The King's Fund

Ideas that change health and care

# Population health in Greater Manchester

## The journey so far

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# About this project

The Greater Manchester Locality Directors of Public Health and the Greater Manchester Integrated Care System (NHS GM) funded this research. It was carried out independently and the findings are The King's Fund's alone.

# Contents

# Key messages

- Greater Manchester (GM) has been the 'poster child' for devolution in England, and alongside it, in the health world, the leading light in efforts in and commitment to improving population health. This report dives deep into the details of that journey, and shares how GM has approached improving population health, the success it has had and the challenges it has faced. This is a story that other systems seeking to improve population health can learn from and we set out recommendations and principles for these systems. While the report does not provide a 'drag and drop' toolkit for change, we hope it provides inspiration, pause for thought and help for other systems that have further to go on their population health journey.
- We engaged widely (with more than 40 people) in this research through workshops, interviews and three within-GM local authority case studies of population health approaches. We also reviewed a wide range of existing studies and system documentation about, and from, GM and its work on population health.
- The key learning from GM's journey for others is the importance of a strong and shared vision, committed and distributed leadership, and long-term unshakeable commitment over time. Investing in capability and an openness to scrutiny, learning and challenge support this.
- In GM there is a clear demarcation of roles and recognition of the value of action at both GM level and local authority level, an intimate understanding of the connection between economic goals and population health goals, and constant efforts to align them. This has lessons for a government seeking to deliver a mission for health, the Department of Health and Social Care and NHS England, which have set up integrated care systems (ICSs) as conduits for improving population health, and for other ICSs and partners pursuing population health approaches.

- The **government** needs to ensure that:
  - its health mission has clear delivery plans and is delivered through a population health approach that includes actions across the four 'pillars' of population health (the wider determinants of health, health behaviours, integrated care and systems, and the role of the community itself)
  - the health mission aligns with its other missions and *vice versa* (to ensure, for example, that the economic growth mission does not inadvertently widen health inequalities in population health)
  - sponsoring departments work coherently together below the national level, including through relationships with combined authorities and mayoral roles, and other aspects of devolution as it develops in England.
- The **Department of Health and Social Care and NHS England** need to:
  - reiterate that population health is a core goal of ICSs
  - ensure accountability systems and supporting tools are focused on population health goals
  - design system levers that incentivise and reward action on population health
  - resist the urge to reorganise system footprints, since long-term goals such as population health require constancy and stability.
- Other **ICSs and their partners** pursing population health approaches should:
  - develop a widely owned vision and adopt a clear but flexible framework or model to help cohere efforts in service of it
  - ensure clarity over system-level and local roles and reflect this in governance
  - constantly learn, develop and build capability for population health
  - recognise that health and care system goals are dependent on wider action to improve population health
  - work coherently to achieve population health and economic goals, as they are intertwined and codependent.

# 1 Introduction

Greater Manchester (GM) has been the 'poster child' for devolution in England, and alongside it, in the health world, the leading light in efforts in and commitment to improving population health. Population health is now in the health mainstream and is one of the core purposes of integrated care systems (ICSs). But this was not always the case, and GM has been the pathfinder and the system that has led on its approach to population health.

This journey has not been smooth. It is complex and is intimately connected to the wider devolution journey that GM has also been on, indeed that is where it started. Over a long period of time, formally from 2016 and long before in reality, GM has been developing its strategy and practice of population health at multiple levels, and in many ways.

The King's Fund was fortunate to be asked to help support and assess early progress in 2018. Then the Covid-19 pandemic and the structural changes after the legislation on ICSs interrupted the journey. GM, like many other systems, currently faces severe financial problems in the health and care sector and beyond, and it has seen some of its key leaders for population health retire or move on. And we are at the start of a new government, with a renewed focus on devolution in England, a health mission with a current stated goal of narrowing regional gaps in healthy life expectancy, and a desire to put the National Health Service (NHS) and wider health and social care system back on track.

This is therefore a potential moment of reflection for GM itself, but also for many other systems – whether in some sense to turn back, to focus only on the compelling short-term issues of financial balance and waiting times, or to continue the commitment to improving the drivers and outcomes of population health. It is in this context that this current piece of work sits.

This report is not an evaluation. Its purpose is to reflect on the journey that GM has taken in relation to population health, to understand 'what has happened' and 'how it has happened', and to set out people's reflections on the journey, drawing out key

themes and insights. While it does not provide a 'drag and drop' toolkit for change, we hope this report provides inspiration, pause for thought and help for other systems on their own population health journey.

This report also has messages for the new government in England – that population health improvement and a reduction in health inequalities are possible through devolution but they will not come automatically. Clear intent and consistency over time are required to achieve them.

## Structure of the rest of this report

We start by describing how we approached this research (section 2). We then set out the key concepts of devolution and population health (section 3). This is followed by a brief history of GM's devolution journey, the development of GM's population health approach and how key indicators of health and health inequalities have changed (section 4). We then dive deeper into 'the how' of developing a population health approach through three place-based case studies and draw out key themes and lessons (section 5). We then move forward to the here and now and look at the introduction of GM's ICS, how GM is facing its current challenges and the implications for its approach to population health (section 6). Following this we look at where we go from here, for GM and more widely (section 7). And finally we set out some lessons and recommendations for the government, the Department of Health and Social Care, NHS England and other systems as they seek to improve population health in England (section 8).

# 2 Our approach to this research

Our research included a review of existing literature and data, and interviews with senior leaders across the Greater Manchester (GM) population health system. We also looked in detail at three local authorities within GM as case studies of how population health system approaches have developed at 'locality level', and their relationship with the regional bodies and strategy on population health within GM. This included semi-structured interviews with the following senior leaders in each case study site:

- an interview with the director of public health for the case study site
- a group-based interview with five or six senior leaders in each case study site with responsibility for the population health approach for their locality.

In consultation with the commissioners of our work, we've selected case studies in local authority areas to give a mix of settings and experiences, including urban and more rural areas, areas with higher and lower indexes of multiple deprivation, areas with different health levels and a geographical spread within the confines of GM.

Following consideration of the 10 metropolitan boroughs within GM, we selected the following places for our case study sites: Bury, the city of Manchester and Stockport. More detail on the characteristics of these sites and the rationale for their inclusion is given in the Annex.

In addition to the case study sites, we ran two workshops with senior leaders across GM:

- a workshop with all directors of public health in GM and regional leads with responsibility for population health
- a workshop with the Greater Manchester Integrated Care Board's Population Health Committee.

In total we interviewed and spoke to more than 40 senior leaders from across GM.

# 3 Key concepts: devolution and population health

This report is concerned with two key concepts – devolution and population health – and, in the Greater Manchester (GM) context, how they have been intertwined. It is important therefore to set out some background on both concepts before we move on to our findings.

## What is devolution?

England remains one of the most centrally fiscally controlled states in the Organisation for Economic Co-operation and Development (OECD), with a much greater proportion of tax and spending controlled nationally, through Westminster and Whitehall, than comparator nations. Devolution, in the English context, is the process of devolving powers and the control of budgets (if not how they are raised) from central government to regional and local government, principally to entities known as 'combined authorities'. This takes place through the process of a bespoke 'devolution deal', as set out in the box on page 10.

## What is a devolution deal?

Devolution deals work principally through combined authorities – joint legal structures that partner local authorities in England can set up, with or without a directly elected mayor. While most deals 'go through' a combined authority due to scale, scope, governance and overall coherence, they do not have to (Cornwall County Council holds Cornwall's deal). Combined authorities can become mayoral combined authorities with the consent of the constituent local authorities.

Devolution deals tend to cover powers and budgets in the following areas:

- transport
- education
- training and skills
- housing
- economic development
- planning
- culture.

They may also have some element of control over local finances, typically business rates. Deals can also include 'specials' – in areas that are more specific. The range of powers and budgets varies according to the deal (some areas have received more than one deal over time). GM's own 'special' has been its greater control over health and care spending.

Devolution should not be seen as a one-off event, but as an evolutionary journey as:

- more areas become the recipient of a deal over time
- areas with a deal receive further deals over time
- existing deals are developed further, building on and adding to the original powers
- within the deals, finances, contracts and decision-making have also evolved over time as has the relationship with national bodies.

## What is population health?

A population health approach (Buck *et al* 2018; Holmes 2022) is one that recognises – and maximises – the contributions of the four main 'pillars' of population health:

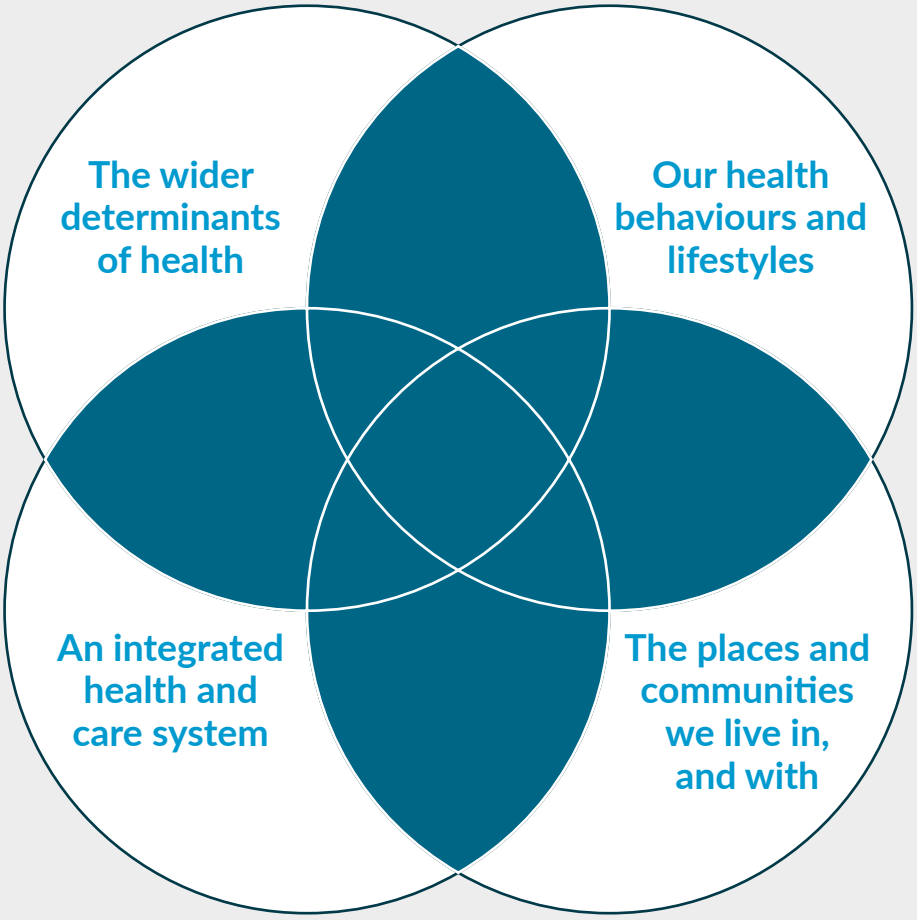
- the wider determinants of health
- our health behaviours
- our receipt of integrated health and social care
- the communities in which we live and work.

We know from huge amounts of evidence over time that what is most important for a population's health is principally the wider determinants of health (that is, the social, economic and environmental conditions in which we live, such as the homes we live in, our household income and whether we have access to green space). This is followed by our health behaviours (whether we smoke, drink alcohol to excess, maintain a healthy diet and do physical activity). The next most important is the health and care services we receive; our genetic inheritance is also important, particularly for some diseases and health conditions. All of this takes place in the context of the fourth pillar: the communities we live in and the social relationships we have, which also have an impact on our health, helping us to stay resilient and to recover well from health problems.

All these factors can vary for individuals. We have more control over some than others, and the relationships between them are not precise. They also interact – for example, people living in poverty and more deprived places tend to live in unhealthier environments, have worse health behaviours and receive poorer services (Williams *et al* 2022).

