Speech by Andy Burnham
Mayor of Greater Manchester

Place-Based Integration and Whole Person Support: the Greater Manchester Model

Manchester Central

10th October 2018

CHECK AGAINST DELIVERY

Today is World Homelessness Day and I have been out early this morning in the city centre on one of my regular walkabouts.

As always, what you take away is the sense that today's society is forcing too many people to live life on the edge and, when they go over, there is no net there to catch them.

Here, in Greater Manchester, we are using devolution to try to fix it.

Our NHS is providing a higher level of support to rough-sleepers than elsewhere, including allowing people with no fixed address to register with a GP and stopping hospital discharge back to the street.

But we recognise the need to go further. Just one night on the streets profoundly damages physical and mental health. When people do fall, our goal should be to pick them up as quickly as possible.

So starting next month, we will introduce A Bed Every Night - a ground-breaking new scheme giving everyone sleeping rough in Greater Manchester the chance to access somewhere safe and warm every night.

We can't meet the costs from public money alone so we are mobilising all sides of GM society - ably led from the front by City Captain Vincent Kompany and the proceeds of his testimonial year - to find the funds to deliver it.

Our goal is to end the need for rough-sleeping in Greater Manchester by 2020 and, given the way people are pulling behind the campaign, I am confident we can do it.

This is just one way in which Greater Manchester is redefining how we build new systems of support for the times in which we live.

70 years ago, Aneurin Bevan came to Greater Manchester to 'receive the keys' to his new NHS.

Now, 70 years on, we are on with making some serious alterations to the house to make it right for 21st Century living.

Today I want to set out in detail for the first time the emerging Greater Manchester Model of public service delivery.

To rise to today's challenges, the NHS needs a change of thinking as seismic as the creation of the NHS itself.

This isn't just what I think and this isn't just my speech.

It's what Greater Manchester thinks and what I am saying today reflects a level of consensus amongst public service leaders that probably doesn't exist anywhere else.

It is the product of 18 months chairing the Greater Manchester Reform Board and all of the energy and ideas that has come through it from colleagues working in public services across our 10 boroughs.

Specifically, it is based on a true meeting of minds between our 10 councils and the NHS.

To represent that, I have invited Donna Hall, Chief Executive of Wigan Council (and Accountable Officer of Wigan CCG) and Greater Manchester Public Service Reform Portfolio lead, and Jon Rouse, Chief Officer of the Greater Manchester Health and Care Partnership, to join me today.

Donna is a public service pioneer and the architect of so much of what you are about to hear. Jon is the country's most forward-thinking NHS leader and we are lucky that he is here defining what health devolution can mean.

When Bevan visited Trafford on that momentous day, he had ministerial responsibility not just for health but for housing too - specifically, the Government's post-war housing programme.

This was no accident. Bevan understood that you cannot have good health without good housing. It dated back to his time as a Councillor in Tredegar where he saw the effects on peoples' lives of living in damp, cold and over-crowded homes.

When we look back on 70 years of NHS history, one of the greatest sadnesses has to be the fact that Bevan's ministerial career was so short-lived. As Professor Ian Cole has said: "Bevan's vision turned out to be the briefest of glimpses."

By 1951, the link between health and housing had been broken and his twin responsibilities had been separated into two different departments.

By the time I arrived in the Department of Health 60 years later, housing and health policy were very much in different Whitehall silos with barely any connection between the two.

And that brings me to an important observation between the job I held then and the one I do now.

As Secretary of State for Health, you can have a vision for health services.

As Mayor of Greater Manchester, you can have a vision for people's health.

There is a world of difference between the two.

Devolution holds the key to breaking down the silos between public services and moving from a picking-up-the-pieces to a preventative approach.

When I was elected, I thought the challenge was all about integrating the NHS with social care. And, yes, it is partly about that.

But as Mayor of the only city-region with health devolution, it has become increasingly clear to me that the unique opportunity Greater Manchester has is to integrate health with everything - early years, education, community safety, housing and employment.

And we are all determined to take it.

[A Marmot City-Region]

Back in February 2010, I received the Marmot Review into health inequalities.

