



Health Committee

Oral evidence: [Integrated Care Pioneers](#), HC 1249

Tuesday 6 May 2014

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Members present: David Tredinnick (Chair); Rosie Cooper; Barbara Keeley; Grahame M. Morris; Andrew Percy; Valerie Vaz; Dr Sarah Wollaston

Questions 1-32

Witnesses: **Jay Stickland**, Senior Assistant Director, Adults & Older People, Royal Borough of Greenwich, **Helen Smith**, Deputy Chief Executive, Oxleas NHS Foundation Trust, and **Dr Rebecca Rosen**, GP, Clinical Commissioner, Greenwich Clinical Commissioning Group, gave evidence.

Q1 Chair: Good afternoon, everybody. As Acting Chair, thank you very much for having us. This is the House of Commons Select, which we now call just House of Commons Health Committee, in this splendid council chamber built in 1903. We have had a very helpful session this morning looking at the work of Greenwich Co-ordinated Care, and we are looking forward to exploring that further this afternoon. We have a range of questions. I will lead off and, please, anybody who feels able and happy to answer any given question come in. I understand you have an informal structure on your side, so I will ask the questions and it is over to you. The first is: what are the key objectives for Greenwich Co-ordinated Care and how will you evaluate whether you have or have not met those objectives? Who would like to lead on that question? Dr Rosen, you look as if you might just be happy to do that.

Dr Rosen: The fundamental aim is to deliver proactive, co-ordinated and, as far as possible, preventive care to a targeted group of highly complex patients and, through that intervention, to improve their outcomes, the outcomes of the individuals and their carers; to improve the working lives of the staff that are delivering the services; and to deliver savings to the health and care system as a whole.

In terms of how we are going to evaluate it, we have a four-themed evaluation, which focuses on process; outcomes for individuals, particularly around their own goals and the central “I” statements that they express as part of this; outcomes for the system as a whole, so A&E admissions, movements into long-term residential care, and so on; and then outcomes for staff, because we believe that a highly motivated, satisfied and well-functioning set of professional staff will deliver a better and more efficient service.

Chair: Thank you. One of the key themes this morning was the issue of whether or not costs could be reduced, how costs were spread, whether overheads were reduced and spread, and the impact on Accident and Emergency. I am going to ask Dr Sarah Wollaston to explore those issues.

Q2 Dr Wollaston: Thank you very much. It was an excellent session this morning, really interesting. I am just wondering though, can I take you back to the graph that was presented to us, admissions to hospital and A&E type 1 attendances? It was put to us that there had been a trend in reduction in attendances, but if you take out the drop from January to February, it strikes me that there is not a trend of downward admissions, if you take out that last month. I can see that there is a trend for admissions, but I just wonder, given that the size of the group you are focusing your attention on in Eltham is only 78, is it possible to make an extrapolation from that to this graph? I just wondered.

Dr Rosen: I am pleased you asked that question and we presented the simpler of two graphs this morning just to not bog people down, but the more valuable graph is the one at the back of your pack, if you are willing to look at that one, because that tells what our whole system story is. Let me start at the end of your question. You said, “Is it fair to attribute the reduction to what we have done now?” and absolutely the answer is, “No, it is not fair.” We could not possibly do that. That downward trend you can see over two years for admissions—I am sorry, the red line of the first graph—is the product of the two years of developing and delivering integrated care through the series of integrated teams that we described to you; the JET team, the integrated discharge team’s close relationship with the hospital, and we absolutely believe that that has delivered that downward trend.

Q3 Dr Wollaston: Is that available to everyone, not just the 78?

Dr Rosen: Yes.

Q4 Dr Wollaston: Because there is a separate issue, the 78 you are focusing on in Eltham. Are the JET team available across the borough as a whole?

Dr Rosen: Yes.

Dr Wollaston: Thank you for qualifying that.

Dr Rosen: That absolutely is the product of a whole system transformation, and if you do go to the slide at the back of your pack, you will see a disruption in the data in November 2012 when we basically opened an urgent care centre on the hospital site. There is the urgent care centre activity, which is the top of those three lines at the bottom, the blue line. Then there is the type 1 A&E, which is the orange line, at the bottom of the top three. The blue line of the top three is the sum of urgent care and A&E.

