THE NORTHERN POWERHOUSE PARTNERSHIP

HEALTH IN THE NORTH

LEVELLING UP FOR HEALTHIER LIVES TO BUILD A NORTHERN POWERHOUSE

LESSONS FROM BOTH SIDES OF THE PENNINES

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Section One

THE IMPORTANCE OF LEVELLING UP HEALTH

LESSONS FROM BOTH SIDES OF THE PENNINES

Henri Murison
Director of the Northern Powerhouse Partnership

The business and civic leaders that make up the Northern Powerhouse Partnership are passionate champions of the North's economy, making the case for investment in productivity enablers such as railways, schools, colleges and universities. However, tackling unequal life chances remains a critical challenge. This can only be achieved at a local level, improving the life courses of individuals and families through the integration of services in individual neighbourhoods.

As the government pursues a mission to better integrate health and social care, and champions greater co-operation and integration across places, the time is right to examine what has been achieved in spite of the challenges in the system today.

While there are leading examples of best practice right across the North, our initial focus will look at Greater Manchester and Leeds (against the backdrop of West Yorkshire as a whole). Cities are considered both in the context of their broader city regions, and in the context of the wider Northern Powerhouse.

Opportunities are undermined by systemic health problems, and there is much more to be done across Northern towns and cities. Levelling up is a much used phrase, but if it is to mean anything then it must be that underlying geographic inequalities are addressed.

Health outcomes are determined by far more than just the quality of care in hospitals. Newcastle upon Tyne, for example, has exceptional acute and regional care services, yet has some of the least healthy residents in the country

" Levelling up is a much used phrase, but if it is to mean anything then it must be that underlying geographic inequalities are addressed. "

Population health remains a primary focus of the Northern Powerhouse. As previous research by the Northern Health Sciences Alliance[1] has highlighted, health inequalities are a key part of the productivity challenge.

In this report, we are delighted to bring together a range of expert Northern voices from both sides of the Pennines to share their own assessments and lessons for the future of health devolution.

I would like to thank our contributors to this work. For the forewords for each city region, Baroness Blake, former Leader of Leeds City Council, and Howard Bernstein, former Chief Executive of Manchester City Council. From Leeds, Tom Riordan, the Chief Executive of Leeds City Council, and Tom Bridges, Arup's office leader in Leeds. From Greater Manchester, Sir Richard Leese, Leader of Manchester City Council, Deputy Mayor of Greater Manchester and Chair GMHSCP, Ruth Boaden from the Health and Social Care Partnership and Honorary Professor at The University of Manchester, and Rowena Burns, Chair of Health Innovation Manchester.

1 https://www.thenhsa.co.uk/app/uploads/2018/11/NHSA-REPORT-FINAL.pdf

HEALTH IN THE NORTH
LESSONS IN LEVELLING UP FROM LEEDS

Judith Blake
Baroness Blake of Leeds
Former Leader of Leeds City Council

Section Two

FOREWORD

Across West Yorkshire we have shown the difference a local partnership approach to health care can make. I'm proud of the changes the West Yorkshire and Harrogate Health and Care Partnership has delivered and excited about the future impact this strong partnership model will achieve.

The pandemic exacerbated the already huge health and care challenges across the North, and I believe to level up on health care we must continue to increase the influence of local authorities in Integrated Care Systems. In West Yorkshire we have shown that strong local relationships and partnerships can deliver better health and care, help people to improve their lives and address the vast inequalities that are known to improve their quality of life.

Serving a population of 2.7 million, people the West Yorkshire and Harrogate Health and Care Partnership is led by a Partnership Board which provides formal leadership and sets strategic direction. Made up of Council Leaders, Health and Wellbeing Board Chairs, Chief Executives from a range of NHS organisations, the third sector and patient representatives - it clearly demonstrates the power of partnership.

The Partnership was made possible through a Memorandum of Understanding that retained the independence of local authorities,

> *"I believe to level up on health care we must continue to increase the influence of local authorities in Integrated Care Systems."*

The Partnership's Five-Year Plan does not shy away from tackling some of our region's biggest health and social care challenges, including mental health, cancer, urgent care, maternity services, and health inequalities. To date this has led to several significant achievements, such as the development of joined-up vascular services, better critical stroke care and a new residential facility for children with serious mental health problems. All of which have undoubtedly saved lives.

Securing funding for the pioneering new hospital development at Leeds General Infirmary has been another significant success. The ambitious plan for two state-of-the-art hospital buildings (one will expand health services and the other will be a new home for Leeds Children's Hospital) shows how Leeds is leading the way on patient care.

I'm immensely proud of the work Partnership officers did during the pandemic, aligning with the Leeds system to support vaccine rollout, shielding programmes, and ensuring that primary and acute care continued to be delivered to the highest standard.

Our region faces many health and care challenges. Some are structural and require a cross-system focus while others will need a stronger response from health and care services. I am in no doubt that the West Yorkshire and Harrogate Health and Care Partnership will meet these challenges head on - the Partnership is determined to transform health and care outcomes for current and for future generations.

Section Three

HEALTH AND CARE IN LEEDS

DEVOLUTION, DEMOCRACY AND INTEGRATED CARE SYSTEMS

Tom Riordan
Chief Executive of Leeds City Council

As the second largest local authority area, Leeds has always prided itself on having the size to shape (within national policy) its own destiny and design, a distinctive approach rooted in a compassionate, connected, and inclusive health and wellbeing offer. Until relatively recently it has done this under the radar. Only in the last few years has Leeds drawn attention to itself for the way it manages its health and care system.

Just 'getting on with the job and delivering' also meant that successful approaches in aligned areas, (for example the drive to become 'child friendly' or an inclusive economic growth strategy designed to harness the power of anchor institutions to drive change in communities) have also been 'slow burners' that other areas are now seeking to replicate. Leeds has attracted a number of big names in recent years, and the pitch for Channel 4, Sky, Burberry and the British Library drew upon health, wellbeing, green space and inclusivity as the heart of the city fabric. Recent inward investment from the Bank of England and the location of the new UK Infrastructure Bank in Leeds also provide huge opportunities to use the dividends to improve health and wellbeing across the city, as does the long overdue return of Leeds United to the Premiership.

I will examine the drivers behind health and care integration in Leeds in the age of the Integrated Care System. In particular focusing on the partnerships that have developed across the City in recent years to improve the health of populations, address inequalities and create a foundation for improved outcomes over coming years. This will include consideration of the opportunities provided by closer working with the newly statutory West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System) and the newly elected Mayor and the West Yorkshire Combined Authority. These partnerships will be increasingly important as the COVID-19 pandemic has shone a light on health and wider inequality in Leeds whilst also turbo-charging efforts to integrate and narrow the gaps and ease the gradients that blight everyday life for many people.

LEEDS HEALTH AND WELLBEING BOARD (LHWB) – DRIVING CHANGE THROUGH PARTNERSHIP AND PEOPLE POWER

The Leeds approach is rooted in an understanding that unacceptable levels of health inequality need to be tackled by health systems but also that the health system alone cannot tackle the factors that drive poor health, including housing and homelessness, lower levels of education and skills and lower life expectancy and disability free life expectancy compared to the national average.

In 2016/17 Leeds designed a new Health and Wellbeing Strategy (LHWS) (http://inspiringchangeleeds.org/ambition/lhws/). This was followed by the Inclusive Growth strategy in 2018 (http://www.leedsgrowthstrategy.co.uk). Both these strategies have twelve priority areas including shared approaches to workforce and skills development, green growth, active travel and enhancing existing child and age friendly initiatives. The LHWS is rooted in three vision statements that are owned by all partners and engraved into the city fabric. These describe how partnership working will improve health, support economic development, and drive development of a compassionate, fairer city.

These are:

- **Everything is connected** – a strong narrative that drives partnership and integration, brings together acute and community services, physical and mental health services and helps shape stronger relationships with universities, community, business and third-sector organisation, while driving digital inclusion through integrated health and care records.

- **Leeds will be the best city for health and wellbeing** – opening up ground for conversations about existing needs, and evidence, as well as discussions on how quality and outcomes must be improved via a rigorous approach to population health improvement and benchmarking Leeds against other core cities and similar authorities.
- **Improving the health of the poorest the fastest** – this principle acts to ensure that strategies, services and operational activity across health and care consider the structural inequalities inherent both in society and in service provision. Regular monitoring includes comparison between Leeds and deprived Leeds, using Index of Multiple Deprivation deciles as baselines.

Both strategies have clear ambitions to level up the city by aligning health improvement with inclusive economic development that boosts the skills of local people and improves outcomes in the most deprived areas. There are many examples of this working in practice. Leeds Teaching Hospitals Trust will be moving to state-of-the-art new premises in the heart of the Leeds innovation district over the next few years. This includes our universities, the Nexus incubator for innovative digital and health technology businesses and start-ups, as well as a number of other private and public services.

> *"The NHS, the council, universities and business have come together through a number of partnerships to find sustainable local solutions that reduce inequality in the city."*

The Inclusive Anchors Programme uses the purchasing and organisational power of large organisations to drive social value, promote local business and ensure that good work opportunities are extended to deprived areas. The Leeds Academic Health Partnership was established to better connect research and innovation across health, academia, local government and business and has developed new approaches to personalised health, workforce and digital health.

Likewise, the Leeds Health and Care Academy was established to grow the Leeds workforce and ensure it better reflects the city in all its diversity. It will support social mobility, developing workforce pipelines from local schools and colleges while remodelling recruitment policies to promote a sense of shared culture. The aim is to promote #teamLeeds rather than silo-based organisational working. A concrete example which harnessed the power of all these partnerships and involved businesses such as Arup (the design and engineering consultancy is in the Lincoln Green project). A local engagement exercise and health needs assessment in an area in the poorest 1% of Super Output Areas nationally (as measured by the 2015 Index of Multiple Deprivation) culminated in a jobs fair that resulted in 55 people starting entry level NHS jobs, while identifying five refugees

with nursing qualifications who are now retraining in the local hospital.

STRONG LOCAL VOICES GUIDE POLICY AND PRACTICE

Elected members, communities and the third sector are at the heart of the health and care conversation in Leeds. The Labour leadership in Leeds has prioritised health and wellbeing as one of the 'three pillars' of the city approach (the others being inclusive growth and tackling the climate crisis). The health and wellbeing board also includes Liberal Democrat and Conservative councillors, whilst independent and Green councillors also receive regular ward-based updates on health and care. Broad political support for the strategy has also been reflected in elected member involvement on the boards of a key partnerships across the city. Our approach to integrated local services and primary care is being driven by Local Care Partnerships (LCPs). These are as coterminous as possible with council community committees and each LCP Board having an elected member around the table. LCPs are an increasingly important component of a genuinely devolved approach to local service development. They put local GPs and practice staff, elected representatives and key services like social care and mental health services at the heart of local systems. LCPs also work closely with other devolved local systems, for example the 33 ward-based community hubs developed during the COVID-19 pandemic and the Neighbourhood Networks designed to work with older people to prevent loneliness and promote inclusion.

> *"These local initiatives symbolise the inclusive, asset based approach rooted in 'working with' people as close to where they live as possible."*

All these initiatives include the third sector, and their representatives and statutory partners continue to fund infrastructure support to enable a diverse sector to help shape both local strategy and service delivery. Regular citywide conversations take place through a 'Big Leeds Chat' that takes conversations about health into communities and a People's Voices Group that amplifies community voice and feeds it back into health and care services. These conversations have helped remodel several initiatives around mental health, primary care and acute services and have increased collective understanding about how people can sometimes struggle to navigate the complex systems and myriad services that operate in the city.

Strong partnerships over many years result in services and outcomes improving. Recent examples, all of which took years of focus and engagement with communities include improvements in levels of childhood obesity in deprived areas, lower numbers of looked after children than other core cities and reduced spend on adult social care as a result of investment in neighbourhood networks that prioritise loneliness and isolation.

INTEGRATED CARE SYSTEMS AND THE PRIMACY OF PLACE

The Leeds system has had to contend with an ever-changing national agenda including NHS reorganisation, ongoing austerity and the demands of a pandemic. Whilst designing a strategy rooted in the city and its values, Leeds has always tried to have strong positive relationships with partners in the West Yorkshire region. This was also necessary because, respectively, the West Yorkshire Combined Authority (WYCA) had limited experience of health systems and the Sustainability and Transformation Partnerships / Integrated Care System had limited experience of economic development and, initially, the social determinants of health.

> *"Leeds had developed a strong approach to population health and the integration of health."*

Social care and the third sector has been a 'work in progress' since before the Government announced the move to integrated care via Sustainability and Transformation Partnerships in 2016.

Whilst the Health and Social Care Act (2012) sought to strengthen the role of competition in the health system, from 2016 with the introduction of Sustainability and Transformation Plans (STPs) NHS organisations were told to promote system-wide collaboration. This change of approach was an acknowledgement that the abolition of a range of NHS bodies, the creation of new bodies, tighter financial settlements and the outsourcing of many services had not improved outcomes and had resulted in reduced co-operation between services.

From 2018 STPs evolved into integrated care systems (ICS) with even clearer intentions to drive integration but STPs and ICSs did not escape the inevitable controversy inherent in NHS change, in part because there are many different approaches to integration. Conversations in the UK and internationally, including in Leeds, touch upon the relative balance between public, private, and outsourced provision, the amount of local democratic control and other freedoms and flexibilities and whether a medical or social/public health focused model of health (or indeed a balance of the two) is most appropriate. As described above, during this period Leeds signed off a strong health and wellbeing strategy. This, coupled with effective political leadership, helped guide engagement with the STP and West Yorkshire Integrated Care System (WY ICS) known locally as the West Yorkshire and Harrogate Health and Care Partnership. A series of 'red lines' for Leeds City Council engagement with the WY ICS were agreed in 2017/18 and these were subsequently supported by NHS and third sector colleagues. These lines included requests for greater focus on health inequality, economic development, and climate change. They also included a call for greater political engagement, the development of a structure that mirrored the local Health and Wellbeing Boards and, perhaps most importantly, that resource allocation would be fair and reflect both population size and deprivation where possible.

