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Devolving health and social care: Learning from Greater Manchester

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Town Hall, Manchester
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Executive summary

In February 2015, Greater Manchester secured an agreement with the government to take what was described as “devolved control” of the £6 billion pa budget for health and social care for the 2.8 million people of the city-region. The aim was to improve health outcomes and reduce health inequalities both within Greater Manchester and between Greater Manchester and other areas of England, and to address a growing gap between need and demand for health and social care and available resources to provide them. A new Greater Manchester Health and Social Care Partnership was established, bringing together NHS organisations, local authorities and other stakeholders in health and social care in the city-region. These changes have taken place in the context of a wider devolution deal for Greater Manchester, and a growing interest nationally in devolution and regional governance in England.

There has been a great deal of interest in health and social care devolution in Greater Manchester, and what others could learn from this experiment. This report presents findings from research commissioned and funded by The Health Foundation and the NIHR CLAHRC for Greater Manchester, which set out to understand how health and social care devolution policy developed, what changes it brought to governance, accountability and organisational arrangements, and how changes to health and care services for people were planned and implemented. The research involved both qualitative and quantitative methods and our approach is detailed in Appendix A. This report largely presents findings from our qualitative research, and the main results of our quantitative analysis will be reported in 2019. The research team was granted access to observe meetings, interview key participants, and collate and analyse documents from December 2015 until October 2017. We are very grateful to all those involved in devolution who took part in our research.

Our key findings are:

- There has been much rhetoric about the benefits and possibilities of health and social care devolution, particularly at the outset when the devolution deal was first struck between national and local politicians and system leaders. There is a strong political and emotional appeal for many people in the idea that decisions about health and social care in Greater Manchester should be made in the city-region, rather than in London.
- We describe the health and social care reforms in Greater Manchester as “soft devolution” because unlike most devolution reforms, they have no statutory basis. They are, essentially, an agreement for administrative delegation between the Department of Health and Social Care, national bodies like NHS England and NHS Improvement, and NHS organisations and local authorities and others in Greater Manchester.
- Most of the policy agenda that is being pursued in Greater Manchester reflects closely the national priorities of the government and the Department of Health and Social Care, and the NHS mandate and priorities and planning guidance of NHS England. In that sense, devolution has not been an exercise in allowing local autonomy or control over policy, but over its implementation. However, some would argue that implementation has been distinctively different, in governance and philosophy, reflecting the particular history of collaboration in Greater Manchester.

- Other approaches to achieving these same policy objectives have evolved in the rest of England, including the Vanguard programme, Sustainability and Transformation Plans/Partnerships and latterly Integrated Care Systems. Arguably, the GM Partnership has prototyped or pioneered some changes now being picked up more widely in England, but it is hard to be sure what is the distinctive or additional contribution of devolution.

- There is near complete consensus among stakeholders in Greater Manchester and, we think, more broadly, that the move towards more local or regional, place-based governance in health and social care in England makes sense. There is also near universal support for the idea that greater integration of healthcare services and of health and social care is needed. However, evidence from elsewhere suggests we should be cautious about claims that such reforms will bring about transformations in population health, service performance or uptake, or efficiency and costs.

- The GM Partnership has assumed some of the behaviours of a statutory body and some have observed that its leadership acts at times like the strategic health authorities which existed before they were abolished in 2012. However, the reality is that this form of soft devolution has its limits, and the GM Partnership has few formal levers to use over NHS organisations, and even fewer in relation to local authorities. Individual organisations continue, understandably, to guard their autonomy carefully and to act in ways that, overtly or covertly, serve organisational self-interest.

- The GM Partnership has invested heavily in building relationships among those health and care organisations which make up its membership, and developing shared governance arrangements and decision making processes which are intended to promote and sustain a collective narrative of managed consensus. However, it is difficult to tell how secure those arrangements are, and they have not yet really been severely stress tested.

- The GM Partnership has consciously sought to take a more transformational approach, embracing complexity and tackling reconfiguration across the system as a whole – in primary and community care, most areas of acute care, mental health and other services concurrently. This is an ambitious strategy – if it works, it will achieve large-scale change much more rapidly, but if it does not, it will have been a very time-consuming and expensive exercise. It is still too early to tell.

- Those transformation plans make some optimistic assumptions about the rates at which planned changes will lead to shifts in demand for health and social care, and in patterns of service usage, which will result in efficiencies and savings. The aspirations which lie behind many of those plans to provide services which are, for example, better coordinated, closer to people's homes, more targeted on need, and aimed at preventing health problems or managing them more proactively are admirable. But our quantitative analysis and research and experience elsewhere suggest that such changes may improve care, but will probably not save money.

- Since the launch of devolution, much effort has been expended in establishing relationships, setting up governance arrangements, and producing and agreeing strategies and plans, and the focus has only more recently shifted toward implementation and changes that service users and the public would notice. The GM Partnership has set out a wide range of changes it attributes to devolution. Many of those examples of course predate the devolution reforms, some represent recent transformation fund investments, and some are still in their very early stages. Those involved, especially at the outset, may have overpromised what devolution would achieve or the timescale in which changes would happen. We think this is well recognised by the GM Partnership's leadership which is now strongly focused on implementation.

Overall, health and social care devolution in Greater Manchester is in transition, and some of those involved would argue that it is still too early to assess the progress or impact of this initiative. It does not seem, at this point, as if other areas are likely to embark on health and social care devolution following the Greater Manchester model, though as we have noted some quite similar reforms particularly to the organisation of the NHS are being pursued elsewhere. At some point, not just for Greater Manchester, a new legislative settlement seems inevitable, to close the gap between statutory legal position and the facts on the ground, and to formalise these new forms of governance and accountability.

That new legislative settlement could pave the way to reform the decades long centralisation at a national level of healthcare policy and NHS provision in ways that create greater regional or local governance, but which might also lead to greater variations in service provision. It could also tackle the longstanding separation of funding arrangements and entitlements for healthcare and for social care in ways that promote integration and reduce barriers to access, though this would probably increase overall costs and require more funding.



Salford Quays
Photo credit: Dpaajones

Introduction 1

In February 2015, Greater Manchester secured an agreement with the government to take what was described as “devolved control” of the £6 billion pa budget for health and social care for the 2.8 million people of the city-region. This agreement was signed by the Association of Greater Manchester Authorities, NHS England and Greater Manchester clinical commissioning groups (CCGs) and included letters of support from Greater Manchester NHS trusts, foundation trusts and the NW Ambulance Service. This report presents findings from research which has sought to understand how health and social care devolution has worked. This introductory chapter sets out our research aims and explains the structure of the report.

1. Introduction

The Greater Manchester Health and Social Care Partnership has articulated from the outset a highly ambitious vision for health and social care in Greater Manchester, with a strong emphasis on differentiating devolution from past reforms and reform elsewhere in England. The underlying logic model of devolution appears to rely heavily on the idea that the effectiveness and efficiency of the health and social care system requires wholesale transformation as opposed to incremental change. It is predicated on the need for 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 agenda for the NHS and social care (Health and Social Care Select Committee 2018) though Greater Manchester has sought to move further and faster than elsewhere. There are similarities with the development of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) elsewhere in England, though Greater Manchester arguably has more devolved control, more formal governance arrangements, more local authority engagement, and a stronger central Partnership Team leading the reforms. In addition, the vision for Greater Manchester encompasses wider public service reform and economic growth agendas, linking with the broader devolution arrangements in the city-region.

Since October 2015, researchers at The University of Manchester have been following the development of health and social care devolution in Greater Manchester. We have worked closely with the Greater Manchester Health and Social Care Partnership and the NHS organisations and local authorities who are involved. The research has been funded by The Health Foundation and the NIHR CLAHRC for Greater Manchester.

Our research set out with three main questions in mind:

- Understanding **policy development and the policy process** – what were the objectives of devolution, how they were constructed and developed over time, and how key stakeholders contributed to or influenced policy
- Understanding the **governance and accountability arrangements and organisational forms** and structures put in place through devolution, how they interact with existing arrangements, and how they work in practice
- Following the **changes to services as they develop** – seeking to understand planned changes and their underlying logic model and then to map and measure their implementation and impact on service metrics and health outcomes

We also identified at an early stage (Walshe et al 2016) three cross-cutting objectives which seemed to us to underpin the logic of devolution – subsidiarity and changes to the level at which decision making and accountability would sit; greater integration of health and care services; and increased efficiency and effectiveness.

Our qualitative fieldwork started in December 2015 and concluded in September 2017. We negotiated access to observe meetings, both those held in public and in private, and to collate internal reports, papers and other documents. This report draws upon a range of data sources including 343 hours of meeting observations, 50 interviews with key informants, our notes from a wide range of events such as conferences and seminars about devolution, and two roundtable events we held. It also draws on our archive of papers and GM Partnership documentation. Our quantitative research has used existing data sets to undertake an ex-ante evaluation of some of the key assumptions underlying service changes in Greater Manchester, and this report presents those findings. Further quantitative analysis to track changes in healthcare usage and health outcomes metrics set out in the Greater Manchester plan Taking Charge will be reported in 2019. Our research methodology is outlined in detail in Appendix A.

We are hugely grateful to many people from the Greater Manchester Partnership who have contributed to both our qualitative and quantitative research, and to our funders for their support. It is important to note there are some limitations to the research – for example, our qualitative fieldwork was focused mainly across Greater Manchester rather than in individual localities, and though we followed the development of devolution for two years, we ceased fieldwork in October 2017. We have not studied the wider programme of devolution in Greater Manchester, or undertaken fieldwork to study some similar initiatives (such as Sustainability and Transformation Partnerships) elsewhere.

This report is authored by the research team as listed, but we would like to acknowledge the contributions of other academic colleagues at The University of Manchester including Yiu-Shing Lau, Matt Sutton, Kath Checkland and Ruth Boaden. We are thankful for many helpful comments on earlier drafts of this report from our funders, from colleagues from the GM Partnership, and from our external peer reviewers and our Advisory Group. Of course, responsibility for the analysis, interpretation and conclusions in the report and any errors rests with the research team.

This report presents our main findings, drawing on documents, interviews and meeting observations to illustrate those findings. We have chosen not to quote directly from interview transcripts and meeting observation notes, in part because it is difficult to do so and still maintain the anonymity of our participants, but we do seek to make it clear how our findings are grounded in our fieldwork.

First, chapter 2 outlines the background to devolution and the history and wider context for the current reforms in Greater Manchester. Then chapter 3 provides a detailed and largely chronological account of health and social care devolution in Greater Manchester, tracing its origins from past efforts at collaboration and joint working, outlining how the devolution agreement came about and the preparations for devolution, and setting out what has happened since the GM Partnership was established. Next, chapter 4 draws on qualitative research to describe the development of the collective arrangements for governance in the GM Partnership, and explores how what we term “soft devolution” has evolved over time, and how relationships between organisations have developed. Chapter 5 then draws on both our qualitative and quantitative research to examine how health and social care services and systems have changed, tracking and describing progress in three of the main transformation themes – improving population health, transforming community based care and support, and standardising acute care. Finally, chapter 6 brings together our conclusions, and discusses what can be learned from the experience to date of devolution in Greater Manchester.



Manchester Central

Merry Christmas

Merry Christmas

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Manchester Central
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Placing devolution in context

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In this chapter, we put Greater Manchester health and social care devolution in a wider conceptual, historical and political context. We first explore what is meant by devolution, before turning to situate devolution in the historical and geographic trajectories of the United Kingdom. We discuss how the current devolution agenda principally focused on city-regions in England may be distinguished from previous devolution to the nations of the United Kingdom in the late 1990s as well as other changes within England since. Then we examine how health and social care devolution fits into the wider context of reforms to the English NHS and its relationship with local government.

2. Placing devolution in context

2.1. The meaning of devolution

Put simply, devolution involves a downwards shifting of power and resources usually from national to sub-national levels. It may cover a range of political, economic and social domains and may also address issues associated with identities, policy divergence and the nation state (Mackinnon, 2015). As a process of state re-structuring, devolution can be seen as part of a set of wider trends which have reshaped the traditional idea of the nation-state including economic re-structuring, globalisation, and public services reform (Jessop, 2002; Rodriguez-Pose and Gill, 2003; Brenner, 2004). Devolution may involve the shifting of a combination of political, fiscal and administrative powers usually to an elected body or form of government at sub-national level though the term is also used to describe the transfer of powers to local but non-elected public bodies.

Some authors attempt to place devolution within a typology of decentralised governance. Here, more modest forms of de-centralisation move from de-concentration towards delegation and devolution of public sector functions (e.g. Rondinelli et al., 1983). But the distinction drawn between delegation and devolution is often difficult to make unambiguously. For example:

“Delegation refers to the transfer of government decision-making and administrative authority and/or responsibility for carefully spelled out tasks to institutions and organizations that are either under its indirect control or independent”.

(Cohen and Petterson, 1996: 11; our emphasis).

“Under devolution, the central government allows quasi-autonomous local units of government to exercise power and control over the transferred policy”.

(Schneider, 2003: 38; our emphasis).

We are cautious about simplistic accounts of devolution which evoke a zero-sum, single block transfer of power from one discrete level to another when in fact there are a complex set of processes to be negotiated. Devolution raises important questions about where best to locate democratic accountability, decision-making powers, financial controls, regulatory functions, political power and other responsibilities. Perhaps unsurprisingly, in a changing world shaped by various economic and political tensions and crises, and given that states are increasingly influenced by a wide-range of actors and organisations, where any agreement is found, this may not remain fixed for long. As one prominent actor in UK devolution once observed: “devolution is a process, not an event” (Davies 1999).

Research into devolution offers a rather mixed picture of its consequences or effects. It has both its advocates and opponents, shaped by disciplinary and theoretical debates as well as different political positions. Those in support often emphasise that devolution promotes an economic dividend with increases in financial self-sufficiency and economic competitiveness. Lower levels of decision-making are often argued to be most efficient and flexible, and better at managing with limited resources and offering enhanced local empowerment and democracy (e.g. Donahue, 1997; Keating, 1999; Oates, 1972). Along with the more recent claims that it may enable outcome-focused, place-based organisation of services, this all sounds quite familiar within the current English devolution agenda.

Others urge more caution, suggesting that there is often a lack of empirical evidence to substantiate the claims made for devolution (e.g. Rodriguez-Pose and Bwire, 2004). They suggest that a gap may exist between the rhetoric of devolution and the reality, and note that the devolution of resources and responsibilities may have profound implications for notions of equity and fairness (Rodriguez-Pose and Gill, 2003). Indeed, whilst many of the apparent benefits of devolution have ostensibly become ‘common sense’ within an English context, at the same time many commentators criticise the consequences of increased variation and divergence and the so-called ‘postcode lottery’ that may result (Bivins and Crane, 2017).

There is no neat academic consensus on the effects and consequences of devolution processes. After all, there is no reason to assume that shifting resources and responsibility downwards will in and of itself lead to the intended outcomes. It is important to be clear about what functions and services are under negotiation through such processes (Peckham et al., 2005). Crucially, what matters is to understand the interactions that cut across and between these different levels of government and decision-making. This requires us to look closely at the specific institutional arrangements and policy issues at hand.

Since devolution can clearly take many forms and the governance and re-making of sub-national territories is in turn influenced by their particular historical legacies and inherited institutional landscapes (Pike et al., 2016) it is helpful to situate our understanding of health and social care devolution in Greater Manchester in the wider context of the development of devolution within England.

2.2. Towards English devolution

The United Kingdom has a complex and contested history of devolution. The following account is inevitably partial and condensed, with particular emphasis on England to establish the context for Greater Manchester. This emphasis is in itself quite unusual given that until recently, England was seldom mentioned in devolution legislation (Bogdanor, 2001). However, the recent city-regional devolution deals have not come from nowhere, and there is a history of tensions between central and local government, stalled attempts at regional government and growing concern about economic spatial unevenness which is important to understanding the conditions under which recent devolution deals have been established. We first provide a national overview before turning to focus on how Greater Manchester features in this narrative.

Broadly speaking, and not without challenge, the UK can be understood to have long operated with a centralised political settlement. When the NHS was created as part of the post-war settlement in 1948, it was one aspect of a Keynesian national welfare state focused on equalisation and redistribution of wealth and infrastructure across the UK. Over the course of the second half of the 20th century, central government increasingly expanded its reach into local government, exercising increasing financial control over local government from the 1970s onwards (Cochrane, 1993). Whilst the extent to which this increased centralisation was successful may be debated, local government increasingly became a target for reform with the 'pre-eminence of the Treasury and the treatment of local expenditure as a matter for national decision' (Rhodes, 1986: 239).

At the same time, and particularly under successive Conservative governments from 1979 onwards, there was a shift from seeking to support and protect national and regional economic interests towards intentionally exposing industries and regional economies to both national and international competition and using markets to drive competitiveness even where this would accentuate regional or other inequalities. Local authorities were re-structured to become more 'entrepreneurial' and to embrace a range of public management reforms, including outsourcing, competitive tendering and increasing managerialism. These were, of course, simultaneously deeply political struggles, with Labour-led municipal councils, for example the Greater London Council and Greater Manchester Council, in direct opposition to the government of the time (Quilley, 2000), which led ultimately to the abolition of metropolitan county councils in 1986. In this context, ideas of English *devolution* rarely gained much attention.

It was devolution within the United Kingdom to Scotland, Wales and Northern Ireland in the 1990s that marked what Bogdanor (2001:1) termed the 'most radical constitutional change this country has seen since the Great Reform Act of 1832'. As Coleman et al. (2015: 377) observed: 'The UK is an example of a unitary state where the countries of Scotland, Wales, and Northern Ireland have some autonomous devolved powers delegated by the UK Parliament. This has developed as a way of enabling these countries to have forms of self-government whilst remaining within the UK'. Consequently, the devolution settlements included health and social care policy and provision and four different systems for health and care began to evolve from the common foundations of the NHS.