I think it looks pretty stable, but we have not been able to fit a regression line yet. We will do and we will happily send that to you, but that is on top of 2% population growth and it is against a background trend around the country of A&E data going up. The other line I want to draw your attention to is that yellow line, but please disregard November and December. The yellow line, we believe, from April 2010 through to September 2013, we have not fitted the regression line, but you can see that is a downward trend and it is the proportion of people going to A&E who converted into admissions.

Interestingly, you have to disregard the very sharp spike upwards, but September/October perhaps slight lip upwards was when the old trust dissolved and the new trust formed. We need to look into that, but that probably is the disruptive effect of organisational change

and we are just working now to get those systems back in place. I think this does tell a story.

The 78 people that we are looking at now are a different group and they are our effort to tie together all the different teams that we have into a coherent whole that can focus on the very highest risk people who ricochet in and out of all kinds of services, not just A&E—the GP, housing officers, drug and alcohol services—and to try to, first, deliver them a better experience of care and, secondly, remove some of the activity from all parts of the system because care is more organised.

Q5 Grahame M. Morris: It was a very useful session this morning and thanks to everyone who participated in that. It has aided my understanding and I think the whole Committee. Just to go back to your first answer, Dr Rosen, and I do not know whether it is maybe a question that Jay or Helen could answer, when we are talking about the evaluation and the four elements that we saw in the evidence that you submitted in a flowchart in the pack and then you talked about costs process, staff experience and health outcomes, but just dealing with the Patient Reported Outcome Measures. What evidence do you have from the scheme from the pilot that it works for patients? I do not know whether Jay or Helen would be better placed to answer that.

Helen Smith: One of the things as part of our partnership approach, plus our colleagues in Healthwatch, is to work with some patients who have used our services to try to capture that patient experience for us and help us use that to inform how we develop the service in the future. I believe that work has already started and is under way. We feel they are just the right body to be working with people who use those services, to understand the impact it has had on their lives and the things that they felt were good about the service and the things that they feel could be improved to give us that good qualitative feedback.

Q6 Grahame M. Morris: Is it fair to say that you are still working on the evaluation from the patients' perspective? Is there any interim feedback from Healthwatch as to how it has been received by patients or service users, I am not quite sure of the right term, compared to the old system that was not quite so streamlined or integrated?

Helen Smith: We have not had the formal report yet from Healthwatch. The information that we do get back is by the team itself, of course, who do feed back, through the Integrated Care Board, comments from patients and carers. We have not yet had Healthwatch's formal evaluation, but we are expecting that fairly soon.

Q7 Grahame M. Morris: Would it be reasonable to send a copy to the Committee when you receive it?

Helen Smith: Yes, of course. We are happy to do that.

Grahame M. Morris: Thank you very much.

Q8 Barbara Keeley: Thank you for the presentations and information that we have had so far. We have had many questions already about financial resources, but I am going to return to that and it is a two-part question. First, can you just tell us what the overall financial context of the local authority is and has been since 2010? Have there been budget cuts and

how much? Has that meant any actual cuts or changes in eligibility for adult social care? That is part one.

I think you said that you had worked out or were working on how you are going to utilise the allocation you received as part of the Better Care Fund. Perhaps you could confirm that. Is there any concern on behalf of acute providers, who are partners, about the impact of the funding changes on them? I suppose two sides of the impact of funding changes: first, what has happened to the local authority; and, secondly, if acute providers have to have that adjustment for the Better Care Fund, are they concerned about that?

Jay Stickland: I will start the question because it is quite a detailed one. It is in several sections and my colleagues might want to come in as well from the health perspective. In terms of the eligibility you talk about, Greenwich has maintained, as with many councils, the critical and substantial level and we have not changed that at all. We have continued to provide services to people who fall into the critical and substantial area of need. We have, of course, like every council, had cuts.

Q9 Barbara Keeley: Could you say how much there have been overall?

Jay Stickland: I can talk in terms of social care. We had about a 20% cut in our staffing and we managed to protect our actual care budgets. How we managed the cutting staff was through the integration. That was one of the big drivers for us, around integration. Previously to this, we had a separate management structure, and at the time when the savings came around, we moved to a single management structure where health and social care managers shared the management responsibility and teams were pulled together. That enabled us to make significant savings in our staffing budget with no change in terms of our frontline staff. Obviously, that is what we wanted to protect, so we continued with that.

