HOUSE OF COMMONS

Health Committee

Oral evidence: Integrated Care Pioneers, HC 560
Monday 14 July 2014

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Members present: Dr Sarah Wollaston (Chair); Grahame M. Morris; David Tredinnick

Questions 33-67

Witnesses: **Dr Carl Ellson**, Chief Clinical Officer, South Worcestershire Clinical Commissioning Group, **Dr Bernie Gregory**, Well Connected Clinical Lead, and **Dr Richard Harling**, Director of Adult Services and Health, Worcestershire County Council, gave evidence.

Q33 Chair: [Audio missing]

—is as robust as it can be. In the interventions that you are doing here with the Well Connected project or pilot, in terms of another group of similar population size where there are not similar interventions, a kind of scientific control, if you like, is there any comparison there that could reasonably be made?

Dr Ellson: I am not conscious that we are comparing our local health economy with another exact local health economy and I do not think we have put thought into that. What we are very conscious of is looking at our current performance against the metrics that Richard has mentioned, such as hospital admissions and access to primary care and so on. We know where we are now and we would obviously hope that in two or five years' time those would continue to improve as a result of the Well Connected work.

Q34 Grahame M. Morris: In gathering the evidence that would indicate the programme is delivering what the patients desire in terms of outcomes, how do you intend to monitor these patients and seek feedback from service users like Healthwatch and so on?

Dr Gregory: We seek views in a variety of ways. Yes, Healthwatch is on the board of the Strategic Partnership Group to very much be a voice of the population of Worcestershire. Beyond that, we have access into a wide variety of service user forums, a number of council forums. We run a number of workshops in terms of individual projects, taking into account patient views. There is data such as the Friends and Family metrics, the national GP survey. I think it is about bringing together evidence from a wide variety of patient consultation and engagement, gathering that up together and looking at the final outcome.

Dr Ellson: If I could just add as well, these are the services that have yet to be defined but an idea, if you like, about the way we would like to commission services over the next two to five years. In building up the service specifications, as I said earlier, we want to involve the public in working with us to come up with our service specifications and also to work with us to identify the parameters by which the success of those services will be compared in years to come. At the moment, it is all work in progress. We mentioned earlier about the client group that we are looking at delivering services to differently, but very much it is about involving those in how we do measure it, almost like a specific Friends and Family approach to how services are now and how they will be after two or five years.

Q35 Chair: Can I return to a point that Grahame was making earlier? One of the problems with all of these pilots is that the quality of data has not been there. In order to justify rolling it out to scale across the country, the data really does matter. Another issue that has been raised in other areas is that very often it is just a very small client group that can benefit. Could you be clear with the Committee about whether this will benefit the whole community or just a narrow part of the community?

Dr Gregory: No, the programme is there for the entire population of Worcestershire. Obviously, different elements of the transformation programmes may be focused on particular population groups, but the access to services is definitely for the whole of Worcestershire. Some parts of the programmes will be running specific pilots in which there may be contained groups of population that we are specifically looking at, but by and large most of these are services that are already there and up and running. We are just trying to join them up more effectively and they are available for the whole population.

Q36 David Tredinnick: Good afternoon. Looking at the briefing that we have received and listening to you this morning, it seems that the typical political law of unintended consequences—I am not saying you justify as a politician but it certainly applies to us—might be applying to where we are here in that in trying to develop a system of integrated care one of the things you manage to achieve or will achieve through this is discovering new health requirements, new issues that need to be dealt with. On the one hand, we are talking about decreasing costs by integration, but isn't perhaps the opposite the case in that what you discover through this new integration, this crowbar under the flagstones as it were, is a whole range of new issues that have to be addressed? I put it to you that perhaps both increasing costs and increasing demand will at the same time do completely the opposite of what was intended.

Dr Harling: First of all, we need to understand that this probably is not going to be a revolution. We are not starting from a point where care is completely not integrated and then moving to a point where it is completely integrated. This is a journey that we have already been on for a number of years. Like a lot of other areas, we have a number of what we believe are real strengths where care is very well integrated, very high quality, but we also recognise ourselves that we have other areas and other services where that is not as good as we want it to be. As we move forward, we are going to have to look at those individual service areas and think about how we can continue to improve the quality but also contain the costs. While I accept the risk as you put forward, which is that we do identify unmet need, we are simply not going to have the budget to deal with that, so we

are going to have to construct integrated services in the future to deal with what is going to be a greater demand within the budget that we have. We simply do not have an alternative.