Within England, successive governments began to explore the idea of devolution, albeit with different geographies. For example, the first Greater London Mayor was elected in 1999, following the establishment of the Greater London Authority the previous year after a referendum. Elsewhere, however, attempts at establishing regional elected assemblies stalled after they were rejected in a vote in the north east in 2004. It is worth noting, by comparison, that no such democratic mandate was sought for devolution in Greater Manchester.

Localism has, in different ways, always existed as a feature of British politics, be that the powerful local government figures of the late nineteenth century, the post-war municipal socialism of some cities or the pragmatic Toryism of the shires (Clarke and Cochrane, 2013). Much like devolution, as a rather imprecise term spanning a range of policy and political issues, localism has been a gift to politicians from across the political spectrum.

2. Placing devolution in context

Following the centralisation of the 1980s, a new localism agenda was pursued towards the latter stages of the Labour administration in the 2000s. However, localism came to the fore under the Conservative-led coalition government which passed the Localism Act 2011 providing a statutory basis for giving new freedoms and flexibilities to local authorities and communities in a range of areas. Increasingly, calls were made by central government to empower local government, communities and individuals on the basis that local people were best placed to find solutions to local issues. Thus narratives presented localism in terms of increased democracy, the removal of bureaucratic 'red tape' and 'taking power away from Whitehall and putting it back in the hands of councillors and councils' (Pickles, 2011: np). Initiatives such as Total Place began to emerge, under the idea that the re-organisation of public services around place could simultaneously improve how services are provided and save money (HM Treasury/CLG, 2010). And yet, for all the empowerment of local authorities, this localism became intertwined with the politics of a centrally-driven period of unprecedented fiscal austerity.

As a consequence of the Localism Act 2011, Greater Manchester was able to become the first Combined Authority in 2012. Senior actors in the city-region used its track record of collaboration and good relationships with the Cameron-Osborne administration to become the first city-region to negotiate a devolution deal in 2014, largely behind closed doors, with little involvement or engagement of local councillors or MPs and with hardly any public debate or engagement (Jenkins 2015). Soon known colloquially as 'DevoManc', the devolution deal incorporated control over a range of budgets including transport, housing and skills and employment to support an economic growth agenda, on the condition that a directly-elected Greater Manchester mayor would be established. While there was a reference in the agreement to Greater Manchester producing a business case for health and social care integration, the announcement of health and social care devolution came several months later. The deal was criticised by some stakeholders for the near absence of democratic engagement or scrutiny and the way it was concluded by a small elite group of local authority leaders (Kenealy et al. 2017), although it could be seen as the culmination of years of institutional reform in the city-region (Gains, 2015).

The Cities and Local Government Devolution Act 2016 marked a significant return towards the metropolitan tier of government, albeit in a rather piecemeal fashion. As Deas (2014) has observed, under devolution not only are city-regions being imagined as the level or scale at which functional economic

interactions take place, but that '[c]ity-regions are the principal scale at which people experience lived reality' (Storper, 2013: 4). Much like the localism agenda that went before it, devolution to city-regions has been accompanied by continuing fiscal austerity and a shift of responsibility from national to local levels to implement and absorb reductions in local authority funding (Lowndes and Garnder, 2016; Etherington and Jones, 2017).

Corresponding with the rise of the broader Northern Powerhouse agenda backed in particular by the then-Chancellor of the Exchequer, George Osborne, devolution has been presented as an attempt to address the regional spatial unevenness of the national economy and to improve regional economic performance. The Treasury has exerted considerable influence within these elite-driven devolution deals (Tomaney, 2016). Indeed, some argue that 'despite all the talk about devolution, this remains a strongly centrally prescribed process of state restructuring' (Ward et al., 2015: 422). Cautious of the gap between rhetoric and reality, Ayres et al (2017) draw the conclusion that the full extent of the promised 'devolution revolution' across England has not occurred.

And yet, devolution has never just been a national project. For senior figures in Manchester and to some degree in wider Greater Manchester, devolution has been a long term ambition and the metropolitan region has played an important part in the development of the idea and the underlying policy framework. Long-established senior figures in local government have championed the ability of Greater Manchester to work pragmatically with the government of the time in the interests of the city-region and its people, and marshalled the economic and social case for change. Devolution forms the latest development in this narrative of Greater Manchester's urban renaissance. For many, the election of Greater Manchester's first mayor in May 2017 marked a particularly important turning point in the development of this narrative – although the outcome of the election was never in doubt, the process provided a legitimacy for the postholder in articulating both within and across Greater Manchester and at a national level a distinctive manifesto for government. The mayor's formal powers are substantial, though they are largely exercised in collaboration with the ten local authorities and their leaders, but his informal positional authority and political momentum are considerable.

But arguably, it has been the devolution of health and social care which has received most attention both nationally and regionally as part of the wider devolution process and so we now turn our attention to setting that enterprise in context.

2.3. The context for health and social care devolution in Greater Manchester

Before the formation of the NHS in 1948, local authorities played a major role in healthcare services, funding and running municipal hospitals and community health services. But for reasons of both national and local politics, the creation of the NHS brought all hospitals under the aegis of the Ministry of Health and a structure of appointed regional hospital boards and hospital management committees. Further reforms in 1974 brought community health services and public health, which had remained with local authorities since 1948, into a new integrated architecture of largely appointed regional, area and district health authorities, in parallel with elected local authorities which now had no healthcare responsibilities but remained in charge of social care. Since then a succession of NHS reforms has, paradoxically, often spoken the rhetoric of localism and devolution but effectively brought ever greater centralisation, with command and control from what is now the Department of Health and Social Care (Klein, 2017: 14). Until the 1980s, local government remained involved as up to a third of members of health authorities were councillors appointed by local authorities, but that link was severed when reforms were introduced in the 1990s which split responsibility for commissioning and providing health services and created the NHS internal market.

Since devolution to Scotland, Wales, and Northern Ireland in 1999, their healthcare systems have started to diverge from England with in general a move away from markets and competition, while the NHS in England has continued with a variety of organisational forms for commissioning and the creation of NHS foundation trusts for hospital provision and primary care trusts (PCTs) to both run community health services and commission primary care and secondary care. However, there continued to be a level of regional governance in regional health authorities, latterly called strategic health authorities. Even so, the rhetorical calls for devolution and local freedoms continued (Working for Patients White Paper, 1989; Delivering the NHS Plan, 2002)

The coalition government reforms of 2012 brought perhaps the most significant changes to NHS governance, creating over 200 clinical commissioning groups which were membership bodies of general practitioners to commission secondary healthcare, abolishing primary care trusts and strategic health authorities, and moving most of their responsibilities to a new national body, the NHS Commissioning Board (which was soon retitled NHS England). Though proposed with the overt aim of liberating the NHS from central control, these reforms proved profoundly centralising in practice (Timmins 2012), and removed for the first time any formal regional tier of governance, though NHS England quickly established a structure of area teams to manage a wide range of administrative challenges which required a regional perspective. These reforms also moved some responsibilities for public health which had been held by PCTs to local authorities while also creating a new national body, Public Health England (Gadsby et al., 2017).

The story is different for social care which was once largely funded by government and provided by local authorities and health authorities, but which through a series of reforms in the 1980s and 1990s is now partly funded by local authorities and partly funded by out of pocket payments by service users and their families, while most services are now provided by the private sector. Access to local authority funded social care is means-tested and local authority budgets have been under increasing pressure in the years of austerity since 2010, so entitlements to care have been progressively stricter, payments to private sector providers have been driven down, and access to social care has become more difficult for many people in need of services. In 2012, the coalition government's White Paper *Caring for our Future* sought to reform and standardise the way eligibility for care was assessed and, subsequent legislation in the Care Act 2014 introduced a new set of rules and criteria for assessment, but did not address growing concerns about the adequacy of public funding, the fairness of means-testing for social care services, or the problematic interface between NHS continuing healthcare and social care services (Department of Health 2012; Care Act 2014).

2. Placing devolution in context

That tension which exists between healthcare which is tax-funded, free at the point of use and largely provided by the public sector and social care which is means-tested, for which many people have to pay out of pocket, and which is largely provided by the private sector is self-evident. The tensions have become more pressing in the recent period of austerity as cuts to central government grants to local authorities (NAO 2018a) and consequent reductions in access to social care have effectively increased demand for health services. There have been many attempts to encourage health and social care integration, with powers to pool budgets in health and social care and to delegate functions of NHS bodies to local authorities and vice versa provided by section 75 of the NHS Act 2006. More recently, the Better Care Fund was established by NHS England to pool up to £5.9 billion pa of funding between CCGs and local authorities for schemes largely aimed at improving social care and reducing demand for hospital services. However, a study by the National Audit Office found that service integration has been slower and less successful than planned and the Better Care Fund has not delivered the expected savings or reductions in hospital activity (NAO, 2017).

In many ways, the NHS today is living with the legislative legacy of the Health and Social Care Act 2012 and the fragmentation and centralisation of the NHS that resulted (Timmins 2012, 2018a). In 2014, NHS England published a document titled the Five Year Forward View (FYFV) (NHS England 2014) which marked a fundamental change of direction – from competition and markets towards collaboration and integration, though the Health and Social Care Act 2012 remained in place. It argued that ‘the traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need’ (NHS England 2014: 16). The document set out a number of so-called new care models, aimed at integrating community and hospital services, and led to the establishment of a programme of Vanguards – pilot project designed to test out these new care models across England.

The announcement of Greater Manchester health and social care devolution in February 2015 needs to be seen in the context of these existing institutional arrangements, in which responsibility for healthcare spending rests ultimately and firmly with the Department of Health and Social Care, while responsibility for social care spending rests with each individual local authority. It was agreed that Greater Manchester would take responsibility

for its £6bn health and social care budget from April 2016. The twin stated aims were to improve health outcomes and reduce health inequalities both within Greater Manchester and between Greater Manchester and other areas of England, and to address a growing gap between need and demand for health and social care and available resources to provide them.

However, these aims are far from the whole story. The rationale for health and social care devolution was and remains quite contested. Some saw this as an historic opportunity to gain greater regional governance of the NHS, and to integrate health and social care under local government control. Others regarded it, more pragmatically, as a way to resolve the fragmented and complex organisational legacy of the Lansley NHS reforms and a longer history of purchaser/provider arrangements, replacing them with simpler, place-based integrated healthcare systems. Some took it to be an opportunity to reform health (and social care services) to focus more on public health, primary care and prevention and less on urgent, acute and specialist care. Some argued it was a way to bring together health, social care and other public services to address the wider set of social determinants of health – such as education, housing, employment, and the environment. Others saw it as a way to secure greater efficiency and effectiveness at a time of very constrained resources. At the same time, some stakeholders doubted these aims and saw devolution as a transfer of financial burden at a time of austerity, or a technocratic exercise in reorganisation, or a way that unpopular changes to local services would be pushed through.

Unlike other components of the devolution deal which represented hard transfers of power backed up by orders made using powers in the Cities and Local Devolution Act 2016, the devolution of health and social care was made and enacted through an administrative agreement between the Greater Manchester Combined Authority, NHS England, clinical commissioning groups, NHS trusts and foundation trusts and local authorities. The Greater Manchester Health and Social Care Partnership has no separate statutory existence, but is hosted by NHS England which employs its chief officer and most senior staff. All the existing accountabilities for NHS organisations and local authorities to regulators, national bodies and government remain in place. Health and social care devolution has added a layer of organisational complexity to an already complex landscape, despite the shift in emphasis towards place-based collaborative working and integration (Checkland et al. 2015).

Similar place-based reforms have been developing elsewhere in England, again without any change to the underlying legislative provisions of the Health and Social Care Act 2012 (Hammond et al. 2017). NHS England has organised the NHS into 44 geographically based Sustainability and Transformation Partnerships (formerly Plans) which bring together NHS organisations and local authorities to work collaboratively on place-based planning and delivery of health and social. The scope for STPs is broad and foregrounds improving quality and developing new models of care; improving health and wellbeing; and improving the efficiency of services. Indeed, Greater Manchester is designated as one of the 44 STPs covering England, originally announced in 2016.

From April 2018, 10 of the more developed STPs (including Greater Manchester) have been designated as Integrated Care Systems – which are described as even closer partnerships of NHS organisations and local authorities which will take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Evaluations of the early development of ICSs suggest that while there is considerable enthusiasm in some quarters for the concept, realising it in practice is difficult and progress has varied considerably. They caution against unrealistic expectations of transformation and change, note that establishing ICSs requires a lot of groundwork and relationship building, and set out a lengthy list of requirements for their future development (Charles et al 2018).

In July 2018, following the announcement of a longer-term financial settlement for the NHS, work commenced at NHS England on developing a ten year plan for the NHS which is due to be published in late 2018. It seems likely that this plan will build on the place-based reforms outlined above, and provide some further support for these developments in Greater Manchester and elsewhere, though some have cautioned that the lessons from past exercises in long term planning have not been learned (Edwards 2018).

2.4. Summary

This brief review of the meaning of devolution and its history in England, and of the health and social care policy and system context for health and social care devolution in Greater Manchester, makes it clear that this is far from being new territory – there is a long and complex history to relationships between central and local government and the NHS. It also helps to illustrate that the term “devolution” itself has been used to describe a wide range of legislative and administrative reforms involving some shift of power and responsibility between levels of government.

There have been multiple, overlapping and often contradictory reforms of the organisation and governance of health and social care commissioning and service provision (Holder and Buckingham 2017). The underlying problems have not changed much – the tensions between free healthcare and means-tested social care, between centralised NHS governance and democratic local government, and between seeking improvement through competition and choice versus improvement through integration and collaboration. Klein (2017: 16) suggests that ‘The forces that have driven centralisation – accountability for public funds and equity – have not changed. Neither has the capacity of the centre to define expectations and monitor performance at the periphery. While it remains the ambition that every citizen should have the same standard of service – an ambition still to be fulfilled – the scope for devolution will remain constrained’.



Clarence Mill, Tameside
Photo credit: Clem Rutter

Health and social care devolution in Greater Manchester: a chronology **3**

In this chapter, we provide a chronological outline of the development of health and social care devolution in Greater Manchester. We first discuss the history of joint working across Greater Manchester both through the Association of Greater Manchester Authorities and through NHS organisations and networks. Next we turn to discuss the build up to the devolution deal in 2015 and the preparations for the establishment of the Greater Manchester Health and Social Care Partnership in April 2016. Then we describe how the GM Partnership has developed since it was set up.

3. Health and social care devolution in Greater Manchester: a chronology

3.1. A history of joint working in Greater Manchester

Devolution in Greater Manchester builds on many years of joint working across the city region. Following the abolition of the Greater Manchester Council in 1986 (Local Government Act 1985), the Association of Greater Manchester Authorities (AGMA) was established as a voluntary collaboration between the ten local authorities. AGMA has since played a critical role in shaping policy and governance across the metropolitan area, and has developed and changed over time in response to the needs of its constituent local authorities and the city-region (Ward et al., 2015). Relationships with central government substantially improved over this period, as senior leaders particularly in Manchester moved away from political hostilities associated with its past left-wing agenda to instead pursue a position as an entrepreneurial city-region happy to work pragmatically with governments of either main political party. From its investments in assets like the Manchester Airport Group to its close partnership with property developers in the regeneration of the city centre, the narrative of a business-friendly, successful, place with a track record of embracing reforms has emerged, if rather carefully curated.

Whilst much attention on joint working focuses on AGMA and the continued influence of key senior figures in Greater Manchester, there is also a history of collaboration between NHS organisations in the city-region. In 2005, the Association of Greater Manchester Primary Care Trusts was established with formal joint decision making authority to jointly commission health services across the area, and it has played a central role in the Healthier Together initiative to plan the reconfiguration of certain acute services in Greater Manchester.

The Localism Act 2011 provided for the establishment of combined authorities with Greater Manchester Combined Authority (GMCA) becoming the first, building on the foundations created by AGMA. In 2013, it published the Greater Manchester Strategy (GMCA/AGMA, 2013) *Stronger Together* which set out a vision for achieving sustainable economic growth and the reform of public services. It documented initial work underway to integrate health and social care as part of GM's public service reform ambitions. The initial GMCA Devolution Agreement (Treasury/GMCA, 2014: 1) contained a reference to an invitation to GMCA and GM Clinical Commissioning Groups (CCGs) to develop a 'business plan for the integration of health and social care across Greater Manchester, based on control of existing health and social care budgets'.

1986	Association of Greater Manchester Authorities (AGMA) formed as a voluntary association of the 10 local authorities, following abolition of Greater Manchester County Council
2005	Association of Greater Manchester Primary Care Trusts established with formal joint decision making authority to jointly commission health services across the area
2009	Greater Manchester given City Region status and allowed under Local Democracy, Economic Development and Construction Act 2009 to establish a combined authority with formal delegated powers for public transport, skills, housing, planning, and economic regeneration
2011	Greater Manchester Combined Authority (GMCA) established—the first formal administrative authority for Greater Manchester since the abolition of the county council
2012	Greater Manchester Association of Clinical Commissioning Groups established, with lead CCG arrangements for specialised and joint commissioning and coordinated approach to service reconfiguration
2013	GMCA and the Local Enterprise Partnership issue joint strategy for economic growth and reform
July 2014	Greater Manchester and government agree £476m of government funding for growth and reform plan
November 2014	GM Devolution Agreement sets out further devolution of powers on planning, land, transport, and fire services, and changing governance of GMCA to introduce arrangements for a directly elected mayor from 2017
February 2015	Memorandum of Understanding agreed for health and social care devolution, covering £6bn a year of expenditure

Adapted from Walshe et al. (2016)

Figure 1. The history of joint working in Greater Manchester

3.2. Preparing for devolution

In February 2015, Greater Manchester secured an agreement with the government to take control of the £6 billion pa budget for health and social care for the 2.8 million people of the city-region (see figure 1). This agreement, formalised in the Health and Social Care Devolution Agreement 'Memorandum of Understanding' (MOU), was signed by representatives of AGMA, NHS England (NHSE) and the twelve Greater Manchester CCGs. Providers were not formally party to the initial agreement although the MOU included letters of support from Greater Manchester NHS trusts, foundation trusts and the NW Ambulance Service.