It is also fair to say that our commissioners got very involved in terms of how were we going to see the whole service go forward. We believed that we needed to make sure that people were utilising their skills. In terms of social workers, we knew that they were a very important group of staff with a very specific group of skills, so we moved our brokerage and care planning processes out of the social care domain into the third sector. That was done simultaneously, so that the third sector could understand personalisation and how they had to change their delivery models to fit within the new care structure. All those things had to align and we had to work together to get all those fitted, and, through that, we were able to make our savings in that way.

In terms of the Better Care Fund, we obviously sat down with our colleagues and we have come to an agreement. Again, the benefit we had was from an integrated process. We could recognise how the whole system had to continue to function. We had a very clear idea of where we needed to place resources to ensure the whole system worked and we came to an agreement on that and signed off our report.

Q10 Barbara Keeley: Just before you leave that, you have not said what the overall position of the local authority is. What has been the change from 2010 to now?

Jay Stickland: The overall position is our services have been static. Unlike many authorities, we have had a slight reduction in our residential placements and a slight reduction—

Barbara Keeley: Sorry, the council's overall budget.

Jay Stickland: I do not know the council overall.

Barbara Keeley: Perhaps we could just have the figures later.

Jay Stickland: We would be glad to send you the figures, yes, of the council.

Dr Rosen: Can I just add one thing about the Better Care Fund? I hope that we have pointed out three areas in which there are savings to the system from the two years we have had of whole system integration that we are now weaving together and developing and attaching to primary care, which is our phase 2. They are from reduced conversions of A&E to emergency attendances, reductions in the long-term care placements, and an increase in the proportion of patients who leave a short-term rehab without the need for a long-term package.

For us, the Better Care Fund is the investment that we need to enable that to happen. Part of that, getting back to this morning's discussion, is investment in the additional voluntary sector and statutory sector services to address the extra needs that we are meeting. Only our evaluation will tell if the further reductions in emergency admissions and long-term placements outweigh those investments, but what we are also finding is that this work is revealing gaps in our services. For me, in Woolwich, it is drug and alcohol and dual diagnosis services and we will invest in them through our Better Care Fund. It is a stated commitment. We will not be able to meet all the needs of the people in Woolwich, I agree with you. In this financial climate there will be eligibility criteria, but we are confident or perhaps optimistic that, by investing in those services early, we will prevent the journey of people through to this kind of chaos and we will be able to address some need, but I bet it will not be all of the need. We will then have to see whether we outweigh that with the savings from the three pods that we have talked about.

Q11 Andrew Percy: Just a clarification on the eligibility criteria for social care, and I may have misheard you, did you say you have or have not changed the eligibility criteria?

Jay Stickland: We have not changed it.

Q12 Andrew Percy: It is substantial and severe needs?

Jay Stickland: No, it is substantial and critical.

Q13 Andrew Percy: Substantial and critical, sorry. When did it move from moderate?

Jay Stickland: I have been here nine years and it has always been at the same level. I think about 80% of councils tend to work on the top two. There are a minority who work on moderate.

Q14 Andrew Percy: I am just interested, because my council is still working on moderate.

Jay Stickland: We do obviously have the universal offering range that those people can access and I did talk about that this morning.

Q15 Andrew Percy: Which is the £10 referred—

Jay Stickland: But that is just one example. There are hundreds of services in that particular range of things. I just gave one particular example today. We would tap into lots of those different services.

Q16 Andrew Percy: From Government, how much was the Better Care Fund allocation for Greenwich? I missed that.

Dr Rosen: £12.2 million or £14.2 million. We can find out; it is £12.2 million or £14.2 million.

Q17 Barbara Keeley: Just one aspect of the question—I know there were a few parts to it, but just so we have that information—are any of the acute providers concerned about the impact of a Better Care Fund given it will mean less funding for them?

Helen Smith: One of the gaps we have had in terms of our processes of care is that we do not have the Acute Trust firmly enough to get to the table talking with us. The reason for that is not that they do not support the project in principle, which they do, but they only formed on 1 October. There has been a huge task for Lewisham and Greenwich Trust in establishing itself and getting to understand and getting to know Greenwich and taking over the Queen Elizabeth Hospital, which, as you will know, was under very significant strain when they took it over.