Even if I had remained Health Secretary long enough to agree to full implementation, I wouldn't have been able to do it.

As the review itself acknowledged, many of the policies that would determine people's health were not in the control of the Department of Health.

Implementing the review's recommendation of taking a life course approach to improving health and, within that, giving highest priority to early intervention and young people's educational and social development, would have required the full buy-in of the entire Whitehall machine.

Knowing that world as I do, I am confident in saying that it would never have come. Whitehall departments like nothing more than fighting turf wars.

Instead, we have a much better chance of implementing the Marmot Review from the bottom-up rather than top-down.

And that is what we are doing in Greater Manchester.

We are taking the life course approach, with a focus on those key moments of transition.

We want all children to arrive at primary school ready to learn; all teenagers to leave secondary school with broad life skills and a sense of purpose and hope for the future; all people to have a stable home life, without the fear of homelessness; and all older people to stay connected and active.

These are the four main priorities of our Reform Board: school-readiness, life-readiness, ending homelessness and active ageing. We are working with Professor Sir Michael Marmot and his team at the Institute of Health Equity and hope to be named a 'Marmot City-Region' where we benefit from on-going advice and support on the implementation of our policies.

The Greater Manchester Model of Public Service Delivery

So how are we doing it?

We are developing a new model for public service delivery based on person, place and prevention.

The changes we are making are not yet fully developed in all parts of Greater Manchester but are well underway in all 10 boroughs.

It starts with the integration of commissioning. Four (and soon to be five) of our local authority Chief Executives are now also Chief Officer of the local CCG.

The shift to a single budget and place-based commissioning is fundamental.

It creates the financial incentive to think about early intervention and prevention.

And we are doing that within a locality delivery model based around neighbourhoods of 30-50 thousand citizens, rather than around themes, policy areas or organisations.

Each neighbourhood is served by an integrated place-based team - with co-located professionals from all public services working together.

To support this approach, we are working towards wider integration of the provider side - organisations with a view stretching from home to hospital - with the development of local care organisations in all boroughs

Names, not numbers

As we have built this model, a constant theme has emerged at our Reform Board: names, not numbers.

Focus on the people in the community who most need our support, rather than the statistics that public services are forced to monitor by their Whitehall departments, and build integrated solutions around them.

I could spend a long time explaining this but the best way to convey it is to show it in practice.

So here is a short video of a place-based team in action in the middle of their Operational Huddle and I'm proud to say it comes from my former constituency of Leigh.

[VIDEO]

As you can see, it is both simple but also profound.

Professionals are spending their time much more productively and are empowered to change lives.

The voluntary sector is at the table as an equal partner.

There is one conversation about the people who are effectively the super-users of public services and new thinking about how best to deploy local resources - statutory, voluntary or community - to build person-centred solutions.

In time, I want the place-based team to be the pre-eminent public service forum in each locality from which all other individual services take their lead and through which they solve their problems.

So if the police or fire service are regularly being called to the same address, or if the A&E is seeing the same person attend repeatedly, then they should engage the help of the place-based team to get underneath the reasons why.

The Greater Manchester model sees public services as one system rather than a collection of institutions. This in effect reverses the tide of the last 30 years of public service reform.

Instead of a drive towards more institutions, fragmentation and outsourcing, it is about the very opposite - a one integrated public service team with that ethos at its heart.

Thinking and working in this way is the seismic shift I was calling for at the beginning. It is the game-changer.

It's about much more than structures. It adds an ingredient too often lost in the bureaucracy of public services: trust.

The post-war welfare state quickly became about processes rather than people or relationships.

Relationships are the most important things in our lives - they motivate us to change, to do better, to live fulfilled lives. But we have designed human relationships out of our systems.

Rebuilding trusted relationships between citizens and state is at the heart of our Greater Manchester Public Service Reform programme.

In truth, the Greater Manchester Model so far is owned and understood by public service leaders.

The next stage is to win the hearts and minds of all public service workers and go further, faster.

Later this year, we will publish a White Paper setting out the Greater Manchester Model and inviting people to sign up to its principles.