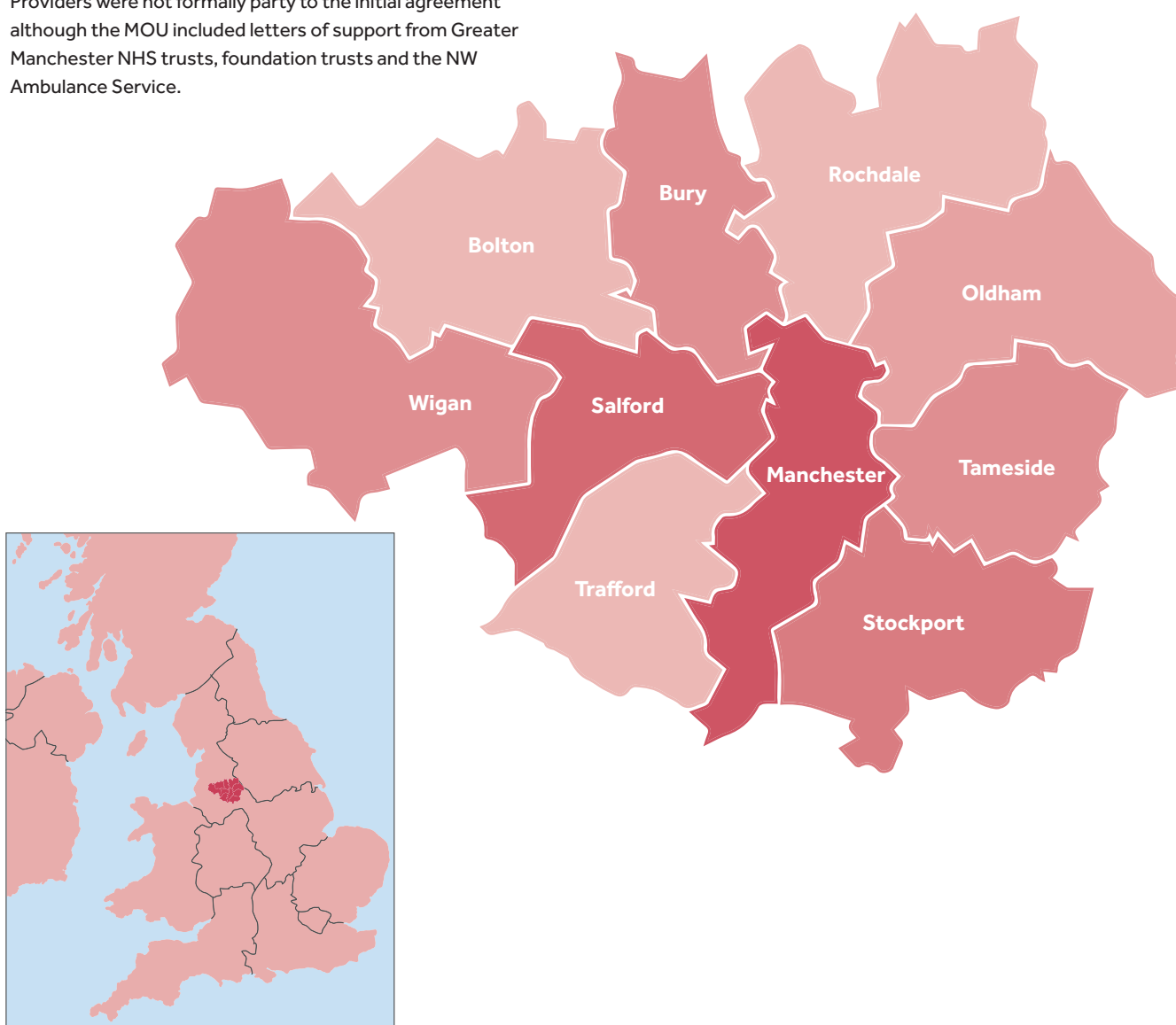


Figure 2. Map of Greater Manchester local authorities (adapted from Ordnance Survey OpenData)

3. Health and social care devolution in Greater Manchester: a chronology

The MOU outlined the principle that ‘all decisions about Greater Manchester will be taken with Greater Manchester’ (AGMA/NHSE/NHS GMACCGs, 2015: 5; emphasis in original). It confirmed that Greater Manchester would remain part of the English NHS and social care system, meeting statutory requirements and duties including those of the NHS Constitution and Mandate. Despite references to ‘devolution’ of responsibilities or funding within policy papers and popular media, as noted in the MOU such references formally relate to the delegation of commissioning functions and resources to a joint commissioning board. CCGs, local authorities and NHS England remained accountable as statutory organisations. A directly elected Greater Manchester Mayor was a condition of the 2014 devolution agreement, albeit with temporary arrangements until May 2017, but the mayor was to have no formal authority over health and social care.

The stated aims for Greater Manchester health and social care devolution outlined in the MOU were: to substantively improve the health and wellbeing of the 2.8m population with particular emphasis upon public health and prevention rather than reactive care; to close the health inequalities gap within Greater Manchester and between Greater Manchester and the rest of the UK; to deliver effective integrated health and social care across Greater Manchester; to shift care closer to home; to strengthen a focus on wellbeing including public health; to contribute towards economic growth of Greater Manchester; and to develop links between the NHS, social care, universities and science and knowledge industries to encourage innovation (AGMA/NHSE/NHS GMACCGs 2015). Health and social care devolution built on the aims of the GM Strategy (GMCA/AGMA, 2013) and devolution agreement (2014), wherein improving the health and well-being of the population is associated with a wider ‘growth and reform’ agenda that reaches beyond health and social care.

The formative stages of health and social care devolution in Greater Manchester were led by a transition management team, formed of approximately 20 staff that were either on secondment, attachment or working in addition to their existing roles. It included the interim chief officer for Greater Manchester health and social care devolution; chief executive, Manchester City Council; director of health and social care for Greater Manchester devolution; alongside other representatives from NHS organisations and local authorities in Greater Manchester, GMCA and the NHS England area team.

In July 2015, a further MOU was signed with Public Health England and NHS England committing ‘to create a single unified public health leadership system capable of contributing to a transformational and sustainable shift in the health and wellbeing of the population’ (Public Health England et al., 2015: 128). As part of this process, a Greater Manchester director of population health was to be appointed ‘funded from existing resources for a time limited period’ (Public Health England et al., 2015: 125).

The activities of the devolution transition management team involved working closely with NHS England in the GM Devolution Programme Board whilst the Partnership was in shadow form. This task and finish group was established to oversee transition until the formal delegation and was co-chaired by the chief executive of NHS England and chief executive of Manchester City Council. The close involvement of NHS England illustrated the high profile nature of these reforms.

During this transition period, in July 2015 the long established GM Healthier Together Committees in Common, comprising representatives from each of the 12 CCGs in Greater Manchester confirmed its decision to create four shared single services for emergency abdominal surgery. A high-profile judicial review was launched to challenge the decision, but it was upheld. Healthier Together provided a key example of NHS organisations in GM working together to create shared services and the use of delegated decision making between GM organisations, predating the devolution agreement.

In December 2015, the strategic plan, *‘Taking Charge of Health and Social Care Devolution in Greater Manchester’* – or *Taking Charge* – was published (GMCA/NHS in GM, 2015a). The ambition of devolution was described as delivering the ‘fastest and greatest improvement in the health and wellbeing of the 2.8 million people living across GM’ (GMCA/NHS in GM, 2015a: 4). It set out a number of key objectives: upgrading the approach to prevention, early intervention and self-care; redefining how primary, community and social services become the cornerstone of local care; standardising and building upon specialist hospital services through the development of shared hospital services; and creating efficient back office support. *Taking Charge* outlined the need to address existing fragmentation of health and social care and the poor health outcomes in Greater Manchester. Moreover, it argued that the health and social care system had to change in order to address a predicted £2bn deficit by 2020/21. A one-off £450m

3. Health and social care devolution in Greater Manchester: a chronology

Transformation Fund from NHS England to help enable transformation over the five years, was announced at the same time. This funding was intended to 'drive the transformation changes in health and social care required' (GMCA/NHS in GM, 2016a). It was made explicit that this funding was not intended to address financial deficits.

As a 'high-level' strategic document, Taking Charge outlined the overarching plan for devolution, the governance structure in Greater Manchester, the focus upon place-based locality plans in the ten localities, early implementation priorities as well as setting out intended population health outcome targets around three areas of start well, live well, and age well. The model for devolution was predicated on a shift in activity from reactive, crisis services to preventative services, shifting from use of in-hospital acute care to out-of-hospital 'community-based' settings. It set out five transformation themes (see figure 3).

The first theme – a radical upgrade in population health prevention – sought to control or reduce growing demand for public services through more people taking responsibility for their own health and well-being through self-care and prevention as well as public health interventions. The second theme – transforming community-based care and support – was focused on delivering integrated care in each of the ten localities, led by local care organisations (LCOs) or similar single service integrated models which would bring together health and social care staff to deliver care in a community-based rather than hospital settings. The third theme – standardising acute and specialist care – focused on acute service reconfiguration and standardisation to centralise services to a smaller number of lead provider sites within Greater Manchester. The fourth theme focused on the standardisation of 'back-office' functions building on the recommendations of the Carter Review (2016).

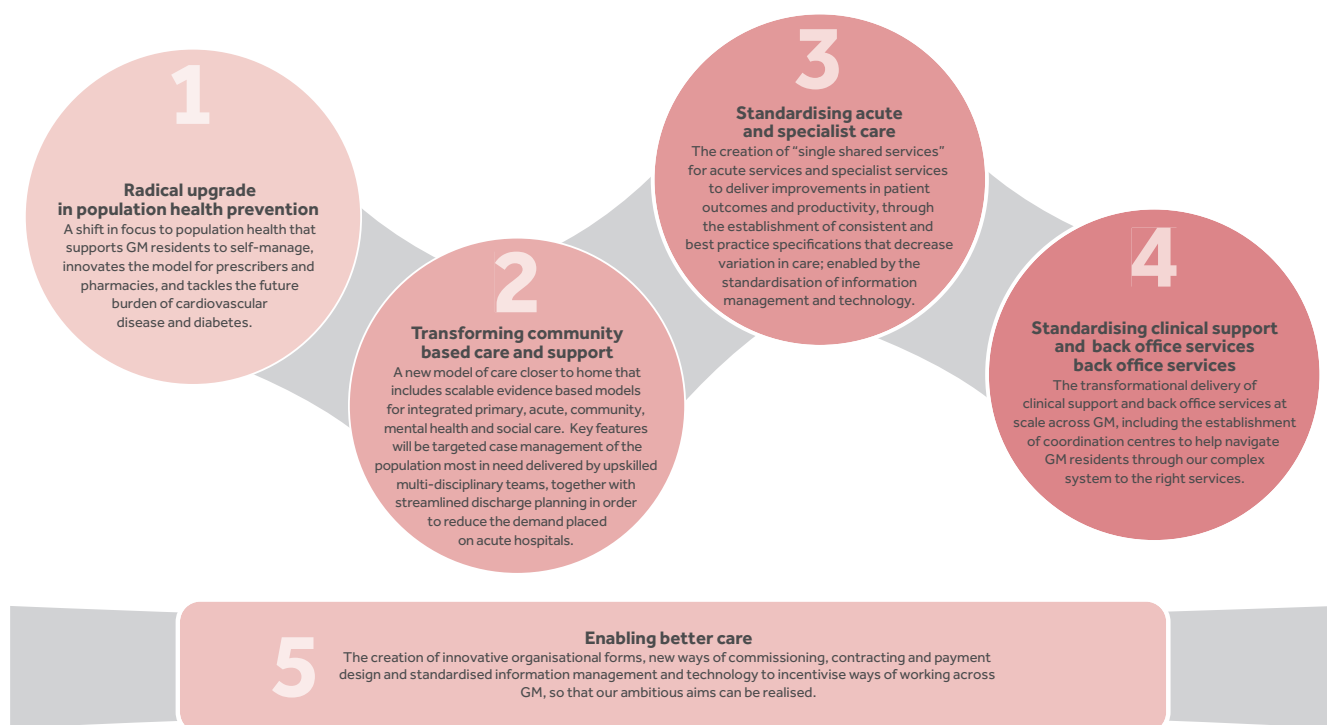


Figure 3. Taking charge: transformation themes (GMCA/NHS in GM 2015a).

3. Health and social care devolution in Greater Manchester: a chronology

These transformation themes were supported by a range of enabling programmes involving reforms to estates, workforce, information management and technology (IM&T) and innovation. In addition the plan set out cross-cutting themes to be co-ordinated at the Greater Manchester level in primary care, cancer, mental health, learning disability, dementia and services for children. A further objective of 'aligning our health and social care system to education, skills, work and housing' was later formally added to the Implementation Plan for Taking Charge (GMCA/NHS in GM, 2016b: 17).

In order to achieve these objectives, a planning process was articulated with each of the 10 localities within Greater Manchester being required to set out their vision for their locality for the next five years as a 'place'. This involved defining how they would improve the health and wellbeing of their local population and how they would change services to contribute towards reducing the growth of expenditure in Greater Manchester. Locality plans were assured and signed-off by each locality health and wellbeing board. Whilst there was some

recognition of a degree of difference between localities' needs, the plans broadly adhered to common principles of joined up commissioning, joined up provision and a focus on prevention and improving population health. The process of locality planning involved submission of first draft implementation plans to the GM devolution transition team and to revise those plans locally following feedback. The plans were required to describe the governance for establishing joint commissioning, integrating financial planning across the locality, an understanding of their place-based payment mechanisms and their communications work, and a key component of access to transformation funding.

It was clear that new ways of working together would be needed, and Taking Charge set out proposed governance arrangements in some detail (see figure 4). As a whole, the GM devolution plans involved 37 statutory organisations: 10 local authorities, 12 CCGs and 15 NHS trusts and foundation trusts, along with representatives from primary care, Healthwatch, community and voluntary sectors, Greater Manchester Police, Greater Manchester Fire and Rescue Service and NHS England.

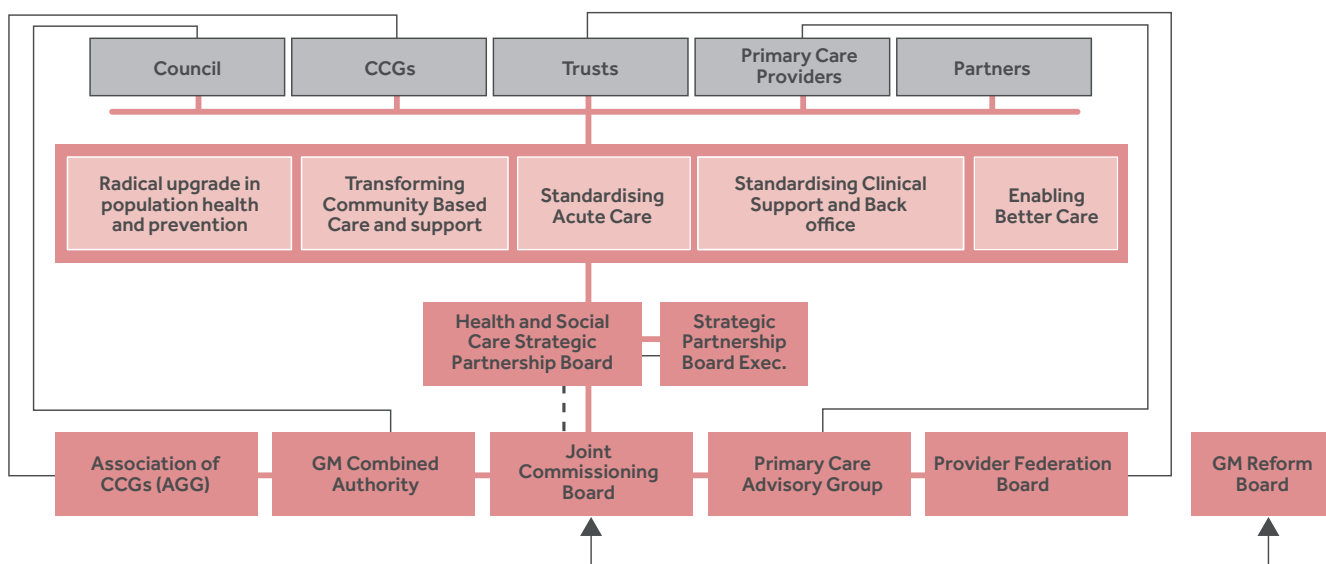


Figure 4. Initial governance arrangements in Greater Manchester

3. Health and social care devolution in Greater Manchester: a chronology

All of those interests were represented on the Strategic Partnership Board (SPB) which was set up to provide overall strategic direction for Greater Manchester health and social care devolution. It met in public at the end of each month with a remit which included:

- Agreeing the GM Health and Social Care Partnership strategic priorities;
- Ensuring that there remained ongoing and significant organisational commitment across the GM health economy to both the devolution agenda and a devolved health system;
- Providing leadership across the GM health economy to ensure that the key strategic priorities for a GM health system are achieved.

At the outset some quite complex stratified voting arrangements were put in place for the Strategic Partnership Board. For a proposal to be carried, it had to have support of 75% or more in all four membership groups eligible to vote – namely, GMCA, CCGs, NHS trusts/foundation trusts and NHS England (though during our fieldwork we did not see these voting arrangements actually used). Representatives from the four primary care provider groups (dental, general practice, optometry and pharmacy) joined the SPB in November 2015.