Our approach with the Acute Trust has been to keep talking with them so that they have been kept informed, but they are not yet fully members of the Integrated Care Board. We certainly hope that they will be because they are clearly critical in all of this. I do not think I could comment on what they think in terms of the Better Care Fund. I do not know, Rebecca, if you—

Dr Rosen: There are two things that they are looking for. One is reductions in length of stay, because we have significantly lower lengths of stay than the neighbouring borough and we know that we can reduce that further. The other is relief for A&E. In the short period of time since it was formed, which is six months, we have begun to make progress in helping the pressures in A&E. I say that we still have some pretty poor A&E data here, but the contribution of this system to the newly-formed trust: we are just getting going on making sure that it works here for A&E and the admission avoidance.

Q18 Valerie Vaz: Can I just start by saying thank you to everyone at Greenwich and also our Health Select Committee secretariat for a very informative day here this morning? Just following on from what you were saying, Helen. Clearly there are some savings being made at the acute end. Do they hang on to that and is the better way of looking at this as a kind of pooled budget?

Helen Smith: Undoubtedly, the next step for us is to look to see how we put an appropriate commissioning framework around the work of the whole system and we have had discussions about that that. We do not have any agreements that I can report to you today, but what is critical is a number of things in that. I know, myself as a provider, that if activity is being taken out of one part of the system then it is incumbent on the whole system to make sure that actual costs are taken out as well. We have not yet established

what the system will be in terms of where we put the incentives, particularly financial incentives, and how we put a shared system in place that incentivises the right behaviour.

We have discussed things like having perhaps an alliance contract in place with all the key stakeholders involved in that, which would then incentivise everybody to deliver towards an integrated goal with a risk share system sitting on top of that. I have to say that is very early discussion and there is no agreement about that, but that has to be the next step. We have to get that formal commissioning framework around it and then, out of that, we need a contracting framework. That has to be a win-win and that is difficult. Nationally, this is a problem that all health economies are grappling with.

Q19 Valerie Vaz: Is that something you can use the Better Care Fund to look at?

Helen Smith: Certainly, in terms of the commissioning framework, the Better Care Fund is a very significant investment in the local health economy. In terms of how we use that to put the right incentives in place, that is going to be absolutely critical going forward. Yes, absolutely the Better Care Fund will need to be part of that.

Q20 Valerie Vaz: You are one of the 14 pioneers. What kind of support are you getting from the Department of Health or Monitor or various other support bodies behind you to ensure that this succeeds?

Helen Smith: We are certainly getting local support from our project manager, who is here in the public gallery, who has been a great support to us in terms of helping us identify what are the places, attacking problems that we are coming up against and helping us find solutions to those.

Jay Stickland: We have tapped into some of the more general conversations that are around information governance and IT. We have people from our organisations who are having discussions, because there are at least two IT solutions that are being looked at around sharing information across organisations. It is very helpful, both at a south-east London level but also at a London level, in terms of IT and information governance. It has been made very clear to us that if we have a specific issue that we want to flex a system then we can talk to our NHS IQ project lead and work with our senior link officer as well about trying to talk people like Monitor about different things.

What we are finding it is more about sifting out things. Initially, there was almost too much help. We are trying to work out how we then picked out the specific bits that become useful and where we needed to go for that, but NHS IQ have been very helpful.

Q21 Andrew Percy: I have a couple of questions. I will start with the intermediate beds because we have a planning announcement. What are we doing in terms of intermediate care beds? Have you increased the number of intermediate care bed facilities as part of this?

Jay Stickland: We have a total of 56 intermediate care beds in Greenwich, and we have had them for some time. I did explain this morning that we are very fortunate. We have a range of intermediate care beds that range from sub-acute where we have a geriatrician who attends to do ward rounds so we can manage people with high need, through to extra care flats for someone who just needs to regain confidence. That is an absolute vital part of

that, so we have that. We did have a slight increase over the winter months to help us with an additional influx of people coming through the system, but we are back to our core numbers now again, which is the 56.

