Healthy London Partnership

The impact of health and care devolution: what can we learn from GM?

London Health and Care Strategic Partnership Board

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What is GM aiming to achieve for its citizens through devolution?

*"**The benefit to the 2.8m people here is that it will remove false boundaries between hospital care and neighbourhood care and support, to ensure residents receive better joined up care. It will also prioritise early help and support to ensure people are able to take more control over their health and prevent existing illnesses from getting worse. And it will mean we look at the big things which affect all our lives – housing, education, work and health – all at the same time**."*

More specific aims and commitments are contained within different strategies. Early plans particularly focussed on improvements which would be realised through better integration, and a core set of population health outcomes:

Devolution and place-based integration will improve the experience of health and care

*"**People will tell their story once**, including the role of any informal family carers, and a 'key worker' will be responsible for coordinating the support needed."*

*"Medical, social and emotional needs will be identified in one process, leading to **more timely and appropriate support** from the people or services that are best placed to help."*

*"Hospital discharge will be better coordinated from hospital to home, supporting **more effective and rounded recovery**, including emotional wellbeing and adapting to being back in the home environment."*

*"If people are supported to live well in their community, connected to family, friends and activities in an environment in which they feel safe and included, they are **more likely to sustain a good quality of life and less likely to see a deterioration in their health and independence**."*

"Person and community-centred approaches focus on what is important to people, what skills and attributes they have, the role of their family, friends and communities and, given all this, what they need to enable them to live as well as possible. This includes enabling people to:

- ***look after themselves better**, including understanding their condition, managing their symptoms and improving their diet, and education tailored to particular conditions*
- ***have meaningful relationships** that help them improve their health and wellbeing through, for example, peer support networks and community groups*
- ***work collaboratively with professionals**, such as collaborative consultations and health coaching."*

Devolution will also enable achievement of certain population health outcomes

Outcome	Measure
START WELL	
More GM Children will reach a good level of development cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3250 more children, with a good level of development by 2021.
Fewer GM babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in GM to projected England rates will result in 270 fewer very small babies (under 2500g) by 2021.
LIVE WELL	
More GM families will be economically active and family incomes will increase.	Raising the number of parents in good work to projected England average will result in 16,000 fewer GM children living in poverty by 2021.
Fewer people will die early from Cardio-vascular disease (CVD).	Improving premature mortality from CVD to projected England average will result in 600 fewer deaths by 2021.
Fewer people will die early from Cancer.	Improving premature mortality from Cancer to projected England average will result in 1300 fewer deaths by 2021.
Fewer people will die early from Respiratory Disease.	Improving premature mortality from Respiratory Disease to projected England average will result in 580 fewer deaths by 2021.
AGE WELL	
More people will be supported to stay well and live at home for as long as possible,	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

GM have explained how they are achieving stated aims

A number of short films have been produced, answering key questions:

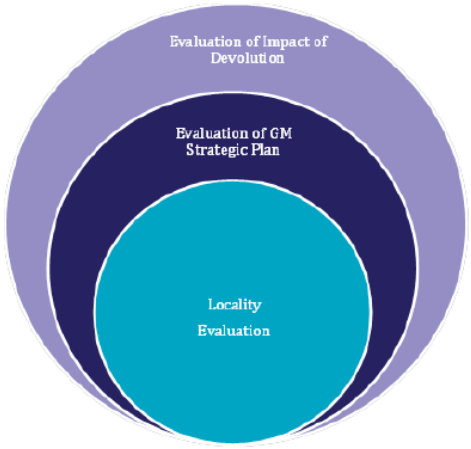
Question	Answer
How is devolution bringing together health services?	• The CCG and the council have come together - one budget, one governance structure, one management team and one strategy. • Transitioned from a District General Hospital to a Local Care Organisation - this includes the transfer of social and community services so everything is under one organisation.
How is devolution changing the way health and social care services work together?	Devolution has helped us get in the same room and communicate better – public health, alongside GPs alongside nursing. All those providing care can plan together, we can support each other, see where we duplicate etc.
How is devolution helping GP services?	• greater integration of social care teams with community nursing and general practice. • ensuring that care is given by same people, not by a stranger. • starting to navigate people through a complex system in a more manageable way. • improving access, giving people the best chance to see a medical professional when they need to. • standardising care – our residents will get the same high standard of care wherever they live.
How will devolution change the relationship between patient and GP?	We would like to see a restoration of traditional relationship between GP and patient. Too many GPs are overwhelmed. They have no time to think and plan care. We can change the model by giving them more support (e.g. community pharmacists, district nurses and social care). We hope this will give GPs more time with people who need it the most.
How will devolution improve people's life chances?	We have quarter of a million people out of work; 70% of whom have a mental health condition. There is no relationship nationally between DWP and the DH. Locally, however we've got co-commissioned services between health and care – that makes the difference.
How will devolution tackle health inequalities?	Social factors contribute to good or bad health. Improving these factors (e.g. getting people into employment) is part of our health strategy - our shared goal.
What will devolution mean for patients, carers, and those who work in the NHS?	Arrangements aren't being made by anonymous civil servants in Whitehall, it's citizens of GM working with local people and health systems. We want to enthuse our workforce, and we want them to see their role as supporting their local communities.