Q37 David Tredinnick: To what extent do you think through bringing these services together you can reduce duplication? Or is it the case that rather than reducing duplication you are running systems in parallel because it is easier to do that?

Dr Harling: I think you are quite right that the evidence base at a system-wide scale that integration will save lots of money simply is not there, or it is not there yet. When we reflect on aspects of our own system, which again could be reflections that are applied nationally, we know there are examples. If you take the example of a patient assessment, we know there are examples of where different groups of professionals are asking the same people the same questions over and over again. Now, that is not good for the customer but you can also see how if you can ask one set of questions once there is potentially an efficiency there. Intuitively, greater integration ought to save money, but what we need to do is to make sure that we realise those opportunities. We have a lot of learning to do and one of the benefits from being a pioneer is that we can try things out, learn from them, share our best practice for other areas to benefit from, and obviously vice versa because I do not think there is any area that does everything really well. Every area has pockets of good practice and what we want to do is to take all of them, learn from the best and build on that.

Q38 David Tredinnick: Isn't the situation further complicated by the fact that the Secretary of State has said that he wants to put the patients at the heart of the health service and that, if that is to be the case, then patient choice flows from that statement? Indeed, the Health and Social Care Act has put in place health and well-being boards and Healthwatch. The remit of Healthwatch is to be the consumer champion, I read, so how are you going to cope with patients who may be demanding different kinds of therapies that are not normally being offered by physicians?

Dr Harling: What we need to understand is whether we deal with those choices at a population or individual level. One of the examples that we have seen in the last week or so is comments about individual patient budgets in the NHS, which is a fantastic opportunity for greater patient choice because it means that individuals will control their own allocation of money. What there are also likely to be from that are consequences. For example, if everyone chooses to go to one hospital rather than another, then the second hospital becomes unviable. The question will arise: what do you do about it? Now, that is not a matter that historically we have been particularly keen on grasping, and we all know of examples where hospitals have lost activity but have been bailed out by other bits of the system. As we want to evolve patient choice, we also need to understand that it comes with consequences in terms of where the money flows to. We also need to understand the political implications of those consequences.

Q39 David Tredinnick: I absolutely understand that coming from Leicestershire where we have Leicester Royal Infirmary and George Eliot Hospital in my constituency and patients have choices and preferences. I am thinking more about patients' personal

preferences and I think what you were alluding to in the answer to my last question was about personal budgets. There have been these very successful trials conducted by the Department of Health, which have shown that if you allow patients with long-term conditions, it should be said, to have some control over how their budget is spent, several things happen. Three things specifically happen. The first is that the actual costs of the care tend to decrease. Secondly, and perhaps I should have made this point first, the patient satisfaction goes up. It also has shown that life becomes immeasurably easier for the carers, who can then reorganise their lives so they can go out to work. The fourth point is that some of the therapies that patients have been asking for may not be very popular with doctors, such as piano therapy or even going to a sporting event, tai chi, having reflexology, aromatherapy, which is very powerful from the point of view of helping patients who have anxiety. Are we not in a whole new paradigm here where we are going to have to as part of this package listen to patients and what they want?

Dr Harling: I think the whole personal budget debate opens up some really interesting discussions. I get the impression that areas around the country will have the opportunity to go further in terms of piloting some of these NHS personal budgets. There are two things for me that we will need to think through. The first is that there are consequences about people's choices. If they are choosing to spend money on one thing rather than another, what do we do about the thing that they are no longer spending money on? We will not have the money to double run it. The second thing, on the example of some of the complementary therapies you have identified, again if people choose to use those and they are unsuccessful and they appear then at the door of A&E as a consequence, what would the NHS say to them? Would it say, "Come in and have some treatment" or would it say, "Unfortunately, you have spent up to the limit of your personal budget and, therefore, we are going to have to charge you 50% of care"? So, again, it is a really interesting discussion and it will open up some of these difficult political, moral and financial issues that come as a consequence of that.

