

**UNDER EMBARGO UNTIL 19:30 ON 29/11/17**

**Teddy Chester lecture:**

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Partnership (GMHSCP)**

## **Taking charge? Learning from health and social care devolution in Greater Manchester**

(Lecture is based on the work of Jon Rouse and Warren Heppolette, Director of Strategy and Development, GMHSCP)

### **Introduction**

In April 2016 Greater Manchester took charge of its health and care system as one Partnership spanning NHS and local government, commissioners and providers, physical and mental health. In doing so we embarked upon a major transformation programme - a programme that is rooted in a clear and distinct philosophy, that the NHS belongs as part of a

wider system of population health, and should be accountable to the people through the framework of local as well as national democracy.

Tonight, I will attempt to describe our rationale and ambition for transforming health and care in Greater Manchester and the beginnings of its application. In doing so, I will locate that endeavour in the history of the NHS; the development of Greater Manchester and, most significantly; the evolution of society's commitment to a free health service.

The lecture will tell a particular story of the 70 years of the NHS, following certain relevant channels and zooming in on key inflection points in its development. It will also highlight characteristics of Greater Manchester which have roots over the past two centuries. It will begin to illustrate the application of new models of care and support which have their own genesis in ideas from across the globe.

The lecture is based on the ongoing work and thinking of a small group in the Partnership team, but in particular I want to reference the key contribution of Warren Heppolette, Director of Strategy and Development at the Partnership who helped me prepare this lecture, but has also been a key guiding hand in the development of our devolution programme since day one. I am very pleased that he is also here tonight.

## **The Cracked Foundations**

Nye Bevan was very clear on what was created in 1948. However, the relationship between the *concept* of the creation of health by collective action and its *consequence* – the establishment of a free health service - is often overlooked. In our view this oversight has infected decades of development in health and care and never managed to overcome the defects which Bevan himself recognised.

For us in Greater Manchester, the starting point for our NHS was not the establishment of a *service* but of the confirmation of a *promise*. A promise made by, and on behalf of every citizen that we will care for each other. As Bevan stated, “*health by collective action, builds up a system of social habits which constitute an indispensable part of what we mean by civilisation...society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical skill can provide*”. It was a commitment to solidarity through a social model: one for all, all for one.

It is worth reminding ourselves of these initial principles as we identify the consequences in terms of what we understand, observe and operate as the NHS.

The NHS was established on the basis that the community “*set aside an agreed proportion of the national revenues for the creation and maintenance of the service it has pledged itself to provide*”. This is the single connecting point to the national endeavour which devolution, whether in GM, or in Scotland, Wales, or Northern Ireland, has never sought to break – a system based on national taxation as a protection against any return to what Bevan described as a “*patchwork of local paternalisms*”.

This is the coping stone of a remarkable achievement as the NHS has remained the only immovable piece of the post-war settlement. As national commitments to full employment and social housing declined, the collective will on healthcare, born from the classless comradeship and clarity of vision which emerged from the Second World War has refused to budge.

However, there are defects, acknowledged from the outset but fundamentally unresolved. In fact, they have deepened over the following decades as policy-makers lost sight of the depth and breadth of the initial promise and focused largely on structural interpretation of the service commitment.

The crucial deficiency was the three way split between hospital, General Practice and community or social services which was baked into the 1948 settlement and has had consequences in relation to accountability and fragmented service planning and delivery ever since.

The national command structure of the NHS, with a particular emphasis on hospital management, established what still feels in most of the country like a feudal model of accountability through various iterations of area health structures governed by the appointed equivalents of NHS 'Lord Lieutenants'. As a result NHS planning has often borne no relation to primary healthcare, patients' underlying needs and the relevance of the care provided out of hospital through social services. The dominance of the hospital sector over primary and social care has exalted specialist intervention over the general disciplines of prevention and continuous care. And it has been near to impossible for elected local government to couple the assets of the NHS to a wider strategy of economic and social development.

Whilst half-hearted attempts at bridging the gap were evident through the decades after the Atlee government, the grip of the medical profession, at least that part which acted collectively, consistently sought to reinforce the divide. The Redcliffe Maud Royal Commission in 1969 went as far as recommending that

the NHS be brought within a new system of local government – the response of the Lancet was to declare that, “*administering the health service is too serious a matter to be shared with the citizenry*”.