A population health approach is one that recognises the four key pillars of population health and the complexity of how they interact, and critically responds to that. Such an approach can be taken at national, regional, integrated care system (ICS) and place levels. Figure 1 on page 12 shows how the four pillars are interconnected.

**Figure 1** The King's Fund's population health framework




Source: Buck *et al* 2018

Taking a population health approach at a systems level means fulfilling the following actions:

- allocating resources and effort towards where they will have the biggest effect – for example, systematically shifting resources to the wider determinants of health pillar over time, as this is what is most effective at driving population health

- paying attention to, and expending effort at, the overlaps where the four pillars meet (the blue areas in Figure 1), such as at the boundary between the wider determinants and an ICS, for example looking at how ICSs and other institutions are fulling their roles as 'anchor' institutions through procurement that creates social value, and being an active employer, helping people farthest from the labour market[1]
- ensuring partners in the pillars support and work together, making the best use of the resources and effort across the system, for the population as a whole, not just for their part of it – this is a system leader's main responsibility
- designing payments, incentives, accountability and other levers that support rather than work against the first three actions:
    - this is the responsibility of the organisations that are part of a population health approach locally, for example those 'in and around' an ICS
    - but these organisations also operate in a context that others set – for the NHS: NHS England and the Department of Health and Social Care; and for other partners: other government departments
    - these 'system overseers' have a crucial role in incentivising local organisations to act in ways that are consistent with a population health approach.

In conclusion, devolution and a population health approach can go hand in hand, particularly through their ability to:

- take more control over and shift resources towards the wider determinants of health
- do so in a way that is likely to improve population health
- pay more attention to the areas where the pillars of population health overlap.

GM was the first regional area in England to receive a devolution deal and to be able to act on it. Further, unlike other devolution deals, it also received more delegated powers of health and care system decision-making ahead of the wider move to ICSs. In theory, therefore, GM was a 'population health system' waiting to happen. How did it get there? We explore this in the next section.

1 Anchor institutions are large public sector organisations that are rooted in place and connected to the communities in their local area, such as universities, hospitals and local authorities (The Health Foundation 2021).

# 4 Devolution and developing a population health approach in GM, 2015–19

It is often stated that the spur for devolution for Greater Manchester (GM) was the process of investing in key transport infrastructure in the region and the co-operation and co-ordination that GM's 10 constituent local authorities and the, then, Association of Greater Manchester Authorities required (Greater Manchester Independent Prosperity Review 2018). This in turn helped GM develop further the vision, confidence and coherence to work *across* the region and *for* the region, both politically and economically. This led to the creation of the Greater Manchester Combined Authority in 2011, and with it the governance structure to be in prime position to be one of the recipients of the emerging policy of English devolution.

The Greater Manchester Combined Authority was the first combined authority to receive a major devolution deal, announced in November 2014; connected to this was a unique deal around the National Health Service (NHS) and social care (Alderwick 2022). This included the delegation of planning and decision-making for the £6 billion health and social care budgets to a coalition of public agencies, brought together under the Health and Social Care Partnership (Walshe *et al* 2018). In addition, GM had access to a health and care transformation fund of £450 million to develop its services (Greater Manchester Independent Prosperity Review 2018). This was not additional funding *per se*, but was GM's proportionate share of the resources committed to the NHS via the government's 2015 spending review (HM Treasury 2015), committed upfront to support transformation (including for some national priorities in primary care and mental health), compared with incremental shares for other parts of England over the period of the spending review.

## Developing a population health approach, 2015–19

By 2015, GM therefore had a number of things in its favour to start seriously on its approach to population health, including:

- a combined authority to house its deal, which included some of the key wider determinants of health, and a wider history of partnership and co-operation between local authorities
- an additional, unique deal on health and care, and a partnership structure (the Greater Manchester Health and Social Care Partnership) to support it
- an upfront transformation fund to introduce some of the long-term changes to health and care that were needed, in the expectation that this would be paid back over time.

In the mix too, and not to be underestimated, was the office of a mayor to help co-ordinate, cajole and advocate, and a lot of political alignment from the constituent local authorities. Finally, and perhaps a key underpinning to all of it, GM had a very strong cadre and network of experienced leaders across the region who had been on this long journey together, in turn supported by analytic and wider capability. What this gave GM too was a curiosity and a desire to learn.

A major ambition of GM's health and social care devolution from the outset was to enable the greatest and fastest improvements to health, wealth and wellbeing for the 2.8 million residents and wider population it serves (**Walshe *et al* 2018**). And the Greater Manchester Health and Social Care Partnership did not hang around, committing to a series of life-course population health targets across the strategic plan for GM. The dual devolution allowed GM to locate this in a whole-system approach, recognising the importance of action on the wider determinants of health, and the formal health and social care system, while seeing its communities and population as assets for health, not just a collection of health problems. This was brought together under the GM Population Health Strategy (**Greater Manchester Health and Social Care Partnership 2022**), supported by a range of analytical business cases.

## An early assessment of GM's progress on population health in 2019

In 2018, The King's Fund published two reports on population health: one on a vision for population health (Buck *et al* 2018), which introduced a framework for population health (*see* Figure 1); and the second one on what England could learn from international cities and regions that have made sustained progress on complex population health issues, what roles those cities and regions played and what enablers helped them do so (Naylor and Buck 2018). During 2018, The King's Fund helped facilitate debate and thinking on GM's approach to population health and was commissioned to write a private report, delivered in 2019, which assessed progress to date, drawing from the learning set out above, GM's own experience and wider work.

The report sought to understand GM's strengths, and which areas deserved more attention. It was comparative in nature, assessing GM against the key roles and enablers that other international cities had used, in order to make headway on complex population health problems. And it was also qualitative, as for the research The King's Fund interviewed key players in GM's journey on devolution and population health.

The King's Fund found that GM was calling on the tools and powers that many successful regions and cities internationally were also using,[2] and like elsewhere, there was a debate around where responsibility and power lay between the regional bodies and local ones, and between the combined authority and the Greater Manchester Health and Social Care Partnership. There was also a tension in trying to resolve the relative roles and decision-making between them.

Nonetheless, we also found a very strong sense of shared purpose across key leaders in GM. A sense of continuity and structures that many other international regions and cities did not have (with the possible exception of New York's Board of Health) helped with this. Many leaders, particularly at senior officer level, had experience across sectors and over time, resulting in a very strong cohered cadre of senior leaders, all committed to the same vision for the health and wellbeing

2 *See* Naylor and Buck (2018) for more details but this includes: taking up roles such as co-ordinating city-wide action, mobilising the population, and promoting innovation, while using tools such as planning and existing regulatory powers, consistent system leadership, ensuring relevant expertise is close to decision-making, and clarity over governance structures, supported by the political power of mayors and similar.

of the people of GM. However, there was recognition that the job was only half done and that: the 'massive cultural shift' of the common goal of becoming a population health system needed to be embedded across the system in terms of action; GM could be inward-looking and needed to learn more from other areas and systems; GM could take a stronger approach to the assets in its communities across the region, notwithstanding strong approaches in some places such as Wigan (**Naylor and Wellings 2019**); and GM should focus more strongly on fewer projects and priorities.

The report made no direct recommendations; however, it considered that GM should reflect on several key areas, including: what GM can learn from other city regions and Wales[3]; the differing views on priorities that we heard about; how the central role relates to the 10 local authorities in GM; how the Health and Social Care Partnership role and the Greater Manchester Combined Authority role fit together; harnessing the power of GM's communities; and opportunities for realising the full potential of population health roles across GM.

However, overall, our judgement was that GM was rightly seen as a leader on population health in England and was in a strong position to capitalise on that in the future.

> *GM has many strengths. The approach to population health is more ambitious than other cities we have assessed. A shared and consistent narrative is vital to supporting and sustaining a population health approach, which by its nature means working across complex systems. GM has this shared narrative amongst its senior leaders. It also has many of the enablers, and undertakes many of the roles, that we see being utilised by international cities who are successfully improving the health of their populations. Its challenge now is to develop further but it is in a very strong position to do so.*
>
> (Baylis and Buck 2019)

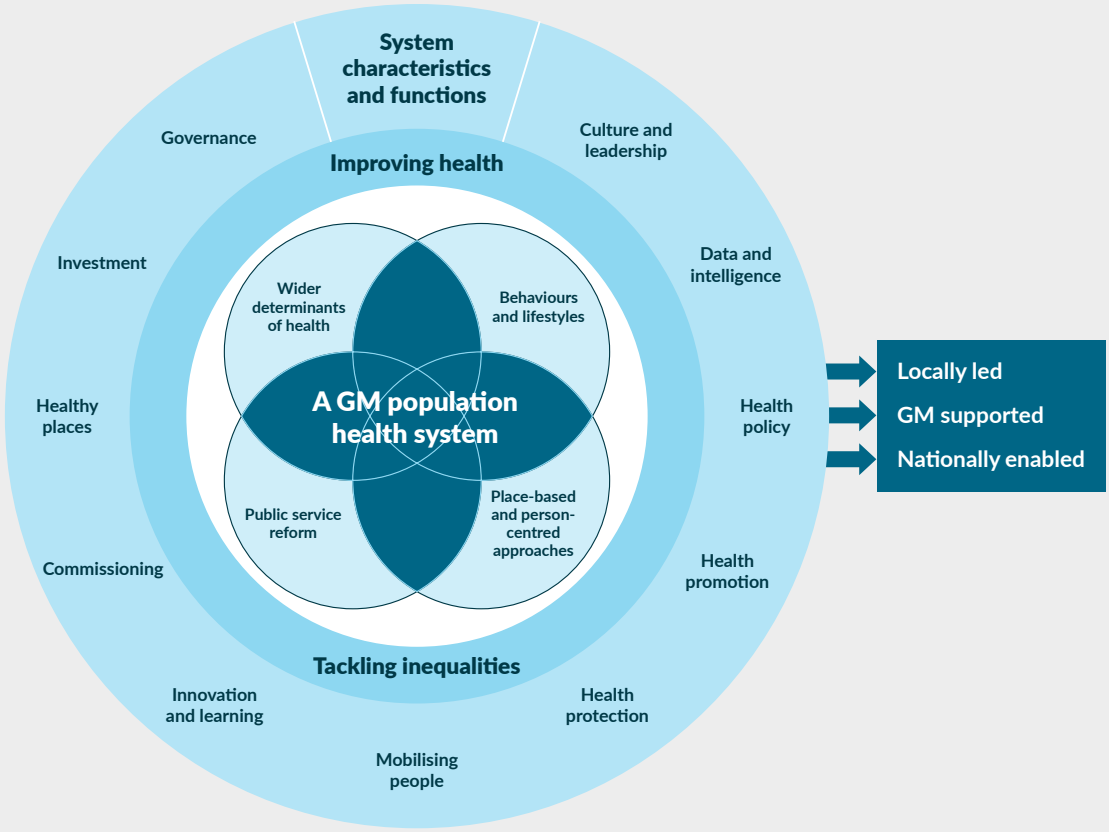
3 In the context of the Future Generations Act and legislation on health in all policies, designed to incentivise statutory organisations and bodies to take into account the long-run impact of their actions on wellbeing and the impact on health of wider policies, *see* **www.futuregenerations.wales/**.

## The development of the GM population health model

Following the 2019 report, Greater Manchester Health and Social Care Partnership adopted an adapted version of The King's Fund's population health framework to help cohere and further drive efforts on population health (*see* Figure 2). It also started to develop thinking on: further key levers for change, including the role of leadership for population health and the connection between local and GM-wide leadership; financing mechanisms; and learning from other areas.

This was connected to GM's integrated public services and reform agenda, with the model for health and care services built on a stronger integrated neighbourhood model capable of addressing the root causes of poor population health (Greater Manchester Combined Authority 2019).