As a result of these conversations a Memorandum of Understanding (MoU) was drafted that set a clear direction for WY ICS and its subsequent strategy. The MoU stated that local government's regulatory and statutory arrangements would remain separate from those of the NHS. Whilst councils would be subject to the mutual accountability arrangements for the partnership, they would not be subject to a single NHS financial control total and its associated arrangements for managing financial risk. Through this MoU Councils agreed to align planning and performance improvement with NHS partners where it made sense to do so. Democratically-elected councillors would continue to hold the partner organisations accountable through their formal Scrutiny powers.

From March 2019 there has been a 'Partnership Board' in place chaired by the leader of Calderdale Council, and including Council leaders and Health and Wellbeing Board Chairs as well as Chief Executives from the range of NHS organisations, the third sector and patient representatives. The Partnership Board provides the formal leadership for the WY ICS and is responsible for setting strategic direction. It provides oversight for all Partnership business, and a forum to make decisions together as Partners.

As a result of this approach, current WY ICS plans are rooted in 'primacy of place' with services delivered and strategy designed as close as possible to people themselves. Primacy of place enables Leeds (and other areas) to determine, within national guidance, its own destiny and drive change locally, preventing over-reach of the ICS. It is predicated on a subsidiarity test with three components:

1. **Critical mass/scale** – the size of the issue requires a regional focus, or alternatively a service is so specialist it can only be delivered at scale (e.g. bariatric surgery, residential mental health provision for children or services for rarer cancers)
2. **Best practice** – sharing of innovation and best practice across the ICS region
3. **'Wicked issues' and resolving system-wide intractable problems** (e.g. workforce issues and managing competition for limited staffing resources)

Primacy of place is continuing to drive conversations as the new statutory ICS model emerges and Clinical Commissioning Groups (CCGs) are abolished. Conversations about governance, assurance and strategy continue to be inclusive of all partners and predicated on an understanding that strategy, staffing, and resources are best managed in place. Lessons from Greater Manchester are instructive with each area continuing to develop different approaches to shared leadership and local strategy within an overall model designed to integrate and promote population health.

REFLECTIONS ON THE FUTURE OF INTEGRATION AND PLACE

> *"The West Yorkshire and Harrogate ICS rightly prides itself on the strength of its partnerships and the inclusion of a wide range of voices. As a result of the many years work it is in a strong position as it evolves towards a more formal statutory role."*

Whilst there are risks inherent in any re-organisation of the NHS, the experience of Leeds and West Yorkshire demonstrates how attempting to influence the shape, governance and strategy of the ICS model pays dividends. However it is a process that stands on the backs of existing partnerships such as local Health and Wellbeing Boards that have shaped local culture and priorities over many years. It is not a given that an ICS will choose a model of integration rooted in broad partnership that prioritises population health and tackling inequality. Involvement of elected members, setting up partnership boards and engaging with combined authorities all skew the conversation away from a narrow understanding of health that can result in overly focusing on hospital performance and funding and towards a social model of health that takes inequality, inclusive growth and climate change seriously. It is also instructive that in Leeds the acute sector has been strong supporters of the local approach, understanding that turning off the taps of an ever-increasing demand for planned and urgent care is contingent on developing effective early intervention and prevention and bolstering public health and social care.

When coupled with the involvement of the third sector and public and patient representatives it has been possible to begin shaping a culture that enables strategy to be remodelled and is subsequently followed by changing the conversation about services, delivery, and impact on people themselves. Recent examples of this in West Yorkshire include system-wide conversations about institutional racism in health and care, a renewed focus on suicide prevention and child health and a new improving population health programme that has highlighted the challenges of stalling life expectancy and poverty in the region.

Turning structural issues around in Leeds and in West Yorkshire will be a huge challenge. As noted, we have some strong outcomes that have taken years to nurture but also face a population ageing in poor overall health, more children living in poverty, lower social mobility, and higher unemployment post-COVID. Likewise, lower relative investment in key areas like transport and basic skills all exert negative influences on health. Understanding the tools at our disposal and the evidence base for what works will be increasingly important. The challenge has been acknowledged first in Leeds and the other West Yorkshire systems (Bradford, Calderdale, Kirklees and Wakefield) and then by the ICS. Partners have chosen an integration model rooted in tackling these issues in the health system and beyond it. Build Back Fairer (https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review) describes the evidence clearly and the election of Tracy Brabin as West Yorkshire Mayor, and her stated intention to work closely with Greater Manchester Mayor Andy Burnham provides a strong grounding for working in place, in region and across region, learning from best practice whilst standing solidly behind a clear strategy that is explicit in its challenge to health inequality.

Section Four

LEADING THE WAY IN HEALTH INNOVATION

Tom Bridges
Arup Leeds Office Leader, Director Cities Advisory

The City of Leeds has a strong track record as a health innovator. In 1869 Florence Nightingale worked at Leeds General Infirmary sharing her wealth of experience in providing critical care and infection control in different settings. Today the city remains a centre of expertise in infection control, Professor Cath Noakes from the University of Leeds is a leading expert on infection control in buildings and is currently a member of the Government's Scientific Advisory Group on Emergencies (SAGE).

Leeds is at the centre of a dynamic and growing ecosystem for health innovation, that covers Leeds and Bradford, with links to other assets in Sheffield, the Humber, Teesside, and Newcastle-upon-Tyne.

The Northern Powerhouse Independent Economic Review identified Health Innovation as one of the prime capabilities of the North, responsible for 540,000 jobs as of 2013 – which equates to 7.4% of all employment.[1]

The main features of this health innovation ecosystem include:

- Design and manufacture of medical devices and prosthetics
- Vaccine manufacturing including vaccine components
- World leading capabilities in health informatics and longitudinal research
- A mission-orientated approach to addressing major health challenges
- Innovation districts

There is a network of linked assets and expertise across the health ecosystem in Leeds that includes world-class university strengths and businesses, such as Johnson and Johnson Medical Devices presence in the city. I want to explore how we can build on these capabilities to enable the innovation necessary to tackle the UK's significant health challenges, as well as to realise the opportunities that stem from new technologies, health and care systems, alongside product innovation.

The health ecosystem can offer huge benefits to people and go some way to tackle the significant North-South divide in health outcomes. Improving health would reduce the £4 gap in productivity per-person per-hour between the Northern Powerhouse and the rest of England by 30% or £1.20 per-person per-hour (generating an additional £13.2 billion in UK GVA). It would also unlock global market opportunities, helping drive more rapid and productive economic growth for the North of England.

DRIVERS FOR CHANGE

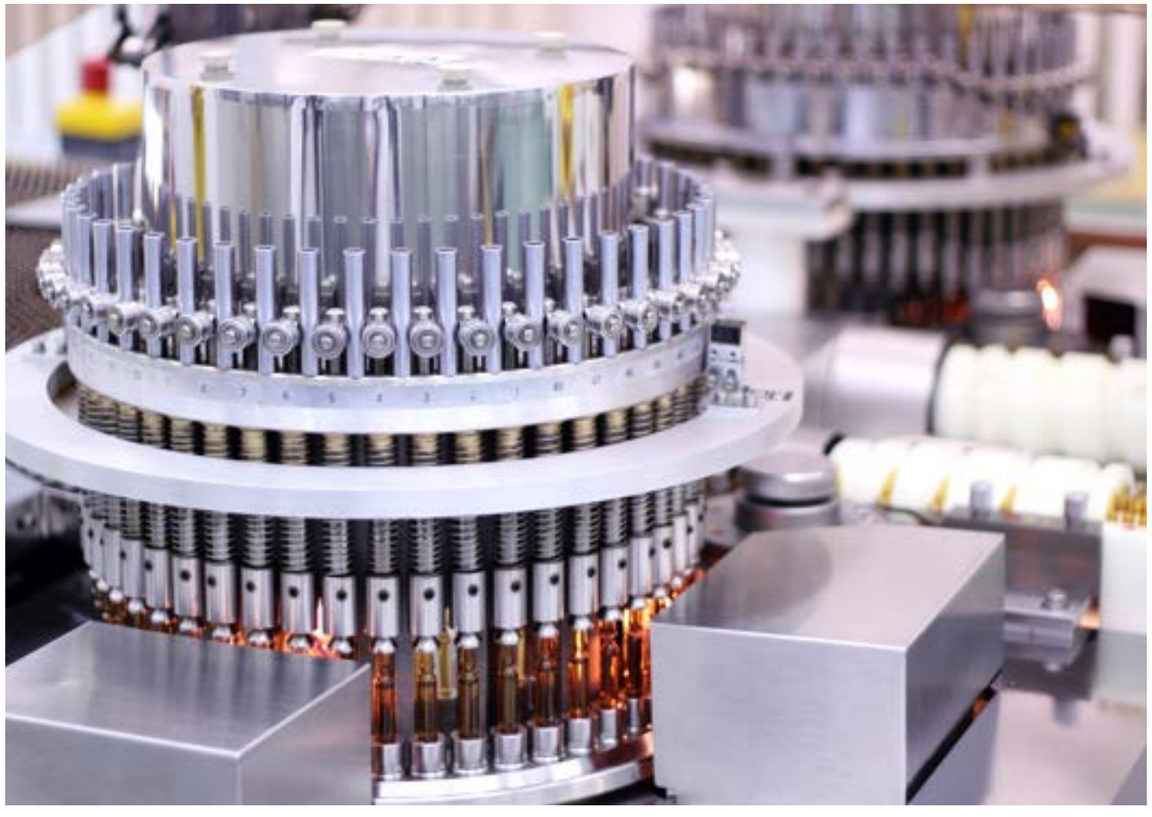
What is currently driving change in health innovation? There are certain systems and society drivers, with COVID-19 obviously a priority issue. Not only is how we continue to deal with the pandemic and its fall out (the increased pressure on the NHS for example) important, we must also ensure the recovery levels up fairly across the UK. The ageing population and the upward pressure on healthcare costs also need to be considered. As does the R&D roadmap and devolution - again a key proponent of levelling up. Central to health innovation is also a need for clear integrated health and care pathways, a need to develop and retain the workforce (as mentioned earlier) and, importantly, a need to increase productivity.

Within technology a clear driver for change is big data, AI and machine learning along with mobile and remote delivery. Genetic sequencing, editing and proteomics continue to have a large role as does precision medicine.

MEDICAL DEVICES

In the 1900s Charles Thackray designed the world's first ever hip replacement joint and manufactured it at a plant in Beeston in South Leeds. Leeds is still a major hub of expertise in medical devices. Today DePuy Synthses (part of Johnson & Johnson) have a major R&D facility on the original Thackray site in Beeston.

In 1969 RSL Steeper (today known as Steeper) opened its first premises in Leeds. Steeper is a world-leading manufacturer of prosthetics and one of the UK's largest manufacturers of orthotic products. As a support partner of the NHS, Steeper has established long-term relationships with over 35 NHS trusts across the UK, including: Harold Wood Hospital, Mid Yorkshire Hospitals NHS Trust, and an award-winning service with Leeds Teaching Hospitals NHS Trust.



Firms like Steeper have been attracted to Leeds partly because of the huge expertise and track record in commercialising innovation - which the University of Leeds Department of Biomechanical Engineering has led the way on. However, the sector also faces constraints, particularly regarding the availability of suitable grow-on space in the city[2]. This has led some firms, including University of Leeds spinouts to relocate away from the city[3].

VACCINE MANUFACTURING

In 1925 the firm Croda was formed in Rawcliffe Bridge (near Goole) to refine Yorkshire wool grease into lanolin. Croda went on to manufacture a wider range of chemical and industrial products and in 2019 made the well-timed acquisition of Avanti Polar Lipids.

Croda is now manufacturing the lipid nano particles necessary for mRNA vaccines, that enable Pfizer and Moderna's Covid vaccines to work. These fatty coatings contain the mRNA molecule to enable it to reach and enter cells in order to trigger an immune response.

While we should be proud of these developments, they are seated in vertically integrated global supply chains of major vaccine manufactures. The North of England has yet to benefit from the type of horizontal integration and business-to-business links that are a feature of successful health and life sciences clusters.

INFORMATICS AND LONGITUDINAL STUDIES

In the 1970s Dr Peter Sowerby who ran a GP Practice in Egton (North Yorkshire) started systematising patient record keeping. Firstly, as a way of enabling GPs to access patient details regardless of which of his five surgeries across a large remote area they worked at, and secondly to analyse patterns behind outbreaks of diarrhoea and farmer's lung[4]. Dr Sowerby and his colleague Dr David Stables digitised the records and from this the firm

Egton Medical Information Systems (EMIS) was established and then grew to be one of the largest health informatics businesses. Today the firm is located in Leeds along with other health data firms such as TPP, and NHS Digital which is also headquartered in the city.
A specialist cluster of firms has developed around them, with firms such as BJSS providing software, and aql providing wholesale telecoms services.

Without these capabilities in Leeds the NHS would not be able to operate in the best of times, and the pivot to remote delivery of healthcare during the pandemic, as well as the huge success in organising the vaccine programme and booking system would not have been possible. The Leeds integrated health and care system has led the way in creating the Leeds Care Record, a single patient record for people whether they are requiring primary, acute, social, or mental health care. This is supporting better and more integrated pathways for people as they experience different parts of the health and care system.

Just as Dr Peter Sowerby fifty years ago sought to exploit the power of data to analyse patterns of disease in a remote part of North Yorkshire, the scale of patient data (once anonymised to ensure confidentiality and data security) combined with rapid advanced in computing power is providing powerful

1 Bambra Mumford, Brown et al (2008) Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity, Northern Health Sciences Alliance, Newcastle.

2 Ref LCC / UoL Medtech study

3 The Newsroom, (2017) "Leeds should establish a science park to keep talent in region", Yorkshire Post.

4 The Origin of EMIS 26-02-2001 15-15 version2.rtf_.pdf (emisnug.org.uk)

insights into health challenges.

