

## **Response to Call for Evidence**

### ***The Health Devolution Commission***

#### **An inquiry into the value and accountability of devolved health systems**

#### **Author**

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#### **Introduction**

1. In 2015, Greater Manchester (GM) has landed a landmark devolution deal in health with the government. National Health Services (NHS) England agreed to delegate some functions to the city-region, including strategic planning and administrative responsibilities.
2. Through the Devolution deals, a new Greater Manchester Health and Social Care (GMHSC) Partnership was introduced to bring together 37<sup>1</sup> statutory institutions, including 10 local authorities, 10 CCGs and 13 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, to take charge of the health and social care economy of the city-region and to undertake the responsibilities outlined in the Health Devo MoU. The body is responsible for strategic planning and financial and monitoring oversight of the £6 billion budget for health and social care in GM.

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<sup>1</sup> 37 at the time of signing MoU on 2015, but Manchester CCGs/Trusts have merged. Current count is 33 organisations

3. With 5 years now since Devolution has started, the governance surrounding the GMHSC continued to evolve over time, where a lot of institutional architecture is involved to reconfigure the system to engage various stakeholders in working collectively.
4. The evidence submitted in this document draws from the data that was collected between July and December 2018 and presented in the author's PhD thesis (submitted on 2019 and defended 2020).
  - a. 38 semi-structured interviews were conducted, which included members of the GM HSCP project management and executive team; CCG directors; Public Health directors; senior leaders from local authorities; General Practitioners (GPs) and clinicians from provider and foundation trusts; and members from voluntary sector and other partner organisations who were involved in multiple streams of decision-making within the Partnership.
  - b. They acted as key informants for the thesis, providing narratives about the emergence of the Partnership, how the organisations interact with one another, how collective decisions were made within the governance, and how the health devolution and the Partnership had impacted the delivery of health and social care services in GM.
  - c. To comply with the ethical procedures, this study obtained an ethical approval from both Manchester Metropolitan University (sponsor) and the Health Research Authority (HRA) (NHS sponsor).

**How can challenges of accountability, power and control be addressed in devolved and integrated health systems?**

*What is the relationship between central government, NHSE and devolved health areas?*

Role of NHS England

5. The absence of legislation meant that NHS England was able to preserve the national characteristic of the NHS by ensuring that not all statutory responsibilities were fully discharged to the GM. This is in order to preserve the 'N' out of the NHS and to ensure that the national standards and assurance processes are not lost in the devolution process.
  - a. It was a hands-off mechanism that allowed them to exercise influence whilst giving the Partnership some level of autonomy in defining their own paths and setting their own strategic agenda.
  - b. A senior local authority leader, however, highlighted that the intention of the NHS to preserve the 'N' is problematic in a way that not everything has to be implemented on a national level across the rest of the country (L05). The NHS needed to acknowledge that different regions have different needs in terms of addressing their population's own health outcomes, thus making it quite difficult to achieve improvement if devolved regions are still subjected to national assurance and control.
6. Some participants felt like GM Devo Health deal it was being enforced or mandated rather than encouraged (P03, P04). Since without written statutes, NHS responsibilities cannot be devolved legally, thus, the MoUs were put in place "to push collaborative work despite the statutes separating it" (P03, P04). This only caused misunderstanding as to what the true meaning of Devolution is about especially when on a hindsight, devolution does not really entail what it's meant to be.
7. The power awarded to GM was therefore, in some respects, an illusion (G03). Whilst it alleviates the GMHSC Partnership from the bureaucratic processes and enables them some level of freedom to do things differently, the irony is that GM is still subjected to NHS constitution and mandate.
  - a. This was illustrated in the GM Strategic Plan, where transformation programmes such as decreasing A&E waiting times and the implementation of the locality plans were patterned against the NHS Five-Year Plan.

- b. A Partnership project management director said, “The central national governments said yes it's something that we're prepared to consider, but we want to see a coherent Five-Year Plan for Greater Manchester.” (G05). This was a way of NHS England practicing its meta-governor role by “steering, not rowing” and making sure that GM still complies to national policy.
- 8. The outcomes of the negotiation for the Devolution agreement illustrate that NHS England is still playing the role of a “meta-governor” orchestrating control mechanisms to assert political authority whilst also indirectly influencing the practices and preferences of distal networks and hierarchies to promote their agenda. This was visible throughout the institutionalisation of the GHMSC Partnership.