Devolution of certain functions and budgets will better enable GM to achieve its aims

Case study: Specialised commissioning

- GM have gradually taken on more responsibilities for specialised commissioning, mostly recently specialised mental health services.
- GM report that this will aid them in achieving integration of care for the whole patient pathway and also enable pursuit of creative service design solutions.
- For example, GM are building on the work of their cancer vanguard and considering a re-design of the whole pathway for citizens with, or recovering from, cancer. GM's new responsibilities enable them to incorporate all specialist cancer services into the re-design process. This means that even those receiving very specialist cancer treatment can experience a system that is joined up from the first point of contact.

GM partners have designed a tripartite approach to evaluation



Locality evaluation	• A consistent approach to the evaluation of each locality will lead to a comprehensive evaluation that allows the same key features of each transformational change to be analysed. • Particular attention will be paid to the new form and function of the system as well as new integrated commissioning and provider arrangements, including contracting on an outcomes basis. The impact on the workforce and population outcomes will also be key areas for attention. Where possible, the locality health and care data will be overlaid with other key socio-economic data – including on employment, education, housing and others. • The evaluation will also focus on understanding the importance of relationships between partners, shared values, and leadership style – in particular whether they help or hinder progress.
Evaluation of the GM Strategic Plan	• The second strand of the approach will focus on whether the system works at a GM level, whether the population as a whole have better outcomes and are satisfied with the new architecture and ways of working and whether the leadership of the whole system has enabled the ambitions and vision to be realised. • This will include what is distinctive about Taking Charge – in particular the focus on population health and the wider determinants of health – including the link to wider public services and broader socio-economic and environmental factors.
Evaluation of GM devolution	This is work is being undertaken by the University of Manchester and was funded by the Health Foundation and the National Institute for Health Research. Whilst this work has a specific focus on devolution as a national policy and its impact on health and social care in GM, it must be aligned to the rest of the work. The first year of this part of the evaluation focused on the formation of the partnership, describing and analysing governance, accountability, and organisational forms. The second year will consider the impact of devolution at a locality level and whether devolution has helped or hindered progress in the localities.

The evaluation of GM devolution has outlined the intended benefits and provided some information on progress

GM have commissioned an external review to evaluate the impacts of devolution*.

The first interim report (March 2016) set out the following intended benefits of devolution:

Subsidiarity and local governance
"At its simplest, this is the idea that decisions about Greater Manchester should be taken in and with Greater Manchester, rather than at a national level. But in fact it also means greater coordination and collaboration in decision making... ***The new governance arrangements are designed to promote consensus based decision making on difficult issues*** *such as resource allocation or service reconfiguration, making it more difficult for any organisation to defect…"*

Integration around place and people
"The current system is seen as highly fragmented and vertically siloed, with complex governance arrangements and limited capacity to set strategic direction and act collectively at both local and national level. No-one seems to be in charge, and services and organisations follow their own agendas. As a result, transitions of care and care pathways across organisations do not work well. People find themselves interacting with a bewildering array of different and disconnected services, and there is little sense of geographical identity and service coherence or direction. ***Devolution, it is argued, will bring integration in governance, planning, and delivery of services. Integration seems to imply a strong focus on designing and implementing local care organisations to bring health and social care together, with common care pathways and ways of working*** *across Greater Manchester using shared systems, resources, and back office functions…"*

Efficiency and effectiveness
"Fragmentation produces waste, inefficiency, and poor effectiveness, and it is thought that devolution can produce savings by eliminating duplication and unnecessary service provision. Equally, it is suggested that current services are demand-led and demand-inducing, leading to spiralling levels of activity and cost, particularly in unplanned or urgent care; better service planning will lead to earlier intervention, better prevention, and more ordered care processes, especially for chronic disease and multimorbidity. ***The advocates of devolution emphasise that this is about much more than health and social care, and that changing those services means addressing worklessness, skills and training, schools, young people's services, crime and offending behaviours, and more.*** *They have a wider and more ambitious definition of health and wellbeing and argue that people have to take greater responsibility for their health. They estimate that without change, the continuing pressures of demand and existing barriers to efficiency and effectiveness will create a £2bn a year funding gap for Greater Manchester's health and social care by 2020."*

The second report (Winter 2016) give some commentary on progress of devolved arrangements:

"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."*

*As noted on the previous slide, the work is being undertaken by the University of Manchester and was funded by the Health Foundation and the National Institute for Health Research.

