A Different Way: Lessons from the Greater Manchester Devolution Journey’

Chief Officer of the Greater Manchester Health and Social Care Partnership Jon Rouse CBE
Introduction

Five years ago, Greater Manchester struck a deal. It’s NHS and local government organisations would collectively take responsibility for oversight of the National Health Service and use the associated powers and resources to lever the whole public service economy in support of creating a system of population health. Greater Manchester would also deliver the NHS’s own national plan, the Five Year Forward View at pace. In return, the Government and NHS England committed four forms of support between them – delegated freedom to act, an aggregation of transformation funding, a settlement for social care and a planned capital settlement. The first two of these commitments were delivered, the other two have not been fully delivered yet.

Greater Manchester has kept its promise. Through effective and binding governance and the injection of Mayor authority from May 2017, we are creating a system of population health, where all public policy-making is now bent towards improving people’s health. Planning policy, transport policy, housing strategy, child development, tackling worklessness – these and many other policies increasingly have health at the centre.

At the same time, a much deeper movement is occurring. By enabling charities, business and academia also to put their collective shoulder to the wheel, we are kindling a social movement where our citizens are demanding better health, and we are able to provide the opportunities for them to get fitter, healthier and more connected.

Impact

The results speak for themselves. Through this period of austerity, the Index of Multiple Deprivation shows that Greater Manchester has become relatively more derived. But when we look at the health and wellbeing sub-index we see something different. While in some cases the gains are marginal, nine out of ten districts have improved their ranking and all ten have fewer districts in the 10% most deprived areas for health than they did in 2015.

There are reasons for optimism. We have fewer people smoking, fewer unsafe births, more children getting a healthier start in life, an improved mental health offer, increased levels of physical activity, improved cancer survival rates, more opportunities to overcome health issues and get back into work, more focus on preventing premature frailty, a big rise in social prescribing to reconnect people and prevent isolation, fewer people in residential care and more people living independently. And I could go on.

And yet, when you look at some of our key NHS constitutional standards, we, along with the rest of the country have gone backwards. With the exception of mental health access and waiting times which are significantly improved for children and adults in GM, we are struggling
as a system to meet demand. On cancer and elective care, we held on for much longer than most of the country in maintaining the key Referral-To-Treat and Cancer Standards but now we too have slipped down the slope of scree. And on the key A&E standard of 4 hour waits, Greater Manchester has struggled. While some of this is a product of demography that does not tell the whole story.

On one level the story of devolution to date is counter-intuitive. Shouldn’t those goals that are more open to managerial intervention shift first? If you have demand pressures, then create more supply, improve flow, increase productivity. And shouldn’t those objectives that require a genuine shift in outcomes through changes in behaviours and multi-systemic influence, take much longer? Yet we have seen a different pattern. Why is this?

The formal quantitative evaluation of the first two years of devolution is not quite complete but I am confident that it will show a similar pattern – that there has been a discernible and distinctive shift in dynamics at the community level – more confidence in ability to self-care and improved impact of primary and community care, but much less impact when you study the way that the NHS itself is functioning, particularly in the acute phase.

Recognition

In this final lecture, I want to do three things. I first want to explore why this emerging pattern of the devolved system in terms of what we have got right and perhaps what we have got wrong? I then want to look at what all that means for Greater Manchester going forwards, what should change and evolve. And finally, what might be the implications for national policy in this next period? In addressing these questions, I would stress that these are my personal views and remarks. I’m not on this occasion speaking on behalf of the Partnership.

I will start though by recognising three individuals who have been critical in our story to date. Of course, many other people have contributed but these three have been pivotal. The first is Sir Simon Stevens. It is not an exaggeration to say that without Sir Simon’s continued quiet patronage, devolution may well have folded. It is testament to his character that he has given us the space to get on with it, including sometimes to fail. I never lose sight of the personal risk this entails for Sir Simon. He remains personally accountable to the Secretary of State and Parliament for everything that happens in Greater Manchester. And yet he has been permissive and supportive.

