suggested that nobody else is thinking like this. There is awareness that this is not an instinctive response and way of working for frontline healthcare practitioners, and that it would require them to 'do things differently' in the community, and support a different type of conversation between themselves and service users. Such a change to a self-management approach will require a shift in thinking with regards to what it is to be a caregiver within a provider market. Some providers were already looking at new service models and self-management approaches and the devolution team were interested in looking at how these, and other approaches to patient activation, could be scaled up.

There was evidence to suggest that between one third and one half of social care costs can be taken out of the system through the implementation and use of community responses. As well as organisational reforms, the GM devolution team must be alert to these more subtle workforce reforms and think differently about the solutions to crisis and responsiveness. Any savings generated through integrated care will need to be balanced against finding unmet, yet appropriate, demand (e.g. the missing 1000s). It is not yet known how such scenarios play out, in financial terms, over the course of several years.

An intention to develop single, placed-based integrated organisations was confirmed but that there was a need to be pragmatic with regards to how contracts would be connected. It would be necessary to identify how, within this, you maintain a breadth of provider types.

It was asked whether the devolution team would be looking to develop and implement new data sets as part of the reform agenda, or whether they would be principally be relying on using existing data sets to monitor changes and it was confirmed that there was a need to build something that uses existing data in a clear way, right down to the patient level, as tracking patient and service changes is not possible within the existing system. However, at present the focus is on identifying how existing datasets can be pulled together in an intelligent way. A 'data gap' was likely to be within the realm of community services.

Arrangements for researchers to access data sets within information governance and confidentiality provisions were discussed. Researchers had been seconded into organisations, such as Public Health England, in the past for this reason. Yet, while local data is very helpful and informative, it's sometimes necessary to work with high level national datasets in order to permit use of a comparator. This will be particularly the case here where the focus is on

identifying what H&SC devolution can offer to the system over and above 'usual' healthcare change initiatives and programmes.

High-level outcomes certainly needed to be examined: health outcomes, experience of services and financial sustainability. An outcomes framework is being developed with partners to see if 'the dial is being changed in the right direction'. The next stage is to identify what outcomes we wish to look and contract for. Within devolution the power is using the idea of population health and a risk stratification approach to help to understand population health outcomes. It would be easier for the research team to identify where actual and quantifiable impact may be more likely, and within what time period, once the strategic plan was available.

4. The national context: wider learning and developments

Five contextual factors that were unlikely to change were outlined, particularly in the short term: (a) the amount of money available within the H&SC system, (b) performance challenges, (c) the political sensitivity of the NHS, (d) devolution will remain asymmetrical (no examples of this can be identified internationally), (e) transformation will rely more on 'how' things are done (i.e. mechanisms), than on 'what' is done.

The primary implication of this is that 'change has to happen', but that countervailing pressures were strong. Some things will never be within the gift of GM, but the thing that may differentiate GM from the rest of the country may fundamentally be the strength of the local leadership, the organisational development plan, and the willingness and ability of the region to learn. It was hoped that the research agenda could help identify learning for other areas. Discussions with other areas reveal that, within these, there is perhaps a lack of local ownership of problems and an absence of collective leadership and planning. It was queried whether GM has an exceptional set of circumstances that had led to the opening of a policy window, with GM now establishing a powerful narrative around the need for change. It was further highlighted that the fact that GM 'is different' may, in fact, turn out to mean that the devolution programme pursued is not simply replicable elsewhere.

There was a strong sense that it was important that the leadership of NHS organisations and LAs were comfortable with the uncertainty that came with some of the devolution programme, although there will also be a more known element which concerns achieving conformance, standardisation and sustainability of known effective interventions and systems. It is anticipated that, even internationally, c.40% of all of the solutions that will be explored over the next three to five years are things that have not been tried and tested, but this is, in itself, exciting. Some of the answers would only emerge over time.

A key feature is that the locality plans are being used as the foundation of the strategic plan. The common threads of these are being drawn together across GM, but the GM devolution team are also providing feedback to localities to indicate where plans are not sufficiently ambitious. In relation to the strategic plan, and its operationalisation, there will undoubtedly be some areas of contention and disagreement, as the changes require both an intellectual and principled leap, but the fact that open and honest conversations are taking place and are being shared, already makes this process 'different'. Local leaders will need to set aside the needs of their own organisations, and focus on the wider needs of GM. The strategic plan only represents a formalisation of these conversations that are happening within the system.

5. Next steps

The research team will need to be supported in accessing meetings, stakeholders and key informants and work in 'the field' will commence. Over the next few months plans for the research will develop in more detail particularly on areas for both quantitative and qualitative fieldwork. We need to develop plans to continue the round table dialogue and establish ways in which 'safe conversations' can be had within GM to both feed into the research and to promote early feedback from the research- "air pocket" opportunities. Means of sharing applicable learning nationally also need to be established e.g. more such round table events with perhaps a wider audience.