The GM arrangements have started demonstrating results across many different programmes of work

1. Providing person-centred care and managing winter pressures
2. System performance and finances
3. Delivering improvements in key services
4. Workforce
5. Attracting innovation and new partnerships

1 Providing person-centred care and managing winter pressures

GM have more joined up working between health and social care that anywhere else in the country.
Each area in GM now has a team working across health and social care to make sure that discharge arrangements from hospital work effectively. This has resulted in a reduction to the number of delayed discharges across GM.

New ways of working are being tested by the difficult winter period and GM have reported that partnership working has enabled them to better manage these pressures. The GM UEC Operational Hub collects, analyses and reports key performance and flow information, to support decision making as part of the escalation processes. It also acts as a single point of contact for regional and national winter reporting – reducing the burden on local systems.

Whilst performance against the 4-hour waiting time standard did fall, GM have reported that partnership working meant that:

- The numbers of delayed discharges remained low. The delayed transfer rate has been falling and is predicted to continue to fall during the winter months (December figures pending at the time of writing).

- No hospitals reached major incident status due to the increased pressure.

All localities have produced robust locality plans, which gave them access to a share of the transformation funding to support delivery. GM have cited many examples of innovation coming from the localities, for example:

- Employing community navigators to help people find the right support in the voluntary sector, reducing pressure on GPs;

- Using technology to improve the way that care homes work with GPs and hospitals to avoid unnecessary admissions and GP call outs;

- Much closer working with sectors such as housing, employment, leisure and the police to make sure that local public services are working together to address those factors that can lead to poor health.

The focus for 2017/18 and onwards is delivery at locality level to ensure that locality plans and investment translate to new models of care that reflect the needs of citizens. The senior management team of the partnership committed to spending a significantly larger proportion of time visiting localities to gain an understanding of projects and monitor how these are translating into different models of care.

2 System performance and finances

GM's performance against national targets has fluctuated but, at the time of the 2016/17 annual report almost all national targets were being met. The partnership reported that:

"Devolution has given us the opportunity to support improvement through a culture where peers and partners proactively challenge and support delivery at all levels of the Greater Manchester system."

Greater Manchester delivered a strong financial performance in 2016/17 despite significant financial challenges for the NHS and local government locally and nationally. At the end of the 2016/17 financial year, it was reported that:

- Overall GM health and social care budgets delivered a surplus of £237m which is £157m better than planned. This has been achieved through a strong financial performance in all sectors with CCGs (£46m better than plan), NHS Providers (£107m) and GMHSCP central budgets (£4m) performing better than their plans for the financial year and local authority budgets within the scope of GMHSCP funding delivering a break-even position.

- NHS providers delivered a significant overperformance against the control totals agreed with NHS Improvement. This strong performance attracted additional national funding into Greater Manchester from the Sustainability and Transformation Fund.

A significant caveat is that much of the surplus was generated through one off measures and additional national funding, however GM reported that:

"The strength of the financial performance in 2016/17 is testament to the benefits of a collaborative approach to managing financial risk across the partnership."

3 Delivering improvements in key services

GP Services

- The biggest areas of investment in GM has been primary care.
- Greater Manchester GP practices are currently performing better than the national average on measures of patient satisfaction.
- In November 2017, 96% of GP practices in Greater Manchester were rated as outstanding or good by the Care Quality Commission – this is higher than the average for England. The London figure is 90.9%.

Cancer

Greater Manchester's cancer networks have performed better as a system than others in England over the last few years. In particular, GM have consistently met the national target of 62 days' wait from referral to treatment.

Mental Health

The emphasis has been placed on bringing together communities, public services and individuals to improve the mental wellbeing and life chances of the people of GM. The following key benefits of the co-produced strategy for the population are:

- By 2021 at least 3.9k children and young people will have access to evidence based mental health services;
- New mums that experience mental health problems will receive better care:
- Everyone in mental health crisis will receive immediate access and support;
- People will not have to travel out of GM for mental health services that they should receive here;
- People with serious mental illness currently die approximately 15-20 years younger
- than the rest of the population, therefore there will be better physical healthcare to meet their needs;
- Extra support will be offered to the long-term unemployed and those with mental health issues at risk of losing employment;
- Through the suicide prevention strategy, the number of suicides will reduce by at least 10% by 2021;
- GM will be the best place in UK for those experiencing Dementia and their carers.