The second is Lord Peter Smith, ex-Leader of Wigan Council and Chair of the Partnership Board. When devolution was first constructed it is fair to say that there was anxiety among some of the senior NHS leaders about what they perceived as the local politicisation of the NHS. Peter’s wise and calm leadership has defused much of that concern and enabled the Partnership to become deeper rooted, as trust has grown. Even in the last few weeks, following my decision to move on, it has been rewarding to watch NHS and local government leaders getting around the table, sleeves rolled up, working together on what should happen next.

And the third is the Mayor of Greater Manchester, Andy Burnham. As well as the personal support and challenge he has given me, it is the Mayor, working with the Council Leaders, that has facilitated the creation of this much bigger policy arc, that properly joins economic development and public service reform. This bridge has allowed population health to start to infuse the rest of public policy and of course vice versa, as the NHS starts to recognise its responsibilities with respect to homelessness, child development and positive ageing.
However, before this starts to sound like an Oscar acceptance speech without a statue, let’s inject a dose of reality. We should be under no illusions that the devolved health and care system is at a crucial junction. On the surface it may seem set fair, with a new Government that is making positive noises about devolution and a commitment from the national NHS bodies through to 2024. The GM Partnership is in the process of preparing its second delivery plan. There is agreement from NHS England that GM will have complete control of at least the fair shares funding under the national Long-Term Plan and can expect control over some of the targeted funding as well.

Most importantly, we have mature and increasingly confident local governance and leadership. GM has proven it can get important stuff done. Indeed, Greater Manchester remains the only real example of NHS and local government coming together as a truly equal partnership, where the important decisions are taken together; the only place that has resolved the fracture in the 1948 NHS settlement that separated local health services from local democracy. We have a partnership with the proven ability to deliver; dare I say, a partnership that is oven ready.

However, there are real risks too. I worry about the number of layers of management in the NHS – many different national programme teams, regional offices, Integrated Care Systems and Clinical Commissioning Groups – it’s a crowded field that arguably raises an ethical as well as a managerial problem, particularly when we look, say, at the cuts that the local government or police sectors have had to absorb over the last 10 years. As well as the cost, this number of layers and sources of management oversight runs the risk of slowing down the process of transformation as local systems are continuously forced to look up rather than out.

There are though equal risks for Greater Manchester itself that cannot be attributed to the national construct. For all the benefits of formality, decision-making in the devolved system can be slow at times. There is still an understandable tendency to hide behind a sense of fiduciary duty to one’s own organisation rather than what is genuinely in the public interest for Greater Manchester as a whole. And there is real variation in to the extent to which individual localities have grasped the once-in-a-generation opportunity of devolution, and the transformation resources that have travelled with it, to bring about radical reform of their models of provision. All have moved forward, but the distance between the ‘maillot jaune’ districts and the ‘lanterne rouge’ is greater than we started, and just as we are about to enter the higher mountains.

So first, let’s look back in some more detail in the journey travelled to date. I will start with three things I think we have we got right and three key lessons I think we’ve learned, which might help explain why we have made an impact on some of the key determinants of poor health but struggled with some of the NHS standards

Positives

The first major positive was that GM had and has a clear rationale for wanting the devolved model. The driver for devolution was the understanding that poor health was acting as a massive barrier to the economic development of the city region and to addressing inequality in accessing economic and social opportunity. The driver was not to integrate health and care, which was always just a means to an end, and a pretty limited means at that without the rest of public service.
The clarity of this rationale was writ large across the first five-year plan – Taking Charge. In defining five key outcome goals, GM chose outcomes that it was impossible for the NHS to meet alone - healthier babies, improved school readiness, more people in work, more older people living independently, and reduced mortality from killer diseases – every one of these requires a whole system effort.

And with the exception of mortality from cardio-vascular and respiratory disease, GM can show evidence of progress on every one of them. We have concentrated on what we believe matters most and will make the biggest difference for the GM population. This doesn’t mean that we think constitutional waiting time standards aren’t important – they are - for safety, quality and experiential reasons – but they are not the most important goals. And so, what we need here is a rebalancing at both GM and the national level. GM has to strive to do better in meeting the constitutional standards. And Government and NHS England need to design a constitutional scorecard that cares as much about mortality and morbidity, as whether people are waiting too long in the A&E waiting room.