Q22 Andrew Percy: Just leading on from that—with your permission, Chairman—we went to Denmark and Sweden. We are not a well-travelled Committee. It is our own trip, unlike other committees, but we did go and see Home Care in Denmark and the equivalent in Sweden. One thing we were presented with in Denmark, I think it was and probably in Sweden as well, was that the people who went through intensive home care often required less support at the end of it than at the beginning. I noticed in the pack you provided us with that, on average, 64% of people entering a new pathway require no further services after completion of the pathway. There is not a comparator to that. How does that compare to what a similar co-op would have been under the old system? Would they have required ongoing care, continuing care?

Jay Stickland: Yes. What previously happened and still happens in many areas is that home care is introduced at the point of crisis and, therefore, people become accustomed to a certain level of support, two or three visits a day, or whatever. What we did was a radical change whereby everybody who initially requires any form of support goes through a reablement process. We have an in-house. That is a local authority-run service, although it can be accessed by health and social care and that is the same with many of our resources, and people undergo a period of reablement.

Basically what that means is a physio/OT will go in. They will set the exercises and what needs to happen and then the reablement team go in there, maybe up to four times a day, and carry out those activities. Then there is a multidisciplinary meeting every week reviewing all the people that go through the system to see if you can reduce services. That has proved very successful. We currently have 64% of people coming out requiring no services and that compares favourably with the London average of about 50%.

The other thing to mention about it, you are not quite comparing like for like, because many in-house services select people who have conditions that are particularly responsive to reablement. In Greenwich, everybody has that opportunity and we still manage to get a much better outcome from that.

Q23 Andrew Percy: Presumably, that goes towards your £900,000 saving. Perhaps, Chairman, we could have more information. I am a Conservative, so I do believe you can spend less money and provide a better service, but even I, despite that, struggle to understand where the £900,000 of savings is. It does seem incredible. Great if it has happened and all the rest of it, but I still do not think we have drilled down enough on that. Perhaps we can have something after this Committee in more detail about where those savings have been made, and presumably this is one of those ways.

I suppose that just leads on to the final question regarding the tariff. Again, there is another saving that was identified—although we thought the tendency went towards this £900,000 this morning—was, of course, the reduction of activity in the acute sector. Of course, what we have heard is that saving is not realised back in the social care or in primary care sectors. I wonder if you could say something about tariffs and payment by results and

how that is working within the system; whether it is working against it and what reform is necessary about that.

Jay Stickland: Some of my colleagues might want to come in, but just carrying on the theme of reablement, it also does play into how the CCG can save money because we have increased the amount of initial community interventions. First of all, CCG does not get charged at all if we manage to keep the person in the community. In other words, if the GP phones up and our teams go in there while the person is still there, there is no additional charge for the CCG. If we catch them in A&E, there is one charge, which is at a lower rate, and, again, because I did say our teams are in there seven days a week, 8 in the morning until 8 at night. So there is a presence in A&E. Again, that reduces the cost for our CCG colleagues. Likewise, if they catch them at the AMU, which is like the ward prior to being admitted, again we attend two ward rounds a day. By pulling people out before they get into the actual acute system, all those costs help our CCG colleagues and keep the price of the overall thing down.

Now, our savings in terms of the local authorities is at the other end when people get discharged. We are not putting services in straightaway because we are stabilising the person and getting them better; then our long-term packages are shorter and the number of people having to go into care is as low as possible. Does that help?

Andrew Percy: Yes, it does.

Helen Smith: I would support also what Jay said. Savings anywhere in local health and social care funding can be a good thing and we should all support that, but we do have two different systems of payment, of course. We have the tariff payment by PBR within our Acute Trust and then we have a block contract for the delivery of non-acute services. What I was saying earlier about needing to review our commissioning framework, this is why it is so critical because the system that we have at the moment focuses on activity and payment to institutions, rather than getting everybody working and payment being linked to outcomes, quality improvements and the delivery of integrated care.

At the moment, the two payment systems sit side by side. They what we have and we have to live with them, but they do not provide us with the maximum type of incentives that we could put in place if we look at the commissioning framework. We have examples in the country now—for example, down in Somerset, where they are working with the Acute Trust to try to put an alliance contract in place and try to put a financial gain and risk share in place across a whole range of agencies. That certainly is the next step for us. At the moment, the systems sit side by side and we live with them, but they could be better.