The Strategic Partnership Board Executive (SPBE) was a smaller body established to support the main SPB. It did not meet in public, and its remit included:

- To receive regular reports on the delivery of the locality plans, and refer any concerns that are identified back to the relevant locality;
- To provide a forum for the membership to raise any issues relating to the delivery of locality plans that cannot be addressed at a locality level;
- To propose to the fund holders of the Transformation Fund the allocation in accordance with the agreed criteria, and to seek reports from the recipients to enable reporting to the Strategic Partnership Board in relation to each of the investments.

There was also a Joint Commissioning Board (JCB) which brought together all the commissioning bodies in GM into a Joint Committee for GM-wide binding commissioning decisions. Throughout our research it remained in shadow form because agreement was not reached on how the arrangements for delegating commissioning to the JCB would work, and it did not meet in public. It was to be responsible for delivering the Greater Manchester commissioning strategy, and commissioning services at the Greater Manchester level.

The GM Association of Clinical Commissioning Groups: Association Governing Group (AGG) existed prior to the devolved arrangements and continued to meet. The renewed overall ambition for AGG has been to lead the improvement of population health outcomes for the population of GM; to agree strategic priorities to ensure that they are fully aligned to the GM Strategic Plan and CCG priorities; ensure all member CCGs act collectively and in the best interests of the collaborative in order to implement key decisions and successfully deliver the change and represent a unified voice as the leaders of health commissioning in Greater Manchester.

A Provider Federation Board (PFB) was also set up which brought together the 15 NHS trusts and foundation trusts to support providers to work together with a remit to improve patient outcomes and the quality of patient care, achieve financial stability and create a sustainable service largely through service redesign and reconfiguration. A wider leadership team of the local authorities was already in place in the city-region, which involved senior leaders of the 10 local authorities across Greater Manchester.

3. Health and social care devolution in Greater Manchester: a chronology

These quite elaborate and complex new structures were intended to bring people and organisations together and to create new accountability relationships, as well as to secure and sustain consensus and commitment to decisions. They were also intended to foster a change in culture which would support joint working, and to formalise organisations working together.

While the *Taking Charge* plan was being developed and these new structures were being put in place, many other changes were underway. For example, the localities of Salford and Stockport were both selected to be part of the national FYFV Vanguard programme in March 2015. A two-stage review for a Manchester Single Hospital Service led by Sir Jonathan Michael commenced in January 2016 and this process led to the subsequent merger

of Central Manchester NHS FT and University Hospital South Manchester NHS FT in 2017. After being placed in special measures as part of the national Keogh mortality review, Tameside Hospital NHS FT began reforms which led to it taking on responsibility for running community health services in Tameside and Glossop and being renamed as Tameside and Glossop Integrated Care NHS FT in September 2016. Local authorities had their own reforms underway as well, often in response to austerity and cuts in funding. For example, Wigan Council had established the Wigan Deal to encourage moves towards 'asset-based' approaches, models of co-production and changing relationships between the council and individuals which promoted increased individual responsibility and resilience.

February 2015	Memorandum of Understanding agreed for health and social care devolution, covering £6bn a year of NHS spending.
March 2015	Devolution Programme Board met for the first time. As a board to oversee transformation, it was co-chaired by Sir Howard Bernstein (Head of Paid Service, Manchester City Council) and Simon Stevens (Chief Executive NHS England) and included representatives from NHS and Local Authorities bodies in GM as well as NHS England. It was disbanded in March 2016 in advance of formal delegation.
July 2015	Memorandum of Understanding agreed with Public Health England and NHS England on securing a unified public health leadership system to help transform population health. Appointment of the 'Director of Population Health Transformation' followed on the 30th September 2015.
July 2015	'Healthier Together' decision to centralise some specialist surgical hospital care on to four sites to improve outcomes was confirmed. This decision later went to judicial review and was upheld.
December 2015	Governance arrangements for health and social care approved and strategic plan 'Taking Charge' published. One-off £450m Transformation Funding is confirmed.
January 2016	Judicial review to Keep Wythenshawe Special challenging the Healthier Together decisions is unsuccessful.
April 2016	Devolution 'goes live' with the formation of the Greater Manchester Health and Social Care Partnership. New governance arrangements in place ready for formal delegation from NHS England.

Figure 5. Preparations for devolution 2015-2016.

3.3. The development of the Greater Manchester Health and Social Care Partnership

The Greater Manchester Health and Social Care Partnership formally came into being in April 2016, and 'took charge' of the £6bn pa budget for health and social care in Greater Manchester though we have already noted earlier that in fact the control of budgets and accountability and governance arrangements of both local authorities and NHS bodies remained unchanged, and that the GM Partnership was and is not, itself, a statutory body. Most of the arrangements that have been outlined above that developed under the devolution transition management team continued and some staff who had been involved continued in their roles, but the GM Partnership did then move to put in place a substantive leadership group, which we refer to as the Partnership Team.

Around this time, a draft version of the Greater Manchester commissioning strategy, '*Commissioning for Reform*', was published following approval at the SPB in March 2016 (GMCA/NHS in GM, 2016c). The strategy argued that bringing together decision-making on commissioning was crucial to overcoming existing fragmentation and enabling the integration of health and social care. Moving to outcome-based, multi-year capitation models harnessing provider collaboration provided a rationale for integrated commissioning. At Greater Manchester level, the Joint Commissioning Board was intended to be the 'lead body for the commissioning of over £800m of activity currently commissioned directly by NHS England' (GMCA/NHS in GM, 2016c). It would focus on developing integrated commissioning for priority areas such as adult social care, children's services, learning disability, mental health and population health. Commissioning for Reform stated that the JCB would phase in an increasing commissioning budget and 'success' would require commissioning at the 'right' level, i.e. locality, sector (a group of localities) or Greater Manchester.

The new chief officer of the GM Partnership took up his post in July 2016. The role is actually an NHS England employee, reporting to the NHS England chief financial officer. NHS England has internally delegated certain assurance roles to the chief officer alongside some direct commissioning responsibilities which among other areas, includes specialised services, public health functions, primary care commissioning and certain CCG assurance functions. There followed a number of new Partnership Team executive appointments, including a chief

operating officer, executive lead for finance and investment and executive lead for population health and commissioning. Additional posts soon followed such as executive lead for quality and executive lead for strategy and system development, and associate leads in primary care, social care and acute care and an associate lead jointly appointed with NHS Improvement.

In August 2016, the Pennine Acute NHS FT was inspected by the Care Quality Commission and received a highly critical report, rated inadequate overall. Normally this would have precipitated the trust being placed into special measures and subject to intervention and support from NHS England but instead it was agreed by CQC and NHS Improvement that the GM Partnership would lead the improvements required, and that Salford Royal Hospital NHS FT (which was rated outstanding) would assume leadership of the trust and develop the necessary improvement plan. Salford's proposals were then presented in public to the SPB and agreed, with expressions of support from the different CCGs involved.

A number of further strategic documents were produced over the following months. This included the primary care strategy, the population health plan and the cancer strategy, and a set of principles for co-production intended to guide collaborative working in Greater Manchester. Additionally, memoranda of understanding were agreed with the voluntary, community and social enterprise sector, Sport England, and the Pharmaceutical Industry Partnership Group. The Pride in Practice initiative to improve access to primary care for the LGBT community which had been established in Manchester in 2011 was expanded across all of Greater Manchester's ten localities.

Over the summer months a review of GM Partnership governance took place and changes were agreed in September 2016 to address concerns about the alignment of locality and Greater Manchester programmes, balancing leadership responsibilities, avoiding duplication, and providing clear oversight of the delivery and assurance of the strategic plan and management of the Transformation Fund. An effort was made to reduce the number of separate projects and groups in place, and to improve oversight. In the following month, there was also a 'reset' of the governance of the on-going acute sector re-configuration work. This was so that a hospital site strategy could be incorporated and also to bring greater coherence for managing its implementation. This work was overseen by a new associate lead post in the Partnership Team.

3. Health and social care devolution in Greater Manchester: a chronology

The Transformation Fund was framed by the Partnership as centrally important and was to be used to support transformation rather than to sustain services and cover deficits. It was said to not involve a 'traditional' bidding-process. A three-stage process was established to support submissions. Criteria were established to ensure that proposals were aligned with the Taking Charge plan, enabled transformational change, consolidated resources, secured value for money and facilitated

learning. Proposals were evaluated by an external independent review, and decisions were made by a Transformation Fund Oversight Group (TFOG) composed of representatives from the GM Partnership who were not compromised by having a conflict of interest (i.e. not currently submitting a proposal) with analytic support from external consultants. Spending from the Transformation Fund is summarised in figure 6.

Date	Funded project	Amount £m*
July 2016	Salford Locality	16.9
July 2016	Stockport Locality	15.8
Sept 2016	Tameside Locality	23.2
Dec 2016	Wigan Locality	14.87
Jan 2017	Adult Social Care (development funding)**	0.12 (revised: 1)
Jan 2017	Rochdale (development funding)**	0.604
Jan 2017	Bury (development funding)**	0.995
Jan 2017	Partnership Team costs	11.2
Jan 2017	Healthwatch	0.2
Feb 2017	Bolton Locality	28.8
Feb 2017	Manchester Locality (LCO and SCF)	12 (up to)
Feb 2017	Primary Care Reform (GPFV national commitments)	41 (up to)
March 2017	Oldham (development funding)	0.77
March 2017	Trafford (development funding)	0.847
March 2017	Transformation Theme 4 - Carter Review (dev fund)	1
March 2017	Health Innovation Manchester	0.5 (revised: 1)
April 2017	Manchester Single Hospital Service	27.2 - 42.5
May 2017	Revised Manchester locality (LCO, SCF and enablers)	37.8
July 2017	Oldham Locality	21.3
July 2017	Healthier Together (inc. 5.5m for stranded costs)	17.2
July 2017	Mental Health (inc. Dementia United)	56.2
August 2017	Bury Locality	14.9
August 2017	Rochdale Locality	23.5
Sept 2017	Trafford Locality	22
Dec 2017	Salford (population health)	3.44
Dec 2017	Wigan Locality (phase 2)	15.43

* These agreed figures have often been revised in light of changing costs covered elsewhere (for instance, IM&T, mental health funding).
 ** Development ('seed') funding up to £1m can be signed off at the discretion of the Chief Officer

Figure 6. Transformation fund spending commitments 2015-2017.

3. Health and social care devolution in Greater Manchester: a chronology

Submissions to the fund were only to be made by locality leads and transformation theme leads. About £60m of the £450m was made available for year 1 (2016/17), although the break-down of funding between transformation and cross-cutting themes, as well as annual split of funding was subsequently adjusted. At the SPBE in July 2016, decisions on the proposals from the first wave of funding were made on four locality submissions. As part of 'Salford Together', Salford's proposal to create an integrated care system and integration care programme for adults received £16.9m. 'Stockport Together' received £19m for the creation of their Integrated Care Organisation (ICO) which joined 46 GP practices to create new care pathways. Tameside and Glossop's proposal for their ICO did not receive funding although decisions on their updated submission were later agreed. Manchester's Single Hospital Service did not meet the initial criteria for funding at that point, though subsequently funding was allocated. Additionally, the Chief Officer of the GM Partnership was later delegated discretionary powers to allocate up to £1m directly for cross-cutting and transformation themes.

Allocation of transformation funding was contingent upon the signing of investment agreements with the chief officer of the GM Partnership. This was quite a lengthy process especially for the first few localities, as the format and content for agreements was developed and metrics and the expected returns on investment were agreed. By the end of 2016, the localities of Salford and Stockport had concluded investment agreements to release their transformation funding. Funds were routed via the CCGs, reflecting the statutory financial accountability arrangements. After some revisions, Tameside and Glossop also received £23m of Transformation Fund allocation to support their Care Together programme in the locality. Wigan soon after received an allocation of nearly £15m to support their plans. The three Manchester CCGs (North, Central and South) formally merged in April 2017, meaning there were now 10 CCGs with coterminous local authorities (with the slight exception of Glossop which is in Derbyshire County Council).

The first Greater Manchester Mayor was elected in May 2017. The new Mayor positioned health and well-being as a key dimension of his manifesto commitments. This included a number of key priorities around mental health, school readiness, support for the carer workforce and homelessness and health. His ambition for an integrated National Health and Care Service drew considerable attention. The only direct link for the Mayor into the GM Partnership is that he chairs the GM Reform Board as well as attending the Strategic Partnership Board.

However, many of his ambitions were adopted and adapted by the Partnership who observed in their annual report: 'We have already forged a good working relationship with the Mayor and his office and are actively engaged in how we can align the delivery of our business plan with the health and care commitments in his manifesto' (GMCA/NHS in GM 2017a). This was reflected in comments from the GM Mayor at the Health and Care Leaders' Summit in 2017: "Today I think is about seizing the opportunity that's before us, the opportunity that devolution in Greater Manchester – that has been long argued for – seizing the opportunity that presents to write our own script, our own future, to do what Greater Manchester likes to do best and that's to do things differently, to do things better. That's our opportunity."

Following extensive work by an external management consultancy, the Greater Manchester Commissioning Review was presented and agreed by the SPB in July 2017. It outlined the development of a single commissioning function in localities and commissioning arrangements across Greater Manchester and how this would shift towards LCOs as the take formation across the city-region. Further developments included the signing of a memorandum of understanding with the Royal College of General Practitioners, the launch of the Greater Manchester Plan and the agreement of £134m funding for mental health services from the Transformation Fund and CCGs.

In spring 2017, the GM Partnership gained additional devolved commissioning responsibilities from NHS England relating to the North West Ambulance Service and 111, and at the end of the financial year published its first annual report and accounts for 2016/17 (GMCA/NHS in GM, 2017a) and a business plan for 2017/18 (GMCA/NHS in GM, 2017b).

By the time we concluded our fieldwork in September 2017, the Healthier Together business case for the four 'sectors' of Greater Manchester had been agreed locally by commissioners. In October, the NHS England National Specialised Commissioning Group agreed the delegation of £40m pa of additional specialised mental health commissioning functions to the GM Partnership. By January 2018, all localities had been awarded Transformation Fund money with most of the resources allocated including funding for cross-cutting and transformation themes. Additionally, a further review of governance arrangements was underway.

3. Health and social care devolution in Greater Manchester: a chronology

April 2016	Greater Manchester Health and Social Care Partnership is formed. The draft Commissioning for Reform strategy linking health and care budgets to
July 2016	Chief Officer of the Health and Social Care Partnership arrives as NHS England employee and subsequent arrival of new Partnership Team.
August 2016	Pennine Acute Trust rated inadequate following a CQC inspection. This prompted the invitation of Salford Royal FT to oversee the leadership of the Trust immediately after the inspection.
September 2016	The conclusions to the review of governance were agreed by the Partnership leading to new boards including Performance and Delivery, Quality, Financial Oversight and Transformation Portfolio Board
October 2016	By October, the new Partnership Team had been installed. This included a co-NHSI/Greater Manchester role. The acute sector re-configuration governance was 'reset' to incorporate a hospital site strategy and manage its delivery. The primary care strategy was also published this month.
December 2016	Salford and Stockport become the first localities to be awarded transformation funding, soon followed by Tameside and Glossop, Manchester and Wigan.
January 2017	Memorandum of understanding agreement with the GM VCSE.
January 2017	Population health plan published.
February 2017	Cancer plan published.
March 2017	The GMHSCP report a £230m 'surplus' in their end of year financial reporting.
April 2017	3 Manchester CCGs merge to become one and Manchester Health and Care Commissioning was formed (a partnership between the City Council and NHS Manchester CCG).
May 2017	The first ever Greater Manchester Mayor is elected.
September 2017	Healthier Together business cases are agreed in GM.
October 2017	Further delegation of specialised mental health commissioning responsibilities.
January 2018	All localities awarded transformation funding and almost all funding allocated.

Figure 7. The development of devolution 2016-2018

Taking charge together: governance, accountability and relationships **4**

Chapters 4 and 5 of this report present the main findings from our research. This chapter explores the governance and accountability arrangements put in place and how they have worked and it is grounded in our qualitative fieldwork of meeting observations, documentary analysis and interviews with key participants (described in Appendix A). We examine how and why the new devolved arrangements constitute what we describe as 'soft' devolution. We elaborate on this concept and the implications for the development of devolution, and for the balance between organisational autonomy and collectivity. We also explain the consequences of the devolution arrangements for power relationships at the local city-region level, examining the extent to which the creation of a new local GM administrative tier has resulted in a growing accumulation of power at this level.

4. Taking charge together: governance, accountability and relationships

4.1. The possibilities and limits of soft devolution

Our research found that Greater Manchester's health and social care devolution settlement is currently relatively limited. In accordance with NHS England's spectrum defining the models of devolution (NHS England, 2016) there has been internal delegation from NHS England to the chief officer of the Greater Manchester Health and Social Care Partnership who is an NHS England employee and who reports to the chief financial officer for NHS England. The Cities and Local Government Devolution Act 2016 has made it possible for government formally to transfer health and social care responsibilities to the Greater Manchester Combined Authority, but these powers or provisions in other legislation have not yet been used. Instead, Greater Manchester devolution might better be described as a constrained or soft form of devolution, enacted entirely within the existing legislative framework for the NHS in England. It is essentially an administrative agreement between the Department of Health and Social Care, national bodies like NHS England and NHS Improvement, and NHS organisations and local authorities and others in greater Manchester. Our fieldwork indicated that the character and quality of the relationships with these national bodies have shaped and constrained what has been possible in Greater Manchester to date.

This means that Greater Manchester's adherence to national policy objectives and processes has remained substantial, despite rhetorical claims especially at the outset about the freedoms enabled by health and social care devolution. Throughout our fieldwork, it was apparent that the Greater Manchester system was closely bound by the 'must dos' and planning guidance set by national bodies.