This isn't about eroding professional identities. While they may be part of a place-based team, it is important to protect the identity of the individual services, reflecting the fact that each has a different relationship with the public and there is a value in that.

We believe people will embrace the Greater Manchester Model because it empowers them to make a bigger difference in line with their public service vocation.

So, Greater Manchester has reached the end of the beginning.

We have done the detailed thinking about our place-based model.

We have also made many of the structural reforms necessary to implement it.

We are now ready to embed it system-wide.

To succeed, there are barriers to remove and challenges to be overcome.

We need to focus on three specifically - financial reform, workforce reform and culture reform - and I will take each in turn.

Financial reform

There will always be an important role for the acute system. But hospitals should be the last resort, the safety net, rather than the default setting for care.

Today, the NHS still uses the term “out of hospital” to define 93 per cent of care delivery.

And that reveals the problem. We start with the hospital and work back from there. What we need to do instead is start in the home.

We won’t achieve our goal of preventative, person-centred services if the financial tide in the NHS still drags towards the hospital through an episodic payment system.

So we need to adapt NHS and social care finances for people with on-going needs, breaking away from the payment-by-results system and developing an integrated year-of-care approach to the funding of support.

More generally, we believe Greater Manchester should now be trusted with more oversight of the whole system and greater freedom in the use of finance.

This year-of-care reform would create the conditions for a Living Well at Home model of care in Greater Manchester.

It will create an incentive to invest in good social care and, possibly, assisted living technology. It will bring social benefits but also economic opportunities too. When Greater Manchester agrees its Local Industrial Strategy with the Government in March next year, expect to see health innovation feature very prominently.

Through Health Innovation Manchester, we are creating a single innovation pathway for the entire Greater Manchester health and care system - simplifying the landscape for researchers and industry innovators.

Greater Manchester has a major opportunity to become a global centre for investment in life sciences and digital - where new concepts can be tested and proven in real-time and real-world environments - and we want to work with the Government to realise that.

My hope for the Living Well at Home model is that it will dispense completely with the broken 15-minute visit culture in social care which severely undervalues the care-givers.

Rather than a crude, production-line approach, we want a system that allows us to consider the individual's whole identity, taking time at the outset to have a different conversation about what matters to them.

This is already happening in Wigan, where new well-being teams are working to build people's capacity and connection with the community.

But we are scratching the surface. In a system where the financial tide drags toward the home not the hospital, we could utterly transform the quality of home care without necessarily spending more money.

So we continue to talk to the Government about the need for NHS tariff reform.

But there are two other big picture changes not in our gift but essential if the Greater Manchester Model is to become fully functional.

At present, we are using it to manage pressures on social care funding.

Despite significant reform, we still face a recurrent funding shortfall in social care of £116m by 2020-21.

To deliver the full vision, we require a longer-term settlement for social care.

And here's the crucial point: that reform needs to align social care funding fully with the NHS principle if it is to support the single budget principle on which the Greater Manchester Model depends.

A system which requires people to pay for their own social care but get medical care for free will be inherently inefficient and never truly preventative.

More importantly, it will never deliver fairness. Until we have public services which treat dementia equally with cancer, we won't have a 21st century solution.

So we need to ask people to pay differently for social care - not in the form of up-front charges but in the form of a fair tax based on their assets.

Greater Manchester stands ready to demonstrate how additional investment, smartly applied, can ease pressure on the NHS, especially in hospital services, but also in GP surgeries.

But, even within the constraints of the current funding system, we are already showing what is possible through place-based integration.

The total number of care homes rated as ‘outstanding’ or ‘good’ has increased from 55 per cent in 2016 to 71 per cent today.

For domiciliary care agencies, the total number rated ‘outstanding’ or ‘good’ has risen from 63 per cent to 85 per cent.

Delayed discharges have reduced and we are outperforming other areas in the country on key measures such as improving access to primary care, quality of acute stroke services, improved access to children’s mental health services and improvement in cancer survival rates.

And despite a challenging financial environment, Greater Manchester has generated system surpluses over the last two years, significantly contributing towards the financial position of the NHS position as a whole.

More broadly, through the innovation led by our Ageing Hub, we are rethinking support for older people in the wider community, with the World Health Organisation recently designating Greater Manchester the UK's first age-friendly city-region.

