HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 27 March 2023

3.05 pm

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Members present: Baroness Pitkeathley (The Chair); Baroness Armstrong of Hill Top; Baroness Barker; Baroness Finlay of Llandaff; Lord Kakkar; Baroness Osamor; Baroness Redfern; Baroness Shepherd of Northwold; Baroness Tyler of Enfield; Lord Watts; Baroness Wyld.

Evidence Session No. 7 Heard in Public Questions 66 - 74

Witnesses

I: Rt Hon Andy Burnham, Mayor of Greater Manchester; Mark Fisher CBE, CEO, NHS Greater Manchester Integrated Care Partnership.

Examination of Witnesses

Andy Burnham and Mark Fisher.

Q66 **The Chair:** Welcome to this meeting of the House of Lords inquiry into the integration between primary care and community care. We are very grateful indeed that we have as witnesses for our first session today the Mayor of Greater Manchester, Andy Burnham, who will be known to many members of my committee, and Mark Fisher, the CEO of NHS Greater Manchester Integrated Care. You are, as it were, the most mature of the integrated care systems. There are integrated care systems elsewhere now, but yours was the first, so we are particularly grateful that we will be able to draw on some of your rather longer experience than that of many integrated care systems.

We will take it in turns to ask you questions, as you know. I will start off with the first one. Has the new integrated care system in Manchester allowed closer co-ordination between local government and NHS leadership in the operation of primary and community care services?

Andy Burnham: Good afternoon, everybody. It is a great opportunity for me and Mark to be able to update the committee on where we are. As you say, we have been on a path towards ever greater integration for some time. The answer to your question is yes, and it is getting closer all the time. It is an evolutionary process, possibly, rather than a dramatic event, but in the six years that I have been mayor I have seen in Greater Manchester the increasing sense of one public service, of people working as one team around individuals, families and communities in places. That has been the direction of travel for a long time.

The integrated care system reform codified how we had been working for a long time. I see signs of it going even deeper. Mark will probably talk more about the five-year plan that was signed off by our integrated care partnership on Friday. It is very much a health in all policies vision. At the very basic level, when we are thinking about supporting people, it is looking at health in every possible way from the early years right up to active ageing.

So the answer is yes, and it is not just at the Greater Manchester level. We have developed a locality model, a place-based model, where you take, say, a population of 30,000 to 50,000. We have worked up from those building blocks, so the integration happens at that locality level as well as at the Greater Manchester level higher up. We are becoming closer all the time.

I can see a day when the organisational boundaries will simply not exist in the way they do at the moment. We are not there yet. We are walking rather than running. We have to move at a pace that is right for everybody, but the path that we are on is ever greater and closer integration. We could talk to you this afternoon about things we have already done in the last few years that are different, for instance the health-based approach we have taken to homelessness, or the way we have sought to redesign our support in the early years. On every level, we are taking a highly integrated approach.

The Chair: May I come to you also, Mark? Could you combine in your answer whether this approach has made it easier for you to deliver services to your local communities?

Mark Fisher: As the mayor said, we have been on this journey for some time. I would describe some practical things and some behavioural things. In practical terms, we have a single care record, which applies right across our system. Whether in GP practices, local care organisations or primary care, everybody uses it, and that has been of massive benefit.

We also have what we describe as a no lanyard policy. In our teams across communities and neighbourhoods, you get the service, whether that is from your district nurse, primary care or local authority services, without it being clear which organisation people are coming from, and that is very helpful.

I genuinely believe that this has been of real, practical benefit. To give the committee an example, the Government allocated, in two tranches, our share of the extra £800 million in total for social care over the winter. There was some debate in government about whether that money should come to local government or to the health service. In the end, it was a combination of the two.

We agreed in Greater Manchester that all the money would go into local government, but that local government would spend it, in agreement with the ICB, on proposals and policies that were signed off jointly by the health service and by local government. To me, that showed the power of our integrated arrangements.

Q67 **Baroness Wyld:** Mr Burnham, I vividly remember you talking in the Public Services Committee about the work that you did with health visitors and the digitisation of records, which we could perhaps touch on. I wanted to ask you both for a bit more detail on the new strategies and models of care that you have implemented, and how successful these have been in bringing primary and community care together.