Q24 Andrew Percy: It is a barrier for delivery?

Helen Smith: Sorry?

Andrew Percy: It is a barrier for delivery.

Helen Smith: It is what it is. It is not a barrier in the sense that that is the system we have, but we could improve it.

Q25 Chair: Before I call Rosie Cooper, I just want to ask you about regulatory regimes. Health and social care are generally regulated by the Care Quality Commission.

You have Monitor. You have Trust Development Authority. Do all these different regimes cause any problems for you? Is that something that you think needs to be addressed?

Dr Rosen: One of our core messages through the day is that this is bottom-up work, about changing the way professionals work, and you can do an awful lot irrespective of regulatory regimes when you are focused on quality and improvement. Is it a barrier to the day-to-day development of different ways of working? I do not think it is, although these guys can add if they do. However, in terms of the way that it is sending out different institutions, running after quite a lot of process, it is time consuming. At the moment it does not feel like it is pulling us together. It feels like we are pulling ourselves together perhaps, despite having to work towards regulatory requirements.

Q26 Rosie Cooper: Conversations we have been having today are rather broad-brush and have been short of actual numbers. I know you have promised to send us these numbers. Barbara has asked about the overall council budget. I just want to make sure that we include the social care budget and also the amount of money that you have for commissioning the third sector support. I think that is missing. I am grateful for that kind of figure being supplied and any that I have not asked for that you think is useful.

I would like to direct my comments to Helen. You have just been talking about the commissioning framework and that the newly-formed trust is not at the integration table quite yet, as you described it, but they must be setting their plan for the future. They know the Better Care Fund is going to strip out quite a lot of top-line cost for them and that, if you commissioned it from other places, they have to provide services, however that is, and you talk about sharing risk. The pilot that you have across the borough, what impact will it have on the trust, do you think? Do you think it would affect the viability of the trust? What should they be planning for?

Helen Smith: I do not think I can comment on whether it would affect the viability of the trust, but the impact of the pilot on all of our services is that hopefully people will be supported in their own homes and their use of primary care, secondary care and non-acute services will change and will become more efficient, more streamlined and more focused. The impact for the secondary care acute trust will be that the pattern of their activity may change. It may change in terms of, certainly one hopes, the unplanned care. Clearly, one of the things we want is a reduction in the use of unplanned care resources.

In terms of the rest of the hospital, because unplanned care is only one small part of what an acute trust delivers, what we would like to do, and certainly what we hope to do and what we are doing in some areas, is working with colleagues in the Acute Trust to be delivering services differently and in different environments, particularly people with long-term conditions. For example, how do the community health services—things like the diabetes specialist nurses—work with colleagues, consultants, in the Acute Trust in a different way; in a way that focuses on reducing the use of acute secondary hospital resources, keeping people more in the community?

Q27 Rosie Cooper: Absolutely, and I am very involved in having an integrated care trust in my own area, so the principle is established. What I am trying to get to is, if the Acute Trust is not yet at the table, how are they going to prepare for this and will the change of commissioning mean that they will be subject to—it is about actual figures. How much money is going to disappear out?

Helen Smith: I think we all want to respond to that. In some instances, it is a national issue about how we relocate the locus of care and support our Acute Trust to continue to be sustainable. It is clearly absolutely critical that they do. We do not know the answer to that. What you have to do is we have to involve our Acute Trust colleagues in this whole system we are delivering and work with them about what—

Q28 Rosie Cooper: You said they are not involved. You said before that they are not at the table.

Helen Smith: Yes, but in terms of getting a commissioning framework in place, they have to be involved in that so that we can get—

Q29 Rosie Cooper: But too late; you will have made all the decisions and they are to be given what you decide.

Jay Stickland: In fairness, I am on the Clinical Leadership Group, which is for six boroughs. Obviously, today you have come to talk about the Greenwich Co-ordinated Care, but obviously it works within a greater patch. Particularly the acute hospital, you must remember, Greenwich is only one of the boroughs that use that particular hospital, although we do use it a lot.