Dr Ellson: Can I just add one as well? As a commissioner, we are responsible for the services that we commission to the public that we serve. If you remove our responsibility and pass that over to individuals, do they become responsible for the quality of the services that they individually commission? At the moment it is manageable, but in due course, yet again, it is an unanswered question. How do we start to police these services that are given to those patients that they are in turn commissioning themselves?

Q40 Chair: I guess that returns to the point about collecting evidence and also the dilemma you will face. I presume that if people decide to take their personal budgets elsewhere that might make a day care centre unviable. The story will always be a closure of service rather than the fact that people are exercising choice. Do you have plans for how you can deal with that?

Dr Ellson: We did briefly discuss this this morning, didn't we? It is about double running. There will be a period during the evolutionary process of the next five years where people's choice may dictate that they seek alternative provision, but we still have to keep the current providers open and serving their public who have not made that choice. I think in maybe five or 10 years' time this will sort itself out, but in the short term there is going to be some double running. Again, we do not have the answer to that today but we are very aware that that will be a problem in the future.

Q41 Chair: You will be collecting the evidence on those double running costs as we go forward?

Dr Ellson: We are in a way at the moment with our acute services review that you may have heard of. We are looking at reconfiguring services and centralising some of them, which probably will incur increased costs in the short term because of standing costs and also because we do not want to, I suppose, inadvertently under-provide. We would much rather be in the position to over-provide and realise afterwards that we could reduce the level of expenditure. If you like, it is a real example now of where we are, which obviously feeds into the system.

Q42 Chair: One area I was particularly impressed with this morning was your palliative care project and that you have managed to almost reach the 60% target; in fact, the first in the country for allowing people to die in the place of their own choice. One of the many ways that you got to that point was you instituted a number of measures, but one of them was allowing free social care at the end of life, even for people who might otherwise be self-funders. The evidence from that kind of project is vitally important if we are going to persuade other areas to adopt the same model that you have developed. Again, it would be very helpful to have your evidence on that if you can possibly let us have that as a Committee.

Dr Ellson: Yes, we will ask, as we said earlier, Simon Rumley and Debbie can certainly provide you with evidence of the work that was explained to you this morning.

Chair: Thank you.

Q43 Grahame M. Morris: You may be aware that we have visited this afternoon the Timberdine community-based nursing and rehabilitation unit, and an excellent facility it is in terms of offering reablement and rehabilitation to stroke victims, some step-down care and some intermediate care, and a range of services that allow people, given the necessary skills, which may be fairly basic in terms of relearning the skills to be able to walk around and to be able to cope for themselves and so on, to live a more independent life. The benefits are better outcomes for them and there are cost savings because there is less time spent in hospital as an admission, for example. On that kind of principle, on that concept, does the evidence base for integrated community care support the anticipatory care plans? Intuitively, if we anticipate and we identify at risk groups, and these may be older people, frail elderly with poor mobilities, at risk of escalation of ill health and hospital admission, is the evidence that the interventions through the Well Connected programme have paid dividends there in terms of better outputs, better patient experiences and outcomes, and cost savings with less hospital admissions?

Dr Harling: First of all, thank you for visiting Timberdine. I know that the staff were really pleased to have you. Timberdine is an example of one of those things that we are really proud of and that we think works really well. We have pretty good evidence there both in terms of customer experience—so people say that they like it—and also in terms of its role in enabling early discharge and rehabilitation after an episode of acute hospital care, be it a stroke or something else.

We do quite a lot around anticipatory care. Around the county we have what are called virtual wards, and what they do is they segment the population to identify the highest risk people who are at risk of a hospital admission and then intervene to try to manage them in the community to try to avert that. We do think that those evidence some signs of success. One of the things we want to do is to build on those where they have been relatively small scale and scale them up to more industrial population size scale. Whenever we do something like that, we try to evaluate the patient impact of it very carefully. One of the challenges to that is that obviously health and social care is a very complex system with a whole multitude of factors. Trying to work out the impact of one individual service or one individual intervention in the context of a whole lot of other social and service changes can be quite difficult. As I say, we do try to collect the data so that we can try to build that library of learning of the things that we think work well locally that we can share and looking reciprocally for other areas to share their better practice.