Data is transforming how we understand health trends, the interrelationships between different conditions and the efficacy of different sets of interventions across the health and care system. Big data in health is a particularly powerful tool when combined with new technologies such as AI, machine learning, wearable devices, and genetic sequencing.

These technologies are enabling the practice of 'precision medicine', sometimes known as 'personalised medicine'. Instead of a one-sized-fits all approach to medical treatment based on an average patient, precision medicine considers and analyses the genetic characteristics, the lifestyles, the age, and ethnic group, to identify the right combinations of treatments[5]. The Leeds Academic Health Partnership's Living in Leeds Project is seeking to make Leeds a "research ready" city by making it easier for researchers and care providers to access health data, building on the efforts as part of the NHSA Connected Health Cities programme which has also led to the Great North Care Record in the North East and Cumbria. Through this data they will gain insights on how to improve health and care in a way that builds patient trust.

In addition, major longitudinal studies are providing valuable insights into the efficacy of interventions across the health and care system as well as in relation to the wider determinants of health. For example Born in Bradford, which is a partnership between University of Leeds, University of Bradford and Bradford Teaching Hospitals Foundation Trust is tracking the health and well-being of over 13,500 children and 30,000 Bradfordians, and the impact of early life interventions on people's health.

BUILDING THE LEEDS WAY

The Building the Leeds Way project is an ambitious plan to develop a new adults' and children's hospitals, a new Pathology laboratory and regenerate the Leeds General Infirmary site. Building the Leeds Way will expand on Leeds' current health-care ecosystem and is truly a unique opportunity to make a positive impact on the health and economic prosperity of people across Leeds, Yorkshire and the beyond.

The brand-new Leeds Children's Hospital (LCH) will bring together clinical services for children and young people under one roof. One of the largest specialist hospitals for children and young people in the United Kingdom the LCH will provide expert care in areas including cancer treatment, neurology, liver, kidney and bone marrow transplantation, and gender identity services. Due to be completed in 2025, the new LCH will offer outstanding healthcare in an environment that harnesses the potential of digital advances, new technologies and treatments, research and innovation. The adults' hospital will provide fully integrated healthcare and will include day Case Surgical unit, new inpatient Maternity Centre (centralised with neonatal services), new endoscopy unit and a multi-Specialty Assessment Area for specialist surgical patients.

The £27m pathology laboratory based at St James's University Hospital will provide state-of-the-art pathology services for the wider city region. Built to accommodate cutting edge equipment and specialist technology, the new laboratory – due to be completed in 2023 - will be designed to provide fast, accurate, routine and specialist testing. Supported by the West Yorkshire and Harrogate Health and Care Partnership, the new facility will serve hospitals across Leeds, West Yorkshire and Harrogate. It will allow Leeds Teaching Hospitals NHS Trust to bring many of its pathology services together into a purpose-built laboratory.

INNOVATION DISTRICT

The Innovation Pop Up that has opened in the Gilbert Scott building at the Leeds General Infirmary is the first phase of the Building the Leeds Way and a major step in expanding the Leeds Innovation District, building on the progress established by the University of Leeds nearby Nexus service and building to support university-industry collaboration and spin-outs from academic research.

The Innovation Pop Up is providing a base to health tech businesses which are scaling to locate in Leeds (e.g. 3D Lifeprints who work with clinical specialties in Leeds Teaching Hospital Trust on 3D surgical planning). The Pop Up is also supporting inward investment for example Betalin Theraputics who are undertaking pre-clinical studies of advanced medicinal therapeutic products to treat diabetes at Leeds in partnership with Newcastle. Betalin have established a UK base in the Nexus innovation centre.

The Leeds Innovation District is set to become a world-leading centre for industry and innovation. Already there has been investment from the University of Leeds in its £40million Nexus innovation hub, and in the £80 million investment in the Leeds Beckett University of Film, Music and Performing Arts.

It is hoped this activity will grow out to prime the redevelopment of the wider site as part of the Leeds Innovation District. The development will be brought forward between 2023 – 2026 onwards.

" The Leeds Innovation District will form part of a network of innovation districts with a health focus across the North of England, including: Helix, Newcastle, anchored by the National Innovation Centre for Ageing; Knowledge Quarter Liverpool; Corridor Manchester and ID Manchester; and the Sheffield Advanced Manufacturing Innovation District, which is expanding to incorporate the Advanced Wellbeing Research centre at the Olympic Legacy Park; and the proposed new innovation district in the centre of Bradford next to the planned Northern Powerhouse Rail hub. "

ECONOMIC IMPACT

The investment in new hospitals will unlock five hectares of redevelopment opportunity at the heart of the Leeds Innovation District with the potential to create around 3,500 jobs in health technologies and a GVA benefit of up to £11bn NPV.

This will bring together Leeds Teaching Hospitals NHS Trust, Leeds Beckett University, the University of Leeds, Leeds City Council and the private sector to drive regeneration, innovation and economic growth for Leeds and the wider region.

Leeds Teaching Hospitals' ambition is to be a global leader in the identification, adoption, and scaling of health innovations. Driven by clinical and operational needs and enabled by increased collaboration with industry and academia. Leeds has a strong track record, for example after undertaking the first in human trials of the Medtronic evolut valve Leeds is now one of the largest centres globally for transcatheter aortic heart valve replacement.

The Leeds General Infirmary (LGI) Development Site project is a programme to release the surplus section of the old estate at the LGI, which is no longer suitable for modern healthcare. There are a variety of opportunities for mixed-use development, creating spaces for education, innovation, commercial uses including retail and office space, and accommodation to support the growth of the Leeds Innovation District.

MAKING IT WORK

Building the Leeds Way is a once in a generation project that will boost not only the health but also the economic prosperity of people in the region and the wider UK. The team involved in the project liaised with Government to ensure their ambitious plans would come to fruition. Speaking with senior Treasury officials and;

- Edward Argar MP, Minister of State at the Department of Health and Social Care who is responsible for capital developments
- The Rt Hon Steve Barclay MP, Chief Secretary to the Treasury
- The Rt Hon Rishi Sunak, Chancellor of the Exchequer
- Lord Prior at NHS England

Those involved in the project worked hard to ensure government knew about the huge health and economic impact Building the Leeds Way would have for the people of Leeds and beyond.

The way NHS business cases are considered, despite the Green Book changes instated by the current Chancellor, excludes economic benefits from decision-making around a new hospital business case. It is the lack of prosperity in many parts of Leeds that leads to its health inequalities, and so economic growth in West Yorkshire and ensuring it benefits those neighbourhoods across the travel to work area that need it most. An innovation district in Leeds will do as much for health inequalities as any gains in acute patient treatment, if it indeed helps catalyse the higher productivity economy needed in changing communities. Productivity is a part of how we address population health in the future health and wellbeing settlement that the North most certainly needs, dying younger without the same quality of life or health than those in the South as well as being less economically prosperous.

The progress of Building the Leeds way is fantastic and already we can see that the impact on jobs and economic growth for Leeds and the wider region of the project will be lasting. An independent Economic Impact Assessment report indicates that the direct and wider economic benefits will be worth between £5.5bn to £11.2bn in net present value terms. It's so exciting to be at the start of a project that will have a huge impact on the health and economic prosperity of people across Leeds and Yorkshire for generations.

CALLS TO ACTION

While Leeds really is leading the way on innovation and creating a healthcare eco system along with a vibrant innovation district there are several areas where Government could offer further support so we can invest in these projects for generations.

We have six key policy recommendations which come to the fore, for the newly elected Metro Mayor and Government to join the local authority and health partners in pursuing:

1. Supporting the development of grow-on space and support for med-tech businesses
2. Support to building horizontal integration in drug discovery and vaccine manufacturing to create a North of England cluster
3. Exploiting the huge opportunity around precision medicine
4. Embracing a mission-orientated approach to innovation and economic growth in health, focusing on tackling the significant health challenges the North of England faces, for which the solutions can have global applications
5. Building the broader innovation ecosystem – including levelling up R&D spend
6. Backing innovation districts

You can find our more about Building the Leeds Way at leedsth.nhs.uk/about-us/btlw/

5 Precision Medicine | FDA

HEALTH IN THE NORTH

LESSONS IN LEVELLING UP FROM GREATER MANCHESTER

Sir Howard Bernstein
Former Chief Executive of Manchester City Council

Section Five

FOREWORD

It would not be difficult to argue - as we emerge from the pandemic - that our health and social care services have been challenged in a way that we have not seen before. Nor would it be difficult to deny this is not the first crisis we have had to face.

The challenge of rising demand, falling population health, annual winter crises was a characterisation of the years before the pandemic. And it was one of the principal reasons why the devolution of health was seen as a priority in Greater Manchester.

We wanted to widen and deepen our commitment to public services reform ensuring that people and neighbourhoods were at the heart of change; developing new early help and intervention models to support those in need and working with people and commissioning services in different ways to promote their health and well-being.

The pandemic has intensified the requirement for change. We have seen how the vulnerable have been disproportionately impacted, reinforcing the relationship between localities with below average GVA and localities whose residents experience below average health outcomes.

And cosmetic change won't do. We have had enough of that.

> *" We need an outward facing place-based approach to reforming our services with a strong health and care system at its heart. "*

A new drive for devolution where real power to prioritise new and relevant services around people is practical, always recognising the need to meet appropriate quality standards and with the capability to innovate.

When we talk about the power of innovation we don't often think about health and life sciences, the transformational potential of healthy and active communities and the pathways these can create for success and a growing economic base.

Breathing new life into our towns and cities is as much about public service transformation as it is about the creative endeavour of good place making. We can't deliver the productivity improvements the nation requires without a significant improvement in population health outcomes.

As we embark upon the task to re-purpose and re-energise our urban centres, new approaches to stimulating active travel, creating more green spaces, new community and education hubs will rightly secure a higher priority by civic leaders, residents and investors alongside mixed use and employment related development.

But so too will building upon local digitisation capabilities which tailor public services that better understand economic inequalities and community under-performance and build upon their strengths and opportunities supported by the wider assets to be found in different City Regions.

That is how in my view effective place leadership will be increasingly be judged.

Section Six

THE GREATER MANCHESTER STORY

THE HISTORY AND NATURE OF DEVOLUTION IN GREATER MANCHESTER

Sir Richard Leese
Leader of Manchester City Council, Deputy Mayor of Greater Manchester and Chair Greater Manchester Combined Authority (GMCA)

There has been a longstanding history of collaboration across local government and other public services in Greater Manchester (GM) dating back to 1986, which it can be argued has led to GM being at the forefront of english devolution for a number of years.

Notable events have included the Manchester Independent Economic Review (MIER) confirming the relationship between health and GM's economic potential in 2009 and the Community Budget pilot (2011-12) bringing these elements together and informing the principles and objectives of comprehensive public service reform. There was also already a significant history of collaboration in the GM NHS (the GM Stroke service, the Making it Better and Healthier Together programmes and the GM Major Trauma network) not limited to hospital services but also including the Association of GM Clinical Commissioning Groups (CCGs) and, prior to that, the Association of GM Primary Care Trusts.

Figure 1: The Greater Manchester Strategy

A devolution deal for GM, involving a range of public services[1], was signed on 3 Nov 2014[2] within the context of a growing interest nationally in devolution and regional governance in England. This significantly extended the responsibilities of the GM Combined Authority and established the role of the GM Mayor, as well as inviting consideration of the potential for health and social care devolution.

Since 2014 there have been 6 'devolution deals' in GM of which health and social care is one.

These agreements have enabled the region (GM) to have more power and control over budgets including (in addition to health and social care):

- more control of local transport, with a long-term government budget to enable planning of a more modern, better-connected network
- new planning powers to encourage regeneration and development
- a new £300 million fund for housing: enough for an extra 15,000 new homes over ten years
- extra funding to get up to 50,000 people back into work
- incentives to skills-providers to develop more work-related training
- extra budget to support and develop local businesses
- the role of the Police and Crime Commissioner being merged with the elected mayor
- the elected mayor being responsible for the fire service
- more control of planning through the GM Land Commission.
- control of investment through a new 'earn back' funding arrangement which gives extra money for the region's infrastructure and means certain levels of economic growth are achieved

Most elements of the wider devolution deal were transfers of power from Whitehall to GM, using the power in the Cities and Local Government Devolution Act 2016.[3]

The scale of the devolved arrangements informed the strategy for GM: Our People, Our Place with a vision to 'make Greater Manchester one of the best places in the world to grow up, get on and grow old'[4] (Figure 1). One of the ten priorities focuses specifically on health: 'Healthy lives, with quality care available for those that need it'. In July 2019 a 'white paper' on the model of unified public services for GM[5] was produced, outlining the ambition to integrate public services at the neighbourhood level to connect the range of contributions to successful lives

HEALTH AND SOCIAL CARE DEVOLUTION

A Memorandum of Understanding (MOU) was signed in February 2015 to establish a delegated arrangement between NHS England and GM which was enacted from April 2016 following agreement of:

- **A 5-year strategy for clinical and financial sustainability** – "Taking Charge"
- **An Accountability Agreement** – containing the commitments to the NHS Constitution
- **A Delegation Agreement** – confirming the delegations from NHSE to the GM Chief Officer

This enabled GM to take "devolved control" of the £6 billion p.a. budget for health and social care for the 2.8 million people of the city-region.