The whole of the first chapter of the Five Year Forward View was dedicated to population health. And yet across the many formal assurance meetings I have led on behalf of GM with NHS England, I have not been held to account for population outcomes, not asked about levels of mortality or morbidity. When we have walked into that room, it has sometimes felt that we have to leave our mission and purpose at the door. That needs to change, not just for GM, but the whole of the country.

The second real positive is that we recognised the crucial importance of primary care from the outset. We gave primary care equal status in our governance structures, we invested early in 100% extended access and support through the GP Excellence programme. We ensured that all of primary care were able to contribute fully through their different specialist networks. Most importantly, we didn’t do unto primary care but rather facilitated a peer-based model of development. We gave the localities freedom to invest further in primary care and to develop networked models aligned with wider neighbourhood multi-disciplinary team working. We also supported the development of Primary Care Organisations where this was the preferred model of organisation.

While primary care remains pressured and fragile, we have undoubtedly reaped a significant dividend. Based on weighted population, overall GM has fewer hospital bed days than the rest of the North West and England as a whole. We have seen a significant reduction in GP referrals into the elective system. We have high quality general practice based on CQC ratings, improved access to NHS dentistry and widespread involvement of pharmacies and opticians in health and wellbeing programmes.

And then came the nationally contracted Primary Care Networks. I understand the driver for PCNs. Based on the vanguard programmes and the large variation in primary care engagement in Integrated Care Systems across the country, a national contracted model can cut through. Even in a mature system here in GM we have seen benefits, with a fresh cadre of medical leaders coming forward and an acceleration in areas of GM that had been relatively slow in the development of neighbourhood models. However, the cost has also been high in dismantling structures and roles that were already in place to accommodate the strictures of a national mandate. And of course, there is more to come. The draft national specifications go beyond the definition of common target outcomes to prescribe ways and means of practice. If adopted in their current form they will cut across many decisions that have already been made in Greater Manchester under the devolved model, and indeed could erode a key principle of devolution which was that NHS England defined the ‘what’ and GM should have freedom to define ‘how’ services are provided. I therefore hope that NHS England will recalibrate and
move back to an outcome-based model that facilitates PCNs to engage fully with their Care Systems and allows for local design and innovation. I know Greater Manchester would be very willing to act as a testbed if there was an appetite for a more system-based approach.

The third big positive is that GM has been clear about the preferred care model and has invested consistently in its creation and evolution. It has avoided over-rigidity and allowed the ten localities to develop variations that fit with their own demography, history and political (small ‘p’) philosophy. At times we have perhaps given too much discretion, but I am glad that we erred on that side of the equation. The consequence is that in the large majority of districts we have an integrated commissioning system between NHS and local government, and the most advanced areas are now starting to extend that to children as well as adults. And again, with one exception, we have a local care organisation or alliance in each geography.

On both commissioning and provider side we have clinical leadership to the fore, in both governance and executive structures. Our models require a genuine commitment to adaptive system leadership, that view every £1 as a locality pound, and that means open book working and the relentless pursuit of shifting resources out of the hospital and into communities, and from specialist care into prevention and early intervention.

When combined with the clarity of governance at GM level, these models have given us one very significant additional benefit – financial grip. By taking a system approach to finances and managing flexibly across both the NHS/local government and the commissioner/provider divide, we have done what the rest of the country has struggled to do – live within our means. At the start of our five-year plan, there was an identified £1.1 billion gap by 2020/21 if we did nothing. Through organisational discipline and astute application of transformation funding we have made significant progress. We delivered a cumulative £440m surplus over the first three years, effectively paying back the fair share transformation resources we received at the outset. Perhaps uniquely, we safeguarded every penny of transformation money to spend on transformation programmes and projects. That is why we have been able to invest so strongly in population health programmes, in primary care, improvements in mental health services and in establishing a neighbourhood model of care in GM’s identified 67 neighbourhoods.

**Lessons**

What about the lessons? The first is that GM made a well-intentioned mistake in asking for its transformation resources to be as heavily front-loaded as was the case. This meant that there was a pressure to make allocation decisions very rapidly and frankly before some local systems and programmes were ready to spend and spend well. It also meant we had to rely heavily on the intelligence we inherited from NHS England about readiness to deliver, some of which turned out to be right and some that was completely wrong. It has also meant that we have experienced an ongoing problem of slippage of resources between years. While this has given us flexibility it has created conditions of uncertainty when a more even distribution of resources over time would have allowed us to make larger commitments to programmes that could perhaps have done more sooner, such as cancer, diabetes or maternity.