The separation deepened, therefore, and the focus of NHS planning and national debate inevitably centred on hospital provision. The 1962 Hospital plan was both far sighted (establishing a hospital building plan for the next decade) and resilient (in that it created the District General and Teaching hospital structure which sustained for much of the next 50 years). However, it could do no more than *implore* local bodies to undertake a similar exercise in the hope that the two parts would fit. The fragmentation was acknowledged but seemingly impermeable and was reinforced for the next 40 years through the removal of the medical officer for health from local government in 1974, a move that would have been incomprehensible at the start of the 20<sup>th</sup> century in the midst of the huge public health gains that had created some kind of bridge between sanitation and sanatorium.

The separation and fragmentation certainly explain the felt absence of co-ordination of care and support, but becomes a source of serious divergence when we track the changes in the burden of disease over the life course of the NHS. In the 1940s and 1950s the compression of morbidity was a consequence of

the ruthlessness of catastrophic health events from which few people survived. Over the past 4 decades the lengthening of the same period occurs as people survive multiple serious events and live with the consequences of stroke, heart attack, and cancer survival. Whilst this change in the purpose of health care could be seen in the formulation of social work and social care as professions in the early 1970s the meaningful connection between NHS care and support for people with long term illness and disability never progressed to a single unified arrangement. In 1948 the split settlement between health and social care, resulting in parallel Acts of Parliament, was merely a fracture, mainly due to the small numbers of frail elderly and the large-scale institutionalisation of the disabled and mentally ill. By the 1970s and 1980s the fracture was a growing chasm, the breadth and depth of which continues to grow to this day. It is no coincidence that from the late 1960s we see a growing body of literature, not just in this country but across the developed world, exploring the need for more effective continuity of care and the integration of disparate interventions.

Our lack of success in adapting the health and care system over this period is not a failure of intellect or imagination but an inability to overcome the height of the walls between hospital, general practice and local social care provision – legislative, financial, cultural. Perhaps the die was cast from the point that Herbert Morrison lost the Cabinet battle with Nye Bevan over

the need to bake in some form of accountability relationship between at least parts of the NHS and municipal government. But this in itself may not have been sufficient when one considers the scale of impact of the misalignment of funding regimes between one part of the service free at the point of use and funded from general taxation, and another means tested and requiring co-payment. The separation created all of the opportunities for cost shunting between the NHS and local government as full responsibility for funding community care services transferred from the DSS to local authorities.

In spite of the resilience and stability of post-war settlement, we can recall the turbulence which certainly touched the health service as the post-war settlement was deconstructed through the 1980s. There was no shyness on the part of the think tanks and intellectual parents of Thatcherism to open a clear debate on individual commercialism versus socialised medicine. However, the certainty that people did not want a privatised health service was held through the tenure of successive Secretaries of State including those, like Ken Clarke, who remained surprised at their appointment because their attachment to the NHS was so public.

We should now take a look out of the window at this point and reflect on where Greater Manchester was at this moment of what passive observers might call intellectual turbulence and

what local actors might more rightly recall as a civil war with the post-war settlement as the battleground. The Greater Manchester Council was abolished in 1986. Or spelt out more clearly, a logical construct reflecting a direct boundary connection of 8 out of 10 of the local authorities to the city of Manchester was dismantled in line with a commitment in the 1983 Conservative manifesto.

The collaboration, however, was not fully extinguished as, alongside some of the functions devolving to the ten Districts, GM retained a series of Joint Boards including those for emergency services and public transport to be run on a county wide basis and serve as a platform for collaboration which was to become more important as the next 30 years played out.

This sense of 'so far, but no further' in relation to health and the spread of commercialism through the public realm did effect some significant change as, on April Fool's day in 1991, the NHS was divided into 'purchasers' and 'providers' and the internal market was established. Aspects of the changes, it must be said, again proved significant and resilient with the establishment of commissioning and GP fundholding which retain relevance in successor bodies today. It was also a switch which ultimately allows for the concept of a population health management to become a possibility as the budgets for a defined population are established in the NHS for the first time.

Additionally, the marketisation of provision ensured that competition between NHS providers becomes a recognisable feature of the landscape for all of the subsequent period.