Andy Burnham: When I spoke to the Public Services Committee, I was describing what we had done on school readiness, which had been a very big focus for us pre pandemic. In particular, we fostered integration, which is the subject of this inquiry. We believed very strongly, and still do, that all professionals have to have visibility of important data. In the context of early years, it was the Ages and Stages Questionnaire that is carried out by health visitors. At the time that we were looking at it, in 2018, it was a paper-based system, so only the health visitor could see, at age two, for instance, the names of kids who were unlikely to be school ready if everything stayed as it was. We have done a very specific piece of work here to digitise the Ages and Stages Questionnaire. I think—Mark may correct me if I have got this wrong—that it has been implemented in about four of our boroughs so far, but certainly the intention is to roll it out more widely.

I would stress to the committee how important this is. Based on the data we have from the reception class of 2022, levels of development have gone quite seriously backwards during the pandemic years. Those kids were two during the first lockdown. If you think about it, as we go into reception year 2023, those kids would have been one, and then, into 2024, those were the kids who would have been born in lockdown.

How we now see what the needs of those children are, and how we now start putting extra support in place so that they are school ready or certainly have a better level of development when they arrive at primary school, is a really serious issue for the country. That is a tool that we have developed, which is probably going to come into its own for us now because we really need to think differently about how we support those young children.

More broadly, I refer the committee to the Greater Manchester care record. In the pandemic, we introduced an integrated care record for our residents. This is a health and care integration, so that you can see all the interactions that health and social care are having with a resident. I have a testimony from a GP who says that it is improving the quality of care when a GP can see all the different interactions that a patient has had with the system, giving them a more rounded picture perhaps than they have had before.

These systems remain very important to us. It is not so much the tech that we need to get excited about, but more the concept of a health professional at any level of the system being able to have visibility of the important data on a particular child or resident. It is work in progress, but there are some really good things there to inform the committee.

Baroness Wyld: It certainly stood out to me last time. Having

captured that data on lockdown is particularly helpful. Maybe Mark wants to pick this up. We have gone into metrics, so we can see where the gap is. Hopefully that will inform the inputs and we will see better outcomes. More generally, what are your metrics? Do you have firm examples of success, not necessarily in early years but in any area where you have put a specific strategy in place with tangible outcomes?

Mark Fisher: We are after two sets of metrics: broad community metrics on life expectancy and people ageing well; and the NHS statutory targets. We are still striving to progress against all the statutory targets, but, in terms of the broader measures, I would refer the committee to the peer-reviewed study published in *Lancet Public Health* in October 2022, which showed that devolution and the integration of public service that showed that life expectancy in Greater Manchester was higher than in comparable areas. The change was larger in Greater Manchester than it had been for England as a whole.

What was particularly interesting was that there were statistically significant increases in life expectancy in eight of the 10 boroughs, and it was increasing at a faster rate. The analysts concluded that devolution and the integration of public service, and the focus on working in neighbourhoods and bringing people together, were directly causative. We can already see that the approach that the ICB structure right across England is designed to bring about—i.e. that integration—is having a potentially powerful effect, which is for the good.

Baroness Wyld: There were some counterpoints in the Centre for Policy Studies report. You could argue that it is coming at it from a centre-right perspective, which might influence its take on it, but did you have any comments on that? Perhaps we could pick it up in Baroness Armstrong's question.

Q68 **Baroness Armstrong of Hill Top:** Good afternoon. I first need to make a declaration. My husband, Paul Corrigan, was involved in the Health Foundation report on integration in Greater Manchester. That does not mean that I know anything about it, but he was involved, so I need to declare that.

I am really interested in what the main barriers have been. Again, Andy, when you came to the Public Services Committee, you talked about feeling that you did not have enough involvement in the acute sector, but could you go through with us the things that you think have been making your ambition for integration more difficult and, if you have been able to do anything to overcome them, what that might be?

Andy Burnham: It is good to see you, Hilary. I do not think that I have ever found any barriers here, in that there has been no resistance beyond, say, pockets of people who do not want to work in a more integrated way. The vast majority of people in our system support the direction we are going in, so there are certainly no local barriers to what we are trying to do.

The barriers, as I have experienced them, tend to be in IT systems, but, more than that, data and data sharing. The control of data remains a really frustrating issue. There is often a cautiousness in people's minds, which I understand, but there is always a much greater benefit to be had from the sharing of data. I gave the example of those kids. It is clearly in everyone's interests for people to see the kids who need support at age two, rather than for that data to be held back. Those data and data sharing issues remain challenging.