**Figure 2 Greater Manchester's population health model**




Source: Greater Manchester Integrated Care Partnership (undated)

## The impact on population health in GM

We have mapped out GM's policy journey to 2019, which left GM in a strong position to move forward, on the eve of the Covid-19 pandemic. Given GM's status as the leading light of devolution and the only area of England with a health and care devolution deal as part of it, there is an understandable interest in knowing what impact devolution has had.

While any complex change comes with the usual riders and caveats, it is now 10 years since the first step in GM's devolution journey took place, with its first devolution deal in 2014. 10 years is starting to be long enough to expect to see some objective change that may be consistent with an effect on population health itself. The first studies attempting this have now been published, based on work that The Health Foundation has commissioned.

The first looked at life expectancy over the period from 2006 to 2019 and was published in *The Lancet Public Health*. The results were highly suggestive, showing that compared with a synthetic control group, GM's life expectancy had diverged positively from what would be expected after its devolution settlement, by just under 0.2 years excluding London, or 1.2 years including London (**Britteon *et al* 2022**). Further, increases in life expectancy were observed in eight of ten local authorities, were larger among men than among women and were larger in areas with high income deprivation compared with those with low income deprivation. More recent follow-up work (Britteon *et al* 2024) looked at a much broader set of outcomes – 98 measures that aligned with the World Health Organization's Health System Performance Assessment framework (**Papanicolas *et al* 2022**). This starts to get under the skin of where improvements were driven from. The authors concluded that these included improvements in public health, primary care, hospital and adult social care services and factors associated with the social determinants of health, including a reduction in alcohol-related hospital admissions. In other areas, including outpatient, mental health, maternity and dental services, change was mixed.

The authors argued that:

> *Devolution was associated with improved population health, driven by improvements in health services and wider social determinants of health. These changes occurred despite limited devolved powers over health service resources*

> *suggesting that other mechanisms played an important role, including the allocation of sustainability and transformation funding and the alignment of decision-making across health, social care, and wider public services in the region.*
>
> (Britteon *et al* 2024)

As Barrand and Briggs (2024) have said in making sense of the findings:

> *The study is important for showing that life expectancy improved relative to the control group throughout the first 4 years of devolution in Greater Manchester. But the nature of this complexity, and the mixed results across the 98 indicators used in the study, means we're still not entirely sure why.*
>
> (Barrand and Briggs 2024)

# 5 The 'how' of developing a population health approach in GM

Because '…we're still not entirely sure why' (Barrand and Briggs 2024) devolution led to improvements in population health in Greater Manchester (GM), this needs to be explored further, either through further analytical work, or through more qualitative work, investigating how population health 'is done' in GM. One element of that is looking at the role of the regional bodies in GM: the Greater Manchester Combined Authority, the Greater Manchester Health and Social Care Partnership and latterly the Greater Manchester Integrated Care System. These bodies play a key leadership, facilitation and governance role, among others. But much actual work takes place, *in place* at local authority level, and is mediated between the regional authority level and the local authority level.

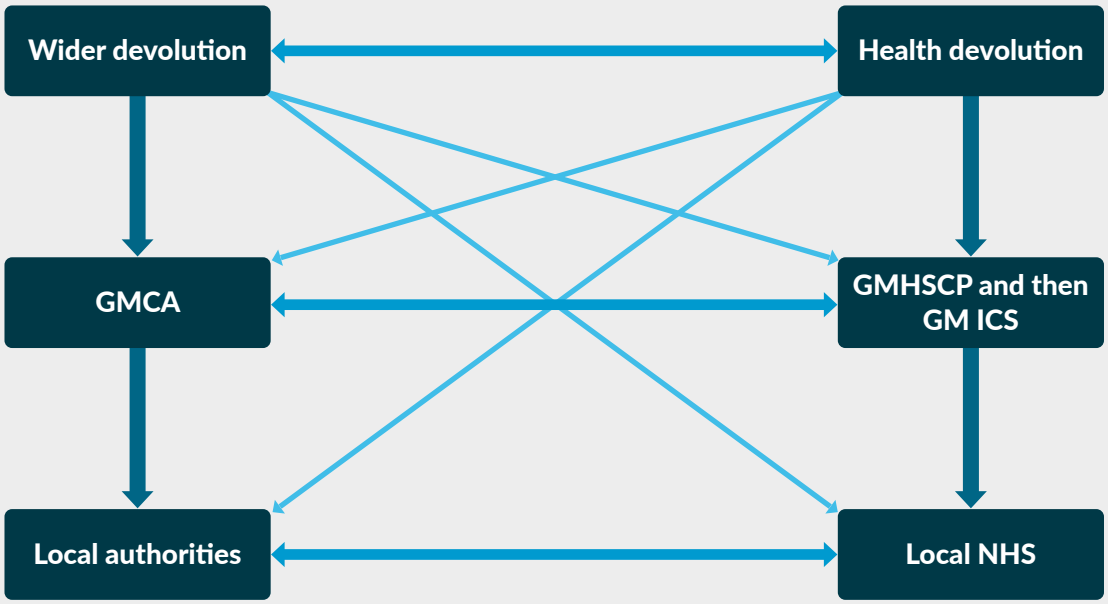
Nearly five years after our initial private report in 2019, we were pleased at The King's Fund to be asked back to 'hold up a mirror' to the system, with a reality check and assessment of how the population health system approach has been developing since 2019, through and beyond the experience of the Covid-19 pandemic, with particular emphasis on:

- the place experience
- the relationship between that and the regional bodies
- the creation of the Greater Manchester Integrated Care System.

## Our approach

Our work and findings need to be understood in terms of the complex set of relationships in GM (*see* Figure 3). The wider process of devolution and health devolution have been on parallel tracks, meaning complex relationships between tiers of government and of the National Health Service (NHS). Our work sought to make sense of how these relationships have worked and the challenges inherent in them, and how this has an impact on population health.

**Figure 3 The relationship between wider devolution and health devolution in GM**




Note: GMCA = Greater Manchester Combined Authority; GMHSCP = Greater Manchester Health and Social Care Partnership; GM ICS = Greater Manchester Integrated Care System; NHS = National Health Service.

Source: Buck D, Jabbal J, Benniche S 2024

## Place: where population health happens

Much of the emphasis of the commentary on GM in the health world has been principally about regional devolution, and on the experience of the NHS. But local authorities are particularly important, as they are where much of the direct influence over the wider determinants of health actually happens. Yet their experience and how they work with the voluntary and community sector and others locally have been less focused on to date.

As part of our research, we therefore conducted a 'deep dive' into the experiences of three local authorities within GM: Bury, Manchester and Stockport. The primary purpose of this enquiry was to understand some of the key enablers and challenges to the GM population health approach at the 'place' level. The three sites were selected following discussions with representatives from the Greater Manchester Integrated Care System population health team (*see* the Annex for a summary of each of the three sites as individual case studies). We reviewed documents and interviewed key leaders in these sites between January and June 2023, through two processes:

- first, an in-depth semi-structured interview with the current director of public health in each site
- second, a wider group interview with members of the local leadership team and selected others from the NHS and voluntary and community sector (the precise make-up varied from site to site – the views of the director of public health in each site informed who was most important to a population health approach, to be invited for interview).

Below we pick up the key themes across our three sites, and wider themes from our sites and from wider conversations with stakeholders, particularly the Greater Manchester Public Health Leadership Group[4] and the new Population Health Committee of the Greater Manchester Integrated Care System.

We start at place level. Generally, senior leaders were comfortable and familiar with the population health system approach in GM. Most interviewees reflected that the

4 Comprising the directors of public health of the 10 local authorities, the director of population health for the GM integrated care partnership and representatives from the Office for Health Improvement and Disparities, the UK Health Security Agency and NHS England's regional public health team.

GM population health model offered an important starting point, which each place could take and adapt for its local population, and that underpinning the specifics was a strong vision and commitment to population health approaches. This had 'held' through the Covid-19 pandemic and into wider structural changes, although it had been tested through the creation of the ICS from the existing Greater Manchester Health and Social Care Partnership (*see* next section for more details).

However, each place started from a different position, and underpinning this was the importance of identity, especially: the identity of the place and the mechanisms through which population health was manifested; the identity of professionals and how they relate to population health, recognising in particular public health professionals as core experts but acknowledging that a population health approach needs to be pursued beyond the public health profession; and the different cultural identities between sectors, including the NHS and local government, and understanding and working through these.

Senior leaders were able to clearly define their place approach to population health. Each site had a population health strategic plan, which had developed differently in each of the sites. All sites referred to the Marmot review in GM – *Build back fairer in Greater Manchester: health equity and dignified lives* (**Marmot *et al* 2021**) – as one of the building blocks for their own iterations of their population health strategic plans, designed with their local populations in mind.

The sites had different emphases in terms of population health and the mechanisms for improving it. Bury's vision rested on physical and economic regeneration, which connected to supporting better lives for its population. This was codified in its 'Let's Do It!' strategy (**Bury Council 2020**). Participants referred to the strategy as an approach 'to all public services working together to tackle poor health outcomes as one of those barriers to people accessing the benefits of economic growth'. In Bury, health and wellbeing are closely linked in a bidirectional relationship with inclusive economic growth. Furthermore, participants spoke of the importance of population health being embedded in everything they do at a strategic level, at a leadership level, in governance and down to teams, rather than being seen as a separate strategy.

> *It is embedded in our whole strategy for the borough, its future, the wellbeing of its population and its economy, and our infrastructure for working together across all agencies to drive those objectives.*

In Manchester, the emphasis was on continuing to build on the learning during the Covid-19 pandemic, with partners within the site actively engaged with local communities and neighbourhood teams to improve population health. Manchester operationalised this through community 'sounding boards' as a way to build and maintain trust with communities. These are made up of community leaders, faith leaders, community groups and others, who come together to be a sounding board for ideas. Interviewees in Manchester noted the importance of the sounding boards.

> *…whilst it initially kind of came out of Covid… we're also using them as sounding boards now for a broader approach to addressing health equity. You know, we involve those sounding boards in terms of key strategic plans such as Making Manchester Fairer. [The sounding boards] are a key part of how we kind of deliver some of that work.*

Stockport's emphasis was different again, underpinned by three pillars that pick up on the emphases above: supporting the local economy; getting the community involved; and thinking about health and wellbeing, given the experiences through the pandemic.

One participant noted:

> *…we did… a kind of big listening project where we did a whole range of engagement with loads of different community partners and people to talk about our priorities. And it led to our One Stockport Borough Plan – [and] it makes that connection towards our services around health and care, our services around children and supporting our most vulnerable, but also the fact we're really ambitious on regeneration, we're really strong on our economy. And I think what we've tried to do on One Stockport is really link the forces of [the] public sector through our One [Stockport] Health and Care Board, the business sector through our economic alliance and the voluntary and community sector through our voluntary and community sector forum.*

A strong sense of professional identity was also clear through our conversations with system leaders and partners at place level, both its strengths and also some of the tensions surrounding it, which interact with cultural identity between sectors, particularly the NHS and local government. The public health profession and the

expertise it brings was felt to be particularly important to a population health approach. As one participant in Bury noted:

> *…we've got a brilliant public health function, and that really matters… the leadership [is important] and understanding the connection between population health and economic ambition and opportunity.*

However, importantly for Bury is the codified nature of its population health approach across all system partners and across professional boundaries. As one participant explained:

> *I think all of that was codified by the Let's Do It! Strategy, and I think that provides a really helpful framework for us in a couple of ways… we've got a Health and Wellbeing Board, which is great, but we've invited the Health and Wellbeing Board almost to be a bit of a conscience of the system, to focus on health inequalities. So that's the overwhelming operation of the health and care system in the borough but we also sit that alongside the Community Safety Partnership, the Children's Strategic Partnership or the Business Leadership Council and a number of other blocks of partnership endeavour, really, across the borough.*

In Manchester, the public health team were seen as key connectors between communities and 'the system'. And those in public health roles thought it was right to keep the role of public health professionals front and centre of the population health approach, as they were well equipped and trained to lead on this. However, participants were clear in conversations that without support/buy-in from system partners the site would not be able to continue to make progress as a population health system.