#### Political leadership

- 9. Political leadership played an important part in driving the devolution deals forward for GM (C04). Local leaders and key figures from the GM Combined Authority played key roles in negotiating for the Health Devo deal.
- 10. Andy Burnham’s entrance to the GMHSC Partnership created a unique and almost synchronic link with the GMCA (G03, P05), which in effect, impacted the way participants interact in the activities in the Partnership level.
- 11. At the same time, another key figure emerged to take command in steering the direction of the GM health and social care economy. Jon Rouse was appointed by NHS England to take on the role of Chief Officer.
  - a. Jon Rouse’s appointment was mostly met with praise by the interviewees. He was regarded as a key driver of the team and an inspirational figure, who motivates the key stakeholders and partner organisations to work harder and collaborate together (G04, L04, L06). He has the vision to drive things forward and has the ability to facilitate conversations, making his addition to the GMHSC Partnership all the more prolific.

- b. Some believe his influential presence bred a positive mindset of “working differently” within and between organisations (G04, F01, P05), making it easier for the Partnership to navigate through the governance structures.
  - c. For instance, a Partnership program management lead suggested that “if we sometimes say Jon Rouse is really keen on this, and Jon Rouse wants this to happen, that makes a difference,” in terms of implementing programmes of work (G04). Another also shared that Jon Rouse’s impact to collaborative working across NHS organisations led to opportunities and conversations that they never had before Devolution.
12. Interviewees think that the presence of both Jon Rouse and Andy Burnham were key to breeding successful relationships within the GMHSC Partnership (L04, P05). They were the two pillars of Devo Manc, holding the entire city-region together and putting it on a pedestal for the rest of the country to see. Both of their outstanding reputation as leaders have created a magnet effect across different areas by attracting a high calibre of professionals who would want to work with the various localities and NHS organisations in GM (L04).

#### Partnership response to Devolution barriers

13. The key stakeholders of the devolution agreement were all statutory bodies (i.e. ‘hard structures’) with existing responsibilities and reporting lines, hence, the Partnership had to resort to collaborative mechanisms or informal institutions in order to overcome the absence of legal power to exercise mandate or enforcement over the partner organisations (i.e. CCGs, Trusts and FTs, etc.).
14. This was supported by overarching governance structures to order the relationships and to order the relationships and organise powers and collective behaviour of the participating organisations.
15. The Partnership strengthened collaborative working by utilising the existing informal networks (i.e. ‘soft structures’) as channels of information and exchange of knowledge.

- a. Primarily built on trust, reputation, and reciprocity, the Partnership core team used shared understandings (i.e. norms or social arrangements) to structure patterns of interaction with the key stakeholders and partner organisations.

### Engagement in all stages

16. The Partnership relied heavily on face-to-face dialogue to build up the relationships and as the collaborative process matures from the direction-setting to the implementation stage.
17. The interviewees emphasised the aspect of strategic building as co-production and co-designing (C01, G01), where it particularly focuses on the level of involvement of the different stakeholders in the creation and development of the strategies and programmes.
  - a. The Partnership made sure that all levels of the governance structure have seen, read, engaged, and discussed all project proposals, strategic documents, and frameworks prior to approval by the decision-making bodies.
  - b. This allows not only an opportunity for the participating organisations to identify best practice, share their expertise, and provide collaborative input, but also a way for them to incorporate their local needs to the overall collective direction of the GMHSC economy (G01, G04, C02). A CCG integration lead shared, “if it's co-designed and they reach out to localities in the development of it, you help with the strategy and it has a strong flavour from each area.” (C02)
18. The co-designing of the strategy and frameworks, in addition to the signing of the MoU, provided a leverage for the Partnership to have some teeth in terms of implementation, monitoring, and assurance.
  - a. Because they have no hard mandatory powers to enforce the strategy, they used it as a buy-in mechanism for all participating organisations to take ownership and collective responsibility of what they originally signed up for (C01, L04).