Dr Ellson: I would just add as well that one of the reasons that the end of life work is successful is, as you say, the anticipatory care plans are in place for that client group. We briefly did discuss also today the care home project that we have going across the county where, again, all of the residents in care homes now have an anticipatory care plan. In South Worcestershire, over 1,000 patients who reside in care homes have care plans in place. That is already producing results by a significant reduction in unplanned admissions. To get that to the level we want it to be in three or five years' time where 5% of the population will have anticipatory care plans, we are going to have to increase that capacity tenfold in order to achieve that, which is no mean feat but it is obviously something we have to address.

Q44 Chair: Could I come on now to the Strategic Partnership Group? Could you describe the nature of the relationship between the various partners? Is that an informal relationship or is it governed by a legal agreement?

Dr Harling: The Strategic Partnership Group is now the group across adult social care and health that oversees a range of transformational change programmes. That group is a subgroup of the health and well-being board. It is largely a partnership of programme management groups. What it does is it oversees changes to the system. It does not at present have any delegated authority from any of the agencies to make decisions or commit resources. It works on the basis of relationships and mutual influence and people coming and honouring their commitments rather than on the basis of a legal agreement.

Q45 Chair: Can you describe how far budgets are pooled and how that risk is managed? Obviously, money is short across the whole health and social care system and while sometimes having a reduction in funding can make people work together more efficiently, if it goes elastic, stretched too far it makes everyone retreat to their silos. Where would you say you are on that spectrum at the moment?

Dr Harling: We currently have an arrangement through section 75 of the NHS Act 2006 whereby the county council and the CCGs align a whole range of budgets. It is largely for mental health, learning disabilities and some aspects of the care of older people and people with disabilities. The total value of that is around £175 million across the four organisations. The vast majority of that is aligned rather than pooled and that means that

the organisations all work together to make sure that the decisions they take are aligned and that they are not moving the system in a different direction. However, the individual decision making and the risk and reward associated with budgets sits with the individual statutory agencies. The one exception is the budget for Community Equipment Services, which is about £3 million, which is a genuine pooled budget where there is a risk-sharing agreement in place.

Q46 Chair: How much do you feel the success of the programme is dependent on those financial alignments and how much of it is about personal relationships between the spirit of goodwill and co-operation?

Dr Gregory: I think to the larger degree it is about the spirit of goodwill and co-operation. As I say, we are not at ground zero here. We have been doing integrated care in different guises for a number of years in the county and it has very much been on that basis. As I said, from my own point of view I would not be here if it was just about the money. We obviously will have to work within the financial environment that we are in, but we certainly cannot achieve that unless we have that trust and development among the senior leaders in the county and then that cascading through all our organisations.

Q47 Chair: If the pioneer programme does generate savings, how would you intend to prioritise them across the system?

Dr Ellson: Our vision about savings in the long term would be to transfer, if you like, an amount of money to the next group down. Bernie hates it when I talk about the 5/40, the 5% of the population who consume the 40% or whatever metric that we get in the future. If, and it is a big if, we can generate savings by producing more efficient services to those people, then to move that money down a tier so that we hopefully prevent the next group down from becoming the next 5/40—it is about the people who were bubbling under the 5/40 to really make sure that we are treating them appropriately so that they do not become the next people in the 5/40.

Q48 Grahame M. Morris: Well, it is leading on from that. Again, just from what we have seen this afternoon and at Timberdine in terms of integrating multidisciplinary teams, that is a very good example that we have seen but is that common where we have joint working? We were told there that there was a group of nurses who had been transferred from the local hospital, from an acute ward, to that facility and they had been integrated in a multidisciplinary team with occupational therapists, speech therapists, other groups who were already there. Is that a common feature of the teams that support patients in this kind of setting?

Dr Harling: I think increasingly it is. Timberdine is a very good example of where that is working really well. In mental health, we have very well developed integrated teams across health and social care, as we do in learning disabilities and, increasingly, in community social work and healthcare in the community. We have social workers, for example, placed in individual GP practices. Again, it is something that we are committed to doing more and more of. We have a lot of good examples where we do things really well and we have that to build on and think about how we do even more of it.