> *The other one is, be honest, things change, instability can happen in any sector with senior leaders moving on. But that would always be a risk that the advocates and champions of this work, beyond the… you'd always expect the public health team and directors of public health to be pushing, but if you don't have that broader partnership support it starts to go away. That's a risk.*

In Stockport, while participants recognised the importance of public health professionals' skills and training to 'do' the technical aspects of population health,

the public health team acknowledged that population health can only be 'done' with all system partners' 'buy-in' and commitment to doing it. As one participant told us:

> *…there's the professional element [public health] but there's the approach [population health], which is about systems thinking, connecting things, thinking about the causes of the causes, the determinants. Why is that happening? Asking why, who's missing from this service offer, who's missing from our conversation? All of those, sort of, elements. Yes we get trained in that in public health school, but if the system is coming to that way of thinking, that's brilliant.*

Although the public health team were seen as important as a catalyst within the system to help develop understanding and system thinking, the population health approach was considered the most important aspect, and it was recognised that it must be 'owned' by the whole system and not just public health.[5]

The cultural identity of service partners was also a strong theme in our conversations – mostly as an enabler to population health system development, but sometimes as a challenge too. What was clear was that there were good, strong partnerships between services at place level. However, some interviewees felt that the cultural differences between the NHS (more top down, and hierarchical) and the local authority (more bottom up, and community led) could create barriers to a system-wide population health approach. Bury had challenged this head on, including through co-location of staff and rolling out strengths-based training for staff (for details on strengths-based training approaches, *see* **Social Care Institute for Excellence undated**), while Manchester continued to work hard for population health to be 'owned' by all system partners but still experienced some challenges between the NHS and local government.

5 See Buck *et al* (2024) for more on the national context around public health and population health leadership.

## The key enablers for sustaining a population health approach

> *Population health is a system-wide approach; therefore, all parts of the system should be expected to deliver.*

Following a review of the data for this project, including interviews with case study participants, workshop discussions and contextual documents, we have identified the following enablers for sustaining the population health approach in GM:

- a clear vision for population health, joint ownership and leadership, and an embedded strategy
- population health and economic ambition – two sides of the same coin
- clear governance and accountability for population health – power and decision-making at the right level
- collaborative, cross-system working
- working with communities.

### A clear vision for population health, joint ownership and leadership, and an embedded strategy

At its core, population health is an approach that aims to improve health outcomes, enhance wellbeing and reduce inequalities across an entire population. This can only be achieved with an active commitment and fidelity to a shared strategy. In GM, there have been sustained efforts – leading up to devolution and beyond – to create a clear vision and shared understanding of population health among system partners to achieve improvements in the population's health. These efforts have paid off, as system leaders told us about the importance of a consistent, unified vision of population health across all levels of the GM system. The experience of the Covid-19 pandemic, since early 2020, re-emphasised this.

> *I think that shared understanding and principle… and priorities [are] really important, how we all come together and recognise our different roles in that, but that we're all going in the same direction… otherwise, we all end up focusing on our tiny bit of that system, not on actually, where do we want to go as a whole collective?*

But a vision is not enough. It needs to be translated into an embedded approach.

> *This feels like the [key difference] to what's gone on in the past, it just is a different level of ownership. And also, workforce and the community elements aren't forgotten here. It's not, oh, great, the chief executives of all these big institutions support it, the VCSE [voluntary, community and social enterprise] and faith sector involvement, the community involvement, workforce is well underway. And it does feel as though we've got something that is a five-year plan, but I think won't be, as we've seen in the past, [be] losing kudos or approach.*

The emphasis in the previous subsection on place was on how our case study sites had embedded population health through the wider determinants of health and the role of the local authorities, but embedding was not restricted to that. We also heard about the importance of embedding population health priorities into local care organisations' business plans. Having population health priorities included in these plans has given prominence and profile to issues that have not traditionally been within NHS business plans, as one senior leader noted:

> *…having things like serious violence within that has really helped to raise the profile of some of the other, kind of, topic areas that are not traditionally in that LCO [local care organisation] business plan but do hit that wider system. So, that's been quite helpful for us to, kind of, get them embedded within that, so they're also under the local authority plans, they're already there at the forefront.*

Finally, many participants noted that without collaborative ownership and leadership of population health, it simply could not be achieved. As one participant noted:

> *…it's too often and too easy if you like for people to say 'population health, that's the public health team's responsibility', and absolutely it's not. It's much, much wider than that. So I think wherever you are in your locality I think one of the first things you need to do is create that narrative, create that sense of this is our responsibility, and be able to sell the benefits and the positives of creating good, positive health for your residents.*

### Population health and economic ambition – two sides of the same coin

Through our work we heard of the 'symbiotic' relationship between population health and economic ambition. The ability to understand this relationship and to convey its importance to all strategic partners has been a strength of getting traction behind the population health model in GM and across our case study sites. As one senior leader told us:

> *Where I think we made a real shift in advance of the devolution… was that, for the first time, I think, anywhere, really, there was a real clear alignment between, or, kind of, an understanding of the symbiotic relationship between economic ambition and population health. Population health is a drag to economic ambition and, therefore, doing something about population health is… you get all those people who care about economic ambition on your side and on your team advocating for you.*

All three case study sites linked their population health strategies to the economic ambition vested within their boroughs. In Bury we heard how the focus on the regeneration of town centres (in the first instance) was grounded in an economic and physical regeneration that 'connects to and supports better lives for residents and work on population health'. Here we heard how regeneration plans (through a population health lens) had taken community-based approaches to increasing physical activity, addressing mental health problems and tackling long-term health conditions where they were most concentrated. This people and community plan, along with the economic ambition through the population health plan, was a key factor in bringing system-wide partners together to 'tackle poor health outcomes as a barrier to people access[ing] the benefits of economic growth'. This connection between economic growth and population health was tangible and explicit, as one participant said:

> *I can really, really feel in Bury as soon as you walk through the door: the regeneration and the focus on the economy and the local businesses. And I think my previous experiences are a health and care partnership, which was very cognisant of whatever you do is probably going to have only about 10% impact on health and you're kind of at the top of the triangle and you're looking to connect with the wider stuff. And here it feels completely the other way round that all that wider stuff and the strategy and the big-picture stuff that is going to make a difference is there in buckets. And the work underneath it then needs to slot in to focus on, okay, how are health and care making the most of that and making those connections?*

In Stockport we heard how supporting the local economy was set as one of three fundamental 'pillars' of the borough's plan, alongside community involvement and health and wellbeing. Senior leaders in Stockport told us how the borough's strategic plan connects services around health and care to a 'really ambitious regeneration [and economic growth] plan'. It does this by linking public services (through the One Stockport Health and Care Board), with the business sector (through the Stockport Economic Alliance) and the voluntary and community sector (through its voluntary and community sector forum). Importantly, this drive towards inclusive economic growth came from local communities and businesses as a direct response to the Covid-19 pandemic – to build recovery and resilience for future 'shocks'.

**Clear governance and accountability for population health – power and decision-making at the right level**

Having distributed joint leadership for a population health system is one building block of sustaining a focus on, and improving, population health over time. But experience from GM shows that a governance system that can help partners to understand their roles and can be held to account by the wider-system partnership needs to support this.

> *…there's a huge element of creating a narrative locally, getting buy-in and helping people to understand what their roles and responsibility are within that population health system, how they contribute, but also having a governance system around that so you can hold each other to account for your contributions.*

At place level, senior leaders told us about the importance of how the various governance and accountability structures interacted locally. Having system partners represented on the various boards was one enabler. However, it also required systems to be clear about where governance between the various bodies interacts and overlaps, and what is strictly within the gift, sphere and influence of one group over another.

Through conversations we heard that many of the locality boards across GM had good system-wide representation of the various partners. Having all these partners on the boards was seen as a crucial enabler in promoting population health approaches. The box on page 34 gives an example from one case study site.

## Governance and accountability – Manchester case study site

In Manchester, senior leaders felt that the population health approach – Making Manchester Fairer (Manchester City Council undated a) – is 'widely owned by the right people at the top' and considered to be 'the key difference to what's gone on in the past, it just is a different level of ownership'.

The Making Manchester Fairer strategy is owned by all the 'key organisations' in the city, which are held to account by local politicians, and the Manchester Partnership Board [Locality Board], which reports to the Greater Manchester Integrated Care Board and the Making Manchester Fairer Programme Board.

The Manchester Partnership Board includes representatives from the Health and Wellbeing Board, which includes partners from across health and care (including the acute trust, mental health trust, the Local Care Organisation), and the voluntary and community sector.

The purpose of Manchester Partnership Board (MPB) is to:

- agree the shared priorities and strategic direction for health and care and public health in Manchester
- ensure integrated and aligned delivery across health and care and public health
- agree any resource allocation within the scope of responsibility delegated to it by another party
- ensure that all elements of Council and NHS services are aligned with the agreed strategic direction
- act as an interface with the GM Integrated Care Board and Integrated Care Partnership (ICP).

(Manchester City Council – undated b)

The Making Manchester Fairer Programme Board includes representatives from Manchester Partnership Board and is chaired by the Deputy Leader of Manchester City Council (who has responsibility for anti-poverty inequalities) and the Executive Member for Healthy Manchester and Social Care, Manchester City Council. The Chief Executive of Manchester City Council also sits on the Board and is the Senior Responsible Officer for the Making Manchester Fairer Programme.

Beyond the right governance structures and accountability at place level in GM, it is important to be clear that powers and responsibilities are distributed optimally: between the regional bodies – the General Manchester Combined Authority, the General Manchester Health and Social Care Partnership and the Greater Manchester Integrated Care System; at place level – the 10 local authorities; and at neighbourhood level – other bodies and partnerships, such as local care organisations.

Participants acknowledged the importance of population health models at regional level for coherence, to help increase the amount of evidence on what works, and of a sustained and stable vision and leadership for population health. This also extended to the 'doing' at scale, as one participant said:

> *…there's opportunities for Greater Manchester to be looking at actually what can we do at scale, that if we did this at scale and if it fits with agendas and priorities within localities, actually how do we help co-ordinate this work to bring it up to what it needs to be?*

Many people we spoke to stressed that, in key areas, population health approaches undertaken at scale at the GM level could have success, which would not be possible through 10 separate local authority approaches at place or neighbourhood level. Many people mentioned tobacco as a prime example.

> *…some of the work we've done on tobacco, as an example, was much better commissioned once at the Greater Manchester level, and actually sometimes when we do things at the Greater Manchester level and don't worry about whether every politician will sign off on it at the local level, it allows us to be a little bit braver as well. So there's real benefits to working all along that continuum from our largest geography to our smallest.*

Restricting food advertising on transport across GM was another example given. As one participant told us:

> *[For example] fast-food advertising on transport for Greater Manchester, if we're making those changes there's no point me trying to do something in Bury because people travel across Greater Manchester and that needs to be done everywhere across the transport network. So those are the types of things I think we can really make a big impact, and that will take collaborative working. But as and when we do do things like that, I think that will help.*

Furthermore, senior leaders felt that the Greater Manchester Combined Authority provided the whole system with an influential level of advocacy and support for a population health approach, which has to some degree protected it from cuts and been important for helping the whole region keep the focus on population health, as one participant told us:

> *…the place where it's worked really well is where we've got advocacy at that GM level. We've got people working who know other influential people in the GMCA [Greater Manchester Combined Authority], we've made relationships with key people in the mayor's office, so the mayor's kept involved. Now, that is something that we could not do individually as locality DPHs [directors of public health], but we do benefit from. Because obviously the GM political landscape is pretty steady and consistent. So I think in that respect having that kind of political – with a small p – advocacy role with the GMCA as well… because the GM population health team do work really well and closely with the GMCA team.*

Finally, strength was found with regard to having the GM tier trying to protect resources for the system-wide population health approach, as one senior leader noted:

> *…this conversation… about spend on prevention and how we seek to address the challenge of increasing our spend on prevention within a massively cash-strapped system. I feel that Greater Manchester leadership around that question is probably the best approach.*

However, things were not always smooth. Interviewees acknowledged and stressed the importance of a 'two-way' relationship between localities and GM and the importance of trust and clarity on who did what.