The Greater Manchester Health and Social Care Partnership (GMHSCP) was established, hosted by NHS England. The health and social care elements of devolution were enacted through an administrative agreement – formalised in the MOU. There was no change in formal statutory accountability for NHS organisations or local government. Regulatory powers were devolved to GM for commissioning only, not for providers or social care. GMHSCP consisted of every NHS organisation and local authority in GM, as well as other key stakeholders including the voluntary sector, patient groups and regulatory bodies,

Decision-making was shaped by a number of principles (Figure 2):

Figure 2: Principles[9]

Focus on people and places rather than organisations, pulling services together and integrating them around people's homes, neighbourhoods, and towns

Design things together and collaborate, agreeing how we do things collectively, to make our current and future services work better

Be financially sustainable and this must be secured through our plans and service reform

Join our budgets together so we can buy health, care, and support services once for a place in a joined-up way

Be fair to ensure that all the people of Greater Manchester can have timely access to the support they require

Be innovative, using international evidence and proven best practice to shape our services to achieve the best outcomes for people in the most cost-effective way

Strive for the best quality services based on the outcomes we want within the resource available

The MOU also contained a set of principles, which included subsidiarity – ensuring decision are made at the most appropriate level - and *"all decisions about Greater Manchester will be taken with Greater Manchester. Where national policies apply, decisions about the implementation of those policies that are made about Greater Manchester will be made with Greater Manchester"*.

WHAT WAS THE AMBITION?

The ambition for GM health and social care was set out in "Taking charge of our Health and Social Care in Greater Manchester"[7] ("Taking Charge") in Dec 2015, following the signing of the MOU in Dec 2015 and prior to formal devolution of funding for health and social care from 1 April 2016.

The vision was described as *"to deliver the fastest and greatest improvement*

Figure 3: Objectives contained in the MOU

To improve the health and wellbeing of all the residents of Greater Manchester (GM) from early age to the elderly, recognising that this will only be achieved with a focus on prevention of ill health and the promotion of wellbeing. We want to move from having some of the worst health outcomes to having some of the best;

To close the health inequalities gap within GM and between GM and the rest of the UK faster;

To deliver effective integrated health and social care across GM;

To continue to redress the balance of care to move it closer to home where possible;

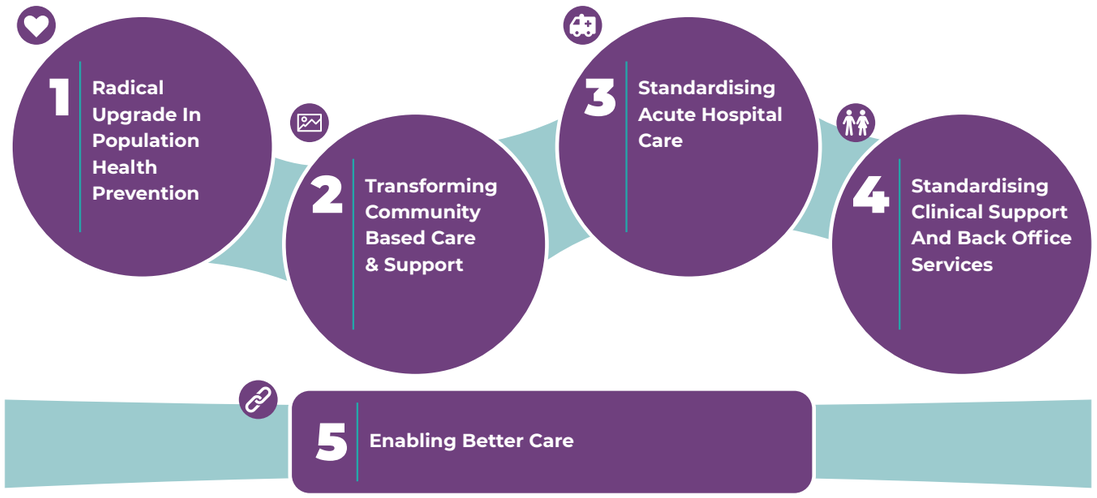
To strengthen the focus on wellbeing, including greater focus on prevention and public health;

To contribute to growth and to connect people to growth, e.g. supporting employment and early years services; and

To forge a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population.

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/369858/Greater_Manchester_Agreement_i.pdf
2 https://www.gov.uk/government/publications/devolution-to-the-greater-manchester-combined-authority-and-transition-to-a-directly-elected-mayor
3 https://www.legislation.gov.uk/ukpga/2016/1/contents/enacted
4 https://www.greatermanchester-ca.gov.uk/ourpeopleourplace
5 https://www.greatermanchester-ca.gov.uk/media/2302/gtr_mcr_model1_web.pdf
6 https://www.gmhsc.org.uk/wp-content/uploads/2018/06/GMHSC-Partnership-Annual-Report-1617.pdf
7 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/The-big-plan-Taking-Charge.pdf

Figure 4: Greater Manchester Transformation Portfolio[6]



in the health and wellbeing of the 2.8 million population of GM, creating a strong, safe and sustainable health and care system that is fit for the future" and plans to 'create a new health and care system' and to 'reach a 'new deal' with the public' were presented. This was consciously a transformational approach, embracing complexity and tackling reconfiguration across the system as a whole and was widely regarded as an ambitious and potentially high-risk strategy[8] with its objectives being those in the MOU (Figure 3)

It was positioned as a key component of the overall GM ambition *"to become a financially self-sustaining city region, sitting at the heart of the Northern Powerhouse with the size, assets, skilled and healthy population, and political and economic influence to rival any global city."*

These objectives and principles led to the articulation of 4 transformation themes along with cross-cutting programmes (see Figure 4) and a series of quantified aims (see Figure 5).

These themes comprised plans supported by funding through the award (by NHS England) of £450m of transformation funding over 5 years in addition to the £6 billion p.a. budget for health and social care, and focused on:

- **Radical upgrade in population health prevention:** A fundamental change in the way people and communities take charge of – and responsibility for – managing their own health and wellbeing, whether they are well or ill. This included exploring the development of new relationships between NHS and social care staff and the public who use services, finding people who are living with life changing health issues and do not even know about them and investing far more in preventing ill health, enabling people to start well, live well and age well.
- **Transforming community-based care and support:** The development of local care organisations where GPs, hospital doctors, nurses and other health professionals come together with social care, the voluntary sector and others looking after people's physical and mental health, as well as managers, to plan and deliver care. So when people do need support from public services it is largely in their community, with hospitals only needed for specialist care.
- **Standardising acute hospital care:** Hospitals across GM working together across a range of clinical services, to make sure expertise, experience and efficiencies can be shared widely so that everyone in GM can benefit equally from the same high standards of specialist care.
- **Standardising clinical support and back-office services and enabling better care:** Other changes to make sure standards are consistent and high across GM, as well as saving money. This includes exploring sharing some clinical and non-clinical support functions across lots of organisations. Giving people greater access and control over their health records and ensuring they are available in hospitals, GP practices and with social care so people can tell their story once. Investing in GM wide workforce development; sharing and consolidating public sector buildings; investing in new technology, research and development, innovation and the spreading of great ideas.

Figure 5: Aims by 2021[10]

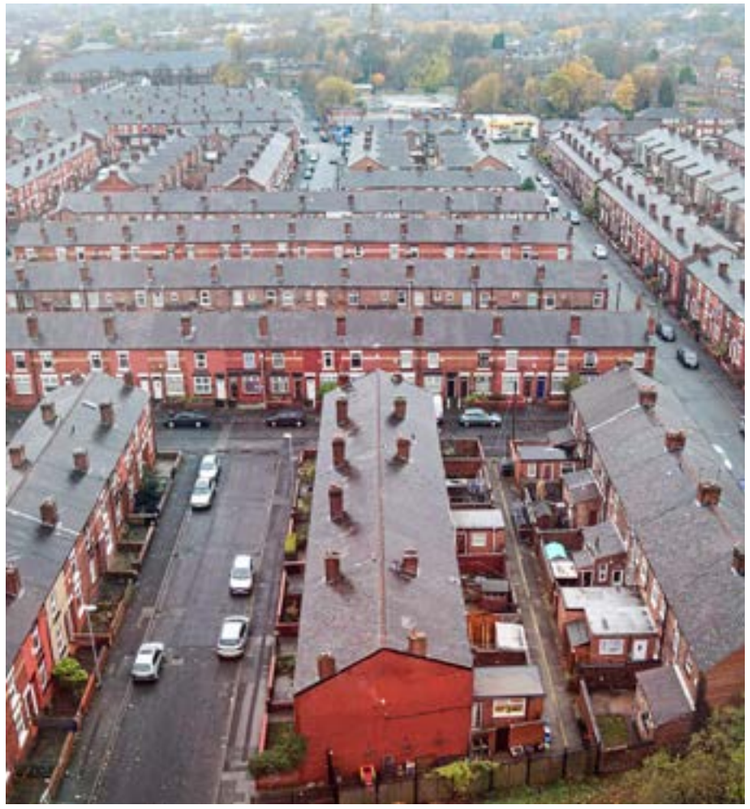
1,300 fewer people dying from cancer
600 fewer people dying from cardiovascular disease
580 fewer people dying from respiratory disease
More children reaching a good level of social and emotional development with 3,250 more children ready for the start of school at 5.
270 more babies being over 2,500g which makes a significant difference to their long-term health
More children reaching a good level of social and emotional development with 3,250 more children ready for the start of school at 5.
Supporting people to stay well and live at home for as long as possible, with 2,750 fewer people suffering serious falls.

8 Walshe K, Lorne C, Coleman A, McDonald R, Turner A. Devolving health and social care: learning from Greater Manchester: The University of Manchester, 2018. https://www.alliancembs.manchester.ac.uk/media/ambs/content-assets/documents/news/devolving-health-and-social-care-learning-from-greater-manchester.pdf

9 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Taking-Charge-summary.pdf

10 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Taking-Charge-summary.pdf

Plans were developed for each of these areas – with the 10 locality plans being developed and funding awarded from the Transformation Fund once these had met the criteria for funding. Each locality funding application was approved by system governance within GM during the first two years of devolution with details of each plan and when they were approved available from GMHSCP[11] as well as individual localities.



POPULATION HEALTH

Devolution provided an unprecedented opportunity to address health inequalities. Breaking down organisational silos; utilising the assets of individuals and communities to take control of their own health enabling a focus on the root causes of ill-health. For example, strengthening the links between health, work, and economic prosperity to take a truly whole systems approach to population health and wellbeing.

The GM Population Health Plan[12] was agreed in January 2017. Building on prior commitments made in an MOU with Public Health England (PHE) in July 2015[13], and in "Taking Charge", it set out a collective ambition for delivering a radical upgrade in population health. It focused on themes that set out the approach to delivering population health consistently at scale across GM and taking the multiple opportunities across the life course to enhance quality of life.

- **Start well** – improving the level of development that children in GM reach, reducing the number of low birth weight babies
- **Live well** – more GM families being economically active, fewer people dying early from cardiovascular disease, cancer and respiratory disease
- **Age well** – more people supported to stay well and live at home for as long as possible
- **Person and Community Centred Approaches (PCCA)** - asset-based community development and actively involving communities as a way of working
- **System reform** – the ambition to create a unified population health system across the GM economy which is organised to deliver at pace and scale.

The GM Population Health Plan was aligned with the wider public sector GM Strategy. With key shared commitments including early years and school readiness; work and health; healthy aging; physical activity and the promotion of active travel; air quality and social prescribing. It is *"unashamedly focused on people and communities … both place-based and where people share a common identity or affinity … connected and empowered communities are healthy communities"* and it tackles both the determinants of health and behaviours[14].

A set of population health outcomes were defined, using the life course approach, and it was noted that bringing some of these up to the England average would represent a significant improvement for the people of GM.

The population health ambitions of devolution have been supported by programmes across GM, or programmes aiming to have GM coverage over time, although most started with work in some localities in order to learn and scale up. The Population Health plans and priorities were chosen to *"add value to the local delivery described in the 10 locality plans"*[14]

HEALTH AND SOCIAL CARE SYSTEM ARCHITECTURE

GM has developed its 'systems architecture' (Figure 6) which supports the plans for its transformation themes (Figure 3) and particularly the focus on community-based care. This shows service providers and commissioning

11 See papers for the Health and Care Board from 2016 onwards available at https://www.gmhsc.org.uk/meetings-and-events

12 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Population-Health-Plan-2017-2021.pdf

13 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/11._GM_Public_Health_Reforms_combined.pdf

14 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Population-Health-Plan-2017-2021.pdf p.4

across GM, within each borough (locality) and neighbourhood. This also demonstrates the integration of health care with other public sector provision including the voluntary and community sector.

The systems architecture includes:

- The establishment of 10 Local Care Organisations (LCOs) integrating provision. The objectives of LCOs are to[16]:
- Enable conditions to be managed at home and in the community
- Secure the contributions of the range of public service partners to provide early help and intervention.
- Support individuals and communities to take more control over their health
- Take responsibility for the management of the health and wellbeing of a defined community
- Each locality is made up of smaller neighbourhoods - GP practices working with other health and care professionals, serving populations of 30-50K.
- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten localities;
- New models of hospital provision seeing hospitals working together in GM at a much greater scale than ever before to a set of consistent quality standards;
- A GM-wide architecture where it makes sense to do things at greater scale – including the GM Commissioning Hub, Health Innovation Manchester, a Digital Collaborative, a Workforce Collaborative and a 'one public service estate' strategy.

INFRASTRUCTURE, GOVERNANCE, AND THE SYSTEM

GMHSCP was established, bringing together NHS organisations, local authorities and other stakeholders in health and social care. Governance arrangements have remained largely unchanged since 2016 (Figure 7). The GM Health and Care Board[15] (Partnership Board), met monthly in public until 2017 and then every other month until January 2020, with papers publicly available.