The second lesson. In my opinion, and it may be only my opinion, I question whether it was right for the devolved Partnership to take delegated responsibility for oversight of the Clinical Commissioning Groups. With the benefit of hindsight, the mixing of formal regulatory responsibilities with a transformational ethos is a cocktail that sometimes gives an unwanted aftertaste. It is very difficult to propagate a model that is based on system working, pooling of resources and collective decision-making if one party, the Chief Officer, is walking around with a stick behind their back, however well hidden. While we have sought to develop a model of
assurance that is more system-based and inclusive, at times the statutory context has pulled us back to a mimicry of the very hierarchical call-and-response model that we were trying to escape from. At the same time, it has arguably hindered the development of a learning system based on the principle of continuous improvement, that we should be aspiring to, a subject which I shall return to shortly.

And the third key lesson. We should have loosened up more around the role of the voluntary and community sectors. That is a critique at both locality and GM level. When I look at some of our biggest successes, such as our mentally healthy schools programme, our Focused Care programme that puts social workers into GP practices or our early years development programme, the voluntary and community sector is writ large. I also don’t believe it’s a coincidence that those geographies that have trusted the voluntary and community sector the most, have made some of the greatest progress in shifting their model of care and taken real pressure off statutory services. We should have gone further, faster in that direction.

Hopes

It’s time though that I looked forward in terms of what I would want for Greater Manchester, and of course I want the best. We have built some fantastic foundations in the last four years, the positives far outweigh the negatives, so my hope is that the devolved system will go from strength to strength.

So, let me offer four main hopes for the GM system over this next period. The first is that GM gets bolder in choosing its priorities. It was probably inevitable but in the first period of devolution GM arguably tried to do too much and ended up spreading ourselves too thinly. Resources will remain tight in this next period so some hard choices will have to be made.

So, what should be the areas of focus?

The first and the most important is to continue invest in and build this overall system of population health, leveraging the wider public system to the cause. Within this sub-strand there will also need to be hard prioritisation, perhaps focusing on child development, nutrition & physical activity, and mental health.

The second is to continue to develop the effective neighbourhood model, including the role of Primary Care Networks, to facilitate self-care and proactively care for those who need extra support to stay well and independent.

The third would be to deliver a fully functioning urgent care system, including mental health crisis care.

The fourth is elective care reform, for the simple reason that the current elective system is completely unfit for purpose and costing us and the rest of the country an unnecessary fortune when that resource could be better deployed elsewhere. I am not talking much about ‘digital’ in this talk, but elective reform is one area where sustained investment in digital development could revolutionise the care pathway and experience.

And the final top priority for me would be progress in tackling four big killers – cancer, CVD, respiratory disease and suicide – to deliberately and unapologetically bend resources towards those pathways in ongoing clinically-led reform.
You will no doubt now all be thinking of what essential priority I have missed out and that is good and healthy. As I say it’s not for me to decide but what I do know is that hard choices have to be made.

**Children**

The second big hope for the future is that I would like Greater Manchester, across public services, but actually across the whole economy, to commit fully to the development of its children and young people as its absolute top priority – to become a child friendly city region. At present, we have a patchwork quilt – Mayoral led commitment to early years and youth opportunity, some districts doing some innovative work on safeguarding and opportunities for looked after children, but what it doesn’t add up to is a consistent and relentless focus. Educational standards – not good enough, SEN provision – inadequate in too many places, complex safeguarding for most vulnerable groups – progress made but still real risks.

And the NHS has no grounds for complacency either. Integrated commissioning for children & young people has to become the norm, we need greater specialism in primary care to manage common conditions better in the community, and we have to reduce mental health waiting times. There is in short, a lot that needs doing. If we believe that children and young people are Greater Manchester’s future, the leadership community has to start behaving consistently in a way that reflects that truth.

**Improvement**

And third, to return to an earlier theme, I would like to see Greater Manchester develop a systemic approach to continuous improvement of professional practice that becomes globally renown. In the first phase of devolution, we have focused on combining our research and innovation assets through Health Innovation Manchester. It was a shrewd move that has already drawn investment, skills and know-how to the city region. In creating that managed interface between system, industry and academia it provides clues as to how GM could build a similar system around practice improvement.