Our approach is working. But we could achieve so much more for older and disabled people if we had a fully-funded social care system aligned with the rest of public funding.

The second reform we need is to put in place the missing piece in the place-based jigsaw.

At present, billions of pounds of public money are being spent on personal support but not aligned to the place-based model.

I am talking, of course, about the DWP budget.

While we have excellent collaboration with the DWP at a GM level, and they are increasingly involved with our place-based teams, policies such as Universal Credit and the way it is being implemented could work against what we are trying to achieve.

Where we have an element of DWP devolution, we are using it well. Our Working Well programme has double the success rate of national equivalents in getting people with long-term absence from the labour market back into work.

But we need much more flexibility in the benefits rules if we are make place-based working work properly.

So we are preparing a bid as part of next year's Spending Review for much greater DWP devolution, possibly along the lines of the partnership model that has underpinned health devolution

Just imagine what we could do for people if all public funding in any locality was united behind a single personalised plan, recognising their hopes and strengths.

Transformational is a term too often used but I would venture that public services provided on that basis would qualify for use of that term. For the first time, we would open up the possibility of closing the inequalities that still scar our country.

2. Workforce reform

Alongside major financial reforms, we need to think about supporting people to work within this Greater Manchester Model.

And we need to be ready to be ready to deal with the shortages to the NHS workforce that Brexit may bring.

To facilitate integration, we have already made it easier for our workforce to move between public sector organisations with our Continuous Service Commitment.

But we need to bring on the next generation too.

The scrapping of the Nurse Bursary has created a risk that we won't attract people into training in the same numbers.

Although we are bucking the national trend in terms of the number of students starting training, our workforce is ageing.

And despite around 1,300 nursing students starting training in Greater Manchester each year, we are a net importer of newly-qualified nurses, with only 40% of our nursing students entering employment here.

So we have launched our nurse recruitment campaign - ‘Be a Greater Manchester Nurse’ - and reviewed the support we give to students and newly-qualified nurses.

Today I can announce the first phase of a new package of support – our Guaranteed Employment Scheme.

The scheme will guarantee a job in the Greater Manchester NHS for all student nurses at one of our four universities on successful completion of their studies.

It is backed by all of Greater Manchester’s NHS providers and universities.

We will move quickly to put this in place for students who begin their course in early 2019.

The scheme will give people more confidence to begin nurse training and, we hope, an incentive to do it here at a Greater Manchester university.

And, by strengthening the connection between Greater Manchester's universities and NHS, I hope they will both teach students about the place-based GM Model, so that they know what to expect on entering service, but also advise us on how it can be improved.

The Guaranteed Employment Scheme is a good start and I hope over time we can build on it.

One of the biggest barriers to nursing is funding living costs whilst in training.

So we're thinking about making it easier for student nurses to access affordable housing and travel.

Later this month, a housing development exclusively for clinical staff will open in Salford. This project is the first of its kind in the country and demonstrates the importance of health and housing working together.

I can see a case for extending the Guaranteed Employment Scheme to other shortage professions and possibly to all clinical graduates.

And it could be a stronger contract. For instance, if newly-qualified staff commit to the Greater Manchester NHS for, say, five years then there might be a case for us to contribute to the repayment of their tuition fees.

What all this is intended to do is send a clear and positive message to young people, those growing up here and those from further afield. Don't just study here. Build your career and life here. Work in GM, have a more rewarding career and make a bigger difference.

Culture reform

The third big reform is the hardest but probably the most important - changing the way the system thinks and acts.

Names, not numbers. See the whole-person, not the problem or condition, and their carers too. Think social before medical, exercise before pills.

The culture change we need in primary care is a system which is more likely to send people away with a course of counselling or exercise than a prescription for medication.

So, like other areas, Greater Manchester is thinking seriously about social prescribing and a new relationship with our community and voluntary sector, including social enterprises, to deliver it.

We have already signed a Concordat with our voluntary sector which talks of a move towards longer-term, core funding to build their capacity to contribute to the Greater Manchester Model.