Estate is an issue. I am proud—as I am sure you are, Hilary—of the LIFT infrastructure that went in during our period in government, with modern health facilities in communities. There has been an underutilisation of those facilities, and sweeping away the restrictions in the way they are financed would allow much more integration where there are not the estate challenges that we have. Those are barriers that I would flag up.

Mark Fisher: I am happy to add two things. I very much agree with the point about information sharing. It is getting out and about and talking to health visitors and others. The ability to share data between different parts of the public service needs more work. It may be case by case, but there is certainly more to be done to enable a single view to be taken of the individual person in front of you.

On the point about the acutes, the ICB now has complete responsibility for virtually all aspects of health provision across Greater Manchester, apart from maybe some very specialised commissioning, whether that is secondary care, primary care or other aspects of care, so we have that ability to bring the service together. We have the budget and we have the performance accountability. In a sense, we now have all the tools in the toolkit to make a success of this, and it is very much up to us to do so.

Baroness Armstrong of Hill Top: The Information Commissioner feels that it really is down to the caution of public servants on the issue rather than the reality of the legislation, but I am sure you would benefit from talking to him individually. What do the rest of the country and the new ICBs need to learn from your experience?

Andy Burnham: That is a good question. The answer that falls straight off the tip of my tongue would be not to dip your toe. Do not talk the talk of integration and then hold back. If you are going to do it, do it properly, because the more you do it and the more deeply you dive in, the greater the returns.

Mark referenced the *Lancet*, and I appreciate Baroness Wyld's point that others might see it differently. It is clear to me that we were making rapid progress on school readiness pre pandemic and going more quickly than England on that issue. We were going more quickly on levels of physical activity, which was linked to the way we were working with our leisure services and thinking about health and leisure together.

One of the big reasons why we achieved that change was linked not necessarily to older people living longer but to the work we did on homelessness, where we reduced deaths of people in their 30s and 40s on the street because of some work we did there that was health service-funded. I remember very vividly, in the early days, being in the office where I am talking to you from now and asking the health service in Greater Manchester to help me with a scheme called A Bed Every Night, where we wanted to provide somewhere for everybody to go every night. The initial reaction from the health service was, "Well, no, we don't fund hostels or places in accommodation". I said, "But you're going to leave my office and walk past people whose health is being catastrophically damaged by sleeping rough, so surely it is a health issue. It can't just be that smoking and obesity are health issues and rough sleeping isn't". To be fair, Mark's predecessor thought about it, came back and said, "You're right about that". Since then, the health service in Greater Manchester has funded A Bed Every Night.

I mention that, because it is an example of the health service diving with us into a difficult issue and being a real partner, as we have now started to unpack the mental health and addiction issues of homelessness.

My message to other people around the country would be not only to talk the talk but to walk the walk and dive in properly. Take the lanyards off, as Mark said. Consider yourself one team and your loyalty to be to the residents of your locality or of Greater Manchester, not the organisation you work for or the professional discipline you have.

As I look around our primary care networks, there are some examples now of that mentality beginning to flourish. It cannot be done overnight, but, in parts of our system at its best, you are seeing a place-based approach that is becoming more and more

organisation or professional discipline blind, which is where we want to get to.

Q69 **Lord Watts:** Good afternoon, Andy and Mark. Can you touch on the investment side? You touched on it in terms of the estate. Do you have control of the way in which the estate is funded? Do you have a plan for identifying the blockages? Do you have the ability to build and change things in a structural sense? You have talked about some of the service levels, but what about the estate itself? Do you have a plan? Do you have the resources? Is that limiting what can be done in Manchester?

Baroness Redfern: I have a subsequent question for Mark regarding data sharing. It might put you on the spot, Mark, but who do you think is holding it up, so that we can get better data sharing?

Mark Fisher: To start with the question about what other ICBs can learn from us, I would say strategic patience. This just takes time. I have been in this post for six months, but I have had the massive benefit of all the work that has been done over the years beforehand. It is all about relationships, which take time.

It is not just about public service integration. This is about the community. This is about bringing to bear on health the power of the community, whether that is employers, schools or a whole range of actors, for the betterment of people's health. That is the real power of the Greater Manchester strategy. It is as much about the community as it is about the public service.

Estate is within our gift. We have major plans at the moment to rebuild one of our major hospitals in north Manchester. That is part of the NHS capital plan. We would always like to be able to do more, but one thing we can do is work creatively with local government across the boundary to see what needs to be done at a local level and integrate our efforts.