Since devolution GM have seen improvements in access, waiting times, and recovery for people seeking talking therapies, such as counselling.

Dementia

- GM consistently achieves higher rates of dementia diagnosis than the national average: our rates are at 77%; whilst the national average is 68%.
- By 2020/2021, significantly more people will get a named coordinator of care, a care plan and at least one annual review of that care plan; and older people will receive diagnosis and referral within six weeks.

4 Workforce

HEE were not part of the original MoU but a subsequent MoU was signed with HEE.

GM has developed a system wide approach to nursing recruitment with some encouraging first results. This has seen an 11% increase in intake of student nurses against a national reduction of 6%.

The Partnership is expecting to build on this collaborative model and extend to benefit Social Care, General Practice and mental health where there are significant staff shortages.

5 Attracting innovation, additional resource and new partnerships

- GM have expanded their partnerships, enabling them to take forward more innovative workstreams and draw on national resources and expertise. These include partnerships (formalised through MoUs) with Sport England and the Royal College of General Practitioners (RCGP). Importantly, these are partnerships between national organisations and the GM partnership. The partnership with the RCGP is novel and brings a wealth of experience to the GM system. The MoU will support the development of this sector within GM, providing educational tools, identification of future leaders and innovation.
- The GM partnership has collectively formed a Transformation Unit (their equivalent of HLP) which brings in external revenue though supporting transformation outside of the footprint. In a time of financial pressure, this enables an additional revenue stream to fund work within GM. See **Annex** for more detail.
- GM have used their devolution agreement to ensure wider benefits for the region by collectively promoting GM as an attractive place for future innovative developments. This is done through Health Innovation Manchester.

The SPB provides strategic leadership and ensures that organisations act as a partnership

The minutes of SPB meetings contain examples of how partners are supporting and championing each other.

SPB as an advocate

The partnership advocates for GM and its citizens but partners within the system also advocate for each other at the most senior levels.

Case study: All areas were due to get capital funding for A&E streaming. Tameside and Glossop did not have a signed-off control total and, as a result, NHSI would not release funding. Capital was required in order to deliver improvements. Tameside requested support to resolve the release of funding. The GM partnership contacted the Prime Minister's Health Advisor and the Chair of the SPB formally appealed to the Department of Health, NHSI, NHSE and Treasury, expressing concerns regarding limiting the ability as a devolved system to make decisions and allocate resources. The outcome is pending but this shows how GM are leveraging their influence to support each other.

SPB as the voice of GM

- The SPB responds to consultations/national strategies or programmes and engages with citizens of GM as a partnership.
- Achievements are increasingly seen to be achievements of the partnership.

SPB as a place to ensure the spread of learning and lessen the load

There are examples of GM partners using approaches from one locality to inform their own plans or applying something that has worked well in one area across the footprint. There are also examples which suggest that the localities divide up the responsibilities for pan-GM work to conserve resources and avoid duplication. For example, it was agreed that all the localities would share an evaluation template and one locality took ownership for designing it.

SPB as the place to align approaches

The Health Foundation/University of Manchester report found that:

"The [governance] arrangements…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'."

Key learning opportunities

Draft

The GM work highlights a number of learning opportunities that London partners may want to consider further:	Proposed approach for London
Significant focus on locality and borough-based integration	Ensure a multi-level approach to integration, building up from borough-based plans
The opportunity for the five sub-regional footprints to become more involved in the pan-London work and explore opportunities for different areas to take ownership for certain workstreams (the 'divide and conquer' opportunity)	Exploring appetite by STPs and wider SPB members to lead on particular opportunities e.g. primary care and regulation
Exploring wider strategic partnerships to bring more expertise and resource into the London system	Supporting the system to navigate and leverage the wider improvement and transformation landscape (e.g. CSU, AHSNs); bringing alignment and coherence where possible to make best use of our collective resources
Ensuring a robust and flexible resource to support transformation that has diverse and sustainable revenue model (the GM Transformation Unit)	Supporting the shift of HLP to a 'fit for the future' model and considering more innovative streams of funding
The GM work shows the importance of grounding transformation efforts in a vision for the population	Explore revisiting the approach to the 10 aspirations and building on our vision and messaging
The opportunity to maximise, influence and reach through celebrating achievements collectively as a city and jointly owning transformation activities; advocating for each other where necessary	Using the influence of the SPB and LHB to advocate for London's health and care priorities, including those which predominantly affect single sectors or partner groups
Learning from the GM 'managed consensus' model for decision-making	Incorporated in the SPB and LEB Operating Frameworks
Exploring our approach to evaluation – we can consider various metrics across the city (e.g. delayed transfers of care, patient satisfaction) but it is also important to consider how we measure our progress as a partnership and the success and effectiveness of our new ways of working	Work currently underway in partnership with AHSNs, Health Foundation and Behavioural Insights Team to explore potential approaches to process and outcome evaluation associated with devolution and wider transformation. [DN: To update ahead of the meeting]