There is another group working currently called the South, which covers the south-east corridor, and we are working with all the hospitals in this particular group. The other one is run by the Greenwich and Lewisham group, but also King's and St Thomas's as well. Conversations are going along through all that corridor about how we can move activity out of the hospital into the community. There are discussions taking place with acute hospitals in terms of starting to have conversations.

We are relatively a short way into the process, but we are talking to acute hospitals and starting to say, "Okay, if we want to take 20% of this activity out maybe we have to look at how you view consultants and how they view the population they look after." Rather than look at it as a process of the consultant has 50 beds or 100 beds, you start thinking about community-based and how you spend some of your time in the community and shift that and move it over, because if we start having dialogues with them about those sorts of things that retains their ability to continue as an acute hospital.

Those conversations are taking place, but obviously today we are talking about the Greenwich Co-ordinated Care, which is one aspect. What you have to do, to do that—and we did touch on it today—is each borough has to create a community offer because, for those acute hospitals to have the confidence for those services to be managed externally, you have to develop a community offer. This Greenwich Co-ordinated Care is Greenwich's answer to that community offer.

Q30 Chair: That is very helpful. I just have a couple of further questions for Helen Smith on patient choices, which was raised this morning. How important is patient choice in the scheme of things? Evidence is that personal budgets, when they are introduced, reduce the costs of treatment and the cost of carers, and they increase the power carers and increase patient satisfaction. Is that something that is important to you?

Helen Smith: We are certainly hugely supportive of personal budgets.

Chair: You are hugely supportive?

Helen Smith: Supportive, yes. Through our integrated mental health services, both health and social care staff play an active role in supporting delivery of personal budgets, and the same as duly integrated care services as well. Patient choice, if I understand you correctly, is a slightly different thing and that is around health. Outpatients can choose their provider. That is something that the cohort of patients that we are talking about, the Greenwich Co-ordinated Care, have rarely, if ever, used. Nationally, patient choice is predominantly used for people needing elective care and it tends to be younger people who would use that. At the moment, it has not played a large role in the co-ordinated care project, but certainly we would want to support any patient in making an active choice about where they got care.

Q31 Chair: Finally, there is clearly a huge amount of good will and trust across the services provided and we heard a lot about that today. How much does that rely on outstanding individuals? If one or two key people decide to move on, does that mean that the whole integrated service would be threatened?

Dr Rosen: That is a question that is put to us often. I am the newest member of this group and I joined the Clinical Commissioning Group two years ago, when this was kind of at the end of its first year, and perhaps if you had asked me then, I would have said if the wrong bus ran over the wrong people we would have been in trouble. I have observed over the time since then that this is now embedded. You heard somebody this morning refer to the fact that people move away but then come back and choose to come back and work here. That is evidence of the fact that it is very professionally satisfying. There is nothing more professionally frustrating than chaos and poor information and poor co-ordination. The fact that we have cracked a lot of that is now hard-wired into the system.

Leadership is important. It is always important and, for my challenge now, the challenge is getting this embedded and just hard-wired into primary care. You heard from Dr Subbarayan this morning. He is a key player in that. It is already spreading out to the syndicate leads and will take time to get that entrenched in primary care, but I would say that it is now hard-wired into the kind of health community and social care fabric.

Chair: Thank you. On that happy note we appear to have run out of time, so on behalf of the Health Committee—sorry, one last question.

Q32 Dr Wollaston: I just have one last question, if that is all right. Much in the news recently has been the parity of esteem agenda. I just wondered if that is something that you feel confident you will be able to address, trying to achieve better services for the people in mental health.

Dr Rosen: Across physical and mental health?

Dr Wollaston: Yes.

Dr Rosen: Estelle was here this morning. Maybe not from the very beginning, two and a half years ago, but certainly all through phase 2 of this work the mental health team from Oxleas are a fundamental and core part of this. We are doing some quite interesting work with our citizens in Greenwich, and it is one of the messages coming in from them about things that we need to do. Through our mental health commissioning lead in the CCG, we are looking to commission initiatives that will improve parity of esteem and that will include training for primary care, but perhaps also going into schools. We might be getting some work in schools to try to improve the awareness of school teachers and school children about physical and mental health issues. It is something that we are very aware of and just starting to seek to address.

Chair: Helen Smith, Dr Rebecca Rosen and Jay Stickland, thank you very much indeed for a most informative and helpful session.