I did a lot of work on information sharing over many years, formerly as director for social justice in government. My own reflection was that this is fundamental, and it is often not the law; it is simply caution. In some part of England, Great Britain or the United Kingdom, there will be a local area that has cracked a particular case. A lot of this is about having a strategy and a structure that enables those examples of great practice to be showcased and the barriers to trust to be broken down.

That is the bit of infrastructure that may need to be put back in place: an ability to share that great practice and those great

examples of where information sharing can make a real difference, because it is fundamental to successful service integration.

Baroness Armstrong of Hill Top: The one problem I see with the no lanyard policy is that nobody knows who is responsible. Who do you hold accountable case by case, and how is accountability sorted in an integrated system?

Andy Burnham: It is a good question. I can see Mark wanting to come in, so I will not hold the floor for too long in answer. It is not that people are completely abandoning their institutional responsibilities. When Greater Manchester was developing this way of working, there was a BBC news report that showed people taking their lanyards off. It was symbolic more than requiring people to walk around without a lanyard. It was an attempt to say, "Look, your loyalty is to the public, not to an organisation", and I do think that is an important ethos to build into integration. "Why are you integrating?" That is the question. "What is the purpose of integration?" It is to better serve the public. It is recognising that the silos created by Whitehall departments often get in the way of serving the public or create conflicting pressures or tensions that are unhelpful.

At the Greater Manchester level, we have tried to create a space at the locality where people can genuinely act with a little more freedom, work together as a team, and be a little more entrepreneurial in getting to the root cause of an issue that is holding a particular person or family back. We are trying to give a bit of permission to work outside the tramlines that are often laid down by organisations or departments.

I hope we have not given a misleading impression of it to the committee. People still have accountability for their roles, but we are asking people to work and think a little differently at the local level.

Mark, I can see you came off mute before. It sounded like you had a very important thought.

Mark Fisher: It is only to reflect exactly what you just said: this is not about removing people's professional accountabilities for providing professional service. This is about integrating where it is sensible to integrate, and acting in that spirit of a single public service. Baroness Armstrong is entirely right that you cannot remove people's professional accountability for providing the service that they have been trained to provide, and nor should you.

Q70 **Lord Kakkar:** In such a system where there are different

professional groups, how do you successfully achieve professional leadership where one group might have previously and traditionally thought that it was to lead the delivery of service impacting directly on patients, for instance?

Mark Fisher: Just to give an example, in several of our boroughs the leadership of what we call the local care organisation, which is the organisation providing community care services, health visitors and so on, is also responsible for providing social care services on behalf of the local authority. We have integrated the leadership at that level so that you have a single organisation looking right across the piece at people's needs. That is not affecting what individual professionals need to do, but that integration leads to all sorts of creative ways in which you can create a better service at the point of use.

Lord Kakkar: How does that work with the delivery of primary care and general practice care?

Mark Fisher: We have not integrated the management of, for example, community care with primary care, because those are run by independent bodies. It is things like the single care record that make the most difference to that practical integration, in that we have a whole range of professionals who can use exactly the same data and see exactly the same picture of the patient in front of them, without having to re-ask the questions or go back to the beginning. That is a massive benefit in providing an integrated service.

Andy Burnham: I think I am correct in saying that we have 65 primary care networks in Greater Manchester, and we are beginning to see some truly innovative practice in those PCNs. One that I visited, which the committee should take a look at, is Healthy Hyde. This is a primary care network that has quite seriously embraced work on health inequalities. To answer your question, it is inspired GP leadership that is driving forward the Healthy Hyde project.

What you then get is a networking of organisations and individuals around that leadership. It is not so much a management structure but a request for a certain way of working, where people start to pull in the same direction. It is often very strong GP leadership at that locality level that then builds that sense of team and gets all organisations and people pulling in the same direction.

I would not want to overcomplicate some of this stuff. Going back to the question about whether Greater Manchester has really made a difference to life expectancy, it is not surprising that you might

make more of an impact in supporting people if all public services and professionals face in the same direction and start pulling in the same direction. That, in its simplest expression, is what is happening. It is happening most in localities where, rather than an appointed leader, there is inspired leadership, often from a GP or sometimes from a local authority employee.

Q71 **Baroness Finlay of Llandaff:** When you talk about Healthy Hyde, Hyde is the area where Harold Shipman was in practice. I wonder whether you felt that the disaster of Shipman had been a stimulus to do things completely differently. Is that why they have been able to move forward in such an innovative way?