Current systems create a tendency to over-medicalise care and that is certainly true of end-of-life care. We need to fund our hospices to deliver the person-centred approach which they specialise in, as an excellent recent report from James Frith MP has recommended, and create a much clearer financial relationship between Greater Manchester's NHS and its hospices.

We have introduced a new deal for carers, recognising their crucial role and making it much easier for them to receive support. As Hilary Cottam has identified, the role of carers is a glaring omission from the 1948 settlement - the presumption being that women would take on this role as mothers, wives and daughters.

But perhaps the most urgent culture change needed to deliver the Greater Manchester Model is the prioritisation of mental health within the system and, true to Marmot principles, children and young people's mental health.

If you speak to the Greater Manchester Youth Combined Authority, they will tell you that mental health is one of the biggest issues for young people, reflecting the way life has changed, but that demand far outstrips the supply of support.

If mental health has been the poor relation of the NHS, then children's mental health has been the poor relation of the poor relation.

50% of mental health problems are established by the age of just 14; 75% by 24. Yet only around 7% of the mental health budget is spent on children and young people. It is a national scandal that so many children are denied support or sent hundreds of miles to receive it.

We are beginning to correct that.

Last year, we announced an investment of £134m in mental health – the largest investment in mental health and well-being anywhere in the country - with nearly 60 per cent of the money supporting the mental health needs of children, young people and new mums.

This year, we are putting in place a flexible specialist Children and Adolescent Eating Disorder service, delivered through multidisciplinary community-based teams, and we will be implementing ADHD standards for children and young people.

We are beginning to roll out 24/7 community-based crisis care for children and young people.

Perhaps the most exciting innovation of all is our Mentally Healthy Schools Rapid Pilot. This involves basing a support and counselling service, provided by the voluntary sector, within schools. It has benefited over 30 so far and we are working on plans to extend it to all GM schools.

However, despite all this, there still remains significant variation. We need to do more to reduce the time it takes for children and young people to receive support and treatment, to prevent problems escalating.

So today I can announce that Greater Manchester will be the first place in the country to start collating and publishing waiting times data for children and young people's mental health services.

Before the end of the year, we will begin publishing referral to first appointment and referral to treatment data routinely, as part of a drive to improve performance and transparency.

The data might make difficult reading.

But publishing it will allow the Greater Manchester system fully to understand how far we need to go to deliver decent mental health provision for children and young people.

This focus can't end with school-age children but needs to consider support for young adults and particularly students.

We have a huge student population – one of the largest in Europe - and we need to do more to support them.

The transition to university can be tough. We also know that around one in five 16-24 year olds experience depression or anxiety.

Despite this, students are poorly-served when it comes to mental health provision.

University timescales lead to most psychological treatments beyond step two IAPT services effectively not being available as referral timescales and waiting lists mean students have returned home, dropped out or moved across treatment boundaries.

So we are developing plans to transform mental health provision for our university students.

This will include: an integrated, single pathway and hub for all Higher Education students, drawing on the iThrive framework; a GP-student passport, so people can keep the GP throughout their student career; and digital consultations.

Devolution is enabling us to rethink the way we help young people navigate an increasingly complex world - including young people with particular needs.

But rather than just producing a Greater Manchester Learning Disability Strategy and Autism Strategy, as we are, we are writing both with people with lived experience.

Doing with, and not to, is a fundamental tenet of the Greater Manchester approach.

Trust people. Build a relationship with them. Focus on their strengths, hopes and dreams.

Above all else, give them hope that things can be better.

Because hope after all is the best medicine known to man.

Conclusion

We have still got a long way to go before people who live here can enjoy the same level of lifetime health as people elsewhere.

But we can at least say this: we know what we have to do to close the gap; we have a model that can deliver it; and we are building a movement for real change.

We are not perfect and we are very much on a journey.

We would welcome your advice and support in developing the Greater Manchester Model as, if we prove it can work here, there is no reason why it can't work elsewhere.

We recognise that change will not come overnight. But, if we all commit to the Greater Manchester Model for the long haul, I am confident that, over the decade, we can make Greater Manchester healthier, happier and an even better place to live than it already is.

ENDS