The Partnership has developed a range of different improvement systems and programmes in support of particular objectives. These have included the realms of general practice, pharmacy, maternity safety, early years development, children’s mental health and social care quality, all with considerable success in terms of shift in target outputs and outcomes. Some, but not all of this work, has been led by clinical networks which have also continued to lead systemic improvement work in other areas, such as community neuro-rehabilitation.

Other improvement work has been focused on organisations. Prominent examples are the Pennine Acute Improvement Board, the Stockport FT Improvement Board and the Pennine Care Strategic Advisory Board, where tools and resources have been brigaded in support of organisational recovery and development.

However, the overall effort would be best be described as partial and fragmented, and with a mixed track record with respect to timely adoption and diffusion of agreed standards and recognised best practice.

So how does GM change that dynamic. A good starting point would to agree an overarching set of principles to cohere the improvement work. This should be a clinically-led process but
involving other relevant professionals such as social workers. It should also be rooted in service user experience and contribution.

Where I hope they would reach is a universal commitment across the Partnership to pursue continuous improvement as an absolute priority, including a commitment to mutual support and exchange. And for GM to become a recognised centre of excellence in the deployment of improvement science in health and care, (and indeed wider public services), harnessing the capability of all relevant institutions in a common effort. It would require a shared commitment to participate in benchmarking and to share learning from improvement efforts openly and transparently, including where such efforts fail. It would mean establishing clinically-led governance and processes to enable rapid adoption and diffusion of proven methods, including effective use of the commissioning system. And perhaps most importantly it would mean prioritising training and development of staff at all levels in the methods and disciplines of continuous improvement, so that they can confidently participate.

If GM can get this framework right it would open the opportunity for far more members of the medical and wider clinical communities to participate in the GM devolution work, working in flexible communities of practice that can be confident that the product of their work has a route through to evaluation and adoption.

Race

Turning then to my final hope. It’s that Greater Manchester will start to get much more serious about addressing race inequality. Having worked in London for many years, it has been a genuine shock to come to Greater Manchester and experience the lack of empowerment and capacity of some of our BME communities in Greater Manchester. I feel this is particularly true of the African-Caribbean communities where I see amazing organisations like the Caribbean-African Health Network and the Mama Partnership putting in massive amounts of voluntary effort to support and advocate for the most vulnerable in their communities, with very little help or even much interest from at least some statutory bodies. I genuinely hope this will change and I know the Mayor has started a dialogue to this end, not least through the establishment of the faith/race panel.

These are then some of my hopes for the GM system. My final question was what needs to change nationally to support that ambition. Three key areas, which are workforce, (and specifically workforce planning), capital finance and local government funding.

And herein lie the real reason why Greater Manchester, like most of the rest of the country has struggled to maintain performance against constitutional standards. While we have made real progress in improving care for people in our communities, the combined headwind of workforce shortages, long-term lack of planned investment and an ageing population has sometimes proven too strong for us to overcome.

Workforce

Health and care workforce planning in this country is not in a good state and hasn’t been for a long time. There are two keys reasons which are related. The first is that we have tended to use the workforce planning model as a means of controlling expenditure. Essentially, what we have done is asked the NHS providers what they can afford and broadly based our numbers on the aggregation of their model. The second is that we plan largely on the assumption that the NHS operates in a closed supply market, rather than competitive market, both with respect to the other sectors such as independent health and social care, but also internationally. We have therefore created an in-built deficit model. Under-supply of key disciplines then leads to higher supply costs as well as greater pressure on the under-resourced workforce which in
turns leads to more burn-out, early retirement and hence even more under-supply. And of course, the whole equation costs more than if we’d planned properly, with contingency, in the first place.

What should we do differently? I would advocate two main changes. First, we should align workforce planning fully with strategy and commissioning. One national body could then work with the Integrated Care Systems to plan the future requirements as an integral part of overall planning.

Second, I would advocate loosening up in terms of public investment in training and development of the future workforce. For example, we have some of the best medical schools in the world. We have other universities who would love to establish a school. We have an offer that is and will be massively internationally attractive. We should allow the schools to expand more freely. Even if that means additional public investment in the training phase for domestic students, there are ways of clawing that back if individuals then choose not to work in the NHS, and if they do commit to stay, the investment will pay itself back many times over.