Andy Burnham: It is connected. I will elaborate on why, and go back to my time in the Department of Health. I mentioned to Baroness Armstrong the investment in primary care. Tameside had significant investment in its primary care estate in the period post Shipman. It was one of the parts of the country with a high number of single-handed GPs operating out of terraced properties, and a very deliberate decision was taken to invest in the primary care estate. Healthy Hyde operates out of one of those buildings. It opened about 15 or so years ago, or maybe a little more.

It is also linked to the challenges that Tameside general hospital had. If you recall, it was a very challenged trust at times, going back 10 or more years. For all those reasons taken together, linked to inspired local leadership, particularly by the local authority chief executive, Steven Pleasant, and Karen James, the chief executive of the trust—Mark, you might want to pick this theme up—Tameside stands out in the Greater Manchester context for really having embraced integration in a more fundamental way, as I was describing to Baroness Armstrong, by diving in rather than dipping a toe. Tameside did that, possibly because of the challenges that it had been through with primary care and with secondary care in the preceding years. We would point to it as a model of good practice. Mark, is that a fair assessment?

Mark Fisher: That is absolutely a fair assessment. We often point to Tameside as the place where integration has gone furthest of all. It is not the only borough in Greater Manchester where it has happened. There are great examples of integration everywhere—Rochdale, Bury and Salford—but Tameside is probably the most consistently integrated.

Andy Burnham: We mentioned the acute system. There has been some scepticism, if I am being honest, in parts of the acute system about integration and whether it can make any difference to what comes through the front door of A&E or what ends up as pressure

on hospital beds. When we talk about Greater Manchester, it sometimes sounds as though we are saying that it is identical everywhere; it is not. Some places are more advanced than others. Tameside stands out because the hospital, as part of its recovery strategy, embraced integration as a way of improving itself, and that makes it quite interesting.

Q72 **Baroness Barker:** Given your previous answer about the *Lancet* study in 2022 on life expectancy, I am quite confident that you will be able to answer this, because you clearly have very good data. How has the integration of care services allowed you to tackle health inequalities across Greater Manchester? We can have a guess about the two boroughs that did not improve. Have you been able to use the data to drill down, to find out why and to shift things around?

Mark Fisher: It is one of the central responsibilities of the integrated care board and the partnership to further drive reduction in health inequality across Greater Manchester. Although we have made some progress, we would all agree that there is a lot more to do. Indeed, the pandemic probably set us back a little, which is fairly clear from the data. This is absolutely work in progress.

The partnership strategy that we signed off on Friday has that absolutely front and centre of our mindset and our objectives. We want the Marmot principles of starting well, living well and ageing well to apply everywhere in Greater Manchester, but they do not apply everywhere consistently.

We have some reasonably good examples of progress, though. For example, we have managed to reduce smoking across Greater Manchester and, indeed, in some of our most disadvantaged areas. That is by the health teams and the local authorities working really closely together in neighbourhoods.

There is a great example in Oldham of how we work with faith leaders, for example, on getting vaccinations into the most disadvantaged communities. We have good examples of practice, but we would all agree that there is a lot more to do.

Andy Burnham: Baroness Barker, as you correctly anticipated, the two boroughs that did not show the same improvement were Rochdale and Oldham. Those would be the places where our health challenges are greatest.

I come back to the central point that, if you create a sense of people pulling in the same direction, it is unsurprising that health should improve. In many ways, health is not created in the health

service. It is created in homes, workplaces and communities, or it is not; it is damaged in those places.

We had the tragic case of Awaab Ishak last year, a two-year-old boy who, as you will have seen in the news, was killed by the damp in his home in Rochdale. This is where this journey goes next to become much more engaged at that level in understanding health, and how and where health is created. If you want to move the dial in Rochdale and Oldham, you have to get much more serious about housing standards. You have to start dealing with insecure employment and all the damage that does to mental health. That is where the journey goes next.

You can integrate services, and that can take you so far in providing a more seamless and joined-up experience to the public, which is good and absolutely what should be done, but if you want to improve health in the most deprived places you have to fundamentally get to grips with things that are making the job of the health service harder, which is employment, housing and all the issues associated with that.