19. The Partnership took advantage of the informal networks formed pre-dating Devolution and used it as a channel to bridge the gaps in the system. Because these relationships were already built in decades of mutual trust and reciprocity, it was easier for the Partnership to bring sectoral groups together and provide a forum for them to generate a collective voice.
  - a. For example, the formation of the Advisory Groups incorporated the GM Association of CCGs, Provider Federation Board, Primary Care Advisory Board, LCO Network, and Joint Commissioning Board, and gave them a role in terms of providing non-binding advice to the main decision-making bodies of the Partnership.
20. More importantly, informal networking became a useful tool for the Partnership to facilitate conversations, engage in discussions, resolve conflict, and monitor compliance between the members.
  - a. The Partnership used principled engagement and face-to-face dialogue outside the formal forums (i.e. meetings, etc.) as collaborative mechanisms to getting the right people to come to the table and sort out their issues or differences before any decision reaches the Partnership Executive board or Health and Care board.
  - b. This was the Partnership's way of playing the role of a mediator, but also establishing trust amongst each other and earning the key stakeholders' respect at the same time.
21. Partnership members used influencing as a mechanism to bridge relationships at different levels within the Partnership, especially in areas where there are existing tensions between local NHS organisations and local authorities.
  - a. Influencing was used in various Partnership activities to persuade people to change their opinions, lobby for ideas, or get their foot in the door to bring together and speak with the right people.

- b. Some believed that the Partnership also brought in members with influential status, like Jon Rouse and his executive team, who have the ability and power to get things done and breed a new organisational culture of collaborative working. This further solidified the existing relationships that have already been cultivated in GM for decades.

22. Another role that the Partnership played was a broker. The Partnership acted as negotiators across the different sectors in order to facilitate conversations and resolve issues before it reaches any formal decision-making venues.

- a. They were the middlemen during discussions, where they practically diffuse or rectify any source of conflict or consolidate opposing views in order to avoid friction in relationships and further escalation.
- b. This ultimately helped in making difficult conversations happen through informal conversations outside meetings. Since the system was used to a competitive way of working, the Partnership had to proactively manage the fragmented relationships and join the dots by bringing all the right people in the same room and facilitate debates or discussions.
- c. Being a broker was mostly helpful during the monitoring and assurance phase, when the Partnership find it difficult to sanction any partner organisations or localities who were not complying with the agreed proposals or programmes that they were expected to deliver.
- d. They used this as a hand-holding mechanism to walk the member organisations through on how they can get from point A to point B and achieve the necessary outcomes that they collectively signed up for.

23. As part of their monitoring mechanisms, the Partnership preferred to resolve any difficulties before a recovery plan is put in place. They step in and assess the severity of the situation and enter a negotiation process with the parties involved to address the issue before it reaches the decision-making bodies (i.e. the Executive board).

### Collective ambition and co-ownership attitude

24. Whilst there were some pockets of resistance and tensions during the establishment of the Partnership from different key stakeholder groups, there was still a strong presence of collective ambition.
25. A lot of the driving force comes from the leadership groups, particularly Jon Rouse and his executive team, who encourage its members to work collaboratively in order to share best practice and create better outcomes for GM. "I think it's brought a spotlight on a new and innovative way of working that we're really lucky to be part of," an LA councillor illustrated (L03). There is a great desire to lift the standards up and improve health outcomes for the population of the city-region and put GM on the map as a pioneer model for Health Devolution across England.
26. There was also a level of "we signed up for this" attitude or co-ownership of problems and decisions became a useful mechanism for the Partnership to enforce rules in monitoring and assurance, whilst also fostering strong community roots.
  - a. Interviewees suggest that the Partnership has given them an opportunity to work differently. For some, it was quite empowering just to have ownership and to take charge of their own health and social care economy (C01, F01, G08, L04, P08).
  - b. For localities that are so tired of getting dictated by NHS England on what to do and how to handle their resources, it was a breath of fresh air for them to be given the responsibility and encouragement to come together and do what they think is best for their area (C01).
  - c. Because the Partnership and its participating members have ownership on its plans and the rules that they crafted to facilitate their decisions and interactions, it fostered a new atmosphere of collaboration that has not been done before in GM or anywhere else in the country.