We found that senior figures in Greater Manchester were careful to frame their vision for devolution as working to a 'place plan' rather than an 'NHS plan' and to emphasise the extent of local authority involvement in the devolved GM Partnership. This approach stressed that developments in Greater Manchester went beyond working between NHS organisations and a focus on healthcare concerns alone, but involved a wider ensemble of health and care organisations and actors and public services more broadly. However, throughout our research we observed the GM Partnership having to balance collective priorities for

devolution with the rolling-out of the national NHS policy agenda. National figures and organisations continued to exercise substantial influence across the Partnership, despite the existence of the devolution deal. The result has been that the devolved health and social care system has not diverged much from the arrangements elsewhere in England, though some would argue that its ways of working, culture and relationships are substantively different.

The fact that the GM Partnership has not secured greater autonomy from the reach of these national bodies through devolution was a disappointment for some participants. Several of them commented on what they perceived as the inability of the GM Partnership to break free of these relationships with national bodies, viewing them as stifling change though others felt that delivering on national policy and accepting the constraints of continuing national oversight had always been a given in the devolution settlement. Pressures to respond to and deliver national priorities consumed valuable time and energy, with A&E targets and Delayed Transfers of Care presenting particular challenges. Some participants thought that a failure to meet performance targets in these areas risked intervention by national bodies. Increasing efforts were focused on mitigating such risks – for example an Urgent and Emergency Care Board chaired by the Chief Officer of the GM Partnership was formed to co-ordinate activities and attempt to improve performance. Sustaining existing services to meet national targets had implications for the GM Partnership's ability to design and implement service changes as we discuss in Section 5. However, it is hard to tell whether concerns about the impact of national targets from participants would really have translated into changing, suspending or even removing such targets if that had been possible through a different devolution settlement.

A key aspect of the devolution deal was a commitment to 'close the financial gap' as a system. Additional financial resources for sustainability and transformation made available to the health and social care in Greater Manchester were not substantially different under devolution from those provided elsewhere in the country, though the GM Partnership has had more autonomy to determine how to use transformation funding. With the devolved arrangements layered over the latest re-organisation following the Health and Social Care Act 2012, nationally-allocated NHS

funding continued to be distributed to local NHS clinical commissioning groups (CCGs) which ultimately remained accountable for their functions to NHS England. CCGs continued to adhere to the national process of 1% retention of a risk reserve (rather than retaining this at their own discretion). NHS trusts and foundation trusts remained individually responsible for balancing budgets. Local authorities retained their existing statutory functions and funding flows, continuing to be bound for example by the national cap on the adult social care precept on council tax increases. Participants increasingly expressed concern about the risks associated with centrally-administered cuts to local authority funding and the effects on social care, and highlighted the impact of national policies on social care funding and the regressive impacts of the social care precept as making their task especially difficult. The Chief Officer of the GM Partnership and other leaders were quite open about the fact that devolution was taking place under challenging financial circumstances.

The relationship between the GM Partnership and national bodies might be conceived of as one of earned autonomy. Good performance in the eyes of national bodies could be rewarded by national organisations exercising lighter-touch regulation combined with more favourable allocation of national capital and increased flexibility around local NHS decision-making. A reported surplus of £237m across the GM Partnership at the end of 2016/17 was seen by the Partnership Team as demonstration of the strength of the system working together in Greater Manchester, at a time of large deficits in many NHS organisations. For 2017/18, a system level surplus, albeit smaller, was expected. Despite the highly constrained NHS capital available for estates and digital infrastructure, the GM Partnership was successful in gaining access to limited capital available nationally. Furthermore, commissioning responsibilities for specialised mental health, 111 and regional ambulance service were devolved to the GM Partnership during our fieldwork.

This serves as a reminder that these relationships are not fixed, and with longer-term aspirations for a 'harder' devolution settlement, senior actors in Greater Manchester were keen to stress repeatedly the evolving nature of delegated arrangements as part of the devolution journey *so far*.

4.2. The growing power of the Partnership Team

In addition to impacting on Greater Manchester's relationships with national NHS bodies and central government, devolution also had implications for relationships within Greater Manchester and in particular, the shifting of power upwards to the new Greater Manchester level. Over the course of our research, we observed the evolution of relationships within the GM Partnership, with the Chief Officer becoming well established as its lead voice over time. Our observations and interviews indicated that he enjoyed legitimacy as the lead of the system, and appeared to bring a renewed sense of coherence to the Greater Manchester health and care system following his appointment. The formal creation of the Partnership Team comprising senior officers and a large team of staff (many transferred from NHS England) prompted suggestions from some participants that a strategic health authority for Greater Manchester was being re-created. At times, the Partnership Team did indeed seem to resemble a statutory body in at least some of its behaviours. It produced an annual report and business plan to provide a summary of progress of the city-regional system as a whole. Furthermore, successive reforms of GM Partnership governance arrangements tightened central oversight and control of activities as was described in chapter 3.

In our fieldwork we found that the formation of the Partnership Team was generally welcomed by senior leaders of organisations within the GM Partnership. In particular, there was recognition among them of the need to bring greater coherence and order to a remarkably complex set of change programmes that cut across localities and Greater Manchester as a whole. However, the establishment of the Partnership Team was not without some concerns from the constituent organisations of the GM Partnership. Ambiguity about the formal role and status of the Partnership Team added to this.

The Partnership Team were keen to reject the idea that they were like a strategic health authority, instead stressing local government involvement and their efforts to encourage bottom-up system-wide empowerment through 'distributed leadership' within the neighbourhoods of each locality, while at the same time noting that they did not have the statutory powers of a strategic health authority. However, they also recognised that some centralisation of power had occurred over time, and argued this was necessary to secure a sufficient degree of consistency and coherence across Greater Manchester.

4. Taking charge together: governance, accountability and relationships

The delegation to the GM Partnership of control over the £450m Transformation Fund provided a key mechanism for the exercise of control at the Greater Manchester level. The fund was viewed as providing a significant opportunity to re-align both financial and patient flows around place-based working of health and care. It was explicitly intended for transformation activities rather than financing individual organisational 'deficits' and the majority of the £450m had been allocated by the end of our fieldwork. The Chief Officer of the GM Partnership and the GMCA Head of Paid Service held joint responsibility for the fund, but staff from all organisations in the GM Partnership participated in discussions about its use. However, scrutiny of applications for funding was undertaken by a separate oversight body. This body used revolving membership to include a range of participants from across the GM Partnership and its operation was considered by the Partnership Team as evidence of an early key success of partnership working in action. Allocations from the fund were generally required to commit to quite ambitious rates of return on investment, and there was some scepticism expressed in our interviews about how realistic the objectives and underlying plans in some proposals were in practice.

The CCGs held the NHS funds allocated for transformation although all the statutory bodies were signatories to the investment agreements and supported the mechanisms introduced for exercising control in relation to performance against these agreements (such as suspending and ending quarterly financial allocations of transformation funding if targets were not met). But questions remained over what would happen if proposed savings were not achieved and transformation did not occur as planned, and about what would happen once non-recurrent transformation funds had all been allocated and expended.

4.3. Tensions between organisational sovereignty and partnership working

Considerable efforts were made over the two years to move towards collaborative based working across both locality and Greater Manchester levels of planning. Yet this occurred in a pre-existing organisational and legislative landscape in which competition and fragmentation were key features. Partnership working was a constant refrain, but this did not mean that it was the norm. A lot of energy was expended in presenting the GM Partnership in consensus to demonstrate the strength of partnership working in Greater Manchester. This manifestation of unity was despite its constituent health and social care and voluntary sector organisations continuing to experience their own individual statutory duties, regulatory requirements and local organisational pressures. Nonetheless, the shared identity of Greater Manchester was reinforced via the organisational rituals of attending monthly meetings held in public, the consistency of policy documentation and so forth.

Participants recognised that national regulatory regimes were still evolving and that legislative reforms to prioritise and encourage system-wide working over organisational priorities had not yet been forthcoming. However, despite the tensions embedded within the organisational and legislative landscape, there was often a remarkable absence of conflict within GM Partnership meetings, both those held in public and those which were not. Some interviewees spoke of an atmosphere which discouraged open expression of dissent. We found that the resolution of conflicts (for example, over Transformation Fund proposals, or funding for the Partnership Team itself) was often conducted outside meetings to mitigate the effects of these on the apparent unity of the project. There was recognition by participants of the value of the new found collective voice and the importance of building relationships between colleagues in different provider organisations. But the emergent, fluid and dynamic nature of devolution sometimes seemed to generate uncertainty and some disagreement among organisations within the GM Partnership.

4. Taking charge together: governance, accountability and relationships

This process presented new challenges not just for NHS organisations but also for local authorities, despite their long history of collaboration across Greater Manchester. For example, despite requests from NHS organisations over 18 months, local authorities were reluctant even to share much information within Greater Manchester on their social care expenditure. For local authorities, their social care spending remained orientated around their own locality, and we were told by participants that it was unlikely that agreement would be reached that “the Trafford pound should be spent in Manchester” (for example), despite the potential benefits of joint working especially where service user or patient flows crossed locality boundaries. Similarly NHS foundation trusts found it difficult to resolve issues relating to the collective representation of the provider voice in various forums where one provider might be speaking on behalf of other organisations, or to act collectively rather than individually. For example, the financial control totals and sustainability funding operated by NHS Improvement to incentivise NHS trusts and foundation trusts to meet their financial performance targets created powerful drivers at the organisational level. For that reason, despite efforts by the Partnership Team, it had not proven possible to agree a system level control total for Greater Manchester as a whole.

The Greater Manchester-wide Joint Commissioning Board comprised the 10 CCGs and 10 local authorities and was positioned at the outset as one of the key opportunities for working together through devolution. However, this body remained in shadow form throughout our research. Its formation required commissioning activity to be ‘delegated upwards’ from individual bodies to legally form a Joint Committee, but our research indicated that organisations were unwilling to do this until they knew how the commissioning process would operate in practice, and what the implications would be for their locality. Indeed, the conclusion of a review of commissioning (during 2017) was to focus future commissioning activity largely within localities through a single commissioning function for health and social care rather than at the Greater Manchester level.

Overall, whilst we acknowledge the time required to undertake changes like this, we found in our fieldwork that there has been no great rush to commit to the ceding of autonomy for the greater good in Greater Manchester. However, this is perhaps understandable in the absence of formal changes to the regulatory regime. This was demonstrated by the move towards system-wide financial control totals. Whilst this might have been appealing for the Partnership Team, for individual NHS foundation trusts, it presented a considerable threat to their financial autonomy. Statutory duties and separate decision-making processes for individual GM Partnership organisations remained with their individual boards. There was no great rush to cede organisational sovereignty, and the ambition implicit in memoranda of understanding conveying agreement to co-produce decision-making was constrained in a competitive organisational landscape. This was the case even when the principles were generally supported by organisations and this necessarily impacted upon the pace of the process.

The presentation of Greater Manchester as a coherent geographical health and care system builds on the existing arrangements with AGMA/GMCA and the near coterminosity of NHS and local authority commissioners. However, given the challenges of overlapping boundaries of different patient flows, regulator geographies and so forth, the idea of a neatly bounded health and care system remains problematic, particularly for providers close to the periphery of the GM boundary or providers with substantial activity and income generated from beyond Greater Manchester.

4. Taking charge together: governance, accountability and relationships

4.4. The pace and scale of the task

The GM Partnership was pursuing a large-scale change process cutting across ten localities involving the design and implementation of what was often said to be over 300 distinct projects or programmes at a time when both local authorities and NHS organisations were experiencing unprecedented pressures in a complex and challenging environment. Moreover, as one of the front-runners of an evolving, extra-legislative set of changes responding to the national *Five Year Forward View*, health and social care devolution was a politically and technically complicated initiative.

In one sense there was an urgency to the devolution process with a 'do nothing' option deemed untenable by senior figures across the health and care system if the oft-quoted financial gap was to be closed and the sustainability of the health and social care system was to be assured. Participants cited the existence of a 'burning platform' as a catalyst for change. This was particularly noted by local authority leaders, who were experiencing some of the sharpest reductions in budgets in the country. Views were expressed by participants that change was driven in part by austerity with nationally determined financial constraints impacting on the delivery of care locally. At the same time, devolution was viewed as providing an exciting opportunity to make necessary changes to service provision in mental and physical health and care services.

Senior leaders in Greater Manchester recognised that their five-year vision for change was very ambitious and that devolution was an emergent, evolving and uncertain process. In the first year particularly, most effort was expended on bringing together the ensemble of actors and organisations working together to make sense of and flesh out the overarching strategic vision.

Over the course of two years, we observed substantial individual and collective effort, energy and enthusiasm invested in developing and implementing policies and strategies. Many reports and strategic documents were produced and agreed, governance structures organised and re-organised, business cases drafted, and memoranda of understanding signed. These included principles for co-production, with a diverse range of organisations (for example, Sport England, the Voluntary, Community and Social Enterprise sector and the pharmaceutical industry). The sheer rate of production of papers and the number of meetings undertaken was remarkable and all this activity played a part in bringing people together and increasing the familiarity of participants across Greater Manchester with one another. Indeed, at times the rate at which the papers were circulated and needed to be agreed upon was perceived by participants as being almost too fast for partners to secure engagement and gain agreement from their individual organisations. Yet, conversely, there was also some frustration expressed by participants that decision-making was not necessarily any quicker than would have otherwise been possible in the absence of the new arrangements under devolution. Apparently contradictory views expressed by participants that the process was simultaneously too rapid and too slow make sense given the activities involved and the scale of the endeavour.

The pace of change also appeared to lag behind the ambitious aspirations presented by GM leaders at the launch of health and social care devolution. This is, in and of itself, not necessarily a bad thing, despite the desire of some actors for things to be otherwise. Furthermore, it is understandable in a health and care system characterised by contradictory pressures to compete and collaborate and in a context where transformation is constrained by the requirement to focus on sustainability of the status quo.

4.5. Politics of devolution and the wider growth and reform agenda

One of the opportunities articulated for Greater Manchester's health and social care devolution was the 'once in a generation' link to the wider devolution settlement for the city-region. Greater Manchester was positioned as having the potential to align health and care expenditure with wider public service resources. With direct involvement of the ten local authorities, health and social care could be orientated closely with the wider growth and reform agenda of the city-region. There was an opportunity to maximise a focus on population health, wealth and well-being, with policies targeting wider determinants of health like education, employment, housing, transport and criminal justice increasingly playing some part in this process. In our fieldwork we found that this aspect of devolution had been slow to develop. Towards the end of our fieldwork, rapid pilots and projects connecting health to aspects such as work and justice were beginning to come to fruition, although the full links to the wider public service budgets had not yet developed.

Over time, we observed a growing recognition of the need to communicate to the public the progress and impact of devolution in Greater Manchester. Linked to this, in the latter stages of our research, there was discussion across the GM Partnership of the need for increased involvement of members of the public and the workforce to gain widespread support for the developments and decisions being made. For locally-challenging forthcoming decommissioning decisions associated with the Greater Manchester-wide plan, particularly in the acute sector, there was recognition of the need for local politicians and community leaders including the new directly elected GM Mayor to understand and be on board with the changes.

While the early development of health and social care devolution took place with almost no public or community engagement, the GM Partnership worked with the Greater Manchester Centre for Voluntary Organisations (GMCVO) in 2016 on a programme of consultation with a wide range of partners and community groups (Matziol and Martikke 2016). This found that "most [participants] seemed to have very little if any understanding. Partnerships reported many participants being aware that something was happening but not knowing any of the specifics". GMCVO is represented on the Strategic Partnership Board, a GM VCSE devolution reference group has been established, a memorandum of understanding between the GM Partnership and the VCSE sector was signed in 2017, and there is extensive voluntary, community and social enterprise sector representation on most other GM Partnership groups and committees. The ten local Healthwatch groups in Greater Manchester which are commissioned by local authorities secured joint funding from the GM Partnership in 2017 for a GM Healthwatch Liaison Function, aimed at promoting joint working and establishing Healthwatch representation in boards, committees and working groups.

The direct involvement of local authorities and elected members within health and social care devolution, meant that elected members were increasingly participating in local health and social care commissioning arrangements which brought new challenges for them. Yet, despite understandable moments of uncertainty through new ways of working together, there were early signs in our fieldwork of leaders, clinicians, councillors and community groups working together across organisational boundaries.

The election of the Greater Manchester mayor appeared to have influenced events in the GM Partnership. The role has only a relatively tangential link in the existing governance arrangements via public service reform work, but there was a developing alignment between the Mayor's manifesto commitments with health and social care planning and a conscious effort by the GM Partnership team to incorporate and cite the Mayor and those commitments in their plans. The election of the Mayor happened relatively late in our period of fieldwork when relationships were still in their early stages although the Mayor did communicate his direct support for the changes in progress.