> *…sometimes I feel like GM are doing things that I don't know what's going on. I think there is a real need for the two systems – the GM systems and the locality systems – to be better aligned and working closer together. I'm not sure if that's working at the moment… It needs to be together, doesn't it?*

Another participant commented:

> *…if there isn't fundamental levels of trust between the tiers of intervention then everybody tries to do everything. The [regional/combined authority] system tries to micromanage and the locality or the neighbourhoods try to undertake work that's*

*actually been agreed to happen at a higher spatial level, and I think that's one of the real challenges we've got at the moment.*

Senior leaders we spoke to suggested ways to improve communication between place, localities and neighbourhoods and the GM 'system'. This included improving formal mechanisms via clearer governance and accountability structures, and using the Integrated Care Board's Population Health Committee, which could prove to be an important vehicle for driving the approach to population health (*see* more on this in Section 7).

In conclusion, it takes continued work and communication to keep the balance of where decisions are made, and where things happen, for population health. GM can point to clear successes, but this has needed and will continue to need constant attention in GM and, by extension, elsewhere.

*…we've got to be constantly asking ourselves the question about which level things fit at, because there are some things like the really highly specialised commissioning stuff that almost certainly is better done at a large geographical level. But some of the other stuff, I think it will move around depending on what the question is. Our thinking can shift around. So if you take marketing and media and campaign and influencing work, there's lots of that that's best delivered by community workers, influencers on the ground within communities, community champions, whatever it might be, who can really connect with what people's motivations are, have a really meaningful conversation with people.*

### Collaborative, cross-system working

Much of the above relies on – and is enabled by – good collaborative partnership working, particularly at the local level. It is clear that this has been a key feature across and within GM over time. But the experience of the Covid-19 pandemic has accelerated this, with participants referring to it as a pivotal time.

*…the pandemic has really helped the relationship between health and local government in Manchester… The city really gelled together and that's been sustained, and so things like the joint work the Council and Manchester FT [Foundation Trust] are doing on the North Manchester regeneration is [now] possible.*

Fundamentally, interviewees felt that the pandemic was a catalyst for genuine partnership working because 'organisational hierarchies got put aside and people coral together'. But there was a concern that this progress in terms of partnership working could be lost given the pressures for the system to 'return to normal' and within the pressured financial context.

### Working with communities

Through our conversations we also heard about the importance of community engagement in developing and maintaining a system-wide population health approach. We heard how the pandemic had laid bare the racial disparities in health outcomes and structural health inequalities affecting populations across GM and the level of mistrust between some communities and statutory bodies. This was particularly apparent within some of the more deprived areas of Manchester, manifest in low Covid-19 vaccination take-up rates.

To overcome some of these challenges, parts of the city embarked on a programme of vaccination outreach alongside setting up sounding boards. These sounding boards brought together community leaders, faith leaders and others to consider the reasons for mistrust and low vaccination uptake and to develop community-based solutions to improve trust between communities and statutory bodies. Since the pandemic these sounding boards have been retained to further improve trust, working on issues such as cancer screening uptake among ethnic minority groups within the city. As one of our interviewees told us:

> *…we've got a much stronger neighbourhood focus, we have health development co-ordinators in our neighbourhoods… it's interesting, the Council have invested in more community development workers in our neighbourhoods, we've brought a service back in-house to the Council to strengthen that. Because of that, not just because of that, but it's like… it's not just, well they're the people who are going to build up trust in the Council, that's not the intent. It's more that recognition that trust takes time to win back and also a recognition by the Council, which they do get, that when they're not the best placed. It's true for the NHS as well, when they're not the best-placed organisation. We're not there yet and we've only taken some of the learning from the pandemic into it.*

Senior leaders in Bury told us about the crucial importance of giving communities at place level real 'agency to improve their own lives, their own outcomes':

> *…because, in the end, unless inequality is tackled in a way that shifts power from public systems into people in communities, population health is not going to shift.*

Finally, Stockport has built an 'ecosystem' of networks, including groups for lesbian, gay, bisexual, transgender, queer and other (LGBTQ+) populations, a race equality partnership as well as a food network, which brings people together to tackle issues such as food poverty, food sustainability, food waste and overweight and obesity. The networks have provided the site with important engagement with population groups within the place but also helped local communities think about their role in supporting one another's health and wellbeing.

# 6 Where is GM's approach to population health now?

Greater Manchester (GM) was the trailblazer for devolution and population health. However, policy and practice have changed significantly in the past five years, and other areas have received bespoke devolution deals, which means they are more able to act through the wider determinants of health, to improve population health. The Health Foundation has a programme of work looking at this, including how devolution can make a difference to health inequalities (**the Health Foundation undated**). *See* also Goodwin *et al* (**forthcoming**) for early findings on this subject.

The main change in health and care policy, however, has been the development of integrated care systems (ICSs), a key purpose of which is to help the National Health Service (NHS) be a much better partner for population health, especially on the wider determinants of health, than it has in the past – one of the chief purposes of GM's 'dual' devolution. The Greater Manchester Health and Social Care Partnership has transitioned from what it was – a bespoke partnership that GM designed – into the Greater Manchester Integrated Care System. Wider structures have therefore caught up with GM and its approach to population health. In this section we set out some of the implications and challenges of this, the wider challenges to GM's work on population health and also the successes that we heard about. So where is GM now?

## The development of integrated care systems – towards population health?

After the health reforms of the coalition government, NHS England, which those reforms established, sought to move to a more collaborative and integrated approach to the provision of services between NHS organisations. At its core, the aim was to provide a more integrated experience and better outcomes for patients, responding to the fact of an ageing population with multiple health conditions ('comorbidities') and with more complex and inter-related needs. It sought to do this through two avenues: first, through learning from various care pilots, the vanguard programmes and similar, and second, through the integration of organisations into partnerships and systems.

This latter integration has been a huge undertaking and started with the development of partnership vehicles on large geographical footprints known as 'sustainability and transformation plans', and later 'sustainability and transformation partnerships'.

In June 2022, legislation in the form of the Health and Social Care Act 2022 was passed that introduced the current 42 ICSs in England, of which GM became one. These systems are intended to better integrate the planning, delivery and experience of care for patients across NHS organisations, and through strategic partnerships and action between the NHS and other organisations, improve population health. They operate through an integrated care board, tasked chiefly with integrating the delivery of care services, and an integrated care partnership, which is a wider partnership for health. Together, they are tasked with adhering to four principles that underpin the whole purpose of ICSs (NHS England 2024):

- improve outcomes in population health and health care
- tackle inequalities in access, outcomes and experience
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Despite inevitable growing pains, population health – and as part of that, a much deeper and serious understanding of the need to tackle inequalities in health in the population – is a core element of why ICSs have been created. We now have early signs, in particular, of how ICSs are thinking through their work on health inequalities, and in turn to what extent this is through a population health lens (Buck 2024a).

## Becoming an ICS

In GM, given the head start it had and its experience of working as a *de facto* ICS, the shift to a formal ICS structure should, in theory, have been a cosmetic change only. But in practice, it has been more of a challenge.

From being an outlier, GM has become enveloped by the pack, in particular in terms of how NHS England manages, assesses and supports ICSs more widely. This has meant organisational and cultural change, as a locally evolved partnership

arrangement has been superseded by one that has a stronger national framework behind it. Many people have previously summarised GM's style as working as '10+1' – the 10 constituent local authorities plus the regional body, the Greater Manchester Combined Authority, of which the Greater Manchester Health and Social Care Partnership was 'the one'. 10+1 implies a partnership of equals, not a hierarchy, and GM has been careful over a long period of time to ensure that decision-making is joint and leadership roles are spread across the partnership.

We heard in our work that the transition to an ICS, the oversight of NHS England and the associated hierarchical management structure, 'tone' and culture of the NHS were therefore challenging for wider partners in the initial stages. An internally commissioned external review in May 2023 suggested that there were problems with transparency, including in relation to performance and finances between partners, over-complex governance and, aligning with what we heard from leaders in some places (*see* below), the ability to make progress at place level stalling in some cases. Finally and most relevantly:

> *…many partners felt delivering the overarching strategy for the system (to improve population health) is conflicting with achieving financial balance and meeting NHS targets.*
>
> (Dunhill 2023)

## Financial and other challenges to GM's progress on population health

GM is not immune to the challenges of adopting a population health approach, and progress has not been linear. Across our work, we found that GM is facing five key challenges to its approach, all driven by the financial challenges of a system that is running hot and that is reorientating to the presence of an ICS: spending on prevention being the first cut and making the business case for population health; level of ambition versus key workforce capacities and bandwidth for population health; the risk of going back to organisational priorities, not system ones; the balance of power between regional partners and place; and some people may not be benefiting from economic growth.

### Spending on prevention being the first cut and making the business case for population health

Unsurprisingly, perhaps, the biggest risk to the population health journey we heard about was how to maintain the focus on public sector reform – and as a key part of that, population health – in a financially challenged system. We heard about a long, proud history of developing good solutions and conditions for the GM population health system approach, but there were some concerns that these would be lost within the current context and financial pressures. Interviewees noted a concern about the loss of learning from population health approaches as the system bows to financial pressure.

System leaders we spoke to told us how prevention is often the first 'casualty' of budget cuts as outcomes in this area are longer term and the pressure is to focus on more immediate issues – for example, achieving NHS targets. As one senior leader put it:

> *The financial sustainability is where I, I think, [we] have most concerns now. And I think this will test the rhetoric and the accountability… it feels as though the rhetoric around health inequalities, financial, will be tested. And I sense already, unfortunately, the easy targets are still prevention where they are, they're easier to cut.*

Leaders told us that it was a constant battle to 'prove' that maintaining a focus on population health would reduce demand on health and care services in the long term. Key to overcoming this challenge is to continue to make the case for prevention and developing the case for continued investment – together – at a system level (*see* Section 7). This must be tied with a coherent and enduring shared narrative and whole-system leadership for population health.

Through our conversations, we heard about the pressure to demonstrate return and value for population health work and the difficulty of doing so. However, positively, senior leaders felt that things were getting better and that, by building the evidence base, the question was not just about reducing demand and cost for public services but also about different ways of working within existing resources.

> *I think we need to get better at using the funds that we already have differently, using our existing staffing and our partners' existing staffing differently, and*

*understanding how we make sure that our efforts to influence all of that spend and those professionals and how they work, we need to have a framework for knowing whether that's effective. We need to have a framework for knowing whether that is making a difference and how we should be going about that to make that work as effective as we can make it. Because I think it is going to be that broader influencing work that shapes what difference we can make over the next few years, at least as much as the stuff that we commission and do more directly using the budgets that we hold at whichever geographical level.*

### Level of ambition versus key workforce capacities and bandwidth for population health

Alongside the financial challenges is the capacity of key parts of the workforce to deliver the level of ambition for population health at place and GM levels.

*…we've set ourselves a really ambitious joint forward plan but we struggle with the capacity to deliver that as well as our role as directors of public health in our locality, and that's not because we don't want to do it, it's just because we physically haven't got the capacity to do it.*

Interviewees also feared, given the financial pressures, that capacity issues would cause less focus and 'headspace' for continuing to make progress on the population health approach, as staff are required to deal instead with the immediate pressures of the 'triple deficit' (the financial deficit, the performance and quality deficit and the population health deficit) in GM.