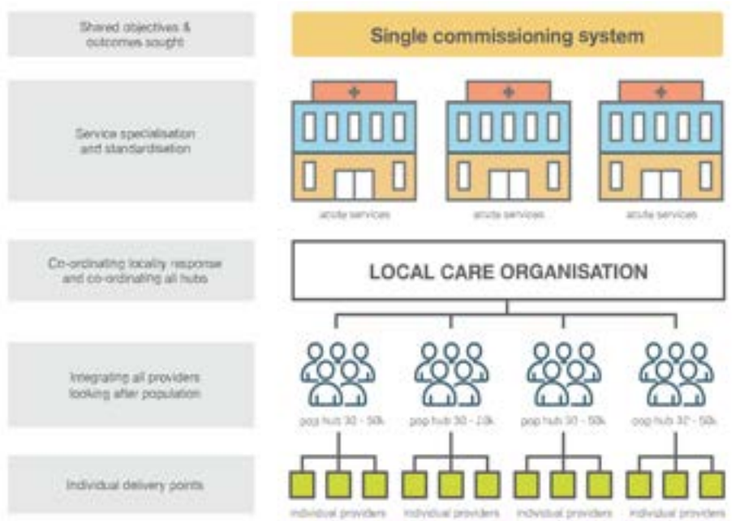
A Partnership Board Executive met more frequently in private, and its key decisions were reported to the Health and Care Board. The GM Health and Care Board receives annual reports and business plans from a range of other Boards as shown in Figure 7. Other governance arrangements representing different parts of the 'system' are unique to GM:

- Joint Commissioning Board (which commissions health and care services at GM level),
- Primary Care Board (which oversees primary care services such as GP services, optometry, pharmacy and dentistry) and developed and supports the implementation of the GM primary care strategy, which focuses on excellence in general practice, improved access, estates and strengthening the workforce.
- Provider Federation Board (which brings together acute, community and mental health trusts)
- Population Health Board (which agreed and oversees the implementation of the population health strategy)

THE GM PUBLIC SERVICE CONTEXT

This system architecture operates within the wider public sector model whose ambition is shown in Figure 8. Some elements of this are already in place and others remain under development. Of note is the relationship with the VCSE, nationally regarded as innovative, which has been confirmed through a MOU and supports the principles of working with communities and enabling support beyond medicine and formal care.

Figure 6: GM System Architecture

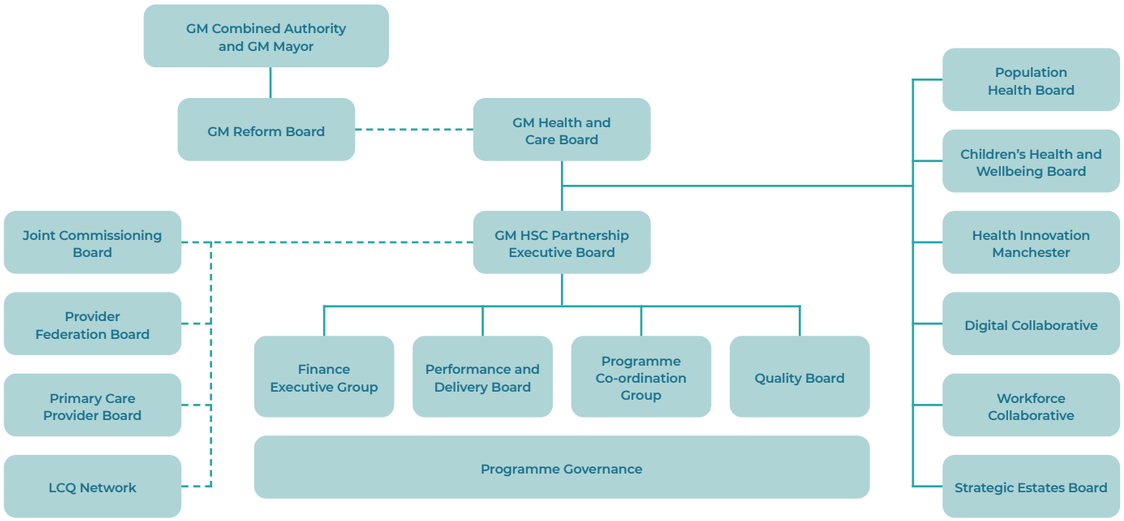


15 https://democracy.greatermanchester-ca.gov.uk/mgCommitteeDetails.aspx?ID=221

16 https://www.gmhsc.org.uk/wp-content/uploads/2018/11/05_Business_Plan_2019_20_and_Annual_Report_and_Accounts_2018_19.pdf Annual Report, p.11 para 4.1

17 https://healthdevolution.org.uk/wp-content/uploads/2020/03/GM-Slides-for-Devolution-Health-Commisison.pptx

Figure 7: Governance Framework[17]



WHAT HAPPENED OVER TIME

GMHSCP have described three different phases of their work[18]:

- **the first phase** – lasting until April 2016 – focused on establishing the devolved settlement for health and care in GM;
- **the second** – broadly until autumn 2017 – focused on embedding governance, strategies and programme structures as well as supporting the allocation of the majority of the Transformation Fund[19];
- **the third** – from autumn 2017 onwards - focused on implementation of the plans.

Since then, a fourth phase (from April 2019 onwards) has involved learning from progress so far (see section Seven) and planning for transition to a new set of statutory arrangements relating to Integrated Care Systems (ICS), proposed in the White Paper of Feb 2021[20] ('Integration and Innovation: Working together to improve health and social care for all). This phase has also included the impact of COVID-19 on GM. Further details of this can be found in the next section.

Figure 8: Whole System Public Service reform

18 https://www.gmhsc.org.uk/wp-content/uploads/2018/11/05_Business_Plan_2019_20_and_Annual_Report_and_Accounts_2018_19.pdf Annual Report p.3, para 2.3

19 Walshe K, Lorne C, Coleman A, McDonald R, Turner A. Devolving health and social care: learning from Greater Manchester: The University of Manchester, 2018. https://www.alliancembs.manchester.ac.uk/media/ambs/content-assets/documents/news/devolving-health-and-social-care-learning-from-greater-manchester.pdf

20 https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

Section Seven

THE FIRST FIVE YEARS

Professor Ruth Boaden
External Advisor on Evaluation, Greater Manchester Health and Social Care Partnership.
Honorary Professor, Alliance Manchester Business School

Since the devolution of health and social care funding to Greater Manchester in 2016[1] the area has been the focus of much scrutiny both internally and externally to determine the impact of devolution. This chapter focuses on the process of change and its impact within Greater Manchester, the learning so far, and how we know what the impact is. There is an increasing recognition that Greater Manchester is only halfway in a 10-year journey, and that not all the original ambition could have been achieved within five years.

HOW DO WE KNOW WHAT HAS HAPPENED?

Internal and external reporting

In addition to regular reporting to national bodies, on a wide range of measures (including NHS Constitutional standards and finance, in line with the rest of England), GMHSCP produced annual reports and business plans which were presented to the Health and Care Board[2] although due to the impact of the COVID-19 pandemic, no annual report for 19/20 or business plan for 20/21 is available.

Perspectives from key stakeholders

Greater Manchester (GM) representatives have spoken on national and international platforms about devolution in GM. For example, in the Teddy Chester Lecture[3] (2017), where the rationale and early analysis of progress was described and in the Telford Memorial Lecture[4] (2020) given by Jon Rouse (the Chief Officer) as he left GM.

Wider analysis

The devolution deals have much wider economic implications as shown in other analysis including:

- The evidence base for the GM Industrial Strategy[5], carried out as part of the GM Independent Prosperity Review (IPR).
- The IPR revisited its recommendations in Sep 2020[6] in the light of COVID-19 and highlighted *"the value and benefit of local decision-making and commissioning"* (p.12) in the GM response to the pandemic.
- An independent and cross-party inquiry into the value and accountability of devolved health systems (the Health Devolution Commission) began its work in 2019 and has produced reports[7], and taken evidence from a range of stakeholders (including GMHSCP).

Externally funded evaluation

The Health Foundation funded an independent qualitative and quantitative evaluation of devolution being carried out by the University of Manchester in 2016; the only independent longitudinal evaluation of GM devolution underway. The initial phase of the qualitative evaluation covered the first 18 months of devolution only and where relevant, its findings are included here. The long-term quantitative evaluation will report in 2022 (due to lags in data availability for GM and the rest of England) and will be supported by qualitative analysis of initiatives within GM which may have contributed to the quantitative impacts.

Locally funded evaluations

As part of its overall devolution agreement, GM committed to undertake evaluation of its plans, which was worked into agreements for the allocation of Transformation Funding (TF). The learning and common themes across each element of evaluation activity will be synthesised during 2021.

Each locality has evaluation being completed during 2021 addressing; structures, governance, and accountability; leadership and relationships; local care approach; impacts on population/ service users, the workforce, and the system. Information has been gathered through data and document analysis, interviews and focus groups. One evaluation report (for Salford Together) is already complete and publicly available[8].

WHAT HAS CHANGED?

a) The health and wellbeing of all the residents of Greater Manchester (GM)

"Taking Charge is working in Greater Manchester"[9] was published by GMHSCP in March 2020 and drew on a range of data about areas where GM data trends could be compared with the rest of England to the end of 2018 (or the 2018/19 financial year, depending on the data source). This data is limited by what is available and collected nationally so that comparisons could be made.

Table 1: Aims by 2021 and progress to date[11]

Original aim	Latest data and comments
▪ 1,300 fewer people dying from cancer ▪ 600 fewer people dying from cardiovascular disease ▪ 580 fewer people dying from respiratory disease	The Greater Manchester Strategy (2017) contains revised/redefined versions of these aims which identify annual reduction targets. The latest data available is from 2018, which is arguably too soon to see any impact post-devolution (2016), given the time that improvements in health take to impact on mortality rates. Improvements in smoking cessation (Table 4) will impact on these aims over time
▪ 270 more babies being over 2,500g which makes a significant difference to their long-term health	Clinical guidance changed in 2015 which made this a less meaningful measure[12], so in its place the rate of stillbirths has been tracked. Latest data is from 2018[13] which shows reductions but not yet to the England average. The improvement in the number of smoke-free pregnancies will have also improved the health of babies being born (Table 4)
▪ More children reaching a good level of social and emotional development with 3,250 more children ready for the start of school at 5.	The GM Early Years programmes has shown particularly strong improvements for more disadvantaged children, with the gap in school readiness rates between Greater Manchester and England among children eligible for free school meals halving over the last 3 years and closing completely in 2018-9 (latest data available)[14]
▪ Supporting people to stay well and live at home for as long as possible, with 2,750 fewer people suffering serious falls.	'Serious falls' are defined as those that lead to an emergency admission but at present GM do not have the evidence needed to make a link between the work that has been done and the cases of emergency admissions due to falls.

Reducing smoking

Case study examples of GM's achievement in reducing smoking are given in Table 2 and Table 3.

The Population Health programme

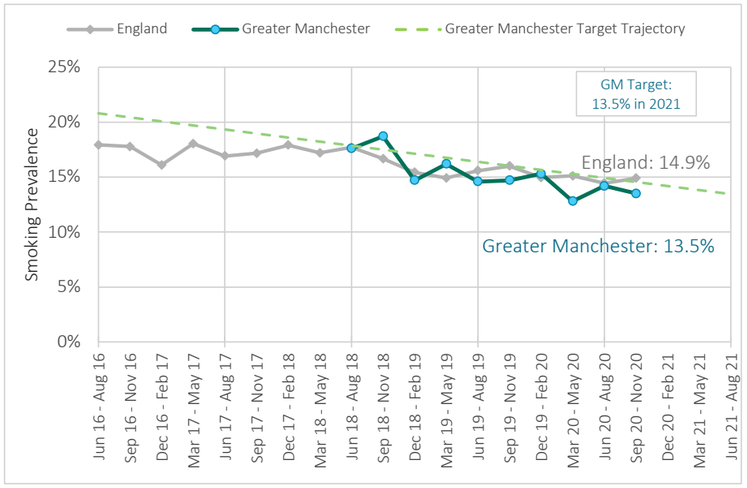
The Population Health programme focused on health and wellbeing priorities and is showing positive impact at this stage with an independent review of the achievements in 2020 clear that *"...each programme has made a significant contribution in terms of learning how to develop and deliver new approaches to population health, and some are demonstrating extremely positive outcomes, even at this interim stage."*[6]

The value of taking a 'whole system' approach to improving health and inequalities was said to have been demonstrated, with GM leadership where scale and consistency is needed, supporting locally led approaches where they are most appropriate. Effective leadership was key to successful mobilisation and implementation.

The challenges of a diverse set of programmes with different starting points and times means that comparison of achievements could be easily made, but this has provided the opportunity to innovate. The challenges of evidencing impact or a performance trajectory compared to others remains a challenge in many programmes because of the lack of national or local data sets, as well as impact often being seen some time after programme implementation.