Wigan Pier
Photo credit: Ben Sutherland

Devolution: making change happen **5**

In this chapter, we examine the changes to systems of care and services been planned and enacted that we have observed in Greater Manchester over the period of our fieldwork on health and social care devolution, drawing on both our qualitative and quantitative research (as described in Appendix A). It is structured principally around three of the main transformation themes in the GM Partnership's plan, Taking Charge – population health improvements;

5. Devolution: making change happen

5.1. A radical upgrade in population health prevention

A major ambition of Greater Manchester's health and social care devolution from the outset was to enable the greatest and fastest improvement to health, wealth and well-being of its 2.8m population. Greater Manchester has some of the worst health outcomes in the country and there are large variations in health outcomes within and across Greater Manchester. For example, a quarter of the Greater Manchester population lives in areas which fall into the 10% most disadvantaged in England, and three CCG areas are in the bottom ten in England for life expectancy. Almost whatever we measure – from rates of chronic disease, smoking or obesity to worklessness, mental health, school readiness or children's dental health, Greater Manchester is less healthy, and some parts of the city-region have among the worst health in the country (GMCA/NHS in GM 2017c). The GM Partnership has from the outset placed particular emphasis on the need for a radical improvement in population health, both as a goal in itself and as part of a wider improvement in wellbeing and community development, recognising the links between health, housing, education, employment and so on. It has also argued the need for a move upstream to prioritise health promotion and disease prevention, both as an end in itself and as a way to manage future demand for healthcare and other services. Of course these health inequalities have persisted for many years, and represent an embedded pattern of social and economic disadvantage in some communities which is likely to be hard to change, especially in the short or medium term. Indeed, many of the plausible levers for change do not lie in the health and social care system at all, but involve long-term efforts to develop community assets and capabilities and secure economic and industrial regeneration, and the GM Partnership's plans for population health should be seen in that wider context (GMCA/NHS in GM 2017c),

The GM Partnership has committed to a series of population health targets that run across the life-course in their strategic plan for Greater Manchester. These were aimed at enabling the population to 'Start well, live well, age well' and included things like reducing the incidence of low birth weight amongst newborns, increasing school readiness amongst 5 year olds, reducing deaths from cancer, cardiovascular and respiratory disease and supporting people to stay well and live at home for as long as possible. Our quantitative research is following the progress on these metrics and the findings will be reported in 2019.

The GM Partnership's 'whole system' approach positioned the health and well-being of its 2.8m population as shaped by more than the formal provision of health and care services alone. Explicit acknowledgement of the need to tackle the wider determinants of health was accompanied by plans to 'empower' individuals and communities to change their behaviours, with individuals expected to take increased responsibility for their own health.

Plans focused on prevention of ill-health, early diagnosis, behaviour change and resilience, underpinned by a more social model of health in contrast to traditional biomedical diagnosis and treatment centred policies, and very much in line with national policies and the Five Year Forward View. Asset-based approaches featured heavily, aimed at increasing the role of the voluntary sector in the formal provision and informal championing of community support and social prescribing. Changing the relationship between the public and public services was central to the plan in Greater Manchester, with an emphasis on championing positive change, rather than focusing on deficits. Self-care and individual responsibility were stressed and whilst structural inequalities were acknowledged within the population health plans, getting individuals to take responsibility for their own health, wealth and well-being was an overarching aim of the planned changes. Research has shown that encouraging citizens to take greater responsibility for their own health is no easy task. During the fieldwork period a Greater Manchester population health strategy was produced and updated and Greater Manchester-wide memoranda of understanding associated with population health were agreed with organisations including Sport England and the VCSE sector. Subsequent strategies aimed at improving population health were produced such as the Making Smoking History strategy (intended to reduce smoking by a third to 13% by 2021), with the backing of the Greater Manchester Mayor. We witnessed the start of pilot projects within localities whilst Greater Manchester-wide projects (e.g. children's oral health, school readiness, focused care etc.) were beginning to be implemented with relatively modest allocations of transformation funding.

We saw the publication of many strategies and discussion of numerous business cases in development. We also observed a great deal of enthusiasm for making tangible improvements to population health, as part of a process involving new actors and organisations in change, including the Greater Manchester Mayor. As with all the allocation and monitoring of transformation funds, business cases and return on investment modelling were used to underpin decision-making in relation to public health investments. By the time we concluded our research, however, there remained a long way to go before a full programme of population health policies was widely implemented across the localities and GM. Improving population health outcomes is not an easy process and we would not expect to see immediate changes, since many improvements take time to come into effect. However, much remains to be done to achieve the GM Partnership's ambitions for population health improvement and the roll-out of population health policies has proceeded quite slowly.

A real risk was that the population health agenda would be sidelined as immediate pressures in health and social care services took priority. All GM Partnership members agreed the importance of the population health strategy and supporting a shift away from treating illness to promoting wellness. However, we observed no major shifts in expenditure away from hospital care to support the population health agenda during our fieldwork. Furthermore, the GM Partnership recognised that public health funding had actually been cut by local authorities over this period following the shift of public health responsibilities from the NHS to local authorities (Gadsby et al., 2017).

Our quantitative research will examine the effects of these policies on population health outcomes. Our approach explicitly accounts for the gradual way in which policies are being implemented. We have used the Greater Manchester Population Health Plan and its subsequent strategies, together with discussions with population health leads at the GM Partnership to extract our outcome set on which the impact of devolution on population health outcomes will be measured. We have used the proposed policy implementation dates and estimated when these policies would begin to have an impact. We have then identified when the data would be available to enable us to measure that impact and plan to use this to enable us to quantify any resulting changes in health outcomes. This work is ongoing, and will be reported on from 2019/20 onwards.

5.2. Transforming community-based care and support

Central to the Taking Charge plan was the view that care should be shifted from hospitals to primary and community-based settings wherever possible. Connecting with the theme of radically upgrading population health, the ten localities adopted a place-based approach to improving care and people's lives. The concept of local care organisations (LCOs) was at the heart of the planned reorganisation of health and care under devolution, with the intention of reducing existing service fragmentation inherited from previous health and social care reforms. LCOs are population-based local adaptations of Accountable Care Organisations. They are provider-led organisational alliances based upon longer-term planning and contracting arrangements, incentivised to manage expenditure and demand, and encouraged to focus on measuring health outcomes. These mark a significant departure from the activity-based payment, competition-based model which underpinned the logic of the Health and Social Care Act 2012 (which remains in place). LCOs were expected to bring coherence and coordination to changes to population health as well as acute services. A summary of the ten locality based LCOs is given in figure 8.

5. Devolution: making change happen

Locality	Summary
Bolton	<p>No agreed name as yet. It will be an integrated care organisation composed of 9 neighbourhoods. Shadow arrangements will be in place in 2018/19 overseen by Health and Wellbeing Board executive and a partnership board. Full 'go live' anticipated for 1st April 2019.</p> <p>First phase in 2018/19 focusing on adult acute and community health services and adult social care with GP-led neighbourhood working. Subsequent phases by 2021 to include children and young people, primary care, mental health acute and community services and community and voluntary and small providers.</p>
Bury	<p>Bury Together 4 Bury – Bury Locality Care Alliance. It will be a provider alliance. MOU for LCO programme board was established for April 2017., and LCO will be established for April 2018 under a mutually binding contract. New contract framework expected from 2019.</p> <p>Focus is on key aspects of the transformation programme this year. By 2021, all age in and out of hospital care to be included except services part of Healthier Together and those not directly commissioned by Bury CCG or MBC. Core primary medical services under GMC contract to be aligned to LCO.</p>
Manchester	<p>Manchester Provider Board (name to be confirmed after contract award). It will be a separate LCO entity (legal form to be agreed) with four equal partners - Manchester University Foundation Trust (MFT); Manchester City Council (MCC); Greater Manchester Mental Health Trust (GMMH) and the GP Federation (MPCP). MFT is lead bidder/provider. Will 'go live' in April 2018.</p> <p>Phased approach to service transfer over three years covering the whole population, whole system integrated approach by 2021.</p>
Oldham	<p>Oldham Cares. It will use an alliance contract. A joint health and social care leadership group, shadow alliance board and alliance establishment group are in place. MoU, terms of reference and draft alliance contract agreed. Anticipated to be formalised and in place for April 2018.</p> <p>In 2018/19, will cover all CCG commissioning, adult social care, integrated children's services, public health, mental health, learning disabilities and devolved business. By 2021 will cover above plus all primary, community and acute care commissioned by CCG.</p>
Rochdale	<p>No agreed name as yet. It will be a partnership with a host provider - Northern Care Alliance. Shadow LCO development board in place, membership being developed. Intended to 'go live' in April 2018.</p> <p>In 2018/19 will cover a significant element of adults health and social care – neighbourhoods including social care, urgent care and primary care. To cover all adults and children's services by 2021.</p>
Salford	<p>Salford Together. It is an integrated health and social care system (IHSCS), with a lead provider for adult services and wider supply chain where providers work together. It has been in place since July 2016 with acute, community, adult social care and mental health for adults and older adults.</p> <p>For 2018/19, all ages in scope for Salford locality plan for IHSCS. Adults acute, community, social care and mental health services. Pooled budget c£240m. Delegated commissioning of primary care.</p>
Stockport	<p>Stockport Neighbourhood Care. It is an alliance provider board working towards becoming an accountable care trust. Alliance board has management team, GP lead in each of the 8 neighbourhoods, and programme team. Launched in Oct 2017, plan to move towards single alliance contract for April 2018.</p> <p>For 2018/19 covers adults with a focus on top 3,500 of adult population (identified by risk stratification) with enhanced case management support. New services grouped into acute interface, intermediate tier, and neighbourhoods. Plan by 2021 to transform delivery of outpatients with focus on self care, GP supported clinical decision making, clinical triage of referrals/investigations, alternatives to traditional appointments, etc.</p>

summary continued 

Locality	Summary
Tameside and Glossop	<p>Tameside and Glossop Integrated Care NHS FT. It is an integrated care NHS FT using FT licence to integrate services. Established Oct 2016. 5 integrated neighbourhood teams established in 2017/18 within ICFT. During 2018/19 ICFT will, subject to due diligence, become adult social care provider. New mental health contract planned for April 2019.</p> <p>Services covered now are community care and hospital services. By 2021, will also include adult social care, mental health, discretionary primary care expenditure. Further ways of aligning GP and other primary care services with the ICFT will be explored over the next few years.</p>
Trafford	<p>Trafford LCO. It is progressing towards a MoU initially, planning to move quickly on to alliance agreement through the Trafford LCO working group. Aiming to launch LCO in shadow form from April 2018. Plan to have alliance board with defined memberships, decision-making processes and accountability.</p> <p>Discussions ongoing about services to include with view to phased approach in 2018/19. Aiming by 2021 to cover all age, all services including mental health, voluntary, social care, acute, primary and community, excluding specialised services.</p>
Wigan	<p>Healthier Wigan Partnership. It is working towards an alliance agreement for April 2018. The Healthier Wigan Partnership board has been in place since November 2016.</p> <p>Services covered in 2018/19 include whole population out of hospital services with some hospital. By 2021, aim to cover out of hospital, acute and specialist services and wider services (e.g. housing, leisure, public health, residential).</p>

Figure 8. A summary of local care organisation development in Greater Manchester (as at late 2018)

Structures for commissioning and providing care in localities have been changing under devolution. There have been moves to pursue integrated health and social care commissioning, despite legislation requiring health and social care commissioning to remain with the separate statutory bodies. Rather than fully merging, locality-wide governance arrangements have been put in place with single commissioning bodies forming through strategic partnerships, and in a number of localities the chief officer role of the CCG being filled by the local authority chief executive alongside other joint working or appointment arrangements. These single commissioning bodies were increasingly being formalised with some pooling of budgets. As we completed our fieldwork, NHS, primary care and voluntary sector providers were starting to come together to formalise the ten LCOs, as outlined in figure 8

Working in collaboration across a variety of professional, organisational and geographic boundaries, LCOs are intended to incentivise health and well-being by aligning payments to population health outcomes, stratifying the population according to 'risk', moving services upstream to manage care more effectively and reduce urgent care demand. They have much in common with a host of other past and current organisational initiatives such as the Integrated Care Pioneers, and the FYFV New Care Models and Vanguard programme.

No single model of LCO was adopted uniformly across Greater Manchester but, commonalities existed among the ten localities. There was a broad expectation that these organisations should be principally driven from the lowest level by neighbourhood teams with an augmented role for primary care. At the end of the fieldwork the 10 LCOs in Greater Manchester were at varied stages of development. The variation in approaches was shaped by existing relationships between NHS organisations, GP practices and federations, local authorities and voluntary sector organisations and perceived strengths and development needs. Many changes were already under way before devolution, such as Salford's foundation trust-led primary and acute care system (PACS) and Stockport's GP-led multi-speciality community provider scheme (MCP) as part of the national FYFV Vanguard programme. However, all 10 localities were broadly aligned to delivering the strategic plan, and an LCO network was established to encourage the spread of 'best practice' between localities.

5. Devolution: making change happen

Most of the Transformation Fund has been allocated to localities to drive these changes, with high expectations of LCOs to deliver their anticipated potential. Across the majority of localities in Greater Manchester, initial investment agreements have been put in place, which are centred on shifting activity away from hospitals as a way of closing the financial gap. Projected reductions in activity and expenditure were based on a series of cost-benefit analyses (CBAs) completed by localities with the support of internal and external consultants.

The assumptions made in the CBAs differed by localities. Estimated policy impacts represent the biggest driver of projected expenditure reductions. Our research suggests that some localities based these estimates on promising unpublished early findings from New Care Models programme such as the Fylde Coast Local Health Economy and the South Devon and Torbay Urgent and Emergency Care vanguards. However, robust evaluations of the vanguards are yet to be published, and a National Audit Office report on the New Care Models programme suggests that activity reductions for those targeted by the vanguards may not have translated into activity reductions for the whole population (NAO 2018b). Other localities have estimated policy impacts based on avoiding a fixed percentage of expected activity growth, seemingly taking little account of existing evidence. Taken together this suggests that the projected expenditure reductions made in locality investments agreements are highly uncertain.

Some other commonly-made assumptions were examined in the initial phase of our quantitative evaluation of devolution. Firstly, projected reductions in A&E attendances were usually assumed to lead to proportionate reductions in non-elective admissions. Secondly, projected expenditure reductions were estimated by multiplying projected admission reductions by historical average treatment costs, implicitly assuming that unit-costs are invariant to changes in treatment volume.

Testing the first of these assumptions using historical activity data, we found that, holding the severity of attendees constant, reductions in A&E attendances were associated with higher than proportionate falls in non-elective admissions. This suggests that if initiatives to relieve pressure on A&E departments are successful, the consequent reduction in non-elective admissions may be greater than assumed by the localities. However, this is dependent on the nature of the intervention and the groups targeted, as changes in patient case-mix and therefore severity may change the relationship estimated here.

However, when testing the second assumption using historical data on unit-costs and volumes of activity, we found that per-patient costs increased as admissions fall, as fixed and semi-fixed costs are spread over a smaller pool of patients at least in the short-term.

Many of the CBAs applied 'cashability' adjustments reflecting a recognition that only a proportion of projected expenditure reductions will be translated into real savings. However, some localities made no such adjustments, meaning projected expenditure savings could be over-estimated.

Our ongoing quantitative research on devolution will assess the extent to which projections made in the investment agreements were accurate and are realised. This research will examine the effects of devolution on activity and expenditure across outpatient, elective, non-elective and prescribing services, as well as effects on the efficiency and quality with which these services are provided, and will report from 2019/20 onwards.

When the 10 LCOs are fully established across Greater Manchester, a major re-structuring of health and social care will have taken place. But even in the more formative stages, LCOs already appeared somewhat at odds with the existing organisational and legislative landscape, and securing widespread support from stakeholders such as GPs for changes to contractual arrangements is likely to remain problematic. The initial expectation was that certain commissioning functions would be transferred into the provider alliance/body of the LCO which would then sub-contract services themselves. Challenges are likely to persist in progressing work undertaken between CCGs and LAs such as pooling of budgets, with continued potential for disputes over organisational form and the politics of changes to commissioning and provision locally, within GM and nationally. A formal contracted approach using the national ACO contract which was intended to be commissioned in the city of Manchester is on hold at the time of writing because the legality of the use of the contracts like this is subject to judicial review, and most LCOs are using alliance contracting arrangements as figure 8 shows.

5.3. Standardising acute and specialised care

A third major component of the developments outlined in Taking Charge across Greater Manchester was a complex set of changes to acute and specialised care involving all the NHS trusts and foundation trusts in Greater Manchester. These changes were intended to address and reduce variation in care and improve patient outcomes across the whole of Greater Manchester through the creation of 'single shared service' models for acute and specialised activity in the city-region, covering in total about two thirds of all acute care activity.

There is a long history of acute care reform and reconfiguration in Greater Manchester. A number of changes to acute and specialised care were already planned or in progress before the advent of health and social care devolution. The pre-existing Healthier Together programme had advanced a range of cases for clinical change since 2012, and reconfiguration proposals had been agreed or were in train for accident and emergency services, acute medicine, emergency general surgery, and gynaecological and urological cancer services. A series of further priority services for reconfiguration were agreed by the GM Partnership in autumn 2016 including paediatrics (and specialised children's services); maternity; respiratory medicine and cardiology; benign urology; musculoskeletal services and orthopaedics; breast surgery services; neuro-rehabilitation; and vascular surgery. Acute service reconfigurations were paused and 'reset' in October 2016 to allow for a more comprehensive hospital site strategy and a single plan for Greater Manchester to be developed. The interdependencies between services, and the treatment of "stranded" costs left when services are reprovided elsewhere have proven complex and contested.

Two of the reconfigurations which predated health and social care devolution in emergency surgery and gynaecological cancer are now in an implementation phase with service changes expected to begin implementation in 2018/19. Changes to the provision of urological cancer services were agreed in July 2017, and planning has subsequently started for implementation. However, with the need to secure agreement across acute care providers and other stakeholders and to go out to public consultation on the changes, the GM Partnership does not expect to move towards implementation for further acute service reconfigurations before 2019.

While the focus of Taking charge was on service reconfiguration, some major organisational changes have happened since the advent of health and social care devolution, and have been important tests of the ability of the GM Partnership to respond to events and plan change collectively. The formation of the Manchester University Foundation Trust out of the merger of Central Manchester Foundation Trust and University Hospital of South Manchester Foundation Trust was undertaken following a review commissioned by Manchester CCG. The Northern Care Alliance was created by Salford Royal Hospitals NHS Foundation Trust as part of the system-wide oversight of the Pennine Acute Trust following an adverse Care Quality Commission inspection and report, and the two NHS foundation trusts are now run by a joint Committee in Common. Greater Manchester Mental Health Foundation Trust was formed through the merger of Manchester Mental and Social Care Foundation and Greater Manchester West Mental Health Foundation Trust. Tameside Hospital NHS Foundation Trust assumed responsibility for managing community health services for Tameside and Glossop and was rebranded as Tameside and Glossop Integrated Care NHS Foundation Trust in 2016.