*…so we can't drop A&E [accident and emergency] waiting times, we can't drop elective care. These are things we have to do. But at the same time, if we just continue to focus on those, the prevention side of things is not going to make significant impact.*

### The risk of going back to organisational priorities, not system ones

Within a financially challenged and heavily scrutinised system, we heard that some system partners were drawn back towards their own organisational priorities rather than system ones. This was particularly evident with the pressure to reduce demand in the health and care part of the system. As one senior leader told us:

> *I think under pressure, sometimes that does shift, doesn't it? Because then your priority becomes how do we stop people rocking up at A&E, rather than how do we improve the health and wellbeing of our residents and make sure that everybody lives a long, healthy, happy life, to the best of their abilities? And that I think is the challenge, isn't it? It's that we end up focusing on, oh, we need to reduce demand for primary care and demand for A&E, but that's not our priority. Our priority is, how do we make the best for our residents?*

### The balance between regional partners and place

The financial pressures, and the shifting architecture of decision-making following the creation of the ICS in GM, have changed the balance between regional and locality decision-making power, and led to a shift in perception from a 10+1 partnership to a more hierarchical relationship. As a result, senior leaders felt that there needed to be greater clarity on the roles and responsibilities of different parts of the system and how they inter-relate.

> *I think that whole thing about locality–GM balance is probably the bit that still feels the wobbliest. It's the bit that… the complexity of it and the sheer amount of change that we've gone through and continue to go through where I feel we have… when things go wrong, it tends to be in that territory, doesn't it, about that relationship between localities and GM? That seems to be the bit where we get stuff wrong more than on other things.*

### Some may not be benefiting from economic change

Finally, and particularly at a borough level, while the focus on population health and economic success as two sides of the same coin was considered a key positive, there was also recognition of the challenge of ensuring economic growth reached all parts of the population, and did not inadvertently widen health inequalities. As set out above, the evidence so far suggests that GM has largely avoided this. But there remains the risk that an economic-regeneration and development-'heavy' approach means opportunities are created for some populations, and not others – indeed evidence from other countries suggests that economic devolution can widen health inequalities (du Plessis *et al* 2019). The challenge is to continually ensure that all local communities are involved and benefiting from economic growth.

Some senior leaders also felt that there had been a loss of collective ambition and loss of confidence about the importance of population health as part of the economic ambition. One told us:

> *I think there's been a collective loss of ambition and a loss of confidence [over the connection between population health and economic ambition] and we've retrenched a little bit. I would really like to revisit and reunderstand that sense of ambition that drove Greater Manchester to the devolution agreement and drove Greater Manchester to extraordinary economic performance, but through the lens of population health and through the lens of inequality.*

# 7 Staying the course in GM

Greater Manchester (GM) has been the beacon for others on population health, and the evidence suggests it is starting to pay off. Yet the journey has not been smooth. Perhaps the single most important lesson for others, and for GM itself, is to stay the course and do what it takes to do so. To turn back now, in the face of organisational changes and financial pressures, would be the wrong course. This section turns to meeting the future, and how GM is planning to stay the course, while not standing still on its journey.

## Meeting the financial challenges *through* population health

GM has severe financial challenges, and this is a threat to the focus on population health, as set out in the previous section. But, unlike some other ICSs, GM has turned the extensive experience, expertise and analytical strengths it has developed through its population health work to make the case that sticking to a population health approach is needed to get to financial sustainability in the medium to longer term.

Modelling undertaken to understand the drivers of the financial pressures in GM showed that they included demographic change (including higher projected births and inward migration), with many people with preventable multiple long-term conditions and deteriorating health unless acted on, cost pressures associated with inflation and health demands, and elective recovery following the pandemic.

Key to the financial pressures, which will grow over time, is that around half of people in GM have some form of sub-optimal health in terms of a recorded ill health condition. Continuing on the current trajectory and taking into account the pre-existing deficit due to an unaffordable model of care have been modelled to result in the system deficit growing to £1.9 billion in a 'do nothing scenario' by 2026–7. While provider efficiencies can tackle a portion of this, the big potential is in terms of greater investment in population health through: targeted prevention and early detection measures; behaviour-change support; proactive care supported by population health management; optimising care for specific cohorts, for example people with cardiovascular disease or diabetes or people who are frail; and

improving care and prevention for the most disadvantaged communities (including in relation to substance use, housing, food insecurity and transport).

An investment in these areas as part of a broader population health approach and implementing them at scale is part of the answer to meeting the financial challenges.

## An honest assessment: a journey that is not finished

As part of our work for this report, we discussed GM's past and future journey at this key moment of reflection with key leaders, including GM's Public Health Leadership Group and the Population Health Committee of the Integrated Care Board. We asked committee members to score GM on some of the key aspects that underpin a population health approach. These were drawn from our experience of working on, and supporting, population approaches across England since our *Vision for population health report* was published in 2018 (Buck *et al* 2018) and bringing together some of that learning to support the background work of the Hewitt review of ICSs (Hewitt 2023). In the support for the latter we argued that to move to become a population health focused ICS required progress and alignment across five key areas:

- using levers (for example, payment systems that incentivise prevention, and shared outcomes frameworks and goals that include all the pillars of population health, not just the delivery of care services)
- adhering to the system principles that underpinned the creation of ICSs and the leadership behaviours that support them
- having the level and distribution of capability within the system to move forward
- fully acting as anchor institutions and using the assets of communities
- taking a population health approach to key areas, including multiple long-term health conditions and children's health.

We asked members of the Population Health Committee to self-assess GM's progress, how far it had come on these big themes and how aligned it was in terms of meeting them as a system.

Areas where most progress was thought to have been made were having clear systems principles and in terms of capability. On the first, we are in agreement. GM has done more to embed a vision, principles and model or framework for population health than any other system. This is apparent across its strategies and governance, and population health is as present in local case studies. The principles are strongly connected to what drives population health at GM and local levels, including economic growth and fairness.

On the second, capability, GM is again making good progress in our view. In particular, strongly connected to its work on population health is its approach to health inequalities – the GM Fairer Health for All (FHFA) framework (Greater Manchester Integrated Care Partnership 2023). This commits to:

> *…continuing to develop GM as a population health system, including shaping an Integrated Care Partnership that takes a population health approach, uses population health management, actively values and includes the contribution and challenge of public health and sees itself as an active partner in shaping the four domains of the GM population health model and the overlaps between them.*
> (Greater Manchester Integrated Care Partnership 2023)

As part of this it seeks to: hard-wire equity into decision-making; increase the power of communities in decision-making; increase the representation of the community in the workforce; introduce proportionate universalism[6] in how funding is spent; and act more strongly on the social, commercial, economic and environmental drivers of health.

And underpinning the Fairer Health for All framework is the Fairer Health for All Academy (Greater Manchester Integrated Care Partnership 2024). This brings together examples of best practice interventions, stories of change and training opportunities related to tackling inequalities across GM. Its key role, however, is to develop the internal capability and networks within GM to tackle health inequalities and how they present themselves, through investing in leadership development, fellows programmes and 'communities of practice'. The Fairer Health for All programme and approach are a key sign that GM is finding the bandwidth, the

6 That is, in order to reduce health inequalities in practice, interventions and actions should be universally offered but with an intensity and a scale that is proportional to the level of disadvantage. *See* Francis-Oliviero *et al* 2020 for a review and critique of this approach.

resources and the space to invest in increasing its capacity and capability to tackle the root causes of health inequalities and poor population health. This is part of a wider 'academy' movement across England's ICSs. This is a good sign, in our view, that population health approaches are here to stay.

However, the Population Health Committee recognised that there is more to be done in other areas, including a deeper population health approach to the prevention, delay and treatment of multiple long-term health conditions and children's health. The area that the committee was most self-critical about, however, was action on the levers for population health. This critically includes the incentives and rewards for focusing on population health. Some of these are in GM's gift, many are not (*see* Section 8).

As part of its ongoing journey, GM also needs to keep asking itself questions and adapt to change. This includes deeper and ongoing analysis to understand the impacts on population health, and to continue responding to wider issues that affect population health. On the first, GM needs to revisit the published findings set out above on the progress it has made on improvements in health and health inequalities compared with other areas. The existing published analysis stops just before the Covid-19 pandemic. We know that the pandemic has disproportionately affected disadvantaged communities. Further analysis is therefore needed to better understand whether devolution and the focus on population health have provided any degree of population 'resilience' or protection, and whether the impact on population health and health inequalities has been sustained beyond the pandemic. GM, like other systems and areas, also needs to pay more attention to areas such as structural racism and the commercial determinants of health, which are increasingly recognised as areas that affect population health.

# 8 Lessons and recommendations

It is hard to stick to the course on population health. As we have seen, Greater Manchester (GM), the 'poster child' for devolution and population health, has felt that as much as anyone, despite its consistent efforts over time. We believe there are lessons for others from this experience – for national leaders and systems, and for other integrated care systems (ICSs) and local partnerships seeking to become more population health focused.

Since the creation of ICSs, there has been consistent central focus and attention on finances and service goals, such as waiting times, to the detriment of important ambitions such as improving population health. ICSs have also lost capability and bandwidth due to funding cuts. This has diverted leadership and management attention away from fulfilling the principles underpinning their creation, including on population health.

The new government has an opportunity to reset this, and to better support the development of population health systems through creating better conditions for ICSs, and through ensuring that population health approaches underpin its approach to its health mission and connect with its wider approach to devolution in England. If the government is to deliver the goal set out in the Labour manifesto that 'Labour will tackle the social determinants of health, halving the gap in healthy life expectancy between the richest and poorest regions in England' (Labour 2024; Buck 2024b), thriving population health approaches are a key ingredient to meeting that goal, and there is much to learn from GM's journey so far on the achievements already made, and where it will go next.

We now set out our recommendations for the government, for the Department of Health and Social Care and NHS England, and for other systems pursuing population health approaches.

## Recommendations for the government

- **Ensure that the health mission has a clear delivery plan and is delivered through a population health approach.** The core goal of the health mission – to halve health inequalities in healthy life expectancy between regions – is galvanising. But it will rely on action across government if it is to be achieved, through supporting ICSs and others but also through the health mission directly. It must therefore include actions across the four pillars of population health (that is the wider determinants of health, health behaviours, the role of an integrated health and care system and the contribution of the community itself), as GM has done at the system level.
- **Ensure that the health mission aligns with the other missions and *vice versa*.** The health mission is dependent on the other missions and *vice versa*. We know, for example, that devolution that narrows economic inequalities does not necessarily narrow health inequalities. Intent is required, and the government should learn from the GM experience on what it takes to follow through on that intent over time.
- **Ensure that sponsoring departments work coherently together below the national level.** Success will require government departments to work much more coherently together at subnational level than they have to date, including through more unified and aligned relationships with combined authorities, mayoral roles and other aspects of devolution and how they relate to ICSs. Again, GM provides lessons on this, and the government should reach out for its advice. The NHS Confederation has also produced helpful thinking on this (Wood 2024).

## Recommendations for the Department of Health and Social Care and NHS England

- **Play a full role and cohere with other missions,** including the growth mission, helping improve economic productivity through its role in keeping people well and productive, and through the NHS's huge role as an economic giant and anchor institution. It must not see the health mission as an insular DHSC-only concern, and it must act positively to support the delivery of other-related missions that are critical for population health. NHS England, as the core agent of the Department of Health and Social Care, must also fully engage with other government departments and their delivery agents.

- **Reiterate that population health is a core goal of ICSs.** This requires consistent strong messaging from ministers and the leaders of the NHS that population health is a core goal for ICSs. The leadership focus and action are too heavily skewed towards waiting times and financial performance, which diverts leaders' attention away from long-term goals for population health.
- **Ensure accountability systems and supporting tools are focused on population health goals.** The existing accountability structures and focus are too heavily weighted towards financial and performance goals. This acts to skew effort, and reward for effort, away from the other founding principles of ICSs – improving population health and tackling health inequalities – and the wider contribution that ICSs make to the economies and societies they are part of. This needs to change. DHSC and NHSE must rebalance accountability systems and tools towards those goals, for example through specifying that ICS shared outcomes frameworks emphasise and include the four pillars of population health and the role of the NHS and its partners in delivering them.
- **Design system levers that incentivise and reward action on population health.** This means alignment on funding and funding mechanisms for population health so that, for example:
  - prevention is adequately funded
  - leaders and systems are incentivised and rewarded for investing in outcomes improvement, rather than process and throughput
  - within the boundaries of ICSs (and other partnerships), resources and effort can flow where they are most effective and provide value for money, including between sectors.
- **Resist the urge to reorganise system footprints.** Multiple reorganisations have a destabilising effect on long-term effort and goals. GM has benefited from having a stable identity over time. For longer-term system shifts, such as population health, this is necessary, if not sufficient on its own.