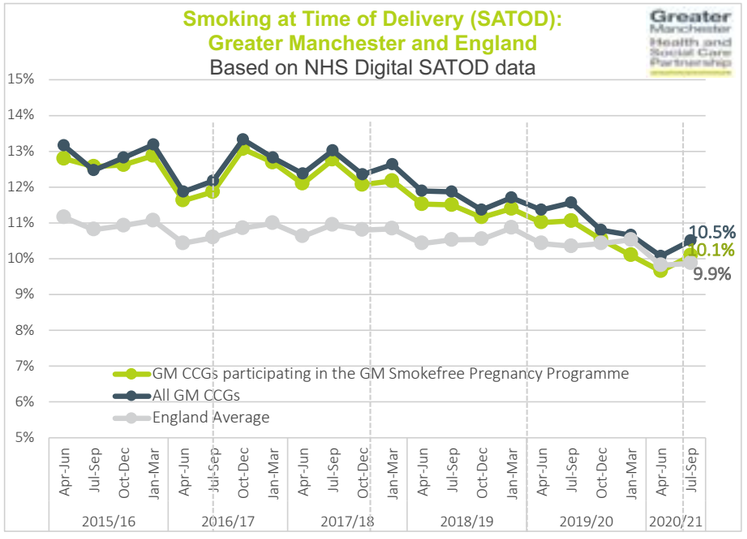
1 Walshe K, Lorne C, Coleman A, McDonald R, Turner A. Devolving health and social care: learning from Greater Manchester: The University of Manchester, 2018. https://www.alliancembs.manchester.ac.uk/media/ambs/content-assets/documents/news/devolving-health-and-social-care-learning-from-greater-manchester.pdf
2 See papers for the Health and Care Board from 2016 onwards available at https://www.gmhsc.org.uk/meetings-and-events
3 https://www.gmhsc.org.uk/wp-content/uploads/2018/04/Teddy-Chester-Lecture-Jon-Rouse-291117.pdf
4 "A different way: lessons from the Greater Manchester devolution journey" https://www.gmhsc.org.uk/wp-content/uploads/2020/01/Telford-Memorial-Lecture-Jon-Rouse-.pdf
5 Greater Manchester: The Emerging Impact of Devolution (2018) https://www.greatermanchester-ca.gov.uk/media/1131/gm_prosperity_review_baseline___devolution_review___november_2018_.pdf
6 https://www.greatermanchester-ca.gov.uk/media/3408/gmipr_one-year-on.pdf
7 For example – Is devolution the future of health and social care? https://devoconnect.co.uk/wp-content/uploads/2019/07/Final-Copy-Health-Devolution-Essays-1.pdf
8 https://www.salfordtogether.com/2020/09/salford-integrated-care-programme-2016-17-to-2019-20-evaluation-report/
9 https://www.gmhsc.org.uk/wp-content/uploads/2020/03/Taking-Charge-is-Working-in-Greater-Manchester.pdf
10 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Taking-Charge-summary.pdf
11 https://www.gmhsc.org.uk/wp-content/uploads/2018/05/Taking-Charge-summary.pdf
12 https://www.gmhsc.org.uk/wp-content/uploads/2020/03/Taking-Charge-is-Working-in-Greater-Manchester.pdf p.7
13 https://www.gmhsc.org.uk/wp-content/uploads/2020/03/Taking-Charge-is-Working-in-Greater-Manchester.pdf p.7
14 https://www.gmhsc.org.uk/wp-content/uploads/2020/03/Taking-Charge-is-Working-in-Greater-Manchester.pdf p.9

Table 2: Smoking prevalence among adults aged 16 and over, Greater Manchester and England[15]



Making Smoking History, GM's Tobacco Control Strategy, aims to reducing adult smoking prevalence by a third by 2021. The 2019 Annual Population Survey (APS) data estimated that 16% of the GM population smoke versus 14% in England, a reduction of 52,000 smokers in GM (or 18.4%) since the introduction of the strategy in late 2017. Routine and manual smoking rates have reduced faster in GM than in England and other parts of the North from 28.8% to 24.5% closing the gap with England (23.2%).

Table 3: Smoking at time of delivery



As part of the Making Smoking History strategy, a programme of support for smoke free pregnancies, families and communities has reduced smoking at time of delivery rates by almost a quarter in the nine participating localities to date, supporting healthy starts and closing the gap with the England rate. All ten localities are now engaged in delivery. Since April 2018 there have been an additional 510 GM babies born smoke-free.

Other examples of achievements of the population health programmes are shown in Table 4, and these reflect the emerging priorities of the programme since 2016.

b) Joining up health and social care locally, and with wider public services,

The opportunity to join up health and care with all public services has been increasingly recognised since the original devolution agreement, and brought into focus through the role of the Mayor of GM. *"... as Mayor of the only city-region with health devolution, it has become increasingly clear to me that the unique opportunity Greater Manchester has is to integrate health with everything - early years, education, community safety, housing and employment. And we are all determined to take it."*[17]. The model of public service delivery that has developed is described as 'based on person, place and prevention'[18] and involves integration of all public services at place level, not only health and care.

At locality level

Each locality has established a local care organisation (LCO), joint commissioning arrangements between health and the local authority (which includes a single accountable officer for the integrated commissioning function) and teams at neighbourhood level which comprise the 'local care approach'. Although this took time to establish in all areas and the arrangements therefore vary in maturity, LCOs are now (2020) in place across GM which is a significant achievement in the time. The exact form of the LCO varies – with three types identified: a lead-provider model, an alliance / partnership model, or a hybrid model. There was no blueprint for this since establishment was based on existing relationships and the historic experience of integration in the locality (with the prior financial strength / weakness of provider organisations enabling or hindering implementation). Locality evaluations report strengthened relationships between organisations and effective leadership, which (anecdotally) formed a strong basis for the COVID-19 response.

Across localities there have been improvements in general practice and social care provision. By 2020 over 96% of Greater Manchester GP practices were rated good or outstanding by the Care Quality Commission (CQC) - above the national average.

The proportion of care home beds and domiciliary care agencies in GM rated good or outstanding by the CQC has improved: this rose from 47% and 63% respectively in 2016 to 66% and 85% in 2019.

At neighbourhood level

Each locality has a series of 'neighbourhoods' serving populations of 30-50,000 people and many (but not all) have a physical presence in a 'hub' with 67 neighbourhoods in total across GM. .

Neighbourhoods are served by 'Integrated Neighbourhood Teams' (INTs) – although terminology varies between locality - and *"they have worked particularly well where they have worked through the whole patient pathway able to better wrap support around people."*[19]. The importance of relationships and leadership has been highlighted: "personal relationships and leadership giving frontline staff permissions to risk take, work differently and innovate are really important."[20] These are widely regarded as the greatest success in localities, and the site of the most tangible changes to date. It is also argued that these enabled a focused and locally sensitive response to the pandemic, and most had already widened their network beyond health and care and included the Voluntary Community and Social Enterprise (VCSE) and other partners.

In some localities, new ways of working and providing services have been implemented initially only in some neighbourhoods, so that impact is not yet seen yet at locality level – *"it is questionable whether the scale of the models and the cohorts they [new ways of working] target is sufficient to impact on the locality's population-level metrics"*.[21]

Some localities report impact on health system usage by specific cohorts of patients e.g. the frail elderly, those over 75, although without any counterfactual ('what would have happened anyway?'). Salford reported positive impact on

Table 4: Additional examples of GM Population Health programme impact

Almost 600 women in four localities have been identified as being 'at risk' of an alcohol exposed pregnancy, with more than 60% of these engaging in support subsequently offered to them
Between November 2015-2016 and November 2018-19, the proportion of adults doing 150 minutes or more of physical activity a week has increased by 2.6% - more than double the national increase of 1.2%. Differences in activity levels have fallen in key areas of gender, disability, socioeconomics, and age
Conversations about nutrition and hydration have been held with almost 1 in 5 adults aged 65 and over in the five areas where the programme was initially delivered. Programme evaluation found that more than 4 in 5 participants who were subsequently provided advice and support to change their diet or lifestyle had a positive outcome.

15 Greater Manchester Health and Social Care Population Health Programme Board, October 2020

16 'Population Health in GM – 20/21 and beyond', internal paper to GM Population Health Programme Board, 8 Oct 2020

17 https://greatermanchester-ca.gov.uk/media/1667/final_place_based_integration_and_whole_person_support_the_greater_manchester_model.pdf

18 https://greatermanchester-ca.gov.uk/media/1667/final_place_based_integration_and_whole_person_support_the_greater_manchester_model.pdf

19 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf

20 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf

21 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf

a range of measures including A&E attendances, quality of life measures and patient experience for specific small scale projects, whilst noting the relatively small numbers involved, and other concurrent initiatives which *"limited casual attribution and demonstrating potential system wide impact"*[22]

The previous GMHSCP Chief Officer (expressing personal views) noted that: *"there has been a discernible and distinctive shift in dynamics at the community level – more confidence in ability to self-care and improved impact of primary and community care, but much less impact ...[on the way that] ... the NHS itself is functioning, particularly in the acute phase"*[23].

The impact on individuals

There are subsectors of the population where support and engagement has been improved, for whom there are individual benefits, which have been described in a wide range of places. For example:

"Whilst Ben doesn't necessarily feel more independent, he certainly feels better able to cope and manage his conditions, stating that he feels he has achieved more in the 12 weeks with the Enhanced Care Team than he did in the previous five years with services."[24]

"I would never have believed how much mum's quality of life has improved. When the different services started talking to each other, it helped them get to know mum better so that their staff could do a good job."[25]

Those who work in the health and care system, particularly those working in community services at locality and neighbourhood level, have also experienced changes and view these positively.

"if you're an average older person with a district nurse and carer, the experience of coordination is much better."[26]

"I hear staff from social care and community health team saying that they feel like they are working more together, and more effectively and smarter to wrap around support for residents."[27]

"I enjoy it because of the integration. You're not isolated. We are all talking to one another"[28].

c) Hospitals across Greater Manchester working together across a range of clinical services

Activity following devolution built on previous progress on e.g. stroke and trauma services and has focused on services including, Respiratory, Paediatric Surgery, Vascular and Neurorehabilitation, some which are now complete. Others remain dependent on the award of, or the use of, capital funding at a range of hospital sites across GM.

The strength and collaboration of the Provider Federation Board was shown in response to the COVID-19 pandemic and further progress on GM-wide imaging has been made. Standardising and supporting Urgent Care services was also accelerated during the pandemic, For example, standard approaches to 'discharge to assess' are now being used across GM. There is a GM-Wide Clinical Assessment Service managing demand away from 999 and 111, as well as supporting demand for mental health crisis services. These examples show the close working between different parts of the health and care system in GM, (including but not limited to hospital care) that will form the basis for the next phase of integration.

d) Changes to ensure standards are consistent and high across Greater Manchester

The requirement for all of England, including GM, to meet the NHS Constitutional Standards[29] which include waiting times for treatment and access to services, did not change with devolution. They have not always been achieved reliably across all areas of GM although there are improvements in some parts of the system and on some measures (specifically on mental health access and waiting times (prior to COVID-19)). The GM system has not reduced the overall demand on urgent care reflected in the 4-hour target performance and noted as something facing all of England: *"we [GM] along with the rest of the country have gone backwards"*[30]

There was a requirement for the GM system as a whole to achieve financial balance and this was achieved up to 2019 (last public report) and[31] claimed as an important benefit of devolution. *"By taking a system approach to finances and managing flexibly across both the NHS/local government and the commissioner/provider divide, we have done what the rest of the country has struggled to do – live within our means ...We delivered a cumulative £440m surplus over the first three years, effectively paying back the fair share transformation resources we received at the outset"*[32]

Greater Manchester has developed a clear model for Health Innovation to drive the economic growth of the city-region through diffusion and adoption of health innovations across a broad range of health and wellbeing-related products and services, described in section six.

This has contributed to several successes for GM which included:

- Success in the NHS England Local Health and Care Record competition for £7.5M of external funding to develop technologies to support sharing of health and care data
- A Healthy Ageing Trailblazer award from Innovate UK led by the GMCA
- £2.5M investment from NHSX for COVID-19 remote monitoring programmes

There are many other areas on which GM has focused that cannot be fully detailed here, including workforce, digital and estates. Each of these areas would claim

22 https://www.salfordtogether.com/2020/09/salford-integrated-care-programme-2016-17-to-2019-20-evaluation-report/ p.5
23 https://www.gmhsc.org.uk/wp-content/uploads/2020/01/Telford-Memorial-Lecture-Jon-Rouse-.pdf
24 https://www.salfordtogether.com/2019/10/bens-story-enhanced-care-team/
25 https://www.salfordtogether.com/2017/11/salford-case-study-working-together-help-mavis/
26 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf
27 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf
28 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf
29 https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england
30 https://www.gmhsc.org.uk/wp-content/uploads/2020/01/Telford-Memorial-Lecture-Jon-Rouse-.pdf
31 https://www.gmhsc.org.uk/wp-content/uploads/2018/11/05_Business_Plan_2019_20_and_Annual_Report_and_Accounts_2018_19.pdf Annual Report, p48, para 6.11
32 https://www.gmhsc.org.uk/wp-content/uploads/2020/01/Telford-Memorial-Lecture-Jon-Rouse-.pdf

that devolution has enabled progress across GM that might otherwise not have been possible, but the full benefits are yet to be realised.

The impact of the COVID-19 pandemic

Governance has remained constant since 2016 with only very minor changes. Prior to the COVID-19 pandemic from March 2020 onwards, when many formal governance operations were suspended and a new governance process to support the management of the pandemic was established.

The GM response to COVID-19 since March 2020 is being analysed for future implications and learning, and some has been published[33, 34]. The role of the VCSE has been crucial[35], particularly in the homelessness and mental health sectors, building on networks already established, identifying and meeting need. Our strengths in innovation have also been crucial (see section eight). Informally, key reflections include:

- the value and utility of neighbourhood working in supporting citizens and all aspects of their needs
- rapid agreement and deployment of mutual aid across the provider sector
- the acceleration of key elements of the digital agenda, in particular the use of the GM care record
- further innovation in support to care home residents
- the role of relationships and leadership, previously described as: "mature and increasingly confident local governance and leadership"[36]

WHAT HAVE WE LEARNED?

Improvement is wider than the NHS

GM's ambition has always been for a whole public service partnership, within a devolved city region and its achievements to date demonstrate the validity of this ambition and the start of its realisation. Partnership with a wider range of agencies and community assets, the voluntary sector is necessary, and achievable.

Relationships and leadership are key

In localities where, for a range of reasons, relationships were challenged or there were significant changes in leadership, progress was slower. Robust governance arrangements and a shared understanding of priorities, challenges and strategy were noted in Salford and Wigan to be key to what they achieved[37, 38].