Annex

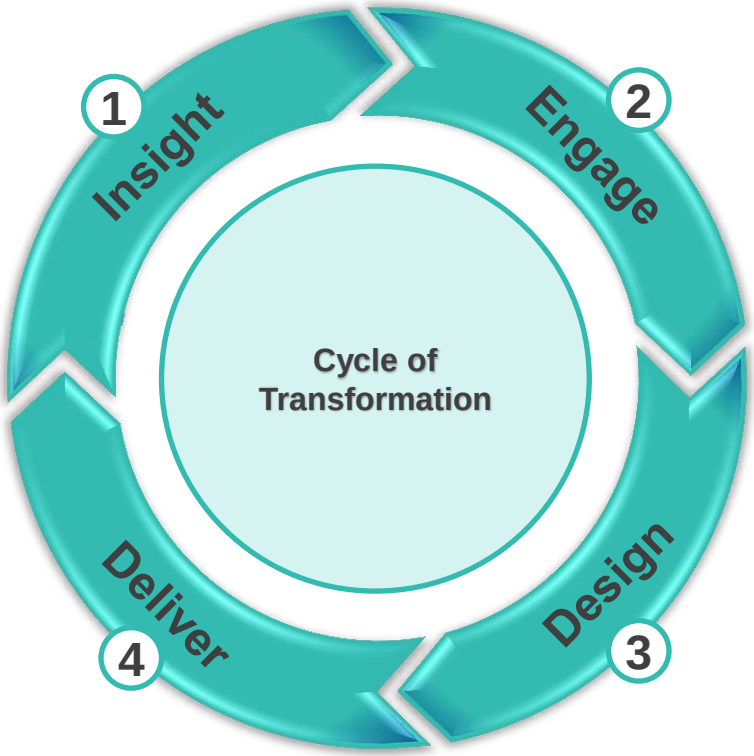
Approaching transformation in Greater Manchester

The GM Transformation Unit provides a model that we might be able to adapt to meet London's requirements

- The Transformation Unit (TU) provide support to organisations at each stage of the transformation cycle and have primarily been working in GM
- The TU are a hosted, NHS-owned, not-for-profit consultancy that are able to provide independent support for strategic transformation
- TU's ambition is to become the leading NHS consultancy supporting transformational change by 2020
- The TU's transformation cycle is described below:

1

At this stage the TU look to bring together thought leaders and key stakeholders to discuss issues generate a common view that addresses the problem and aligns to the current or future population need. The TU partners with academics, national leaders and different sectors to challenge convention and develop a robust case for change.



2

At this stage the TU help to develop positive relationships with stakeholders and partners to ensure a range of perspectives are captured when considering change. This cohort might include patients, carers, the public and other key partners. This phase might also include any required public consultation process.

3

At this stage the TU design the proposition incorporating a review of the latest evidence and clinical standards and consider how this may inform a new model of care. The TU assist with the development of the business case that may outline a range of options and a robust decision making process.

4

At this stage the focus is on the execution of the change and the management of those that are affected by the change. The TU put in place an implementation framework that guides the introduction of the change and ensures sustainability and transfer of ownership.

The Transformation Unit's approach is underpinned by four business units that provide a wide range of services

1 STRATEGIC TRANSFORMATION & PLANNING

- Clinical strategy and engagement
- Pathway / service redesign
- Leadership development
- Independent safety review
- Change management

2 PROGRAMME & PROJECT MANAGEMENT

- Programme management, assurance & support
- Stakeholder engagement and management
- Options appraisals
- Governance and programme design
- Project implementation

3 ORGANISATIONAL STRATEGY & ENGAGEMENT

- Organisational strategy and governance
- Community engagement & integrated impact assessment
- Public consultation
- Marketing and communications strategy
- Research & thought leadership

4 FINANCE & ANALYTICS

- Financial modelling
- Review of LTFMs
- RoI analysis
- Activity and scenario modelling
- Business cases (green book)

Support permeates each component of the Cycle of Transformation