Baroness Barker: It is interesting that you should mention Oldham, which is a place that I happen to know very well, where there was some landmark early work done on public health and occupational health. Given the data that you are generating, which you are able to analyse at a regional level but also very locally, will you be able to pull out better data than could be done elsewhere? We know that the provision of GP services in Oldham has been very poor for many years. Can we isolate that as a significant factor by comparison with other boroughs, for example?

Baroness Tyler of Enfield: You have both talked quite a bit about improving life expectancy in deprived areas, which, of course, is a very important part of tackling health inequalities. I just wanted to know the extent to which you have been focusing on, and indeed measuring, improving healthy life expectancy as distinct from just life expectancy per se. Is that an important part of your integration agenda?

Mark Fisher: In reverse order, on healthy life expectancy, it is about people not just living longer but living more healthily for longer. That is absolutely part of our mindset and the way we try to measure things.

On data in communities, we have exactly the sort of data that will help to illuminate the need for change at very local level. As with all these things, having the data is one thing, but making the change is another. Some of these things just take time to do,

particularly when it comes to moving services from one area of Greater Manchester to another. It is fair to say that there are parts of Greater Manchester where the difference in life expectancy between adjacent places is very marked, so the challenge that we have remains quite significant.

Andy Burnham: There are two issues that fall out of your question, Baroness Barker, which I would like to unwrap. First, as I mentioned to Baroness Wyld, there is existing data that needs to be given greater visibility. The Greater Manchester system is doing that effectively through the work on early years that I talked about, by digitising the health visitor's record, and through the integrated health and care record for all residents.

All integrated care systems across England should think about how you give the greatest level of visibility to all professionals working in the system, so that the data we already have is used better than it currently is and is not kept in a particular silo. That is one thing, and we are doing some of that.

There is also data that needs to be collected but is not picked up by national collection. Greater Manchester has worked to fill in some of those gaps. Let me give you two examples. First, on our teenagers, we began a survey, originally called life readiness, of year 10s and their thoughts, feelings and level of hope. One thing we asked them was, "Do you have hope for your future?" It was quite a powerful question to ask a 15 year-old. That produced data at a very local level, which told you something quite significant about different localities in Greater Manchester and what needed to be done to raise aspiration.

That has since evolved into something called BeeWell, which we are doing in partnership with the University of Manchester. This is a very sophisticated survey of our teenagers and particularly their mental health. It is a level of data that I do not believe exists anywhere else in the system. We decided that it was critical, if we are going to improve the health of the overall population, to understand how teenagers are thinking and feeling, and to act to support them.

A second example is our Big Disability Survey. During the pandemic, our disabled people's panel conducted a survey, because it was clear to us that some of the issues that disabled people were experiencing during the pandemic were probably accentuated versions of issues that other people had, particularly with isolation. That survey has since carried on, and it gives us an insight that national data collection does not. It is more linked to people's thoughts and feelings, which is often the most powerful data that

you can collect.

Those would be two examples of how we have sought to fill in the picture. Whereas national data is often a bit quantitative rather than qualitative, we are trying to get that broader, more qualitative picture in our data collection, and those two surveys have helped us to do that.

Q73 **Baroness Finlay of Llandaff:** You have already mentioned smoking, and I want to move on to health promotion strategies and living better.

Do you feel that integration has facilitated that health promotion or hindered it? How you are working with the services beyond health and social care, such as education and other community groups, which have a big influence, to tackle some of the really big problems of our time, one being mental health, as you mentioned, and the other obesity, which is linked to diet, the way people live and exercise, and a whole range of other things? Have you been able to improve the health literacy generally of the population, or have you even tried to measure whether you have been able to improve it?

Andy Burnham: This is, in many ways, where we have been at our most innovative on population health and quite energetic campaigns in this space. Mark mentioned Make Smoking History, which was a very hard-hitting campaign, but, more positively, I look at what we have done around physical activity.

GM Moving is an organisation that links players from across our system with an interest in the promotion of physical activity. Just to give you an example, they put it to me, in my early days as mayor, that I should give people permission to wear their trainers to work. We like our trainers in Greater Manchester, and that message was very well received when I said that everyone is free to. I would never take offence at somebody wearing their trainers in a meeting if they had been using them to walk to the meeting. It was called Active Soles and remains an ongoing Greater Manchester campaign on physical activity. I indicated before that we had real success on that front pre pandemic, and we could share the figures on that with the committee.