27. *“More subtly, I think it's given us permission to behave differently, to think at scale, to be innovative, to use a different language in a way that we couldn't before. And I think it also allow us to do is take action at a different scale than we ever could have previously. You hope that by taking action at scale, you have a scale impact as well in a way that we couldn't do before.” (G14)*

28. This built up reciprocity between the members, wherein there is almost an immediate sense of pride that supported the way they interact in the Partnership level. “When I speak to my colleagues in Merseyside or in London, they say ‘You're so lucky to have GM devolution,’” an LA councillor said (L03). It enabled for stronger links between one organisation to another, which provides opportunities for mutual exchanges to occur. It also helped build a collective reputation for GM and brought other similar city-region’s attention to GM’s innovative way of working.

*What is the nature of the relationships between local clinical leaders (health commissioners and providers) and civic (professional and elected) leaders?*

NHS culture

29. One of the biggest challenges that Health Devo needed to overcome was the culture of fragmented working within the NHS system. Differences in organisational culture can indeed aggravate the difficulty in collaboration because everyone works in entirely different professional languages and procedures. Each stakeholder group is used to working a certain way that some felt that Devolution is mandating them to collaborate (P03, P04).

30. Different organisations occupy different positions within the Partnership governance, which perhaps makes collective participation more diverse and heterogeneous. Some individuals may have stronger self-interests in achieving more benefits than others, whilst some may exercise deterrent behaviour to cooperation.

31. The retained lines of accountability and the lack of statutory changes within the NHS system resulted in organisations clinging onto their own procedures and representing their own organisational interests when they come to the Partnership decision-making arena.
32. Decisions are influenced by partisan motives demonstrated by their attachments from the organisations' own discipline or the geographical area they represent (P03, P04, C01). There will always be an element of competition arising from the retention of market principles inherited from the Thatcher government.
- a. This led to a level of difficulty in trying to change the way organisations operate because they have always been used to working in a certain manner, i.e. competing with each other.
  - b. For instance, Trusts are deeply accountable to their board of members, where they are used to competing with one another in order to be sustainable. They are subject to quality control and performance checks from NHS England, which are crucial to their survival if they are to risk making collective decisions with other Trusts in GM. If decisions are to negatively impact one's Trust or changes of service will have a disadvantage on another, then they are more likely to make a choice that benefits their own organisation thus making it less likely for a collective unit to reach a joint unbiased decision.
33. Resistance to collaboration is inevitable, especially when organisations operating within bureaucracies needed to change their ways of working and challenge longstanding rules, regulations and attitudes.
- a. GPs are more collaborative by nature because they are small businesses working collaboratively and less competitively in the same neighbourhoods, whilst Trusts are statutory bodies that are organisationally profiled/structured (G15).
34. There is an obvious tug of war in terms of who has more power to make the decisions and which decisions to prioritise, heightening the split caused by the NHS internal

market and Lansley reforms. “Where statutory bodies are set to gain, those decisions tend to make quite easy and things move quite fast,” GP senior officers described (P03, P04).

35. Such difficulties in the system created more friction between groups and make joint decision-making more challenging at a local level. The main challenge, perhaps, is the different organisational cultures, where you've got people from the NHS who are used to working in a certain way and then you've got people in local government working a different way (L01, L02).

36. Despite the scepticism to the delegated arrangements dictated in the constitutional level which in turn limited the levels of action and interaction in the collective-choice and operational levels, the participants recognise the added value or immediate outcomes that Devolution has brought to the GMHSC system.

37. Many acknowledged how Health Devo has enabled the system in so many ways, particularly in creating new formal avenues to meet and work together. Some also believed that although there has been no increase in shared resources, particularly the alleged £6 billion budget for health and social care, Devolution allowed the localities some level of collective control to managing their own existing resources. “It's not new money, no. But it is having control of the resources and having the opportunity to bend it and use it,” an LA councillor explained (L04).

*How does health devolution affect policies to empower individuals to have more control over their health and social care services and outcomes?*

#### Empowerment and incentivisation via the Transformation Fund

38. The Partnership acted as an enabler to the system. They brought closer a new funding stream (i.e. the Transformation Fund) to enable transformative projects to take place

within localities and give the opportunity to deliver better outcomes and close the financial gap.

- a. The Transformation Fund was an important source of financial flow across all localities and arrangements had to be put in place in order for the Partnership to decide who can acquire from this resource, how do they become eligible to receive it, and how do they monitor if the receiving party is utilising it as initially agreed.