So resilient were these changes that the election of New Labour, and the re-setting of the public service investment debate, in the end did not overturn the commercial features of the 1991 changes. New Labour under Tony Blair was elected with a promise to scrap the internal market and GP fundholding, and to replace competition with collaboration. The atmosphere of the 1997 election victory did explicitly challenge the effects of austerity in public service spending and openly sought to rebuild the public realm and the public's connection to their public services. The 2000 NHS Plan, however, whilst heralding a new financial settlement to bring the funding commitment for the NHS up to the European average, also adopts the principles of competition and markets, expands the PFI, or private finance initiative, to build scores of hospitals through private enterprise, and hires alternative providers to deliver some clinical services, while drawing up a vast array of performance targets and national guidelines in an attempt to create uniform standards of care.

This package was a serious attempt to square the circle of local and national relations and respond to the central tenets of the public's appetite for change. It sought to balance national

standards with local autonomy (in the form of Foundation Trusts and PCTs), and the novel development of incentives and levers for staff and organisations.

But it still sought to fix only what a Secretary of State with the tools of the NHS at their disposal was able to control. The application of a long screwdriver designed by Michael Barber from the corridors of Whitehall was actually just another expression of the feudal structure, only with the king in the form of the Prime Minister now seeking to exert direct control over his dominion.

But the targets that were set for the NHS had little to do with the founding principles of the NHS and Bevan's original vision recognised an opportunity for health creation beyond the simple absence of disease. Working close to the heart of the Blair administration in 98/99 as Secretary of the Urban Task Force, I recall there was no shortage of discussion and initiative with respect to the importance of health and addressing health inequalities, through the raft of policy developments on social inclusion. But my memory is that the NHS leadership were largely absent from the process. The unbridgeable three part separation seemed to have permanently frozen our perspective on the NHS and separated the giving of care from the creation of health and the maintenance of independence.

There were of course important voices that recognised the dangers of this separation and the missed opportunity it represented. The insight on the connections which needed to be made were captured in each of the Reports of Sir Douglas Black, Donald Acheson and Sir Michael Marmot.

Arguably, only Acheson had the good fortune to fall onto fertile national ground. He managed to inform the introduction of national Health Inequalities targets and the creation of Health Action Zones, Healthy Living Centres, Health Improvement Programmes and the New Deal for Communities which started to connect the previously ignored determinants of health.

Both Black and Marmot saw their reports received in colder climates.

Those steps in relation to local autonomy and, in particular, the introduction of the Primary Care Trusts however were significant. They set an alignment between the local NHS and local government which felt relevant and right. In Greater Manchester, the second phase of PCT development secured a geographical alignment close to coterminosity between ten councils and ten PCTs and the partial realisation of joint health plans and joint commissioning arrangements which allowed for the pooling of budgets, the development of joint roles and joint services. The tectonic plates may not have been fused, the

embedded cultural differences were stark, but at least a step could now be made from one to the other.

This is the start of the Greater Manchester NHS thinking more deeply about the relevance of place. Beyond the local level and the marriage of PCTs and Local Authorities, the NHS in GM saw and mirrored the collaboration which had led to the establishment of the Association of Greater Manchester Authorities (AGMA). The Association of Greater Manchester PCTs established a formal vehicle to collaborate beyond individual boundaries and facilitated the initial opportunity for AGMA to engage with the local NHS in a way which Strategic Health Authorities, with the honourable exception of Dame Ruth Carnall's team in London, were not particularly receptive to. That collaboration saw the joint commissioning of more complex acute services and took the opportunity to support the development of more concentrated acute responses to stroke, heart attack and major trauma. The roots of those changes supported the development not only of healthcare commissioning in GM, but also of the mechanism for provider collaboration and what we might term GM Acute Services. Their sustainability, when we consider the development of those services occurred through a network without an authoritarian imperative (through an SHA) is remarkable – the Hyper Acute Stroke Service, established in 2009 this year ensured that all stroke units in GM reached category A rating,

the very best provision in the country. Against the turbulence of NHS change over the same period this indicates the connections informed by common purpose and anchored in place can have great resilience and the greatest potential to do good.

In these early breakthroughs we see signs of a new organisational model developing as an alternative to the 'command and control' top down system. It is a more organic model, more cellular, with different organisations and teams combining to secure common goals by pooling skills, using evidence to build consensus, and then focusing on diffusion of the agreed changes through the whole system. It is a more flexible model with much greater permeability for ideas to flow across boundaries and where far more people get to lead. It recognises that leadership can come from multiple quarters – clinicians, absolutely, but also nurses, other health professionals, social workers, local politicians, carers and service users themselves - experts through experience. It speaks to a genuinely collective model.