The GM Moving movement is still a really powerful thing and extends to health services. There is a great innovative scheme called Prehab4Cancer, and I would recommend it to the committee. It began in Salford but is now around the Greater Manchester system, where cancer patients who were about to undergo chemotherapy or radiotherapy undertook a quite rigorous physical activity course as well in order to get ready for the rigours of what

was coming.

Rather than wrapping people up in cotton wool and the old idea of a patient having to sit in a room and not do anything for weeks, it was the opposite: getting people physically active and then helping them to deal with the physical and the mental challenges of treatment, because of the support to remain physically active. Prehab4Cancer won the mayor's award at our Greater Manchester Moving awards. It is a very innovative scheme that almost points to a different philosophy of health and people not being patients but staying really active and strong.

One quick final example is the work we have done on mental health, particularly suicide prevention. We have a campaign called Shining a Light on Suicide. When it was first put to me as mayor, I was a bit unsure. I thought it was a bit too hard hitting, but in many ways that was the point. We had to go over that hump, if you like, and become more direct in our messaging on that. Shining a Light on Suicide is an example of a Greater Manchester campaign that is more impactful than some of the national campaigns. The football League Managers Association has backed us and has been doing work with us on it, and it has been really successful. This is an area where we have been very innovative with our devolution freedoms, and we have delivered some bottom-up health campaigns that have moved the dial quite a bit. Mark, I hope you will agree with that.

Mark Fisher: Yes, absolutely, and I would showcase two other things. One is the Living Well programmes that we are rolling out to every borough. That is all about trying to make sure that people with mental health needs get an intervention so that they do not end up needing statutory services. There is lots of creative gardening and other things to which we deflect people to enjoy.

There is also the work of our social prescribers. In pretty much every primary care practice now we have social prescribers who are doing amazing work, recognising that a large proportion of people who turn up with a potential health need do not need a health intervention but some other intervention, whether that is about their housing, debt advice or a whole range of things. Social prescribers are doing immense work that really proves that case.

The Chair: Those examples will be of great interest to the committee.

Q74 **Lord Kakkar:** What single recommendation or piece of advice would you give to us that we might include in this report to drive the improved efficiency and effectiveness of integrating primary and community care?

Andy Burnham: I could talk at length about social care.

The Chair: We are looking for very brief answers.

Andy Burnham: I will not go down that path, then. We need greater devolution of Health Education England budgets and functions, so that we can do more ourselves on workforce challenges and rethinking workforce, on more blended roles between social care and health, and on new pathways for young people into the health and care system.

You may have seen that we had a trailblazer devolution agreement signed last week with the Government that gives us more control over post 16. If your committee could then empower us with more devolution of Health Education England functions, we would be in a good place to demonstrate how we could change. I know from my days as Secretary of State that workforce in the NHS has never been done particularly well from a top-down level and often misses the target. Bottom-up workforce development is the way to go in these integrated systems, and I would welcome recommendations in that sphere.

Mark Fisher: I would just add something on the targets. We have a target as a system from NHS England for everyone getting a referral, a visit and an intervention from their general practitioner within a certain time. I would far rather have a broader outcome about people getting the service they need from primary care, whether that is a general practitioner, pharmacist or physiotherapist, reflecting the width of potential intervention to enable people to get the service they need, rather than this being a single thing about general practice. I hope we have been able to convince you that our vision of primary care and community care is far wider than just specific professionals. It is about an entire service and a philosophy, and having outcome targets that reflect that would be really helpful.

Lord Kakkar: I know that our marvellous Chair wishes to bring this to a close, but I may just ask the mayor—those were two very helpful answers—whether your office might be kind enough to give us some further information on a point you made earlier. This is a journey between integrated healthcare delivery in the primary and community setting, and the capacity to address the social determinants of health much more effectively. Might your office give us a view on the journey that you have taken, which is very mature, and what the next steps are to that broader objective of having the influence to drive the social determinants of health?

Andy Burnham: Yes, I will happily do that. Mark referenced the five-year strategy that has just been signed off. If we were to send that to the committee, that might be a good start. It is radical in the England context, because it is asking the system to think social rather than medical first, to all the things Mark was talking about before. That should be the first port of call, rather than a medical or clinical intervention. We can certainly provide more.

The Chair: I am very grateful for the offer. On behalf of the committee, I am sure that I can say how very grateful we are for your time this afternoon and for the richness of your answers, which will be of huge interest to the committee. If there is anything else that you feel we could know or would be helpful to us, please feel free to send it to us. I have no doubt that we will be in touch with you again during the course of our inquiry.