GM offers many lessons to other ICSs that wish to adopt population health approaches. We recognise that none of this provides a 'drag and drop' toolkit, as every context, and system configuration, is different. And GM has benefited from a relatively stable political balance among its constituent local authorities, a strong partnership model developed over a considerable period of time and an ICS footprint that maps onto its combined authority. However, any ICS and system can take on the following recommendations.

## Recommendations for other systems pursuing population health approaches

- **Develop a widely owned vision and adopt a clear but flexible framework or model to help cohere efforts in service of it.** This takes time and leadership but providing a guiding vision on the direction of travel and purpose, and having a clear framework to help identify and map contributions across partners and sectors, enabling people to understand everyone's contributions, are essential. Partners from across the system have to 'believe' in the agreed aims of the population health model, and be willing to come together, work together and draw resources, capabilities and workforce together to achieve them. This does not imply rigidity – models need to be flexible and adaptable but do need to guide the overall approach.
- **Be consistent in approach over time.** A vision and framework will help with this, but it also requires coherent leadership, tenacity and commitment. This takes time. Progress towards a clear, structured, embedded vision is not linear and partners need to develop good collaborative relationships. There has to be a willingness and desire to approach the system as a population health one. The journey will not be straightforward – many factors will cause turbulence, including external challenges (such as a pandemic), organisational change and financial challenges. But the lesson is to sustain the approach through a consistent focus on population health as a core goal, alongside and *interdependent with* the wider core aims of financial balance and good performance.
- **Ensure clarity over system-level and local roles and reflect this in governance.** Effort needs to be spent on explicitly developing and clarifying roles between system partners, and between the system level, regional level and place, particularly recognising local authorities as the building blocks of population health. There will be inevitable tensions between tiers and system partners. These need to be recognised and explicitly worked through as part of an ongoing process. Clear governance and accountability lines between system partners need to be agreed, allowing system partners to understand how decisions and action are taken. This includes that some things are more appropriate and effective done at regional level (for example, in some systems, this may involve activities such as tobacco control and the approach to certain types of food advertising) but the default is local and place-based action. Key groupings, such as directors of public health, and connected networks and leadership groups, should be seen as an important bridge between the

different parts of the system. The objective is to ensure places have the appropriate level of permission, trust and power to develop an approach that best suits their local population, and at the ICS and/or regional level, that regions enable places to 'do' the work of population health.

- **Constantly learn, develop and build capability for population health.** Systems need to invest in themselves and in their people, and evaluate and learn over time. Progress will not be linear and learning can depreciate. It takes active attention and investment in capability to respond to the changing challenges of population health. Capability can take many forms, including:
  - analytical power being close to and influencing key decision-makers
  - strong relationships with communities to understand their needs and strengths
  - formal investment in academy and other models that constantly invest in the knowledge and capability of people to take a population health approach, through their roles.
- **Be open to external bodies and the support they can offer**, and develop an evaluative organisational culture that focuses not just on processes and relationships, but also on the impact on population health outcomes.
- **Lead and act on the knowledge that population health and health and care system goals are intertwined and codependent.** Too often, progress on population health is seen as a desirable, a luxury, but not essential to a well-functioning health and care system. While this is partly due to the behaviours, decisions and processes of the Department of Health and Social Care, NHS England and ministers, ICSs are responsible for their own future, and the future of their population's health. Investment in prevention and population health is the route to meeting the two goals of having a financially well-performing health and care system and one that is preventive and focused on population health. The latter must not be sacrificed for the former. This requires strong leadership and a commitment to stick to the course when it is easier not to.
- **Lead and act on the knowledge that population health and economic goals are intertwined and codependent.** At system and place levels, there is more recognition, including from the past and new government, that economic goals and success and population health are intertwined and codependent. This is true for individuals (for example, there is a connection between

good-quality work and health) and for places (for example, there is a link between regeneration and the health of communities). While there will be tensions and trade-offs, economic and population health goals should be viewed as symbiotic through long-term co-designed economic and health strategies. Systems need to be more cognisant of this than most currently are, systematising anchor approaches, but moving beyond them to improve both the economic and health status of their populations.

# Annex: Case studies and their population health journeys

Greater Manchester (GM) is a combined authority area in the north-west of England, with an overall population of 2.8 million people. It is the largest subregional economy in the UK, outside London and the south-east of England. It has 10 constituent local authorities, three of which – Bury, the city of Manchester and Stockport – comprised the case studies in our research for this report. The GM Integrated Care System covers the GM combined authority footprint. The area's average life expectancy is 77.5 years for men and 81.3 years for women, lower than the average for England of 79.4 and 83.1 respectively. Healthy life expectancy is also lower than that for England, at 61.0 years for men (compared with 63.1) and 60.7 years for women (compared with 63.9) (Greater Manchester Combined Authority 2024). Deprivation levels in GM vary between and within boroughs, but overall, at the 2021 census, almost six in 10 children and young people in GM lived in the 30% most deprived lower super output areas (LSOAs) nationally (Greater Manchester Combined Authority 2023).

We now present our three case studies.

## Bury – the story so far

Bury is a largely urban borough situated in the northern part of GM. With a population of 194,606 people, it is the least populated of the 10 metropolitan boroughs in GM. Bury's age structure shows the working-age population to be 61.6% of the population. People aged 15 and under represent 20% of the population and people aged 65 and over represent 18.4% of the population. Life expectancy at birth for men is 79 years, slightly lower than the England average of 79.4, and 82.1 years for women, one year lower than the England average of 83.1. Bury is in the 30% most deprived local authorities in England and the eighth most deprived of the 10 GM boroughs. In Bury, 10% of lower super output areas (LSOAs) are in the 10% most deprived in England (*see* The Bury Directory (undated) for more

background statistics on Bury). Bury was selected as a case study due to it being an early adopter of a population health approach and its positive working relationship with the GM Health and Social Care Partnership, helping refine the relationship and respective roles between place and the regional body.

### What defines the Bury population health approach?

The Bury approach to population health is set within the devolution deal framework, and leaders of place (usually local councils) have a democratic mandate to work with the NHS to innovate and improve the health of Bury's population. Senior leaders told us that paramount to the balance of 'power' between the devolved region and the place-based local authority is the level of permission and trust placed in local leadership (led by councils) to work with the NHS to improve population health. In Bury there is a strong link between the population health model and recognition that poverty is one of the biggest barriers to people accessing 'good work'.

The population health approach in Bury is framed within a vision strategy called 'Let's Do It!', which is set within an ambition for inclusive economic growth. At the heart of the vision is to improve health outcomes *and* deliver economic growth (symbiotically). Within Bury we heard how the locus of change and impact is set at the neighbourhood level – giving communities and partners the power to improve health and economic outcomes. Senior leaders told us about the importance of population health being embedded in everything Bury 'does' at a strategic level, at a leadership level, with regards to governance and to teams too. The borough has taken a deliberate approach to developing leadership at neighbourhood level – setting the foundations and context for change, and for people to lead on a neighbourhood footprint and 'get on with the work' (with permission, agency and trust). Bury has what senior leaders described as a 'genuine' 10-year strategy on population health (framed as the wider determinants of health), one that is:

> *…authentically understood across the system and to a level of maturity that everybody can put their own words to it, but is describing the same thing in their particular context as a partner.*

### Partnership working

Relationships and partnership working are at the heart of the population health approach in Bury. Senior leaders referred to a partnership commitment to, and shared view on, population health as the organising principle.

> *At a place level, you've got the joined-up constructs we have to have, certainly around the ICS, but we've also got other partnerships all connecting in now. This 'Team Bury' concept, where all the partners come together, is a very lively and real and vibrant thing, to the extent that we've now agreed that, quarterly, we will pull together a big group of people, a couple of hundred people now, which is all the partners plus some. I was really wary about doing it because I thought the risk of a big flop is quite high here. Au contraire, we had another one last week and you could feel there are more people coming and the quality of engagement and conversation is very real. Whilst there's a bit of a spectrum, fundamentally, people get it in their heart and have a shared view and you don't get that in many places.*

Bury has put in significant time and resources into creating good collaborative working practices between staff and organisations. For example, we heard how leaders in Bury have created a 'transformation team' within the Bury Integrated Care Partnership. The purpose of this includes:

> *…capability building, of operational management level, giving them the right skills to do some of this [population health approach] and then creating the time and space is something they're doing in their teams as well. So, by making some of this important, around the training, relationship building, et cetera, in that capability building, that's then going through a really good vertical line all the way through, kind of, management and leadership structures.*

Senior leaders described their approach as a 'bottom-up approach to population health. Rather than a top down, our whole approach in Bury is focused on population health'. They acknowledged that this only works if frontline staff know each other, are able to work well together and have a knowledge of the residents and the neighbourhoods they serve. Senior leaders described the importance of leadership and partnership working at the neighbourhood level, to create the context for action at that level. They have:

> *…joined together the whole of the Council with the whole of the NHS, not just those parts of the Council that deal with adult social care or environmental health*

*and population health, but the whole of the Council. That's a key distinction. This is a partnership with the whole of the Council, not one that's focused on integration of services alone.*

Senior leaders across Bury spoke of the importance of bridging the 'cultural gaps' between the NHS and local authorities for successful partnership working. Understanding that problems and solutions are shared has been instrumental in the population health system approach in Bury. As one senior leader told us:

*Because I think where we're at is, all our problems are shared problems. So, the elective waiting time isn't just the NHS's problem. It's a shared problem, and therefore there'll be shared solutions, and some of that is about urgent care, yeah, but the longer-term solutions to some of these problems are not sat in the NHS are they? And I think equally the NHS is also increasingly starting to see that employment is not just somebody else's problem, you know? The NHS employs a lot of people, there's the anchor organisation, so I think we're getting more to a place where these are all our shared issues.*

Furthermore, and as part of this, the leadership put together an intensive programme of strengths-based training for teams and arranged for some different groups of staff to be located in the same place as well. Enabling staff to come together and understand each other's perspectives and ways of working has been fundamental to overcoming some of the challenges of bringing different teams together. As one senior leader noted:

*I think just knowing each other's worlds and being co-located with each other and particularly the strengths-based training was a really important part of their journey. It really strikes me about some of the things that the team leaders were saying that were, kind of, district nursing by background, at the time, about how much of a difference it had made to them working with social workers and understanding the approach that they took to managing user need that was very, very different from a health need. I think that was a real turning point around how some of the health staff really started to change their perspective on how they managed their interactions with people.*

### The experience of the Covid-19 pandemic

The Covid-19 pandemic was described as an 'accelerant' to the population health journey and partnership working towards it in Bury. As one senior leader noted:

> *…it [the pandemic] raised the profile of directors of public health, and the way that we work collaboratively. Through Covid-19, it became a real true collaborative effort and that's [how] the 'Locally led, Greater Manchester enabled and nationally supported' kind of language/phrase really developed… so we all started working as one in a way that we hadn't previously.*

The experience of the pandemic also brought into sharp focus the relationship between economic growth and health – the idea that 'what's best for people's health tends to be best for the economy as well'.