Governance and structure both help and hinder

Effective governance, enabling decisions to be taken at scale when appropriate, is important, along with management of system control totals and planning responses. However, the nature of devolution (termed by some as 'soft devolution'[39]) meant that there were limits to the delegation of regulatory functions to GM which may have restricted the power of the GM system to transform itself. With the benefit of hindsight, it has been hard for GM to both promote and support system working, pooling of resources and collective decision making whilst also holding delegated responsibility for regulation of commissioning: *"We have coexisted with, rather than resolved, the tension between accountability in the NHS and local democratic accountability"*[40]

It takes time to make a difference

This may be due in part to health policy and resultant incentives: *"the difficulty sharing money, budgets and accountabilities created real difficulties and resistance. So, things have developed largely as we hoped, but perhaps at a slower pace"*[41]. But the differing degrees of integration within localities and at GM level prior to 2016, also influenced the different pace of change across localities after devolution. This is in line with emerging national and international evidence about the length of time it takes for integration of health and care to impact on (for example) secondary care usage[42] (which was not available in 2016). : *"The complexity and challenge of demonstrating impact and attribution in large scale change programmes, within relatively short time frames cannot be underestimated."*[43]

The challenges are common

The challenges to a more integrated way of working, as well as to achievement of constitutional standards, are common across England, and likely wider afield. For example:

- Workforce capacity and capability. In areas where new models of care have been established, these may recruit staff from other services which then affects the operation of the whole system. Efforts to establish GM-wide services to share workforce are ongoing.
- Estates and capital funding, which remain a challenge for all areas with calls for changes to the centrally controlled system of allocation[44].
- IT infrastructure and data availability: *"COVID-19 has reminded us of the paucity of local data and intelligence that we have at our fingertips to make decisions"*[45].
- Social care funding, which is a national challenge, and only part of the impact of austerity on local authority funding which is crucial to many of the changes within GM.

Consideration of these for the future is vital: *"Early set up of future integrated care programmes [should] include a robust assessment and optimisation of known enablers, and plan for mitigation of known barriers."*[46]

THIS IS NOT THE END

Planning for the next stage, promoted not only by the 2021 White Paper but the end of the 5-year funding agreement for GM, has encouraged reflection on what has been learned. GM has not reached the end of its journey and much more impact is yet to come. Their own analysis is that :

- more needs to be done to reduce social inequality, drive up wage growth, and boost productivity.
- Public services must spend more time on planned services focused on prevention and early intervention, and less time on reactive, unplanned crisis intervention.
- Because of devolution GM believes it has made more progress than the rest of the country. For example, Working Well, GM's programme to help people back into employment, has been hailed as a national trailblazer.
- GM can now demonstrate how a full alignment of public resource and can begin to unlock the issues which are the key to a good life (economic development and transport planning, housing and land use, public safety and justice). Although GM is still held back from fully realising these ambitions by the legacy of constraints from central government and out of date and piecemeal funding practices.
- Unified public services at the neighbourhood level will be the default in GM which does not prevent the organisation of services on a borough level, or a GM level. If this is needed.
- Organising how public services work together more effectively is not a goal in itself, but rather a basis for the GM ambition to transform the way public services work.

WHAT COMES NEXT?

The White Paper proposes integration *"within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people"*[47].

GM already has wider system working than that envisaged in the White Paper. A whole public service Partnership within a devolved city region. The route to complementary contributions to health creation across the whole of local government, police, fire, economic development, education, skills, and housing is being progressed in GM and the proposals in the White Paper represent continuity of this way of working.

33 https://www.gmhsc.org.uk/wp-content/uploads/2021/03/GM-HEALTH-AND-CARE-RESPONSE-TO-COVID-19-PANDEMIC.pdf

34 "Learning from Innovation in a Crisis"https://www.innovationunit.org/wp-content/uploads/GMCA-innovation-in-a-crisis-Final.pdf

35 Evaluation of the GM VCSE Health and Social Care Engagement Programme, Cordis Bright, March 2021, not publicly available

36 https://www.gmhsc.org.uk/wp-content/uploads/2020/01/Telford-Memorial-Lecture-Jon-Rouse-.pdf

37 https://www.salfordtogether.com/2020/09/salford-integrated-care-programme-2016-17-to-2019-20-evaluation-report/ p.42

38 https://www.kingsfund.org.uk/projects/lessons-wigan-deal

39 Walshe K, Lorne C, Coleman A, McDonald R, Turner A. Devolving health and social care: learning from Greater Manchester: The University of Manchester, 2018. https://www.alliancembs.manchester.ac.uk/media/ambs/content-assets/documents/news/devolving-health-and-social-care-learning-from-greater-manchester.pdf

40 https://healthdevolution.org.uk/wp-content/uploads/2020/03/GM-Slides-for-Devolution-Health-Commisison.pptx

41 Internal interim evaluation report from Cordis Bright and partners https://www.cordisbright.co.uk/admin/resources/case-study-gm-local-care-approach-1.pdf

42 For example, see https://www.health.org.uk/news-and-comment/blogs/integrated-care-programmes-we-need-to-think-long-term-when-implementing-change

43 https://www.salfordtogether.com/2020/09/salford-integrated-care-programme-2016-17-to-2019-20-evaluation-report/ p.3

44 https://www.gmhsc.org.uk/wp-content/uploads/2020/01/Telford-Memorial-Lecture-Jon-Rouse-.pdf

45 https://www.greatermanchester-ca.gov.uk/media/3408/gmipr_one-year-on.pdf

46 https://www.salfordtogether.com/2020/09/salford-integrated-care-programme-2016-17-to-2019-20-evaluation-report/ p.48

47 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960549/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-print-version.pdf , p.7, para 1.13

Section Eight

THE POWER OF PARTNERSHIP

Rowena Burns
Chair of Health Innovation Manchester

The devolution of Greater Manchester's health and care services was built on a strong track record of collaborative working. Over the past twenty years this has been pivotal in delivering sustained investment and growth across Greater Manchester and building its reputation as one of the most successful city regions in Europe.

There were failures as well as successes over this time, and of course deeply felt loyalties to individual towns and cities created tensions and occasionally conflicts. Facing into these tensions was an important part of the maturing process; while trust might at times have been fragile, there was also an undertow of mutual respect, and a belief that on balance there was more to gain than lose by working together.

While this might be said to be a negative driver, it was fuelled by a clarity of strategic vision and ambition which focused on initiatives that could only be realised through partnership – the expansion of Manchester Airport, development of Metrolink, the Commonwealth Games, Media City – projects which reflected an aspiration to compete on a global stage.

A PATH FOR HEALTH ACROSS GREATER MANCHESTER

All partnerships require ambition and clear goals, whether that is meeting identified need, combatting a threat, or grasping an opportunity. It would be difficult to conceive of a greater need than improving the health of our citizens. Parts of Greater Manchester have some of the worst health outcomes in the UK, and the burden of ill-health far outstrips the capacity of some of the finest hospitals in the UK to respond to rising demand. We share global problems, including the long and perilous journey from laboratory to bedside for new therapies and diagnostics. Health services have not benefitted from the disruptive power of digital which has so completely transformed other customer services across multiple industries.

If there is no greater need, there is also no greater opportunity.

> *" The UK is a global leader in life sciences, and the North West plays an important national role in the sector. "*

Greater Manchester's four universities provide excellence in research, particularly in fields which are at the frontier of medical sciences and are major suppliers of trained health professionals and technicians.

We have distinguished hospitals, including The Christie, a highly mature civic leadership, a strong and growing industry base, and well-established business support services through bodies like the Growth Hub and Manchester Science Partnerships.

What was missing was a mechanism through which all these strengths could work together as a fighting force with shared priorities which would make best use of all of its constituent parts. Government policy had placed the acute hospital providers in competition with one another, several hundred primary care providers had few mechanisms through which they could contribute to strategies for wider reform, and the providers of population health and social care services were poorly resourced and largely able only to meet their statutory responsibilities. The day-to-day pressures left little capacity for longer term thinking and reform.

Prior to devolution, health providers and locality leaders had already embarked on initiatives which would provide some of the missing links and allow joint planning and delivery of hospital and community-based services. Devolution, and a budget of £450m to support system transformation at both Greater Manchester and locality level, fuelled a shared belief that it would not be enough to make the existing system more efficient, and that new thinking was needed which started from citizen need rather than an institutional view of service supply. Partners also wanted to tap into examples from other industries of how new business models and service transformation could be achieved, and to bring together the deep expertise of

system providers with the innovative power of industry and the research power of academia.

HEALTH INNOVATION MANCHESTER IS ESTABLISHED

Health Innovation Manchester brought together the city region's four universities, the NHS, the local authorities, Academic Health Science Centre (MAHSC), the Academic Health Science Network (AHSN), and industry. The mission for this body was to accelerate the discovery, development, and deployment at pace and scale of new products and services to maintain good human health, and new diagnostic tools and treatments to improve health outcomes and quality of life.

" In this, Health Innovation Manchester's work would be facilitated by Greater Manchester's uniquely streamlined governance and decision-making structures – a vital advantage for innovators struggling with the complexities of the UK healthcare market. "

The auguries for the new venture were good. The author was CEO of Manchester Science Partnerships at that time and knew from extensive work with large and small life science businesses what their problems were in getting their proven innovations beyond successful trial and into commercial use. There was immense support and enthusiasm for Health Innovation Manchester from the leaders of these businesses for its purpose and endeavour. Manchester Science Park's business mission was to be an active partner in supporting the growth of the sector, and to align this with the wider development of the Greater Manchester economy. Through our work with the AHSC and AHSN, we were aware of a multiplicity of individually excellent initiatives and projects - and equally aware of how much more could be achieved if this energy and initiative could be directed toward a clearer view of Greater Manchester's health and care priorities, and the development of innovations which were consequently owned and championed by the system itself. There was also a need to tackle obstacles to innovation at a cultural level, through organisational and behavioural change so that innovation can be seen as part of the normal course of business. Established business and funding models needed to be changed, to tackle the perverse incentives created by a system whereby the costs and benefits of an individual initiative fell on different institutions, meaning that excellent innovations failed because there was no mechanism for evaluating them in terms of their total return on investment.

The Partners understood the importance of early wins in any collaboration, and especially where the set-up disrupted established relationships and norms. They thus elected to avoid the time-traps of organisational restructures and created Health Innovation Manchester as a virtual organisation, with a Director whose role was essentially one of coordination, bringing together the leaders of the main stakeholder bodies, including particularly the AHSN and AHSC.

PARTNERSHIP IN PRACTICE

Is there a world in which this might have worked? Maybe - on one level there was strong agreement about the value of greater coordination, and many of those involved were active collaborators already to some degree - but the pace required and the need to realign activities to face more directly into Greater Manchester's main health needs depended on a degree of cultural alignment which simply wasn't there at that time. There were also the unsurprising defensive concerns about loss of autonomy, re-thinking priorities, reorganising teams, and positions – these are hard things at any time and harder still in the absence of authoritative mechanisms for acknowledging and dealing with them. Inevitably, "small p" politics proliferated and cut across efforts to build community.

Sometimes, these pain points are a necessary part of the journey toward consensus on what needs to happen. Within the year, partners reviewed progress and concluded that Health Innovation Manchester should be established as an organisation, bringing together the AHSC and AHSN within a single governance arrangement, and reforming the governance from its original steering group forum into a full Board. The search began for a full-time CEO, and work began to shape the new team.

From the outset, the need for an agency dedicated to driving innovation had had the full support at the top of all stakeholder organisations – I would say that this is vital in any partnership, and especially one with a multiplicity of stakeholder perspectives. That support is exemplified in the membership of the Health Innovation Manchester Board, which brings together at Chief Executive and leadership level all of the main members of the Greater Manchester system, together with senior subject matter expertise from industry. The Board's role is strategic rather than operational, and formal meetings are supplemented by smaller group inputs into policy development, industry partnerships, and stakeholder relationships.

An important principle of Health Innovation Manchester 's approach is the ability to tap into the great pool of knowledge and expertise which exists across the system. Health Innovation Manchester has no monopoly of knowledge, expertise, or ideas. The backbone of the organisation is the integrated MAHSC and AHSN teams. A dedicated small core team of senior people work with a much larger virtual team, including senior researchers, clinical academics, and clinicians, and work closely with colleagues from major hospital trusts, the Partnership, Combined Authority, and local authorities. Health Innovation Manchester is hosted by Manchester University Hospitals Foundation Trust. We are active partners to the Manchester Biomedical Research Centre, and host to the Greater Manchester Applied Research Collaboration, part of the national NIHR network of ARCs. Health Innovation Manchester's funding comes from a combination of national monies

from NHSE and the DoH – relating to the functions carried out by the national network of AHSNs – and member subscriptions from the universities and acute hospital trusts. The latter are important in encouraging ownership of Health Innovation Manchester 's work, and innovation "pull", but we are also committed to reducing pressure on the public purse by attracting additional resources through our partnerships with industry.

Health Innovation Manchester's structure is unique in the UK, and there is no other region where the AHSC and AHSN and ARC have come together organisationally, to focus on shared priorities, and make full use of the widest range of knowledge, perspectives and skills in developing and deploying brilliant innovations.

HOW HEALTH INNOVATION MANCHESTER WORKS IS AS IMPORTANT AS WHAT WE DO

Accountability is key - Health Innovation Manchester works on behalf of its member organisations. We are servants of the system. Our power comes only from the mandate we have to deliver outcomes which those organisations have agreed are its priorities, and from our success in delivery. Any agenda which does not conform to this fundamental principle is doomed to fail. This does not at all mean we are a passive delivery agent. We must demonstrably add value to what individual stakeholders could otherwise do for themselves, and we must be effective advocates for what we believe is the right thing to do.

Our added value lies partly in expertise and knowledge, some of it specialist eg. digital, some the product of a global perspective and overview of what the best in world are doing, combined with a deep understanding of how innovation can transform not just how we do things today so we do them better, but transform what we do. For Greater Manchester partners to compete in a global market, and attract investors and skilled employment growth, we need to employ people with skills and knowledge at the highest level, and the ability to give leading investors and innovators the confidence as well as the appetite to do business with us.

Harder to define but just as vital is the ability to combine advocacy with engagement and ownership - to understand other perspectives and drivers and to draw upon these in developing proposals for new projects.