So, while the devolved system formally began on 1 April 2016 the antecedents of the changes we are currently progressing, and even through the relationships which currently exist, are visible in the latter half of the last decade.

## **Breaking New Ground**

The financial crisis of 2007-8 triggered a unique reaction amongst the political leaders of Greater Manchester's Councils. Instead of separating and retrenching they opened and explored.

At this stage AGMA, as a voluntary collaboration had twenty years of joint work under its belt including the development of Metrolink, the city region's tram network, and the ownership and operation of the Manchester Airport Group. AGMA developed as a body that expected to do work together and developed increasing levels of ambition and self confidence in that work.

The response of Greater Manchester to the financial crisis was to interrogate the settings of the UK economy and Greater Manchester's own role within it. It didn't seek comfort or cover for the consequences of the crash, but rather to take responsibility for its own role in informing the response. That interrogation was focussed solely on what drives successful places and successful lives and resulted in a bid to be awarded statutory status as a city region.

To get to that stage, GM had to open itself up to a deep interrogation of its potential and current operation. This was

done through the commissioning of the Manchester Independent Economic Review (MIER). The MIER was a bold step. It didn't seek to play to local prejudices confirmed by a cosy committee of trusted partners, but opened GM up to an analysis which asked an unimpeachably independent panel of global experts a straight question on GM's economic potential.

The response which came in the final report provided a series of challenges which have informed GMs activities and intentions for the 8 years since. The analysis firstly, confirmed that GM was a single, coherent economic geography and needed to be recognised, planned and progressed as such. This was the prompt for the re-establishment of a statutory vehicle to secure the collaboration of the councils and ultimately secured the creation of the City Deal and the Combined Authority.

Alongside that finding was the challenge that GM would not realise its potential until its people realised theirs. That children needed a better start if they were to progress through successful school careers and into productive and rewarding working lives. Significantly, for health partners, the review confirmed that the health status of too many GM residents prevented or shortened the quality and length of their working lives and was acting as a drag not only on their own prospects but the whole economy.

At this moment, on this finding, devolution and the relevance to the health system is confirmed. We have to see whole lives in whole places and be realistic about the relevance and limits of our contribution. We can set the separation between different sectors and organisations aside and view the process of investment, impact and dividend in the currency one GM pound as we begin to explore the potential of scaled integration and what that means for the future of public services. We can accept the limitations of public services without the active participation and control of the citizen. We can see the resources which come not from supplications to Government, but from the release of talent and energy in the people and the alignment of organisations to common purpose and principles.

These principles are worth re-stating as they signal a new deal between citizens and the state which supports the empowerment of local communities which is at the heart of our approach. They herald new relationships that enable shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services - do with, not to. They embrace an asset based approach that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits. They speak to the need for behaviour change in our communities that builds independence and supports residents to be in control, rather than stigmatising and isolating through labels such as 'troubled

family'. They reassert the importance of neighbourhoods and communities of identity – place-based approaches from Glodwick to the Gay Village - that redefine services and place individuals, families, communities at the heart. And they are principles that demand a stronger prioritisation of wellbeing, prevention and early intervention.

I do not believe it a coincidence that the same exploration of a place-based approach with many of the same conclusions was now starting to permeate at least some parts of central government and enthuse local authorities in many parts of the country. The Total Place programme introduced in 2008 allowed geographies to explore whole budget models for managing population needs, and was influential in the rise of co-operative councils and on our devolved model of governance. The long screwdriver was slowly retracting with an end to Local Area Agreements and distant performance management. Only in the NHS has the addiction to top-down performance management stayed intact, finding responsive paths down the hierarchy.

This narrative and the connectedness within and across GM was proving to be more magnetic than the management of the Lansley Reforms leading up to the 2012 Act. Indeed, the new GM CCGs were proactive in connecting and collaborating as a group of NHS commissioners and as a partner to the GMCA.

By 2014, only one year on from their formal authorisation, the GM CCGs were publicly consulting on a package of hospital reforms, Healthier Together, underpinned by clear ambitions on integrated neighbourhood care and primary care access proposals, which carried the public backing of all ten Council Leaders.