Q49 Grahame M. Morris: Following the logic of that argument along and trying to understand how the financial system works, presumably given that Timberdine is taking the strain, and there are also some benefits to the service users and patients from being in a community setting and rehabilitating them so they can return home and be with their families and loved ones, there must be a cost saving to the acute hospital. Is there any mechanism currently to apportion that cost saving to the local authority who is now employing those staff and taking on some of the costs that otherwise would have fallen on the NHS budget?

Dr Harling: One of the other reasons Timberdine is successful is it is an example where we have been able to take cost and capacity out of the acute hospital and put it in the community. We have been able to offer a better experience for people and shift the resources, so that is a win all round. For the local authority, the benefit is as people come through Timberdine, because of the rehabilitation that they are offered, they are then less likely to need long-term care packages, which can be very expensive. Therefore, there is a preventative element both for health but also for adult social care.

Q50 Chair: Could I ask about the Better Care Fund next because that is going to involve a very significant shift potentially from the acute sector to the community? How do the panel feel about Simon Stevens' recent announcements about how the Better Care Fund would be used? Also, how far advanced in planning for its use are you locally?

Dr Harling: The Better Care Fund has been quite an interesting policy journey. It originally started out as a way of trying to shift resources from the NHS to local authorities to support social care, recognising that local authority funding was under pressure. It quite quickly became apparent that this was not new money; it was money that was already committed to other services and, in many cases, it was acute hospital services. We, like most other areas, have submitted our initial details about how we intend to spend the Better Care Fund. That was subject to a national assurance process and that national assurance process was then put on hold pending some changes in policy about how the money could be used. We now have a policy direction around £1 billion nationally being ring-fenced to support the risk of a reduction in acute services not happening. We are now, like most other areas, just reviewing our plans.

One of the things that I think will be an advantage for us is we did not start out by being very heroic for 2015-2016 about shifting vast tranches of money from NHS into adult social care. I know some areas were quite heroic and are having to unpick and revise their plans. I am reasonably confident that we will be able to come to some negotiated agreement for 2015-2016 that all parties can live with and that deals with the adult social care pressures, the CCG pressures and the pressures on the acute trust.

Q51 Chair: One of the advantages of being a pilot was that you were going to have more support; no new money but more support. How helpful has that support been in practice? Could you maybe set out what the role of your sponsor from Monitor is and what kind of advice and help you get from that person?

Dr Gregory: Yes. Our sponsor is Tony Lambert from Monitor. Each pioneer site has been given what has been termed the senior sponsor. From major support through to supporting

the pioneer programmes, a senior person from that organisation is teamed up with a pioneer. Not on a particular basis of we are working direct with Monitor on the Monitor-type issues, but as a senior person that we can go to to try to unblock some of the barriers that might be occurring further up, so someone senior enough that we can contact—and, indeed, have on a number of occasions—just to help the flow of the discussion we have with the Department of Health, for example, in some of the issues we have as a pioneer.

Q52 Chair: Would you like to take the opportunity to put on public record what those blockages have been and how you feel they could be unblocked, if you like?

Dr Gregory: There are a number of blockages in the system. I am struggling to think of the ones that I particularly discussed with Tony, but certainly one of the major blockages we have, and it is common among all pioneers, is around information sharing and the legal issues that surround that. The issue of sharing information for direct care is relatively straightforward and obviously relies on consent. There is also the use of information that we might want to use in the segmentation of the population that we have talked about in terms of the Better Care Fund. We rely on actual different data sets from social care, mental health, hospital data, GP data, to get as accurate a picture as possible. Now, at the moment, the basis on which we can do that is far from clear cut. We are aware that there is a lot of work being done to try to facilitate the pioneers in doing this sort of work, perhaps looking at an exemption to approve the concept or not to take forward hopefully for maybe changing legislation.

Q53 Chair: You mentioned virtual wards earlier. In my area, they had to shut down virtual ward rounds altogether for a while but they are now back up and running, partly because of these data concerns. Are you able to operate virtual ward rounds here without any problems?

Dr Ellson: As all the practices across South Worcestershire and the rest of the county are now sharing the same computer package anyway, they use the same software package, I think there is less of a problem. We think we are looking at services in the near future.