And we should be generous in other professional areas as well by aligning investment to the supply/demand equation. That was what was so strange about the original decision to take away the nursing bursary. It was a financial saving in the short term but very bad economics at the macro level and in the longer term, which of course the new Government is now rightly choosing at least partially to correct.

**Capital**

The second key area for attention, hopefully even starting with the Budget and Spending Review, is capital finance. Capital planning in the NHS is currently near to impossible. I have described it previously as like driving through fog. As an organisation or local system, you can draw up the best plans you can conceive, bringing in other sources of finance, but you still then find yourself like the Dalek at the bottom of the stairs. (Yes, I know they can fly now but respect my age.)

You are first faced with a beauty parade where persons unknown in a distant Whitehall land opine on the relative priority and deliverability of each individual project within your plan. What emerges from that process will almost certainly hole your carefully conceived strategy below the waterline. And for the projects that make it through, you then face the dreaded five case Green Book process, which must have been conceived by the Treasury’s very own Bellatrix LeStrange and Lucius Malfory, a ‘petrificus totalis’ spell that leads to suspended inanimation where the only certainty is you won’t be spending any capital.

I sense this Government really does wants to change this soul draining experience and get capital moving again. So, here’s how. First, there will be some very large projects that need to be negotiated directly between local systems and Government. We have one here in the form of the re-build of North Manchester hospital, backed personally by the Prime Minister. But for the rest, what I would advocate is that at least for the devolved systems and the more mature Integrated Care Systems, there should be a negotiated medium-term capital plan with an agreed set of priorities and an agreed allocation of resources. Assurance would then be at a plan or programme level, rather than individual projects, perhaps on the basis of an annual review. This would then allow local systems to plan their investment programme with confidence, able to level third party sources of matching capital and approach more complex mixed-use schemes with confidence. In return, Government should insist that every £ of public investment in the NHS is sweated to ensure that it delivers human capital as well as physical capital - requirements to work with local government on apprenticeships; on cheap,
sustainable energy; on social value for surrounding local communities; on freeing up land for key worker housing and so on. The deal would be greater certainty for greater value.

**Care**

Finally, local government funding. I am so grateful to the local authorities in Greater Manchester for the role they have played in the devolved journey to date. They have stepped up and then some. Where else in the country do you find local authorities loaning resources to the NHS in more difficult financial years, entering into really challenging risk share arrangements and pooling their resources at a major scale. Local government has borne the brunt of austerity and thus the populations they serve. We all know that the price has been high. It would have been really easy in those circumstances for local authorities in GM to bunker down, to try to ride out the storm. For the most part, they have done the opposite. They have been radical in their service designs. They have cared less about who delivers services and more about the quality and impact of what gets delivered. They have got their own house in order, reforming public health services, driving down delayed transfers of care and driving up quality of social care.

But now, after ten years of austerity, they really have very few places to go. The cracks are showing, on children’s services in particular but also in specialist areas of adult services. I hope that we are now heading for a period of re-investment, particularly in those areas that would make a massive difference to the whole health and care system – in adult social care, in dementia, in Special Educational Needs, in public health, in early years development. That would produce the very best dividend for the NHS and more importantly the populations that need those services.

**Conclusion**

To close, four years is not a long time in the history of our NHS and certainly not the history of municipal government. It’s certainly not long enough to make certain judgements on a devolved model.

I have had the privilege of leading this pioneering journey on its first leg. I cannot see clearly the terrain that lies ahead so you had better weigh my words carefully for I am the one turning off the road, not the one travelling on. I am heading to Stoke-on-Trent, back to my spiritual home of local democracy, and with that, a return to the more careful vocabulary of the local authority CEO serving an elected Administration. So, don’t expect to hear from me again for a while!

I will though be cheering from a distance the GM leadership community, hoping they stick together through the excitement of progress as well as the inevitable hard times that will lie ahead. I hope that all parties will keep faith in what has been started. And most of all, I hope that through the years and decades to come, we will see, here in Greater Manchester, a system of population health that is of global renown and learning.