The most significant positive development of the 2012 Act from GM's perspective was, the establishment of the Health & Wellbeing Boards and the return to local government of public health, at last providing a forum with statutory roots for the NHS and local government to plan formally for a defined population. Allowing that to be mirrored through the same period by the GM Health Commission informed the development of a new ideology for health and social care transformation, building on those reform principles and responding to the challenge produced through the economic review.

The analysis which emerged confronted GM's historic patterns of health demand and activity and the outcomes which that pattern drove. It confirmed that we had operated and contributed to a model of care which was configured for crisis, rather than early intervention or prevention. We had developed expertise in planning hospital capacity for the crises we were failing to head off. We had knowledge of the burden of disease which was not matched by plans to find and treat those known

to be at risk but not benefiting from proactive care – the ‘missing thousands’ on no disease register in their GP’s practice. We had seen the intentions to roll out fully integrated neighbourhood teams frustrated by the absence of sufficient levels of one-off investment which ensured we became stuck at a point of tantalising pilots with the luminescence but sadly also the longevity of shooting stars. We lived by the side of a world top 50 University and acknowledged our lack of pace in bringing innovation from discovery to routine application.

Whilst the Lansley reforms did little to feed our response or enable its realisation, the Five Year Forward View did excite local interest. It spoke to readers beyond health. It had something to say and did so in a language which engaged local government partners. GM was keen to represent a response to that document. Indeed GM was keen to offer NHS England their largest and most connected test bed site – in return for health and social care devolution.

The 3<sup>rd</sup> November 2014 saw Greater Manchester agree a landmark move that was hailed a ‘revolutionary’ moment in local government in England. The deal agreed between the 10 council leaders and the Chancellor of the Exchequer established a devolution package that would give the region an elected mayor in exchange for control over skills, transport, housing, and economic development. An agreement to take

power over the city region's £6bn health and social care resource would follow just three months later as a significant national first.

It is worth reflecting for a moment on the level of audacity these two agreements reflected. Firstly it was clear that GM was representing the level of buccaneering ambition from which self-confident local government leadership grew a century and a half previously. That leadership was clear it was the fulcrum of local wealth and place creation and not solely the administrator of reserved social functions. The existence or otherwise of a 'Ship Canal mentality' is almost a fable, but does feel like a peculiar Greater Mancunian reality which treats the inconceivable as merely inconvenient and assumes possibilities exist to be aggressively pursued. If you don't know the story, then imagine the audacity of weighing the imposition of new taxes from Liverpool; settling on a refusal to pay; and embarking on the construction of a waterway so vast only three ships in the world were too big to sail upon it.

The Health & Social Care Devolution agreement does come with its own degree of audacity as it was done with a clear view on the level of fragmentation, the extent of improvement and the depth of financial challenge which it sought to overcome. After 70 years of perpetual reform without ever addressing the fundamental problem, GM's response was, enough, hand our

precious NHS over, we'll seek to repair the foundations, fill the chasm and build something new that meets the needs of our population now and in the future. Was there a degree of over-confidence in that move – probably; was the emerging partnership entirely unified in its motives – almost certainly not. But we agreed on enough and we leapt.

## **Taking Charge**

Our reform programme is built on the need to reimagine services across our whole care system. In crafting the plan we asked only one main question – who contributes to health creation and how can they be connected?

Through our population health plan we are adopting a life course approach that looks for every opportunity to promote self-care and mutual care across our communities, from promoting smoking cessation during maternity to improved nutrition and hydration in the final years of life.

Through the transformation of community based care and support we are enhancing our primary care services, with local GPs driving new models of care and Local Care Organisations (LCOs) forming to include community, social care, acute, mental health services, the full range of third sector providers and other local providers such as schools. We want LCOs to be

the place where most people use and access services, in their communities, close to home.

Through the standardisation of acute and specialist care we are proposing that NHS providers across GM increasingly work together and collaborate across a range of clinical services. We want a sector which is functioning to the best clinical pathways and the highest level of productivity so people get high quality care when they need it. We would rather see collaboration than competition.

Through the standardisation of clinical support and back office functions we are proposing to redesign our services to meet the delivery and efficiency challenges of a redesigned care system. We want clinical support services which deliver at locality level and back office functions which drive the best possible service models for procurement, pharmacy and estate management. In enabling better care we are proposing to work together to look at the most effective way to deliver our new care models and deliver standardised offers. We want a radically redesigned payment system to drive care in localities, we want technology to support this, we want an innovative and real time approach to research and development and we want one integrated approach to managing our public sector buildings.