If these extensive plans for acute and specialised care reconfiguration are implemented by 2021, they will bring about a very different acute care system in Greater Manchester. Our research indicates that devolution has enabled a system-wide approach to the rather complex Greater Manchester landscape, and has brought providers together with other stakeholders. However, all the challenges of complexity, sector speciality professional and organisational interests and the local politics of hospital provision remain. Whilst co-operation has been apparent throughout the devolution process among organisations, individual organisational pressures and incentives necessarily remain. The current devolution settlement may make system-wide change more likely, but it remains highly challenging.

It is worth noting that the Healthier Together programme of acute service reconfiguration was initiated in 2012 and not signed off by Greater Manchester commissioners until autumn 2017. This illustrates the pace of progress for such complex undertakings can be painfully slow. Public consultation will be a key step in these changes, and there is an awareness of the need to have political figures in localities and the GM Mayor on board with the strategy.

5. Devolution: making change happen

5.4. Enabling devolution: supporting programmes and projects

The ambitious scale of the plans made under health and social care devolution has meant that hundreds of initiatives and programmes were started during our fieldwork, with some entering their implementation phase. These included programmes to provide a system wide response in areas such as workforce, estates and IM&T infrastructure which were seen as key to the delivery of planned service redesign. These were also areas in which existing problems such as staff shortages leading to competition between GM Partnership organisations, diverse and deficient IM&T systems and varying degrees of digital maturity, insufficient NHS capital funding to undertake estates reconfiguration and resource implications of major upgrades to IM&T systems were seen as hampering the ability to achieve the ambitious planned changes and related health benefits. Whilst there were no quick fixes for these issues, the GM Partnership structures and processes facilitated high levels of engagement amongst relevant stakeholders and enabled alignment with regard to these issues of locality plans to those of the GM Partnership.

Specific programmes of work have been developed aimed at improving and standardising care in a range of areas such as mental health, cancer, children's services and dementia. In some cases, these have benefitted from allocations from the Transformation Fund. However, these processes were still at a relatively early stage when we completed our fieldwork. GM Partnership structures enabled stakeholders to come together to work on system wide planning but the engagement of citizens and frontline staff was very limited during our period of observation.

The main Greater Manchester-wide public engagement work under devolution to date has been the *Taking Charge Together* initiative. This exercise undertaken with the Greater Manchester Centre for Voluntary Organisations involved asking the public how they could be helped to take charge of their own health, and what they knew about health devolution reforms. At the GM Partnership level, the development of devolution appeared relatively technocratic and was largely driven by senior leaders in the initial stages. But there has been increasing public involvement in a number of the programmes of work, for example in the boards for programmes on mental health, cancer and children's services. A memorandum of understanding has been established with the VCSE (voluntary, community and social enterprise sector) and the ten local Healthwatch groups have collaborated at a GM level. At the locality level, various public engagement events were taking place, especially during the latter half of our fieldwork.

There has been a strong emphasis placed upon learning and evaluation in Greater Manchester's approach to health and social care devolution, with many visits and interchanges with people and organisations from elsewhere in the UK and internationally. A good deal of time and effort has been spent developing an evaluation framework, drawing on input from a range of stakeholder across the GM Partnership and beyond. At the core of this is the evaluation of the transformation programmes in each of the ten localities. More generally, shared learning between localities has been stressed from the early stages of our study and structures were in place which facilitated this. Additionally, increasingly international 'best practice' was sought, through learning networks with, among other places, New York State and Glasgow.

Devolution unspun: lessons from Greater Manchester 6

In this final chapter, we seek to draw together the conclusions from our research on health and social care devolution in Greater Manchester. We draw together the factual account of the chronology in chapter 3, the findings from our research on governance and organisation forms in chapter 4, and the findings from our research on the implementation of transformation programmes in the three main theme areas in chapter 5. We seek to consider their implications for other areas and for other initiatives aimed at integrating health and social care systems and reforming their governance to take greater account of population, place and the wider public realm. We noted in our introduction the three main aims of our research – understanding the policy process; following changes to governance, accountability and organisational form; and mapping changes to services and their implementation and impact – and we use these broad headings to structure our conclusions.

6. Devolution unspun: lessons from Greater Manchester

6.1. Understanding the policy process: making sense of devolution

The strategy set out in *Taking Charge* and other documents is not unique to Greater Manchester. Indeed, we have noted that most of the policy agenda that is being pursued reflects closely the national priorities of the government and the Department of Health and Social Care, and the NHS mandate and priorities and planning guidance of NHS England. In that sense, devolution has not been an exercise in allowing local autonomy or control over policy, but over its implementation.

Moreover, since the devolution initiative was established, other approaches to achieving these same policy objectives have evolved in the rest of England, including the Vanguard programme, Sustainability and Transformation Plans/Partnerships and latterly Integrated Care Systems. Arguably, these initiatives have much in common with health and social care devolution in Greater Manchester. We might see the GM Partnership as having prototyped or pioneered changes now being picked up more widely in England and as having had more freedom in some areas like transformation funding, but beyond that, it is hard to be sure what is the distinctive or additional contribution of devolution per se.

The early promise of widespread devolution deals with local authorities in many regions does not seem to have been borne out – no new devolution deals have been agreed between government and local authorities since 2016 (LGA 2018), with other emerging deals in Yorkshire and the 'North of Tyne' running into major challenges. Most of the current devolution deals do not include health and social care, apart from those for Greater Manchester and for London, and devolution is barely mentioned in the Department of Health and Social Care's mandate to NHS England for 2018-19 (DHSC 2018), though the language of devolution is being used in some other STPs. It seems that the momentum of the government's devolution programme has diminished somewhat – through changes in national political leadership, the experience of trying to reach consensus about devolution deals with groups of local authorities with divergent interests and political control, and the focus of political and parliamentary attention on Brexit to the exclusion of almost everything else.

While this may have allowed the GM Partnership some additional latitude to get on with health and social care devolution, it may also mean that political support for further potential reforms – for example formally transferring health and social care responsibilities to the GMCA, or giving the elected mayor a more formal role in oversight of health and social care, or creating new organisational forms for local care organisations, or extending devolution further – might not be readily forthcoming.

However, there is near complete consensus among stakeholders in Greater Manchester and, we think, more broadly, that the move towards more local or regional governance in health and social care in England makes sense. At one level, this can simply be seen as undoing some of the effects of the last government's NHS reforms, in which the intermediate tier of strategic health authorities was abolished in 2012 (Hammond et al 2017). It can also be seen as a response to the longer term fragmentation of healthcare services created by the purchaser-provider split, the creation of NHS trusts and then foundation trusts, and the establishment of various organisational forms in primary care of which clinical commissioning groups are simply the latest iteration. With an even longer and more historical perspective, it can be seen as the most recent development in a decades-long debate about the relationship between the NHS and local government, and the place of local government and democratic accountability in health and social care.

There is also near universal support for the idea that greater integration of healthcare services and of health and social care is needed. This can be seen as a necessary response to demographic and social trends in society, like increasing inequality and disadvantage for some groups, rising levels of chronic disease and multi-morbidity, a growing frail elderly population, and so on. It also represents the latest step in the long running debate about how to organise and fund adult social care, and deal with the many inconsistencies and problems created by having separate funding mechanisms and fundamentally different entitlements.

However, we should be cautious about claims that such reforms will bring about transformations in population health, service performance or uptake, or efficiency and costs. The complex reality is that these are wicked problems, and improvements are likely to be hard-won, slow and incremental. That is not a reason to eschew ambition, but to temper it with realism.

6.2. Changes to governance, accountability and organisational forms

We have described the health and social care reforms in Greater Manchester as soft devolution because unlike most such reforms, they have no statutory basis. They are, essentially, an administrative agreement between the Department of Health and Social Care, national bodies like NHS England and NHS Improvement, and NHS organisations and local authorities and others in Greater Manchester. The reason for this is largely that there has been no political appetite for primary legislation to reform or replace the Health and Social Care Act 2012 even though many of the structures and arrangements set out in the Act seem at best irrelevant to and at worst significant barriers to devolution and to the wider shift towards more integrated health and care systems in England. Ministers do have powers to enact some statutory reforms through the Cities and Local Government Devolution Act 2016 and other existing legislation, but have so far chosen not to use them in relation to health and social care devolution in Greater Manchester.

Whether this matters, is open to question. On the one hand, the GM Partnership has assumed many of the trappings and behaviours of a statutory body anyway. It holds board meetings in public and webcasts them, it publishes its board papers, produces many documents like annual plans and reports, and so on. People have observed that its leadership acts in some ways like the strategic health authorities which existed before they were abolished in 2012, but with the added component of local authority engagement in governance. However, the reality is that soft power has its limits, and the GM Partnership has few formal levers to use over NHS organisations, and even fewer in relation to local authorities. It has used its Transformation Fund of £450m creatively to seek to drive change, but that is probably only effective at the margins, and while that additional and non-recurrent source of finance lasts. Moreover, it has not been clear what (if anything) happens if investment agreement targets are not achieved. Individual organisations continue, understandably, to guard their autonomy carefully and to act in ways that, overtly or covertly, serve organisational self-interest.

In part this is because all the existing architecture of governance and performance management for those NHS organisations and local authorities continues to exist, meaning there has been no relaxation or variation in national waiting list, A&E and cancer treatment targets, financial controls, or regulatory oversight. At a time of unprecedented financial austerity for both local government and the NHS, there has actually been little scope for the GM Partnership and individual organisations to behave or act differently if that would conflict with the demands of the current performance regime. But it is also because many of these existing organisations have long established and distinctive structures, cultures and ways of working which are not easily compatible with the new language of collaboration, integration and collectivity.

The GM Partnership has invested heavily in building relationships among those health and care organisations which make up its membership, and developing shared governance arrangements and decision making processes which are intended to promote and sustain a collective narrative of managed consensus. However, it is difficult to tell how secure those arrangements are, and they have not yet really been severely stress tested, by circumstances in which individual or groups of organisations might, for example, be seriously disadvantaged in the interests of the greater good of Greater Manchester.

6. Devolution unspun: lessons from Greater Manchester

6.3. Changes to services and health outcomes: too soon to tell?

There has been much rhetoric about the benefits and possibilities of health and social care devolution, particularly at the outset when the devolution deal was first struck between national and local politicians and system leaders. There is a strong political and emotional appeal for many people in the idea that decisions about health and social care in Greater Manchester should be made in the city-region, rather than in London. This fits with a wider narrative about the renaissance of local government in Manchester and other cities, evoking the past glories of entrepreneurial, civic leadership and strong municipal government (Headlam and Hepburn 2015). It also chimes with more recent thinking about localism, place-based approaches to the governance of public services, and improving the economic and industrial performance and contribution of city-regions like Greater Manchester (e.g. MIER, 2009; Storper, 2013).

Even so, the promises made at the outset, and the targets articulated in the GM Partnership's plan *Taking charge* seem very ambitious. Since the launch of devolution, much effort has been expended in establishing relationships, setting up governance arrangements, and producing and agreeing strategies and plans, and the focus has only more recently shifted toward implementation and changes that service users and the public would notice. The GM Partnership has set out a wide range of changes it attributes to devolution (GMCA/NHS in GM 2018a). Many of those examples of course predate the devolution reforms, some represent recent transformation fund investments, and some are still in their very early stages. Those involved, especially at the outset, may have overpromised what devolution would achieve or the timescale in which changes would happen. We think this is well recognised by the GM Partnership's leadership which is now strongly focused on implementation.

The reality is that major health and social care system reconfiguration is very complex, time-consuming and difficult to enact, and it is difficult to tell whether devolution makes a real difference to the pace and scale of change. In the past, the approach to such challenges in Greater Manchester has been largely incremental – taking one or two organisations, or particular services across all or part of the city-region and seeking to redesign them mostly through negotiation, compromise and consensus. But that can be a very slow process, in which vested interests have little incentive to offer concessions and can block change, service interdependencies are not easily addressed, and shifting costs or realising savings is problematic.

The GM Partnership has consciously sought to take a more transformational approach, embracing complexity and tackling reconfiguration across the system as a whole – in primary and community care, most areas of acute care, mental health and other services concurrently. This is an ambitious strategy – if it works, it will achieve large-scale change much more rapidly, but if it does not, it will have been a very time-consuming and expensive exercise. It is still too early to tell.

It is also worth noting that those transformation plans, and the associated financial estimates on which funding has been allocated to support these complex service reconfigurations, make some optimistic assumptions about the rates at which planned changes will lead to shifts in demand for health and social care, and in patterns of service usage, which will result in efficiencies and savings. They also often contain limited details of the underlying mechanisms which are intended to bring these changes about. The aspirations which lie behind many of those plans to provide services which are, for example, better coordinated, closer to people's homes, more targeted on need, and aimed at preventing health problems or managing them more proactively are admirable. But research and experience elsewhere suggest that such changes may improve care, but will not save money.

Understandably, the challenges of the health and social care system and its reform have preoccupied the GM Partnership and this is where the great majority of time, effort and resources have been invested over the few years. Perhaps as a consequence, work on the population health strategy and its implementation has moved relatively slowly, and some of the exciting ideas that were voiced about better coordination and collaboration between health and social care services and making clear linkages to areas like criminal justice, education, housing and employment have largely not yet materialised.

6.4. Conclusions: what happens next?

We noted in chapter 1 that our qualitative fieldwork took place largely from December 2015 to September 2017, and allowed us to get a detailed and nuanced understanding of the development of health and social care devolution from the perspectives of many different stakeholders, which we have sought to summarise in this report.

Since then, we have continued to follow developments through the many documents, reports, plans, meeting minutes and so on that are in the public domain, and it is worth reflecting on what has happened during 2018, and how that might add to the findings we have outlined.

In simple terms, the direction of travel set during 2017 has been continued in 2018. The GM Partnership published its annual report for 2017/18 and business plan for 2018/19 in July 2018 (GMCA and NHS in GM 2018b) which outlines a host of ongoing initiatives – ranging from an update on the progress in establishing LCOs to participation in everything from the national Dying Matters week to the Pride in Practice initiative. It provides much less detail on financial performance, with a high level summary reporting a GM wide (health and social care) outturn of a £89m surplus compared with a planned £18.5m deficit, most of the improvement in outturn being attributable to national sustainability funding allocations to NHS trusts for meeting their control total targets.

The business plan for 2018/19 states at the outset that:

“2018-19 sees us move fully into the third phase of our operation as a devolved system. The first phase – lasting until April 2016 – was focused on establishing the devolved settlement for health and care in GM; the second – broadly until autumn 2017 – saw us embedding our governance, strategies and programme structures as well as supporting the allocation of the majority of the Transformation Fund; the third has an absolute focus on implementation of our plans.”

The plans outlined are very much consistent with developments in 2016 and 2017, though they frequently assert a need to accelerate progress towards implementation – for example in the service delivery changes expected of LCOs, or the design and implementation of service reconfiguration in acute and specialised care. The financial projections for the year are sobering – with NHS providers predicting a collective deficit of £159m (before provider sustainability funding of £83m) and four providers being unable to agree to the control totals set by NHS Improvement. The plan contains little information about local authority social care spending plans. A long appendix sets out many priorities for action in 2018/19, most concerned with health rather than social care.

In conclusion, health and social care devolution in Greater Manchester is in transition. It is clear already that the devolution deal struck in November 2015 was a starting point, not a destination, and the GM Partnership is now focusing increasingly on implementing a raft of new strategies and plans. The direction of travel in Greater Manchester has been fairly clearly set, though the pace of change in the future is more difficult to predict. Our quantitative evaluation, assessing progress towards the various performance measures and outcome metrics set out in *Taking Charge* is continuing, and the GM Partnership is now commissioning its own evaluations of the development and impact of LCOs and of a number of GM-wide programmes.

It seems likely that devolution in Greater Manchester will need some continuing support from central government including access to resources and some relief from national performance regimes and accountability requirements, and some further devolved powers. It does not seem, at this point, as if other areas are likely to embark on health and social care devolution following the Greater Manchester model, though as we have noted some quite similar reforms particularly to the organisation of the NHS are being pursued elsewhere.

At some point, not just for Greater Manchester, a new legislative settlement seems inevitable, to close the gap between statutory legal position and the facts on the ground, and to formalise these new forms of governance and accountability (Timmins 2018b).

The terms of that new legislative settlement are open to question, and should be a matter for widespread public debate, informed by, among other things, learning from Greater Manchester. In particular, there are two hugely important areas for reform to which the Greater Manchester experiment is highly relevant. Firstly, the decades long process of ever greater centralisation at a national level and fragmentation at a local level of healthcare policy and NHS provision could be reformed, in ways that create greater regional or local place-based governance, though this could also lead to greater variations in service provision. Secondly, the longstanding separation of funding arrangements and entitlements for healthcare and for social care could be reformed, in ways that promote integration, improve efficiency and effectiveness and reduce barriers to access, though this would increase overall costs and require more funding.



Withington Tram Stop
Photo credit: David Dixon

Appendix A.

Research methodology

The overall aim of the research set out in our research proposal to the Health Foundation and the Greater Manchester Collaboration for Leadership in Applied Health Research and Care (GM CLAHRC) was to contribute to the development and evaluation of health and social care devolution in Greater Manchester, and to support the sharing of learning regionally and nationally.