Dr Gregory: That is not determined yet.

Dr Ellson: Okay, but at the moment I am not aware there is a problem.

Dr Gregory: I think it is using the data that you can as far as possible. There is still data that comes in around hospital admissions. There is data that you can collect from individual GP practices. Individual practices may take information that they have with some of the hospital data to produce risk-stratification models. Others are able to utilise information flows that are legal. I do not know all the detail about it.

Q54 Chair: Perhaps it would be helpful if you could set out to the Committee later on exactly what the remaining hurdles are and how that stops you being able to better integrate care.

Dr Gregory: Yes.

Q55 Chair: Were there any other barriers that you wanted to put on record?

Dr Ellson: There is one that involves the boring subject of pension attachment. Across the county, we are very keen on promoting and supporting the development of primary care and we have been very keen on encouraging practices to start to federate. Across South Worcestershire, the 32 practices have now formed a federation, but there are problems with regards the superannuation of services that the federation provides through the individual practices. We have used our pioneer status to ask the questions but at the moment there is not an answer because that federation, who delegates that work back to a practice, that work is no longer superannuable. You can imagine as an ex-GP that that could cause some concern among primary care.

Q56 Chair: Thank you. Any other issues at all?

Dr Harling: We would be very happy to take a sounding from colleagues after this session and send that on to you. The other big challenge that is testing us is about the whole idea of double running. If you think back to the late 1980s and the way we used to organise mental health services, most of it was provided in very large institutions. When you fast forward 30 years, the way we organise mental health services would be almost unrecognisable to someone back then. The way we achieved change was to put in the community alternatives alongside the more traditional forms of care and then move people out of them, so we did have that double running for a period of time.

Now, what we know we need to do over the next five to 10 years is do the same for the care of older people and people with long-term conditions, i.e. move the activity out of acute hospitals and into the community setting. What we do not have this time is the luxury of that double funding and that is going to make it that much more difficult and more challenging. I suppose the other question nationally is whether there was the opportunity for any pump-priming fund that could help to get some of these community alternatives started at scale and at pace. That would really help us, I think, in terms of shifting that mode of care.

Q57 Grahame M. Morris: There are a number of issues around both policy and physical barriers to integration. I was interested in your views on, for example, competition policy and fragmentation, whether that has had a negative effect on the plans to integrate and to deliver a better co-ordinated service. You did indicate to the Chair that you were going to consult with colleagues and come back with your views collectively. Maybe because we are short of time that might be the best way forward. Would you mind if I asked you a few questions about the social impact bond because it seems quite fascinating? This is fairly new to me and it does seem as if it is a form of alchemy insofar as potentially what it could deliver. The idea of using potentially private capital for a socially just cause to tackle isolation and depression and to prevent deterioration in individuals is fantastic, but is the social impact bond an additional resource or is it replacing an existing resource that the councils were previously putting into this particular area?

Dr Harling: Yes, across adult social care in the NHS we are about to go out to market for an investor and provider for services to reduce social isolation and we are looking for

people to fund them through a social impact bond. One of the spaces that we hope it will fill is the ability of the local authority and the NHS to invest upstream. One of the issues we have at the moment is that we are having to make savings extremely quickly and, therefore, the ability of the public sector to invest in some of the prevention programmes is becoming more and more constrained. The one thing that the social impact bond offers us is the ability to get cash in from a socially motivated investor to invest in services that in this case would reduce social isolation and prevent later demand and downstream costs. The advantage is it is cash that otherwise would not be there. The other advantage is that we would then monitor the impact of that and the public sector would only then pay for those services on the basis that they had achieved the outcomes that we wanted.

The other thing that it does is help us to get round this conundrum, which is that we know we should be investing in prevention and early intervention but the evidence base in terms of what reduces demand for health and social care again is quite thin. We are not sure what it is we ought to be investing in, and the mechanism of the social impact bond gives us the confidence that we only pay as a public sector on the basis that it has worked.

Q58 Grahame M. Morris: I am really intrigued by the concept of it. It seems to be a very novel and innovative concept of private capital. You mentioned early interventions and the need to save costs further downstream. Is the idea that this is a kind of pump priming? Could the concept of a social impact bond be extended into, say, social care rather than simply just on tackling isolation in terms of physical care and so on?

