GMHSCP

Evaluation of the local care approach: summary of key findings

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About this summary

This summary presents key findings from the evaluation of the Great Manchester (GM) local care approach. The evaluation focussed on six localities (Bury, Bolton, Oldham, Rochdale, Trafford and Wigan) and involved over 300 interviews with key stakeholders at both GM and locality level over three points in time. First-stage interviews were conducted in February-March 2019, second in December 2019, and third in November 2020-March 2021. The evaluation approach also included a range of locally specific methods such as workforce focus groups and service 'deep-dive' case studies.

The summary provides key findings about the local care approaches':

- Key components
- Structures including approaches to governance and accountability
- Leadership and relationships.

About the local care approach

The core objective of the 'Taking Charge' devolution agenda in GM was to see the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people in Greater Manchester. To achieve this, the local care approach aimed to deliver an **integrated approach to commissioning and service provision across the health and social care system**, with an emphasis on **place-based ways of working**. Stakeholders were clear that the COVID-19 pandemic had not distracted from these aims. Instead, it has reinforced the commitment to the local care approach and integrated working in the localities.

The core features of the local care approach include a **local care organisation** (LCO) and a **strategic commissioning function** (SCF) (discussed in more detail below), as well as a model of **neighbourhood working**. LCOs are not currently legal entities, but alliances of health and social care providers working together to plan the delivery of services, and SCFs at a minimum consist of a joint commissioning committee of Council and CCG commissioners, with a shared budget.

The form of these core features varies in each locality, as the models have been tailored to suit local needs and respond to changing circumstances and challenges.

The neighbourhood model

The neighbourhood model has remained the core and most consistent feature of the changes made to service delivery within each locality. Each locality is organised into geographic neighbourhoods of 30-50,000 people, each neighbourhood is served by an **integrated neighbourhood team (INT),** including district nurses and social care staff and linking to wider professionals. The aim of this approach is to provide **holistic, person-centred, and joined up care**, **keeping patients out of hospital** where possible.

All localities are progressing towards **full co-location and integrated management** of their INTs, overcoming challenges relating to estates and IT systems. Integration with other health and care services is also improving, with increasing involvement in the INTs of mental health, pharmacy and the voluntary, community, faith and social enterprise (VCFSE) sector, for example, via social prescribing link workers.

Progress has also been made in the development of links to the **wider public service reform approach**, including housing and the police, for example, through multiagency huddles in Wigan and Bury. This demonstrates the development of approaches which aim to address the **wider determinants of health** within the neighbourhood model.

Full integration with general practice remains a challenge, particularly due to the creation of primary care networks (PCNs) which did not all align with existing neighbourhood footprints when they were first created. This created challenges in relation to leadership, management and delivery in some localities. However, progress has been made in developing joint working practices and relationships between the INTs and PCNs, even where boundaries remain different. The introduction of joint meetings was reported to be helpful in Bury and Bolton, for example.

The localities are committed to continuing to strengthen the neighbourhood model, for example, through the ambition to create neighbourhood boards and devolve certain commissioning decisions to the neighbourhood level.

Other elements of the local care approach

GM has been ambitious and innovative in its approach to public health, prevention and early intervention. There has been mixed success in this area in the localities. Particularly positive has been the introduction of early screening and health checks, for example in Trafford and Oldham, and the development of Health Champions roles in Wigan. However, in some localities concerns were expressed that resource for programmes introduced as part of the local care approach – including some resourced by the Transformation Fund – with a focus on public health and prevention had been cut before their impact could be demonstrated or remained fragile in the face of continuing financial pressure across the system.

The COVID-19 pandemic served to highlight the importance of public health and strengthened community-based initiatives driven by the VCFSE sector across all localities. As the approach in GM develops, locality stakeholders suggested that the progress made during the pandemic should be maintained and progressed through the development of a joined-up public health and prevention strategy for recovery.

Structures, governance, and accountability

The LCOs and SCFs together make up the key infrastructure required for delivery of the local care approach in each of the localities. The successful development of this infrastructure was highlighted as a key achievement across all of the localities. The structures have proved to be a strong foundation for system decision-making and joint working throughout the real system ‘stress test’ of the COVID-19 pandemic. In turn, the crisis response helped to further clarify and streamline lines of accountability and governance in the localities, leading to quicker and more efficient decision making.

The development of the local care organisations

The pace of **development of the LCOs** in the localities has varied depending on a number of factors:

- The history of collaboration in the locality, for example, through the 'Wigan Deal' which pre-dated the local care approach.

- The quality of leadership and appointment of key roles such as Independent Chairs of the LCO Boards in Bolton, Bury, Wigan and Rochdale, who were reported to provide important challenge.

- The quality of relationships and the specific investment in relationship building amongst senior leaders.