The research had three main objectives:

1

Understanding policy development and the policy process – what were the objectives of devolution, how they were constructed and developed over time, and how key stakeholders contributed to or influenced policy;

2

Understanding the governance and accountability arrangements and organisational forms and structures put in place through devolution, how they interact with existing arrangements, and how they work in practice;

3

Following the changes to services as they develop – seeking to understand planned changes and their underlying logic model and then to map and measure their implementation and impact on service metrics and health outcomes.

The project received ethical approval from The University of Manchester ethics committee (ref AMBS/15/01) and coordinated NHS research governance approval from the Health Research Authority (ref IRAS 192503).

Over the period of the research, while these overarching research objectives remained unaltered, our approach and methodology needed to evolve to respond to the development and timeline of devolution itself. In particular, we extended the time period of fieldwork and analysis for both qualitative and quantitative research to give more time for us to follow the development of devolution and to seek to assess changes and impacts – the third research objective.

A1. Qualitative research methodology

Our qualitative research was mainly focused on the research objectives 1 and 2 above, though we sought to gather information on objective 3 as it started to become available particularly during the latter part of the project. Fieldwork commenced in December 2015 and concluded in September 2017. We adopted a range of qualitative research methods to address the research questions. Data collection was principally undertaken by two researchers who became familiar to those involved in the devolution process. They observed meetings, which enabled the researchers to follow the development of devolution and decision-making processes in situ, taking contemporaneous fieldnotes on both the content and process of meetings, using the recording format shown in figure A1. Notes were typed up as soon as possible following meetings where they were expanded on and relevant details/ figures from meeting observations and available papers were added. They also conducted semi-structured interviews with some key informants, which explored a series of thematic issues in greater depth. Topic guides were adapted according to the type of organisation (e.g. provider, commissioner) and their relevant geography and included prompts to help make connections to issues raised in meeting observations. Interviews involved open questions to avoid leading questions and participants were

welcomed to shape the discussion raising topics which they felt were significant. In addition, we collated policy documents, reports, minutes and papers for meetings and observed various devolution events, conferences, seminars and other associated forums.

In accordance with the requirements of our ethics approval, all interviewees were approached before interview to explain the purpose of the research, and given a participant information sheet and the opportunity to ask any questions and to decline to be interviewed. The voluntary nature of participation and the confidentiality arrangements for the storage, analysis and use of interview data were made clear. Before interview, participants received and signed a consent form. For the observation of meetings which were not public events, the chair of the meeting informed meeting participants in advance of the researcher's attendance and at the beginnings of meetings that the researchers were present and would be observing the meeting, and the researchers were given the opportunity to introduce themselves and the research project as appropriate. On some occasions, participants felt that the matters to be discussed in meetings were not suitable for research observation, and the researchers would then leave for specified parts of the meeting as directed. There were a number of meetings which, for the same reason, researchers were requested not to attend.

Meeting:	Title of meeting
Date/time:	Date/time
Location:	Location and room of meeting
Attendees:	Record of who was attending the meeting (including late arrivals/early departures)
Pre-meeting observations:	Notes of any key developments/issues arising and general observations were taken whilst awaiting the main meeting to begin. This may include reflections on the atmosphere in the room, layout and so forth as well as any points of significance in terms of content of discussion, for example, provision of hand-out or unresolved issues at a previous meeting.
Body of meeting:	This was principally structured around meeting agendas, including opening comments, absences and the main body of matters addressed. Here, the content of meeting discussions and key quotations recorded and the researchers' initial reflections documented. For example, where certain issues progressively gained significance over a sequence of meetings, the researchers would record this, observing how key points of interest were expressed and reacted to by members present. Significant details or analytical points were flagged and marked in bold text when typing up notes following meetings. On occasion, meeting formats differed, for instance a guest speaker or discussion session and note taking format was adjusted accordingly whilst capturing both content and meeting dynamics.
Immediate reflections/ key issues:	Overall analytical reflections from the meeting were noted at the end in bullet point form and elaborated on in more depth when typing up meeting notes afterward

Figure A1. Meeting observation fieldnotes recording format

During the fieldwork, we observed 164 meetings and events totalling approximately 343 hours. we undertook 50 interviews which varied in length from 30 to 120 minutes. Most interviews took place in participants' offices or similar quiet locations,

though some were conducted by telephone, at the convenience of research participants. A sample outline interview schedule is given in figure A2 – this version was for interviewees from NHS providers and similar schedules were developed for other groups.

Opening discussion/refresher of research aim/objectives, ethics, anonymity etc.
• [General opener] How are things going?
• What is/are your role(s)? How become involved in devolution?
• In way of a general overview, can you say what you think is going particularly well and what is perhaps more challenging?
• What are you working on? What meetings attend?
• What influence are providers having under devolution?
• In what ways are relationships changing between FTs under devolution?
• How are things going with 'Transformation Theme 3' work in re-configuring acute services?
• There has been discussion of moving towards system wide control totals, how is system-based working affecting Trusts?
• What about beyond the Greater Manchester STP 'footprint'?
• Can you describe the links with Transformation Theme 2 – Local Care Organisations and community-based care and how that is developing?
• More broadly, what involvement do you and your organisation have in relation to your locality work and on-going changes? How is it changing?
• And the Transformation Fund? How is this working as a process?
• How is transformation affecting relationships between providers and commissioners?
• How have things changed with the Partnership Team? Changing?
• And what about relationships with different national bodies?
• What role of sectors now? (...Healthier Together...)
• Where is learning/critique taking place in the system?
• So overall, what are your reflections of the devolution process to date?
• Any concerns or uncertainties that we should consider?
Note – this topic guide is abridged, and topic prompts are not included

Figure A2. Interview schedule – provider template

The research was ethnographic in nature. Researchers were closely embedded within the policy process, often travelling to and from meetings with senior managers and holding many conversations outside the settings of formal meetings and interviews. This approach helped us to capture the attitudes, beliefs and what might be described as the 'textures' of changing relationships among participants and to examine the process as events unfolded, rather than retrospectively.

All interviews were tape recorded and transcribed verbatim. Meeting observations were written in field notebooks following the format detailed in Figure A1 and typed up as soon as possible following meetings. Relevant supplementary material from meeting papers which was referenced in meeting observations were incorporated into the expanded typed up meeting observation materials. These were saved on a password protected university shared space before being added to a data management programme (NVivo). Data was coded and analysed within the NVivo package.. An initial basic coding framework was developed by the two main qualitative researchers based on anticipated themes and added to through inductive coding. The coding framework was subsequently refined and grouped into parent and child thematic codes (different levels) by the lead qualitative researcher. Emerging analytical findings were discussed and expanded on in analytical 'memos' within NVivo. Analysis and emerging themes were discussed by the team in fortnightly meetings as well as through additional meetings held throughout the process by the main qualitative researchers. Specific analysis sessions based on analytical memos were undertaken by the team. Themes featured in the report were discussed and agreed by the team collectively. The team met periodically with representatives of the GM Partnership to discuss and test out emerging findings throughout the research process as well as holding advisory group and roundtable events which included a series of experts and stakeholders. The presentation of the report reflects findings from data collection and analysis.

A2. Quantitative research methodology

Our quantitative research was mainly focused on research objective 3 set out in the introduction to this appendix – seeking to understand planned changes and their underlying logic model and then to map and measure their implementation and impact on service metrics and health outcomes. Locality investment agreements detail the projected benefits of policies implemented using money from the Transformation Fund. The ex-ante quantitative element of the research comprised two components examining the accuracy of two important assumptions commonly made in locality investment agreements: the proportionality of reductions in attendances at accident & emergency (A&E) departments and reductions in the volume on non-elective admissions; and the degree to which reductions in the volume of admissions translate into cost savings. More detail on these assumptions and a summary of data and methods used to test them are provided below.

The proportionality of changes in the volume of A&E attendances and non-elective admissions

Hospital departments providing emergency care are facing unprecedented pressures. Recent evidence suggests that overcrowding is caused by a combination of demand-side and supply-side factors. Following the devolution of health and social care powers to Greater Manchester in April 2015, plans have been developed to reduce demand for emergency care by shifting care from hospital to the community. Locality investment agreements often assumed that non-elective admissions fall proportionately with reductions in attendances and emergency departments.

We examine how demand pressure and bed occupancy impacts care decisions in emergency departments using national data on attendances at Type 1 A&E departments (those with a consultant led 24 hour service) in England.

We use data on attendances occurring between 1st April 2015 and 31st March 2016 at 132 English Type 1 A&E departments, sourced from Hospital Episode Statistics (HES), supplemented with data from HES inpatient records for the same financial year. We took a random 10% subsample of the full sample for computational ease, generating a sample size of 1,308,203 observations.

We create a measure of A&E demand pressure for each individual attendance based on the number of other patients attending the same A&E department during the period in which the individual may be expected to be in A&E. To ensure that the measure is exogenous, we assume that all patients are in A&E for a 4-hour period, as this is the maximum time a patient is expected to spend in A&E. Patients whose stays overlap with any individual's attendance, and are thus competing for the same A&E resources, are therefore those attending in the 3 hours preceding and the 3 hours following this individual's hour of attendance. To adjust for seasonal and daily variation, we measure demand as the deviation in volume from its expectation, formed by the A&E department's experience in time variation in the volume of attendances in 2014/15.

We measure bed occupancy using data on admission and discharge dates from HES inpatient records. Unlike arrival time at A&E, time of admission and discharge are only available in days and so bed occupancy can only be measured at a daily frequency. The bed occupancy measure for each individual attendance is constructed as the number of inpatients in the provider in the day prior to attendance relative to the maximum daily number of inpatients being treated in the same provider over all days in that year, the latter serving as a proxy for the full capacity of the provider.

We estimated the associations between A&E demand pressure, bed occupancy and numerous methods of patient disposal using multinomial logistic regression. We define patient disposal as having four distinct categories: (1) admitted; (2) discharged with no follow-up; (3) referral or transfer to other care services; and (4) left without treatment. We control for patient demographics and severity, indicators of the date and time of attendance, and hospital fixed effects. The lack of a statistically significant effect of demand pressure on the probability of admission provides evidence for the proportionality of changes in the volume of A&E attendances and non-elective admissions.

A limitation of this approach is potential bias due to time-varying unobserved case-mix. Previous studies examining effects of overcrowding have exploited data from A&E vital signs assessments, but this data is not available in HES. If these measures are correlated both with care decisions and demand pressure, then the impact of demand pressure on the probability of admission will be biased. However, availability of such measures relies on a complete assessment taking place and as a result this data may not have been collected for patients leaving without being seen, meaning they could not have been included as covariates in our analysis even if data was available. In addition, by controlling for a range of observed measures of case-mix, we ensure that any bias is likely to be small. A final limitation is that by controlling for changes in case-mix we are examining the effects of demand pressure, holding the type of patient constant. If interventions implemented as a result of devolution act to change the case-mix and severity of patients attending A&E, the relationship between changes in the volume of A&E attendances and non-elective admissions observed in reality may differ from those predicted here.

The relationship between the volume of admissions and unit costs

Reducing expenditure by reducing the volume of hospital services is a key aim for devolution of health and social care in Greater Manchester. Projections on the cost savings from reduced hospital admissions made in locality investment agreements initially assume that total costs will fall proportionally with volume. This implicitly assumes that unit-costs are invariant to changes in the volume of admission.

However, economies of scale suggest that higher levels of volume mean that fixed overhead costs can be spread over higher levels of output, therefore reducing the unit cost. Higher levels of volume may also reduce variable and semi-variable costs through increases in operational efficiency. A subset of localities account for this by applying "cashability" assumptions, which adjust projections by assuming only a % of volume reductions translate into reductions in expenditure. However, little empirical evidence is available on which to base these assumptions.

Appendix A. Research methodology

The aim of this study is to examine elasticity of unit costs with respect to changes in the volume of admissions, and examine whether this elasticity varies by type of admissions.

We obtained data on volumes and unit costs from annual Trust Reference Cost returns. Reference costs provide annual, Trust-specific, per-spell treatment costs by Healthcare Resource Group (HRG) and admission method (elective, emergency and daycase admissions). We also used data from Hospital Episode Statistics (HES) over the financial years of 2010/11 until 2015/16. From these data, we constructed suspected drivers of unit cost including age, sex, morbidity, and length of stay.

Reference costs and HES data were merged based on Trust-admission-HRG-year. The HRGs used in the reference costs are HRG version 4+ whereas the HES data include HRG version 4. In the 2015/16 financial year, only 15% of HRGs in HES were matched to HRGs in Reference Costs. For this reason, we decided to estimate models without cost drivers as the main analysis and account for cost drivers as sensitivity analysis.

We estimated the relationship between cost and volume, controlling for covariates, hospital-HRG fixed effects and year fixed effects. We took the logarithm of volume and costs, such that the cost coefficient represents the estimate of elasticity. An elasticity of zero indicates that units cost are invariant to changes in volume.

We ran the analyses separately for the following types of admission: (1) All emergency, electives and day cases; (2) All emergency & electives; (3) Only electives; (4) Only emergency; and (5) Only day cases.

We tested the robustness of the results to small numbers by limiting the analysis to HRG-hospital combinations which had more than 5, 10 and 20 observations for all HRG-provider-financial years.

A limitation of this approach is the potential of bias due to time-varying unobserved case-mix. If unobserved case-mix is correlated both with both unit costs and the volume of admission, then elasticity estimates will be biased. This threat is more serious in specifications in which potential cost-drivers are not controlled for. In addition, as elasticities estimated in specifications including potential cost-drivers are restricted to only a subset of HRGs, these elasticities may not reflect observed elasticities over all HRGs. This limits their use in predicting cost changes occurring due to volume reductions resulting from devolution.

A brief outline of the ex-post evaluation of health & social care devolution

The overall aim of the ex-post evaluation is to examine the impact of health and social care devolution to Greater Manchester on population health, healthcare activity and expenditure, health system performance, and wider public sector outcomes.

This aim is supported by 3 main objectives.

1. To assess whether devolution led to average improvements in outcomes.
2. To assess whether devolution led to reductions in income-related outcome inequalities.
3. To assess whether devolution led to reductions in the variation in outcomes across providers and/or geographical areas.

In examining average improvements in outcomes, our empirical strategy aims to identify whether changes in health and social care outcomes in Greater Manchester after the implementation of devolution have been caused by devolution or have emerged either as a result of a continuation of pre-existing trends or due to nationwide policy changes occurring independently of devolution. Difference-in-differences (DiD) methods will primarily be used for this purpose, and broadly involve a comparison of changes in outcomes in Greater Manchester to those in equivalent areas in the rest of England. However, unbiased DiD estimates of policy effects requires the validity of the parallel trends assumption, which stipulates that, in the absence of the introduction of devolution, outcome trends in the post-devolution period in Greater Manchester would be parallel to those in the rest of England. The selection of appropriate methods is therefore guided by graphical and regression-based tests of the parallel trends assumption. If the assumption holds, DiD methods are used. If the assumption fails, we utilise lagged dependent variable regression, an alternative method which a recent microsimulation study has been found to be optimal in the event of divergent outcome trends. Objectives 2 and 3 will be tested by examining whether policy effects vary by the level of outcome and deprivation levels measured at the area/provider-level in the time period prior to devolution.

The initial set of outcome metrics was derived through a detailed examination of the GM Strategic plan and subsequent programme plans, frequent discussions with individuals from within the Partnership, and an investigation of available datasets to ensure metrics are available nationwide and collected at a sufficient frequency. These outcomes were then supplemented with outcomes typically used to track health system and public sector performance.

Potential impacts on different outcomes are likely to emerge at different time points, based on when devolution-induced policies to improve each outcome are implemented, differential lags to when these policies are likely to be effective, and the delay to outcome data becoming available. The ex-post evaluation is therefore separated into a short-term and long-term evaluation. The short-term evaluation is funded by the Health Foundation until March 31st 2019, and focuses on outcomes relating to healthcare activity and expenditure, efficiency and quality of care, and carer and care-user quality of life and self-care, which have been the focus of many locality Transformation Fund applications and the subject of short-term targets for outcome improvements in the GM Strategic Plan. Results from this evaluation are planned to be published in Summer 2019.

The long-term evaluation is conditional on securing additional funding and is planned to run until September 31st 2022. It has four main objectives. The first is to broaden the set of metrics used to measure health system performance, by examining impacts on measures of patient and staff experience and indicators of the quality and efficiency of mental health services. The second is to examine long-term impacts on outcomes examined in the short-term evaluation, recognising that such a large policy scale change may have effects which are either delayed or change over time. The third objective is to study the drivers of outcome change, for example by examining impacts on the healthcare workforce and the organisation of primary and secondary care. Finally, the evaluation will be broadened to examine impacts on population health and wider public sector outcomes linked to the GM Population Plan, supplemented with outcomes typically used to track population health. Results from this evaluation will be published in Winter 2022, although interim reports may be published periodically.



Clarence Mill, Tameside
Photo credit: Clem Rutter

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List of acronyms

AGG	Greater Manchester Association of Clinical Commissioning Groups: Association Governing Group
AGMA	Association of Greater Manchester Authorities
CBA	Cost-Benefit Analysis
CCG	Clinical Commissioning Group
FT	Foundation Trust
FYFV	Five Year Forward View
GMCA	Greater Manchester Combined Authority
GMCVO	Greater Manchester Centre for Voluntary Organisation
GM Partnership	Greater Manchester Health and Social Care Partnership
ICO	Integrated Care Organisation
JCB	Joint Commissioning Board
LCO	Local Care Organisation
MCP	Multi-speciality Community Provider
MOU	Memorandum of Understanding
NHSE	NHS England
NHSI	NHS Improvement
PACS	Primary and Acute Care System
PCT	Primary Care Trust
PFB	Provider Federation Board
SHA	Strategic Health Authority
SPB	Strategic Partnership Board
SPBE	Strategic Partnership Board Executive
STP	Sustainability and Transformation Plan/Partnership
TFOG	Transformation Fund Oversight Group
VCSE	Voluntary, Community and Social Enterprise