Establishing a track record of delivery, and adding value at the Greater Manchester level, as well as for individual localities, is crucial. Health Innovation Manchester's first eighteen months balanced a necessary focus on team building, ways of working, and establishing basic disciplines, with getting some early project wins and building our industry and national policy networks. A three-year business plan was built around five themes - ensuring a constant innovation pipeline flows into health and care; prioritising innovation activities which are aligned to Greater Manchester's needs; accelerating delivery of innovation into service delivery; amplifying existing academic and industry value propositions; and influencing national and international policy. In the first full year of operations, Health Innovation Manchester's delivery against national programmes moved from the AHSN's previous performance to upper quartile, and our pipeline of active projects multiplied, ranging

across the spectrum of health needs, and including longer term research programmes as well as the adoption of already approved innovations. The executive team's expertise and power of advocacy in policy debate quickly increased Health Innovation Manchester's share of voice nationally, while the work of UoM colleagues resulted in the successful redesignation of the AHSC in 2020.

RESPONDING TO THE PANDEMIC

" When the COVID pandemic struck, Health Innovation Manchester had the solid foundations and the agility needed to reorient our work to focus entirely on the Greater Manchester system's response. "

Critically, data and digital technologies had already moved centre stage in the team's innovation strategy, benefitting from the CEO's combination of clinical experience and time in the digital tech industry, and as the pivotal role of data systems and digital innovation in tackling the pandemic became clear, Health Innovation Manchester invested heavily in the digital capabilities required to support our strategic pivot, and was well-placed to play its part.

To that end we formed a novel digital governance structure, specifically to support the Greater Manchester COVID response, working to the priorities defined by the NHSE command and control structures. This included;

- Accelerating the information governance to allow appropriate data sharing
- Maximising the flows onto and use of the Greater Manchester shared care record platform
- Supporting digital transformation in primary care to allow primary care services to be maintained in a COVID secure manner
- Driving digital support for chronic diseases, specifically mental health and the care home sector

We have been successful in progressing these initiatives, alongside maximising the contribution from Greater Manchester academics, particularly through COVID clinical trials. Critical success factors have included having a shared burning platform, streamlined and effective governance creating clarity on priorities and working to overcome barriers, ensuring the necessary capacity and capability is available to drive innovation and transformation, particularly digital expertise, and then being highly transparent in actions with real accountability for delivery.

The work rate across all parts of the Greater Manchester health and care system throughout the COVID crisis has been extraordinary, with absolute clarity of purpose and a shared burning platform. Health Innovation Manchester was able to achieve in weeks what would normally have taken many months. Greater Manchester now has a shared record for 3.1m patients, including data from 443 GP practices, all Greater Manchester mental health trusts, and all acute trusts. This means that any clinician anywhere in the system can get real time data about a patient regardless of where in Greater Manchester they live. There is Greater Manchester-wide agreement on data sharing and security, and governance in place which has allowed the use of anonymised data to facilitate essential COVID-related research. Almost all GP practices are now equipped to provide video consultation and on-line triage and are doing so to great effect.

Building on these initial activities, Health Innovation Manchester's workplan has evolved, adapting to the changing needs of the city region through the pandemic, and has focussed on supporting the A&E appointment programme with an aim to deflect 25% of all potential attendees safely away from hospital to other services, providing the digital solution for NHS staff mass vaccination, and rolling out our care homes solution across Greater Manchester – this now covers over 130 care homes caring for 3,500 residents as they adapt to the changed world created by the pandemic. We are also developing use of the Greater Manchester Shared Care record, using this not just as a passive repository for sharing data but as a platform for transformation with 15 use cases ranging from digital transformation of the maternity pathway, through supporting more effective discharge from hospital, and enhanced care for long term condition management.

Inevitably in this past year, work has focused heavily on improving health outcomes for those in poor health.

" COVID has amply demonstrated the need for initiatives which empower and enable citizens to take better care of their own health and well-being. "

Greater Manchester is uniquely well-placed to take a holistic approach to the maintenance of good human health from childhood to old age; supporting this work through the development and deployment of user-friendly digital technologies will be a major priority for Health Innovation Manchester.

TOWARDS A HEALTHY FUTURE

As I write this we are hopefully moving out of the acute phase of the pandemic and starting to lift our eyes cautiously towards the future. This includes contributing to discussions about the next stages for Devolution in Greater Manchester, and the development of an integrated care system under the proposed new legislation, placing health innovation and economic development very much at the heart of the priorities of the NHS and social care thinking, as well as giving an increased focus on the opportunities created by digital, and the necessary operating model required for an integrated care system to realise those opportunities.

The future organisation needs to consider carefully how best to leverage the huge procurement power of the NHS to become more effective in adopting innovation at pace and scale, both for the direct benefit of patients, and also for the wider economic benefits that coordinated approaches to procurement can bring. Additionally, the promise of rapid decision-making to pull through proven innovations in clinical use is a huge magnet for industry and is both an advantage of devolution which is yet to be fully realised, and very much part of Greater Manchester's agreed Industrial Strategy.

While the governance debates are yet to be concluded, we are already seeing a major policy shift away from competition to collaboration across service providers, and a shift in focus from institutions to localities as the basis for planning services.

Health Innovation Manchester's work will include driving and supporting pan Greater Manchester initiatives, as well as focussing on bespoke work with specific localities and communities to meet local needs, with a view to the future scaling of solutions to the wider benefit of Greater Manchester.

Our portfolio of innovations must deliver to the near-term priorities of partners, specifically recognising the very acute pressures on system priorities which will continue for some time. But we also now have the knowledge and assets which make possible the development of initiatives which are truly transformational, aligning the power of data science and digital technologies to the expressed needs of a total community, and working with that community and with industry partners to develop solutions which meet these needs and create new opportunities for sustainable economic growth.

We will also aim to develop industry partnerships which respond to the strategic priorities of Greater Manchester as a whole, with the elimination of inequalities as a pre-eminent goal, focusing especially on the development of new business models which can transform care pathways and funding structures.

In conclusion, experience and learning from these past five years position Greater Manchester well for the next stage in our devolution journey.

" Much is yet to be done, but if we can ensure that Greater Manchester governance structures work effectively to fast-track proven innovations into routine use across the total population, and if we can maintain our ambition for Greater Manchester as a world-leading innovator, with standards of health uniformly high across the city region, there will be nothing we cannot achieve. "

Despite the complexities, Greater Manchester's bold devolution endeavour is creative, stretching, exciting, and incredibly important. It is a privilege to be part of such a unifying cause, and Health Innovation Manchester will certainly play its full part to make Greater Manchester's extraordinary health ecosystem a huge success.

TOWARDS HEALTHIER LIVES ACROSS THE NORTHERN POWERHOUSE

Section Nine

A BLUEPRINT FOR THE NORTHERN POWERHOUSE

Henri Murison
Director of the Northern Powerhouse Partnership

The tales of the two cities in this report are of huge progress. In essence, better places rely on health outcomes, and health is a critical determinant of successful places. In their different contexts, both cities have set ambitious five-year plans, rooted in individual challenges which rely on wider public sector delivery and the private sector.

The health inequalities that we knew were a threat to our communities have been the source of our vulnerabilities in the last year during the pandemic. Co-ordinated, integrated systems in health and social care (as well as across local government more widely) have made a huge impact. Local Covid 19 track and trace in Bradford and Calderdale are good examples. What comes next is how we address the inequalities which have led to the differential impact of the pandemic.

Post-Covid, we need to continue making strides in co-ordinating an emergency basis for a new integrated approach across the whole of the North of England, built on places leading and government partnering with them.

Population health improvements, delivered by a focus on neighbourhoods, can be delivered with local political will. The context of Greater Manchester is unique in England and has provided a vibrant test bed for new ways of working. The levers of power being handed to Greater Manchester has accelerated a more joined-up approach.

The need to make joined-up approaches to address health inequalities goes far beyond the direct health and social care partners, and school readiness is a prime example of this. Health support for families should be seen in an integrated way with wider services, increasing impact and ensuring joined-up measurement.

In Leeds, the partnership between the NHS and local government is notable and has been done without the momentum of a health devolution deal, as Greater Manchester have. Their achievements have come through their wider approach within their Integrated Care System (ICS), covering West Yorkshire and its neighbours. This indicates a direction of travel for ICSs which respond to a clear and well-articulated plan developed with elected local leaders.

As we see a wider lack of momentum on decentralisation since the original Northern Powerhouse project slowed under Theresa May's time as Prime Minister, it is for the Health Secretary to show the value of devolving decisions. It's time to make national bureaucracies less powerful and replace them with bottom-up structures. We need to rationalise bureaucratic and centralised entities, making the system more efficient as a result. We must trust local partnership, rather than markets, because what markets bring in any capitalist economy is knowledge and shared interest between buyer and seller. The mistake of previous reforms has been to think the NHS can be an effective market, rather than instead realise that it needs the knowledge that comes from effective bottom-up decision making (methods of equivalent benefit to direct markets but secured by a different approach).

> *"The mistake of previous reforms has been to think the NHS can be an effective market, rather than instead realise that it needs the knowledge that comes from effective bottom-up decision making."*

The previous intellectual logic failed to learn the stories of the wider Greater Manchester devolution journey. The modernising of public services in action can disrupt centralising bureaucracies through localism.

The NHS and local care system must be joined up locally where outcomes and shared financial interests drive long-term savings from healthier people in communities having reduced needs of services. As Greater Manchester shows, influencing acute service needs does take time, but the signs of longer-term improvement are there and can be identified.

THE NEXT STEPS ARE CLEAR

In Leeds, the investment for their new hospital to serve immediate communities and those further afield is committed. Tom Bridges from Arup has argued this persuasively - the city in the context of the wider West Yorkshire region has real opportunities.

An innovation district focused on health in Leeds will connect with a site at the Bradford Northern Powerhouse Rail station, and across in Manchester. The Health Innovation Manchester ecosystem is a huge achievement from the wider devolution journey. Facing towards the North East, the Leeds and wider West Yorkshire system can provide the interconnectivity for a future joined-up, fully-integrated Northern ecosystem for health innovation. An economic dividend of a place-led system, open to innovation as well as less bureaucracy.

In Greater Manchester, the important work of improving the join-up of local services continues at pace. Any new national reforms must learn lessons from the devolution projects across the North. We now need to see an approach that marries social care integration with health and that is driven by local leaders, with accountability directly to local communities. The tale of two cities across the Pennines (and of their neighbours in Bradford and Newcastle-upon-Tyne for example) is of excellence. This must be maintained as we grapple with the fallout from the pandemic. It is now time to replace top-down bureaucracies with local systems which have clear political control.

Section Ten

CONCLUSION

Henri Murison
Director of the Northern Powerhouse Partnership

The pandemic highlighted the problems and strengths of the health and care system, and its huge impact on the wider economy and society in the North and across the nation.

We recognise the willingness the government has made to break up the large, centralised decision-making structures which are unsuited to the future of the health care system and country, and certainly don't meet the needs of the public.

Here in the Northern Powerhouse, we have seen the first genuine move to health devolution in Greater Manchester, and five years on from that historic agreement It is clear that genuine place-based decision-making has allowed for a truly collaborative way of working which is changing the nature of integrated care.

> *"It is clear that genuine place-based decision-making has allowed for a truly collaborative way of working which is changing the nature of integrated care."*

We see Integrated Care Systems, within a statutory framework, as an opportunity to develop fully-integrated care in every place and community. The story of Leeds and their partners in West Yorkshire is a welcome reminder of the benefits of this approach, when combined with genuine local integration at a neighbourhood level.

In order to ensure that decision-making becomes more joined-up, we would stress the need for locally-accountable, place-based system boards with maximum control of resources at their disposal. Boards without full control to flexibly direct their resources based on population need will be unable to respond to changing local challenges and risk becoming more, not less, removed from the communities they serve.

The social care system needs a national solution on funding, but a decentralised delivery model. Our system, not just in health but in wider Levelling Up, will be most successful when it trusts those outside Whitehall to deliver more. We need a National Local Health Service, and a National Local Care Service.

Funded by the Treasury, with delivery based on local needs and challenges to keep people well and independent as long as they can be.

Towns such as Morley in Leeds, its neighbours across West Yorkshire like Keighley, and places such as Oldham and Rochdale in Greater Manchester, are areas which have benefited from being part of wider health systems at an ICS level. The larger cities are home to huge inequalities, major economic and social units, and neighbourhoods that have their fates tied to the health of their population. It's time to recognise that investment in places and in the health of their people are not separate but closely interwoven. Success in one depends on the other, and vice versa.

Levelling up on health means closing the life expectancy gap between the North and South, especially in deprived areas. This report reiterates that the heath of the North has a huge impact on the economy so it's vital the government's levelling up agenda includes health and social care. Across the North we are pioneers of digital technology and clinical trials (competing with the best in the world) and we know how to address the social determinants of health– this report is a guide to how we can, and already are, creating meaningful change. However, in order to truly tackle pervasive health inequalities, we need government government to commit to levelling up in all areas, especially health.

THE NORTHERN POWERHOUSE PARTNERSHIP

The Northern Powerhouse Partnership (NPP) was established in 2016 and is a business-led organisation, bringing together Northern businesses and civic leaders to deliver the vision of the Northern Powerhouse, increasing productivity and growth and making a greater contribution to the UK economy. The ambition to deliver the Northern Powerhouse has been taken up by this government, with their agenda to level up the UK and create opportunities throughout the country.

Our leadership comes from our members (represented by the senior leaders from Addleshaw Goddard, Arcadis, Arup, Associated British Ports, Atkins, Barclays, Bruntwood, The Cooperative Group, Drax, HSBC, Mace, Manchester Airports Group, Mott MacDonald, Sellafield, Siemens, TalkTalk, Virgin Money and with sponsorship from EY}, as well as our wider Board members including our Chair George Osborne, Vice-Chairs Lord Jim O'Neill and Professor Juergen Maier, Cllr Sir Richard Leese, John Cridland CBE, Metro Mayor Ben Houchen and Professor Dame Nancy Rothwell).

The Board and our Education and Skills and Transport committees set out our blueprint for how levelling up can be achieved, and the long-term, systemic changes that are required to truly rebalance the UK economy and create a North of England as prosperous as the South.

THE
NORTHERN
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PARTNERSHIP