We don't believe there is any element of this approach which has not been tested before, but we are not aware of any place

in the world which has implemented them all within a single programme.

What we have done is shop globally to source the ingredients for our recipe and so I would like quickly to take you round the world to share where we have drawn our inspiration.

Our first stop is Finland and North Karēlia's approach to tackling mortality rates due to lifestyle. In the 1960s, the province of North Karēlia, Finland had one of the highest mortality rates from heart disease. The community appealed for help, and in 1972 authorities partnered with the World Health Organization (WHO) to launch the North Karēlia Project, which "aimed to transform the social and physical environment of North Karēlia." Experts found that North Karēlians were at risk due to many lifestyle choices: a high smoking population, and an unhealthy diet including excessive salt and butter. Most of the interventions were conducted at a community level involving health services, schools, local media campaigns, supermarkets, food industry, and many others aiming to reverse these high-risk tendencies.

From North Korelia we have drawn our commitment to a comprehensive population health programme.

Our second stop is Alaska and Nuka's approach to person centred primary and community care. Nuka was developed in the late 1990s after legislation allowed Alaska Native people to

take greater control over their health services, transforming the community's role from 'recipients of services' to 'owners' of their health system, and giving them a role in designing and implementing services. The Nuka System of Care incorporates key elements of the patient-centred medical home model, with multidisciplinary teams providing integrated health and care services in primary care centres and the community, co-ordinating with a range of other services. This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services – for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle domestic violence, abuse and neglect across the population through education, training and community engagement.

From Nuka we have learnt that it is the £22 billion we spend on all public services that needs to be bent towards the goal of improved health, not just the money we spend on NHS and social care.

Crossing North America, we next land in Staten Island and their approach to population health insight – passing over the offers from major consultancies and health management corporations, the health leadership in Staten Island trusted its own ability to interrogate the causes of health decline by pulling all of its geo-social-economic and health data into a single

visioning tool. It could ask questions of who was suffering from what kind of illness in which part of the island and, through the breadth of its data sources, begin to explain the causal factors. For example, by identifying the prevalence of childhood asthma in a neighbourhood containing the Island's largest freight depot where hundreds of lorries had their engines idling for large periods of the day and night.

From Staten Island we gained the resolve to develop our own IMT architecture plan so that we ensure that the right data is used for the right purposes for the benefit of improving the health of our population.

Crossing the short distance to the Bronx we admired Montefiore's recognition of the healthcare benefit of investing in prevention from health budgets – for example, the Montefiore hospital provider responded to its predictable patterns of respiratory crisis presentation in summer through the purchasing of air conditioning systems in patients' homes where their risk was greatest. A novel, but small investment from a hospital directly affected patterns of demand and delivered a return in saved costs direct to the hospital.

From Montefiore we learnt that it is about every provider on the care pathway owning the whole pathway and working out the most effective means of intervention.

Crossing so many time zones you probably feel rather dizzy as we arrive in Japan and are humbled by the volunteer-led examples of dementia care and support – recognising that if we get it right for people with dementia, our entire approach to person centred care which mobilises the kindness and gifts of neighbours and communities will be improved. Dementia Friends, open house provision, peer carer support, 24/7 helpline, neighbourhood watch style approaches looking out for and helping ‘wanderers’ and boisterous karaoke all become part of an approach which builds its own momentum to connect individuals, business, carers and healthcare organisations.

From Kyoto we learnt that our voluntary and community sector are equal partners and are often the right people to lead our work.

And now our own examples of best practice are starting to emerge at every level.

Our Focused Care programme is placing social workers in GP practices in our most deprived areas so that we can adopt a holistic approach to understanding and meeting people’s needs.

Our 0-5 dentistry programme is ensuring good habits for some of our poorest children.

The majority of our primary care practices are now fully trained by the LGBT community in how better to meet the needs of LGBT citizens.

Our health and employment programme is getting more long term employed back to work than traditional JCP programmes.

We are connecting digitally our care homes so they gain more confidence and provide more holistic and proactive care for their residents.

And while the small stuff matters most, we are sweating the big stuff too. We completed the merger to create the biggest Hospital Trust in England in twelve months from start to finish. That becomes possible when collaboration is the dominant value.