- The LCO model implemented. GM stakeholders considered that establishing an LCO on a principal provider model was more challenging to implement initially than an alliance model, but potentially provided a more solid foundation, with clearer lines of accountability and responsibility. GM and locality stakeholders viewed this model as successful in Rochdale, for example.

- The use of subsidiarity, with the separation of strategic and operational matters within separate boards, was seen to be successful in Wigan and Rochdale.

The development of the shared commissioning functions

Development of the SCFs across the localities has varied. Progress around four components of the SCFs is summarised below:

- **The development of pooled budgets** managed jointly by clinical and political leaders, where progress has been significant in all localities.

- **The development of unified teams** across the Council and CCG, which has proved challenging below the level of senior leadership, for example in finance departments.

- **The shifting of 'tactical' commissioning** to the LCOs, where progress has been challenging. In some localities there are signs that this is beginning to progress, for example in Rochdale's transfer of the urgent care budget to the LCO.

- **The use of outcomes or value-based payments models**. Stakeholders referred to examples of outcomes-based commissioning in Trafford, Wigan, Bury, and Rochdale but overall progress remains mixed.

Shared roles, particularly the appointment of a single accountable officer with responsibility for both CCG and LA commissioning, were highlighted as key enablers of progress in the development of the SCFs. The accountable officer appointed in Bury, for example, was credited with helping to progress integrated working between clinical and political partners.

COVID-19 presented a number of challenges for integrated commissioning at the locality level. The introduction of block contracting for NHS providers during the pandemic was highlighted as a particular challenge in preventing money from being moved around the system. Rochdale's pooled budget was suspended, and Trafford's Joint Commissioning Board did not meet in 2020, highlighting that some integrated commissioning practices can still be somewhat fragile. On the other hand, the pandemic helped to overcome concerns about 'who pays for what' locally, and in some ways made the commissioning process more agile, for example, by lifting barriers to joint procurement to effectively distribute PPE in Wigan.

The future of structures, governance and accountability in the localities

The future trajectory of the local care approach and its governance structures will be shaped by the outcome of discussions prompted by the **White Paper proposals, published in February 2021, to concentrate commissioning at an Integrated Care System (ICS) level**[1]. For localities in GM, which is an ICS, if this were to happen without further subsidiarity to the localities it could mean diverging from the direction of travel towards commissioning at a locality or place-level.

Stakeholders were keen that the primacy of place and the principle of subsidiarity should be retained under the new arrangements. To achieve this, the localities will bring together their LCO and SCF within a 'whole-system partnership board' (or versions thereof), including both providers and commissioners. This board would retain responsibility for setting the strategic direction and deciding the allocation of the integrated budget devolved to the locality by the ICS, the scale and scope of which localities were clear should not be diminished from existing levels.

This shift presents a positive opportunity for the localities to address some of the remaining challenges in the system, for example in collapsing the commissioner-provider split and making it easier to move money around. The work done so far to develop the infrastructure of the LCOs and SCFs in the localities will provide an important platform from which they can continue to build.

The role of Greater Manchester Health and Social Care Partnership (GMHSCP)

Locality stakeholders were positive about the support they had received from GMHSCP in building their models of integrated commissioning and provision. Examples were given of ways in which GMHSCP had facilitated sharing of learning and closer working between the localities, for example through the Commissioning Leadership Group. Locality stakeholders mostly valued the freedom they had been given and warned against an occasional perceived tendency towards a more 'command and control' approach.

GM system-level stakeholders suggested that as part of a statutory ICS, GMHSCP could transition from a convening role to a more directive one, ensuring more consistency amongst the localities. GM system-level stakeholders reported that it was important to preserve the principles of subsidiarity and place but did not appear to consider this at odds with stronger system level accountability. Maintaining place-based working was considered key to preventing silos between sectors, but stronger accountability was said to be needed to ensure decisions taken at system and place level are better coordinated.

This is not necessarily incompatible with the views of locality stakeholders, some of whom also called for a more consistent approach across the localities. Nevertheless, the wariness of perceived GMHSCP interventionism will mean that any shift to a more directive role will be challenging. This is illustrative of the tension inherent in the system in GM and must be a core consideration within the transition to new system level governance.

Leadership and relationships

Leadership

The quality of leadership in the localities, including of the LCO and SCF, has been vital for the effective implementation of the local care approach. Effective leadership, where present, was

[1] Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk) [last accessed 17 March 2021]

credited with establishing and maintaining a **clear sense of direction and purpose**, and with **ensuring consistency and coherence of decision making**. Good leadership was often described as **'empowering'**, giving people permission to innovate, take risks, and respond to changing circumstances quickly, particularly during the COVID-19 pandemic.