### The future for Bury – the impact of the changing architecture

Senior leaders in Bury described high levels of collaboration between the borough and the Greater Manchester Combined Authority, collaboration that has grown and developed over time. System leaders in Bury referred to it as a system of 10+1 – the 10 boroughs plus the Greater Manchester Combined Authority. Underpinning this collaboration is a high level of autonomy, trust and permission at a local level:

> *…when we had a GM mayor, that was really strong that local authorities are autonomous, and each local authority held onto its own local autonomy, but agreed to collaborate. And that's how GMCA [Greater Manchester Combined Authority] came about, building on the association of Greater Manchester Authority.*

However, there was a sense that, with the formation of the ICS, the balance of power/autonomy had become less clear and that this was something that needed to be worked through.

> *Within local government, they'd had quite a history of working in that way, whereas I think before, I think now because we're going through this thing of the formation of the ICS, which is a single GM, yeah, that's still being worked through as to, well, what gets devolved to the locality, what gets done once at GM… in some ways the formation of, like the ICS… kind of threw a spanner in the works, because we were kind of already doing it.*

Overall, there was optimism about the future, and the continued commitment to the GM 'ways of working': 'Locally led, GM enabled, nationally supported.'

## The city of Manchester – the story so far

The city of Manchester is a populous city in the central part of GM. Its total population as of 2021 is 551,938. Manchester has a considerably younger population compared with other GM districts (91.2% of residents are aged under 65). Of the lower super output areas (LSOAs) in Manchester, 43% are within the 10% most deprived LSOAs in England, making Manchester the most deprived of the 10 GM boroughs (Manchester City Council 2019). Life expectancy in Manchester is 74.8 years (The University of Manchester 2016), 74 years for men and 79 years for women – this is around five years and four years younger than the average for England respectively (79.4 and 83.1 respectively) (Manchester City Council 2022). Manchester was selected as a case study site for its demographics, its challenges and its approach to active learning (particularly from other city regions beyond GM) and developing its population health approach.

### What defines the Manchester population health approach?

Manchester has a long history in its work and focus on health inequalities, in what senior leaders referred to as a 'relentless focus'. However, we also heard how this approach had only been 'owned' by the 'wider system' over the past few years. Manchester has had a Population Health Plan since 2018, which is a 10-year plan for the city. We heard how the plan had been 'really well received', with high levels of engagement and ownership across the system partnership – particularly aided by the Health and Wellbeing Board. This broader system 'ownership of health inequalities' has been integral in Manchester to making 'population health happen'. Building on the momentum of the city's 2018 Population Health Plan, senior leaders were able to shape a borough-based plan following Sir Michael Marmot's review: *Build back fairer in GM: health equity and dignified lives* (Marmot *et al* 2021). In 2022, the city launched 'Making Manchester Fairer (MMF)', a five-year strategy to tackle health inequalities through the social determinants of health. Senior leaders spoke passionately about the strategy and the level of leadership (partnership) engagement and ownership for achieving the aims of the strategy as a key enabler to a population health approach in Manchester.

> *From my experience within the city, I've never known a programme [Making Manchester Fairer] so widely owned by the right people at the top, [including] the*

*leader of the Council, the Health and Wellbeing Board [and the] Manchester Partnership Board, which is our locality board, as part of our new integrated care system arrangement. All key organisations are really… have bought into the Making Manchester Fairer programme and plan.*

*Making Manchester Fairer is a really good example of how partners and systems have come together and everybody's signed up. And really signed up to it. And it's a key strategy for the city of Manchester, it's not a, you know, it's not a local authority strategy or a health strategy or another strategy – it's owned by the system and I think that's really positive and everybody can get behind it. And it's, you know, everybody wants a piece of it, so we have to be… say to people, you know, 'you'll have to wait to get your turn', almost. So that's a real positive I think. And I think we're in a more mature place for that to be able to happen.*

*I think Making Manchester Fairer is landing so well as a raw programme that everyone can get behind. Every corporate department of the Council, our NHS anchor institutions, our VCS, it just feels different to things we've done in the past – where people have said 'oh this is good, this is really good' but not put in the resource or effort.*

### Partnership working

Manchester has a good level of partnership working that has been developing over the past five years. Senior leaders pointed to the formation of the Manchester Local Care Organisation on 1 April 2018 (**Manchester Local Care Organisation 2018**) as a pivotal moment in bringing together partners from across the NHS and the local authority to commission services jointly (pre-ICS). Furthermore, it was clear through our conversations how partners have come together to work towards the key strategy for the city – Making Manchester Fairer. Senior leaders referred to the system as 'fairly mature' to enable partnership working. This maturity not only enables system working but also allows partners to challenge and test the whole system when data about progress/outcomes is reflected back to them.

### The experience of the Covid-19 pandemic

The pandemic experience has had a long-lasting and deep impact on Manchester. Senior leaders told us about the positive impact the pandemic had had on bringing partners together for a co-ordinated response to the emergency. We heard how relationships improved and grew following this, and how they have been sustained beyond the emergency response to continue building a system within a population health framework or model. Additionally, we heard how the pandemic had acted as a catalyst for greater community engagement and involvement in the population health approach in Manchester. This started as an engagement project to improve Covid-19 vaccination rates and overcome some of the trust issues with certain population groups in the city. This led to the city developing a vaccination outreach programme alongside the establishment of 'sounding boards', made up of community leaders, faith leaders and others, who came together to be a sounding board for ideas about what the challenges were and how to increase vaccination uptake in different communities. Senior leaders told us that the sounding boards were not listening boards, with participants being encouraged to be active in the development of solutions. Following the pandemic, the city has maintained and expanded the sounding boards under the umbrella term Community Health Equity Manchester (CHEN).

### The future for Manchester – the impact of the changing architecture

The pathway towards strong partnership working in Manchester has been in development for the past 20+ years, particularly between the NHS and the Council. These relationships were strengthened during what was referred to as the 'CCG era' – where the city created the Manchester Health and Care Commissioning Group – a partnership between the Clinical Commissioning Group and the Council. Having the director of public health as a member of the executive group of the Clinical Commissioning Group was seen as a key enabler in maintaining a focus on a population health model and framework in Manchester. Within this framework, Manchester established a Local Care Organisation as a formal partnership between adult social care services and community health services. At the time of writing, the director of public health was the deputy place lead for the Manchester Locality Team (reporting to the Integrated Care Board). Senior leaders felt that the director of public health having an executive role on the Council as well as within the place leadership team was as an important lever in keeping population health at the forefront of the city's approach/strategy.

Under the previous arrangements (particularly through the Clinical Commissioning Group) we heard how the public health team was able to protect public health/prevention budgets from cuts to resources seen elsewhere in England. Having a leadership role for public health on the Clinical Commissioning Group helped keep the resourcing at a reasonable level, and senior leaders were keen to continue with that joint integration – given the changes to governance following the establishment of the ICS. Within this context, some leaders expressed concern that the pace of change and changes to governance could mean a shift in levels of 'permission and trust' between place and the Integrated Care Board/Greater Manchester Combined Authority.

## Stockport – the story so far

Stockport is a metropolitan district, which sits in the southern part of GM and has a predominantly urban population. According to the 2021 census, Stockport has a population of almost 294,800 people, with 61% of residents of working age (aged 16–64), and a growing ageing population, with 20.1% of all residents aged 65 and over. Average life expectancy in Stockport is 78.9 years for men and 83.3 years for women (compared with the England average of 79.4 and 83.1 respectively). However, life expectancy for men and women in the most deprived areas of Stockport drops to 73.6 years and 77.9 years respectively. Healthy life expectancy is just over 62 and 65 years respectively for men and women (**Stockport Metropolitan Council 2023**). Stockport's last Joint Strategic Needs Assessment (which is currently being updated) showed areas of severe deprivation, with 14% of the population living in the most deprived areas. However, the deprivation is not particularly widespread and 28% live in the least deprived areas, making Stockport notably polarised (**Stockport Metropolitan Council, Healthwatch Stockport, NHS Stockport Clinical Commissioning Group 2016**). We selected Stockport as a case study partly because partnership working and system maturity have been emerging and become more structured and integrated since the Covid-19 pandemic.

### What defines the Stockport population health system approach?

The population health system approach in Stockport has been a fundamental strategic approach. It was described as an organising principle, which sees 'health and the whole of the population, rather than health care services and the people who turn up'. Senior leaders in Stockport have used the population health approach to

shift the narrative for all partners involved, away from the location of 'health' within health services, and towards a vision of 'health' as an encompassing term that focuses on improving the health of the population of Stockport. In doing so, senior leaders in Stockport have worked hard to shift the narrative about illness, morbidity and healthy life expectancy. This shift in the narrative towards a population health approach has been instrumental in bringing partners together across the whole system to find solutions. As one senior leader noted:

> *You start to pull apart the fact that you see some behaviours which lead to chronic conditions being more common in different populations, in different parts of the borough and different parts of the conurbation. And I think that way of thinking really opens up the discussion about population health… And you suddenly start to realise, if we're going to approach all of that as population health, then we really need to be thinking about all of those things that affect this, and we need all of those people round the table if we're going to make a system that is going to address these things – rather than thinking that the hospital will, you know, or the, anything with an NHS badge on will definitely sort this out.*

### Partnership working

Senior leaders we interviewed felt there were high levels of trust and partnership working in Stockport. In particular, the population health model was a key enabler in bringing partners across the system together to address the issues affecting the population and developing collaborative solutions.

The population health approach helped partners to come together 'under one framework' with a clear set of goals – taking them out of a more 'fortress mentality' approach to service development and delivery. Fundamentally, partners have come together with the understanding that the population's health can only be improved by a system-wide response to the issues and that the health system is not going to 'fix' health alone. Stockport has developed these relationships over time and set up partnership working involving the health and care system, public sector services, the voluntary and community sector, and the business community.

### The experience of the Covid-19 pandemic

It was clear that, in many ways, the Covid-19 pandemic had been a catalyst to developing 'really strong, unified relationships across the borough'. The experience of the pandemic enabled conversations among system partners as it exemplified the need for a co-ordinated response across all parts of society to aid recovery and build a resilient system for the future. As one senior leader noted:

> *…there's something about the experience of the pandemic which has exemplified this and, for us, it was the co-ordination across all areas of society that really aided the response. But it's also enabled then, conversations across all areas of society about how important health is and, you know, people's… it's such a fundamental part of everybody's daily life, you know, whether that be immediate or longer term, that it's being able to open up conversations in a slightly different way.*

### The future for Stockport – the impact of the changing architecture

We asked participants for their views on the impact of the changing NHS architecture (with the new statutory bodies – ICSs – being established in July 2022) on the system approach to population health in Stockport. Generally, senior leaders felt that the changing architecture provided Stockport with more opportunities than challenges/risks. This was particularly seen as an opportunity for the NHS, as local government leaders are likely to bring 'questions and scrutiny and interest and energy and creativity' in a way that may not always be the case within the usual ways of working within the NHS (stymied by bureaucracy and central policy diktat). However, the new infrastructure/architecture poses a short-term challenge for the system.

> *…we have to find how all that fits in a melting pot of, then, a Greater Manchester infrastructure and a locality infrastructure, or borough infrastructure, and how those things all connect together. So there's a short-term piece of, kind of, governance and functions and who does what where, that's, kind of, in the midst, and in this very moment.*

Participants felt that the Stockport system had a:

> *…less-developed infrastructure than some other areas of Greater Manchester who'd got further down the integrated route and then have had to, sort of, reframe*

*that now. And we've had less of that integrated work, in the, kind of, governance structures already existing, and so we had the opportunity to really… [build on the relationships built during the pandemic response].*

Having fewer embedded governance structures in place before the establishment of the ICS meant that senior leaders could be more 'creative' when considering how to build their population health system.

Looking towards the future, senior leaders in Stockport felt optimistic about the prospect of a place-based approach to population health going from strength to strength. One of the enablers for this place-based approach was having the chief executive of the local authority as the place lead. This was seen as a strength for the borough, because 'they [the place lead, as chief executive of the local authority] really recognise this synergy, this connection, this opportunity'. Senior leaders stressed the importance of getting governance structures 'right' and seizing the opportunity for improving population health in doing so.

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