Dr Harling: That is our hope that it will do exactly that. What we hope we achieve is a virtual pathway, which is that we get an external investor who will invest in services to reduce social isolation. Then you have a very good evidence base about as people's social isolation is reduced their use of health social care goes down; therefore, there is a saving to the public sector; therefore, that is money that can be reinvested. We are looking for exactly that.

Q59 Chair: I think that we would all agree that reducing loneliness will be a very good thing for those individuals who benefit from it. If, however, it does not generate the savings that you hope it will generate, would you feel it would be helpful to have some kind of guarantee? I know there is no new money for being a pioneer, but would it help if there was at least some kind of guarantee for those pioneers who are, if you like, trialling innovative practice?

Dr Harling: I suppose if the question is would we like a guarantee of more money, then I guess the answer is yes, but I think it is pretty unlikely that we are going to get it.

Q60 Chair: What I mean is, as you say, there is no new money upfront as far as the Treasury is concerned, but does it deter you from taking on innovative programmes like this one, the fact that if it does not generate savings, if you like, you are going to have to find the money from somewhere further downstream?

Dr Harling: First of all, the Treasury has been very supportive of it and the Cabinet Office and the Big Lottery are partners in this, so at least 50% of the outcomes will be met by

them. I think Government as a whole is very interested in trying this approach in all sorts of areas.

Q61 Chair: That is genuinely some new money, then?

Dr Harling: That will be genuinely some new money. Again, that money would only be paid to the investor on the basis that the services had achieved the outcomes.

Q62 Chair: If it achieved the outcomes on loneliness, that does not necessarily mean it would achieve the outcome of reducing admissions to hospital. You have good reason for believing it might, but it is whether it does or whether, just as my colleague David Tredinnick was pointing out earlier, it just uncovers unmet need and addresses people who are currently not receiving the service who might benefit from it.

Dr Harling: Absolutely. We have good evidence that it should do, but there is a little bit of a leap of faith to make that connection between the reduction in loneliness and the reduction, for example, in acute hospital admissions. In that investment that we are putting into this, on the whole we have been very conservative in terms of our assumptions about how much loneliness is going to be reduced and how much acute hospital admissions, for example, will be saved. I think we are pretty confident across the local health and social care economy that the amount of investment we put in is going to reap a reward of at least that in terms of a return and, of course, half that will be picked up by the Cabinet Office.

Q63 Chair: That is encouraging, but if you thought there would be guarantees, would you be prepared to be more innovative in other areas as well? In other words, if it did not generate savings but the Treasury at least committed to picking up the tab if it did not work for those who are trialling new projects?

Dr Gregory: Yes. My understanding of being a pioneer is they wanted to find people who were prepared to be brave, go faster, do things at bigger scale, so that everybody else could learn. I think that is difficult if that puts us at financial risk, and that inevitably means we perhaps have to shut down some of the things that we may do or do it at a smaller scale. Therefore, we get in this endless cycle of a lot of the challenge is doing some things that may be proven in a small scale but are much harder to scale up.

I think if we are to be supported as pioneers it would be helpful to have some sort of financial back-up for the areas in which pioneers will fail because it is without doubt that of 14 pioneers running any number of projects, not all of those projects will succeed. That is almost part of the point that we are prepared to run that ground so that others can learn, but if we are left to pick up the tab, that is not something we are prepared to do for the population of Worcestershire. If we had some sort of additional financial back-up that allowed us to be braver—you talk about what is the overall outcome of the pioneer programme; for me that is part of it. It is that learning. That learning is not just about what succeeds; it is about what fails. People will not be prepared to take those risks, I think, unless they have some sort of financial guarantee to help us out.

Q64 Chair: Looking at the other end of the bargain, if it is successful, one thing the NHS has not been terribly good at in the past is rolling things out to scale when they are successful. As part of being a prior pioneer, is there an obligation on you to share best practice with others if these things are successful?

Dr Gregory: Yes, very much so and we are already linked widely with the other pioneers, both through specific days that we are able to attend but we also have quite a network now of informal relationships. I think there is quite widespread melding among the pioneer group. But yes, definitely going forward we very much see the remit to be to share the learning we have more widely than that.