Stakeholders reported that leadership turnover has been fairly high across most localities. Maintaining consistent, good quality leadership is crucial to the continuing and future success of the local care approach and as such has been a priority for the localities.

Relationships

The quality of relationships in the localities, both within and between partners in the LCOs and SCFs, has improved over the course of the evaluation. Stakeholders reported improved working relationships, trust, and communication between all partners. This has been seen as vital for the success of the local care approach, meaning that several localities prioritised the building of relationships over creating infrastructure. This takes time and needs specific investment.

A similar picture emerges for the frontline staff most impacted by the local care approach, and in particular the INTs where collaborative working practices have developed between professionals. Improvements have also been seen amongst middle managers, who were seen to be slower to adopt the vision of the local care approach in some areas.

At all levels of the workforce, improvements in the quality of relationships were seen to be facilitated by **effective leadership** overseeing **well managed workforce engagement**, **co-location** both of frontline staff and senior leaders, and the development of a **strong sense of place** and **clear organisational culture.** For example, stakeholders reported this was demonstrated by the 'Team Wigan' approach and 'Be Wigan' organisational development training.

Strong relationships developed by the local care approach facilitated an effective response to COVID-19 in the localities, allowing changes to be made quickly and collaboratively. Relationships were seen to be strengthened by the pandemic in turn, which despite challenges including the end of physical co-location in some areas, served to unify staff under a shared goal and led to more flexible partnership working between different parts of the system. For example, new pathways and collaboration between care homes and other services including primary care were reported in a number of localities.

Challenges remain, for example in the persistence of differing organisational cultures between clinicians and local political leaders. However, these differences can also be viewed as enablers of success. Locality stakeholders recognised that partners need to consider each other's ways of working if the local care approach is to succeed, and that individuals can offer each other helpful challenge in order to find ways forward together.

Role of the VCFSE sector and private sector

A key success of the local care approach has been the **improved engagement of and relationships with the VCFSE sector**. The role of representative bodies such as Action Together, which operates across Oldham, Rochdale and Tameside, and Bolton CVS was seen by stakeholders to have been particularly important in ensuring effective representation of the sector within strategic decision making.

The role of even very small, grassroots community organisations in the local care approach increased considerably in response to the COVID-19 pandemic across the localities. VCFSE organisations played a key role in engaging residents, for example in newly established community hubs in Bury, and in various initiatives such as the Equalities Forum established in Rochdale.

Stakeholders across all the localities suggested that VCFSE sector organisations are now recognised as genuinely equal partners in the local care approach, where previously the relationship had been paternalistic.

Stakeholders were keen to continue to build on the work begun by the sector in the community during the pandemic and recognised that a sustainable funding settlement would be needed to allow this to happen. A number of localities highlighted ways in which they have improved funding for the sector already, for example through the Thriving Communities Hub in Oldham which increased the flexibility of its grant allocation with the aim of reducing procedural barriers for VCFSE sector organisations to apply. In Bolton, training in bid writing has been provided to community groups. There is now an opportunity for this good practice to be built upon and rolled out more widely.

Throughout the evaluation and across the localities there has been a sense that **engagement with the private sector in the local care approach remains a challenge**. Some examples were given, particularly relating to work with providers of residential care, but on the whole stakeholders felt that more work is needed to integrate the private sector into the local care approach.

Key achievements of the local care approach

Key achievements identified by the local care approach evaluation include:

- **The development of strong relationships** between local partners at all levels of the workforce, providing a good foundation for delivering integrated care.
- **The development of robust infrastructure arrangements,** in the form of the LCOs and SCFs, to deliver the local care approach and enable effective joint decision making.
- **An increased strategic focus on prevention and the wider determinants of health,** encouraged by the LCO model. Although, as noted above, sustaining this focus and supporting it with sufficient resource has proved more challenging.
- **The effective response to COVID-19**, involving rapid changes to governance and service delivery and flexible working across the system.
- **The increased contribution of the VCFSE** sector to reaching communities and supporting work in the areas of prevention, public health and the wider determinants of health.
- **The implementation of a place-based approach to care**, through neighbourhood working which responds effectively to local need.

Future direction

As the local care approach continues to develop, the localities and GMHSCP must build on the positive work begun during the pandemic. This will mean maintaining a focus on working with the VCFSE sector and continuing to engage residents, as well as investing in prevention, the wider determinants of health and asset-based approaches to care. The disproportionate impact of COVID-19 on certain groups, and in particular on minority ethnic communities in GM, means that addressing health inequalities must be a core priority for all localities as they move into recovery and begin to restructure in response to the White Paper.

Stakeholders were clear that any reform of the system level governance model must not detract from the aims of the local care approach, allowing the localities to continue to build on the gains made in place-based working and maintaining the principle of subsidiarity.