39. Localities receiving the money are incentivised to take part and contribute to the collective vision of GM and use the extra cash to boost their local services at the same time. “The devolution deal has actually provided us a source of funding to help us drive transformation,” a CCG board member shared (C03). Given austerity and budgetary pressures, it was a “drop in the ocean” (G04) that allowed localities to “shift things around” (L01) and enable them to implement their plans, make transformations, and improve health outcomes to their local population.

40. The Transformation Fund also generated an atmosphere of local competition between the localities. Because the funding is limited, the Partnership devised a tedious process on how various workstreams can have access to the funding.

41. Localities were made aware of the kind of conditions in which they could apply to the funding, which included application, assessment, awarding, and monitoring stages (G02). Whilst some were fortunate to be able to bid during the initial stages, others weren't as lucky.

- b. One described how they were only awarded a fraction of what they originally bid for, which makes it more problematic to implement the proposals for their transformational themes (C01, F02).

- c. Another said that the bidding process was difficult enough to go through, where they had to justify their costings and proposed outcomes in front a panel (F01).

42. Currently, all of the Transformation money has been distributed and localities are under pressure to deliver the outcomes they have promised in their locality plans. They have

to keep up with monthly monitoring and assurance checkpoints with the Partnership team to make sure that they are performing as expected of them.

## **Conclusions**

43. Greater Manchester has had a long history of collaboration long before the devolution deals were introduced. They've always had a strong reputation and a track record of working together, which is why it came to no one's surprise that GM was a viable candidate for the devolution deals. There was a sense of pride that GM, more than anywhere else, have succeeded in working together despite the absence of any statutory mandates from the central government. This voice, in particular, was more present with local authorities where key leaders were proactive in recognising the needs of the GM economy by taking upon themselves to pursue and maintain voluntary relationships.
44. Our findings suggest that the Partnership demonstrated that with the right combination of leadership, trust, and collective intention to resolve joint problems, then it is possible to overcome the political barriers of Devolution. They were able to successfully craft, enforce, and monitor their own institutional arrangements to overcome the limitations of the formal rules and to use them as countermeasures to self-seeking behaviour.

## **Appendix**

- i. The premise of the thesis is that health systems leaders of a regional multi-sectoral partnership can come together as a collective unit and act as stewards of their "health commons". They can devise formal and informal institutional arrangements, alongside with collaborative mechanisms in order to address collective action dilemmas, i.e. the sustainability issue of the "health commons".

List of participants recruited for the study

<b>Identifier</b>	<b>Role</b>	<b>Organisational group</b>
<b>C01</b>	Senior CCG Lead	CCG
<b>C02</b>	CCG Integration Lead	
<b>C03</b>	CCG board member	
<b>C04</b>	CCG board member	
<b>F01</b>	Foundation Trust Senior project director	NHS Foundation Trust
<b>F02</b>	Foundation Trust Senior officer	
<b>F03</b>	PFB Senior officer	
<b>G01</b>	Partnership project management lead	GMHSC Partnership
<b>G02</b>	Partnership finance lead	
<b>G03</b>	Partnership project management lead	
<b>G04</b>	Partnership project management lead	
<b>G05</b>	Partnership project management director	
<b>G06</b>	Partnership project management director	
<b>G07</b>	Partnership project management lead	
<b>G08</b>	Partnership senior director	
<b>G09</b>	Partnership project management lead	
<b>G10</b>	Partnership project management lead	
<b>G11</b>	Partnership project management lead	
<b>G12</b>	Partnership project management lead	
<b>G13</b>	Partnership senior director	
<b>G14</b>	Partnership project management lead	
<b>G15</b>	Partnership senior director	
<b>G16</b>	Partnership project management lead	
<b>G17</b>	Partnership senior director	
<b>L01</b>	Councillor (Health and Wellbeing board)	Local authority
<b>L02</b>	Local Authority Senior Leader	
<b>L03</b>	Councillor (Public Health)	
<b>L04</b>	Councillor (Public Health)	
<b>L05</b>	Local Authority Senior leader	
<b>L06</b>	Healthwatch senior lead	
<b>P01</b>	Consultant, partner	Partner organisation
<b>P02</b>	Senior project lead, partner	
<b>P03</b>	GP senior officer	
<b>P04</b>	GP senior officer	
<b>P05</b>	VCSE Director	
<b>P06</b>	Senior project lead, partner	
<b>P07</b>	Senior CCG board member	
<b>P08</b>	Senior CCG board member	