Q65 Chair: By definition, of course, all the pioneer sites are places where there is already good team working but it is about spreading that practice to areas where it is not. Is that something you will be doing going forward at the end of the programme?

Dr Gregory: Yes, and we are already doing that to some degree. We have had a number of other areas contact us, either specific groups asking us about what we are doing or other specific areas who have been asking us what we are doing and what our plans are and the learning we have to share. Indeed, we have learning to have from them. We were very fortunate to be pioneers, but there are many other areas of the country who are not pioneers who are also doing good integration work. We are very keen to learn from everybody, not just the pioneers, and to share that learning more widely.

Q66 David Tredinnick: I would like to finish off by making a comment and asking a question. I wanted to ask one more question, but first say that one of the areas that I have seen that I think has been a huge success so far and where you probably are well ahead of other parts of the country is in your use of communications, use of information technology. I was particularly impressed to see a television screen in the office at Timberdine, which was online in real time to the local hospital. The local hospital knew exactly what was going to happen in terms of discharge of patients so they could plan. That seemed to be very good, and what you have said this afternoon about the different health organisations maybe having the same software and being able to communicate. The third point, of course, is the virtual wards, which the Chair has just asked about, where I think I am right in saying you are communicating with keeping patients out of establishments through the system. To what extent do you think that this information technology system that you are using is important to your work? How highly do you rate the use of effective information technology in this pioneer project?

Dr Gregory: It is seen as one of the key enablers and I will say it is one of our highest priorities. We have talked today, both this afternoon and this morning, about the importance of care planning, of an anticipatory care plan, but that is only of value if all those who need to see it are able to see the care plan. In very many ways, we are ahead in Worcester in having all our GP practices on the same system, the whiteboard system you just described, around capacity, amounts of beds around the county. We are in the process of developing what we are calling an IT roadmap with a really big picture view of how we join up all our information. We have numerous different IT systems across the county. The idea of having one single system that will do the job is what Connecting for Health tried to do over many years for a lot of money and failed to do, but the reality of IT technology

now is you do not need one system. The technology is out there to join systems as long as the gateways are open and you are using the right sort of interconnectivity. We are developing a whole programme of how we can integrate all our different networks between health, social care, and particularly around care plans where you would have that placed centrally, where the patient would own that, where if they want family members to see it the family member can see it. Not all that software does exist at the moment, but I think IT companies are very much now on this wavelength and I think we will soon be in a position, I hope, to be able to bring this together. As I say, we are looking at that as a five-year plan. I think we have more quick wins to do, but to have the most effective joining together is going to take a bit of time.

Dr Harling: I was just going to add the other role we are looking at for technology is in supporting service users on patient choice. The council is doing a lot of work in terms of access to information and advice online, so how to look after yourself, how to plan for your old age, how to find support in your community is all done online, and aspects of the adult social care assessment online, and then the idea of an e-marketplace where with your personal budget you can choose from a whole range of services. You have information about the quality and cost that allows you as a consumer to make an informed decision. The role of technology here is potentially huge and it is one of the things we are quite excited about.

Q67 Chair: I have one final question and that is around the evaluation timetable. The previous pilots that have been done showed that you do not necessarily see any financial gain from the whole system in the short term. Can I ask how long you will be following up any financial gain from this and when you are expecting to see any benefits?

Dr Gregory: Yes. Well, in general terms as pioneers we have been told we will have support for five years. We have a five-year plan, so I think it is that sort of timescale that we are talking about overall evaluation. When we think about evaluation, it is a mistake to think about we have point zero and then five years and you will maybe know in five years' time. An actual evaluation has to be an ongoing, almost month by month process so we can identify the quick wins or the ends where we are failing more quickly. We do not intend to wait five years for that. Again, particularly when we talk about things like financial gains, we do know it takes time for projects to get fully up and running, fully staffed, to really realise the gains that we want. In general terms, I would say five years will give the timescale that we are looking at.

Chair: On behalf of the Health Committee I would like to say thank you very much. We have been very impressed and met some incredibly enthusiastic professionals. I would like to congratulate you on what you are doing here in Worcester. Thank you for having us.

Dr Harling: Thank you.