Of course we still face many barriers and problems. The combination of rising poverty, an ageing population, fiscal constraint and a depleted workforce creates a headwind whose strength sometimes seems that it will thwart our best efforts. But we remind ourselves that our success will not be determined tomorrow or even next year, but rather a generation hence.

We worry that our pace may not be sustainable, are we trying to do too much at once? But then, as one of our partners said

in our last stakeholder review, *“We can’t go any faster but we can’t afford to go any slower”*

And, of course, we know that there are vested interests, mainly outside Greater Manchester, who do not want us to succeed, some for the very same reasons that caused the fractures seventy years ago.

What we can say with confidence is that the building blocks for the transformation in GM are now clear. We have committed to clear objectives to establish a comprehensive population health management model to serve all residents.

That model has three recognisable and consistent features:

- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten districts.
- The establishment of the Local Care Organisation integrating provision across the districts.
- Establish new models of hospital provision seeing hospitals working together in GM at a much greater scale than ever before to a set of consistent quality standards.

The three pillars described above will be supported by a set of GM-wide enabling functions across workforce, digital, estates and medicine. These will include Health Innovation Manchester – driving the diffusion and adoption of innovation at scale

across the conurbation. And a Commissioning Hub to develop common standards and improve commissioning skills across the conurbation.

## **The End of the Beginning**

As I draw towards the close let me loop back to where I started and consider how our devolution efforts are correcting the deficiencies identified at the outset.

Whilst the new hospital models will test and challenge organisations to find meaningful vehicles for formal collaboration and the establishment of single services, I would accept that this is a natural development building on the changes to hospital services since the National Service Frameworks in the 2000 NHS Plan.

The establishment of the Local Care Organisations however is arguably the most significant provider development since 1948. In terms of scale and ambition, this is the response to Acheson, Wanless, Marmot and the Five Year Forward View in a single step. The formalisation of health and social care provision, the mechanism to incorporate action on social determinants and the humility to facilitate from the individual and the community that which cannot be provided from the state is truly radical.

We are starting to see the stories emerge now as to how the operation of the LCOs, even in their nascent form, and particularly at that 30-50,000 neighbourhood level, are starting to change lives, and change outcomes. In addition, we are starting to see our faith in bio-psycho-social models of care and support rewarded – whether that is through the integration of mental health and social support services, such as debt advice, or an example such as the Salford Lung Study, where drug development becomes a matter of understanding population behaviours, not just about the efficacy of a product.

Additionally, we are excited by the developments which have occurred which we never recorded in our plan but suggest that the changes we pursue generate their own momentum and attract new energy and new partners. So the formalisation of opportunities with the VCSE and Faith Sectors, with the Pharmaceutical Industry, with Sport England, with both Greater Manchester Police and the Fire Service, each broadens our solution set and strengthens our resources and assets.

The pooling of resources provides the best available means of softening the funding misalignment between health and social care. However, a full reconciliation between the natural and human relationships and requirements which should provide the logic for the ways in which health and social care is funded has never been achieved. The level of serious bi-partisan

consideration given to a conclusive settlement on social care funding suggests it still stands as the ‘third rail’ of health and care reform. In this respect we do look to the likes of Japan and Germany with envy. We can only hope that the forthcoming Green Paper will represent some real progress and we stand ready to help.

All of these changes will create tensions as the reality of the inconsistencies in the legislation are severely tested. Most profound will be the tension between the integration imperative and the retention of compulsions towards competition between providers. Integration at scale, that is at population level, does not have a ready market and is always more likely to be addressed through the consolidation of existing, place based providers.

The next turn of the wheel for GM could either be legislative, where our approach informs a new national settlement, beyond the Lansley Reforms and the Five Year Forward View, or drive a broader devolution settlement. Either is conceivable and we remain open to exploration with national partners. Whichever of those developments occurs, I believe we have taken steps which will prove irreversible. The establishment of integrated budgets, the increasing formalisation of multi-disciplinary neighbourhood teams connected as part of contractual joint ventures, the mobilisation of wider public services to ensure we

remain committed to pursuing health potential and the placing of the interests of people and place above individual organisations is not something we can now turn back from.

As we move towards the 70<sup>th</sup> birthday of our NHS, we are engaged in an urgent task of renewal and reinvention, to create a health and care system fit for 21st century needs and priorities. We pursue a paradigm shift that is wholly contemporary but also fully rooted in the original vision for our NHS – a social model of care for the people by the people, our people.