HOUSE OF COMMONS

Communities and Local Government Committee

The Committee met at Manchester Town Hall

Oral evidence: The Government's Cities and Local Government Devolution Bill, HC 369

Tuesday 10 November 2015

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Watch the session

Evidence from witnesses:

Members present: Mr Clive Betts (Chair); Bob Blackman; Jo Cox; Helen Hayes; Liz Kendall; Kevin Hollinrake; Julian Knight; David Mackintosh; Mr Mark Prisk; Mary Robinson; Alison Thewliss.

Questions 99 – 157

Witnesses: **Ian Williamson**, Chief Officer, Greater Manchester Health and Social Care Devolution, **Rob Webster**, Chief Executive, NHS Confederation, and **Councillor Linda Thomas**, Vice Chair, Local Government Association Wellbeing Portfolio, gave evidence.

Chair: Good morning and welcome to our evidence session this morning as part of our inquiry into the Cities and Local Government Devolution Bill. Thank you very much for coming to give evidence to us. Before I come to the witnesses, can I just ask the Members of the Committee to put on record their interests? I am a Vice President of the Local Government Association.

Mary Robinson: Thank you, Chairman. As already declared in the Register, my husband is the director of a community interest company in the intermediate healthcare field.

David Mackintosh: I am a Northamptonshire county councillor.

Q99 Chair: Thank you for that. Thank you for coming. Could you just begin by saying who you are and the organisation you represent?

Ian Williamson: Thank you. Good morning. I am Ian Williamson, Chief Officer for Greater Manchester Health and Social Care Devolution.

Linda Thomas: I am Councillor Linda Thomas. I am actually the Deputy Leader of Bolton, but I am the Vice Chair of the Community Wellbeing Board at the LGA.

Rob Webster: Hello, my name is Rob Webster. I am Chief Executive of the NHS Confederation.

Q100 Chair: Obviously health devolution has taken quite a lot of people's interest in terms of being something a little bit different from what has gone before, with the various deals between Government and local authorities. On the other hand, there have been quite a lot of different arrangements tried between health and local authorities, the Better Care Fund amongst others. Is formal devolution as part of the current packages really necessary, given things already happening anyway?

Rob Webster: Thank you, Chair, for that question. Not everywhere is the answer. We are seeing that with some of the bids that are coming through at the moment. One of the things I would say about the Bill is that the ultimate test of it is whether it helps or hinder what is going on in local places. What we see around the country is that most places are working together through arrangements like health and wellbeing boards and local leadership groups to see how they can build sustainable health and social care services, but in the context of that place.

In places like Sheffield, which you are familiar with, they have said that they have a very strong partnership and a set of arrangements in which there is a coterminous set of organisations—one council, one big acute trust, one CCG, one set of mental health arrangements. We have an ambition, through the Better Care Fund, which is much greater than the national minimum being set by Government. Therefore, we are getting on with designing services across the place that we serve in Sheffield, in ways that we think allow us to go quite far without devolution. That is why health and social care is not in any devolution package for Sheffield. In other places like Manchester, with which colleagues are more familiar, they have decided that that is the case.

Not everywhere is the answer. What is essential, though, is that we start to see the place where people live and the arrangements around place as part of the solution to the health and wellbeing of local people, and then think about the contribution that health and care make to that.

Linda Thomas: Really we need to say from the LGA that one size does not fit all. Although I am part of the Greater Manchester devolution, that is not to say that everything we are doing would be perfect for other parts of the country. Obviously we hope people will learn from some of the things we are doing.

We have had the BCF, which has brought people together and focused commissioning better, but it does bring a single unified governance and accountability to the whole of Greater Manchester. Greater Manchester has quite a grown-up type of politics. Leaders have been working together since the 1980s and the demise of the GMC, and there is a willingness to work together. The whole point of devolution is about starting at the bottom with our locality plans and working up but, obviously, as each locality devises its own plan, there are going to be economies of scale, certainly in specialist services, which we will have more opportunity to follow.

The big one for all of us is the preventative agenda. At the moment, we are struggling, because things like public health are being cut. It is going to be the way that we can hopefully deliver better preventative services, because the only answer to helping the NHS deliver and the only answer to all the problems that we have is to have a much better focus on wellness, as opposed to a sickness service.

Ian Williamson: Within Greater Manchester, the area for which I have responsibility, we believe that the devolution opportunity is a tremendous opportunity that we are grasping. Our case for change is a difficult one; we have some of the worst life expectancy in the country and some significant problems with health outcomes. Just last week, it was confirmed through analysis that, if you live in Greater Manchester, you are near the bottom of the league table for early diagnosis of cancer. We also know we have significant financial challenges that are not dissimilar to elsewhere in the country perhaps, but they are significant.

We think there is a case for having transformational improvement for our population that really delivers, and the context of Greater Manchester, as has been mentioned, is such that we think this is a real opportunity for us—the strength of the local combined authority and

leadership over many years, and the NHS commissioning organisations that have consistently worked together over the last 10 years or so, including recently the CCGs. Therefore, this feels like an opportunity to concentrate on the place of Greater Manchester, rather than in a sense just allowing the existing systems and existing organisations to carry on in a way that is not as coherent as it can be, based on that place of Greater Manchester.

Q101 Chair: Is there a danger that something that is sold as a major change will take a bit of time to bed in and you could actually have things getting worse before they get better, as people concentrate on the organisational arrangements rather than delivery of services?

Ian Williamson: I do not believe so. What has actually happened, in the last six months or so since the memorandum of understanding was signed, has been a speeding-up of sometimes difficult conversations, a speeding-up of planning. To give two examples, Councillor Thomas mentioned the creation of locality plans in each of the 10 boroughs, so the CCGs working closely with their council colleagues, third sector partners, providers and others to really work out what needs to be done. That has happened at a more rapid pace than would otherwise have been the case.

The second example would be access to primary care seven days a week, so the 12 CCGs have committed to and are now delivering, and we will have in place, in each of the 10 boroughs by December this year, seven-day access to primary care. I do not think that sort of change would have happened without the momentum and the impetus provided by the opportunity that we have around devolution.

Rob Webster: Can I just say that I think it is a great question that we should apply to each of the bids as they come forward? It is something that we need to consider very carefully as we transform care. What we can see from the finances in the NHS and the stresses in the social care sector is that we are delivering care in a way that we cannot currently afford. If the vast majority of our acute trusts are in deficit, then the difference between the income that we receive and the way that we provide care is substantial, so what we need to do is start to change the patterns of care, and that should be our real focus. We should do that for a reason.

Ian has talked about the reasons why we are changing care, which are to deliver much better outcomes within Manchester and Greater Manchester. It seems to me that our focus should consistently be on whether we are delivering better outcomes for local people, if there is

great clinical leadership behind that and if we are accountable to local people in the right way for making sure that that happens. Those three things were consistently posed as the rationale behind the 2012 Act and they are things we can all sign up to. If we just focus on structure, then we are lost, but if we focus on those things and then ask how devolution or local arrangements and partnership work to support them, we will go further.

Q102 Chair: Can I just ask another question, and I hope it is a great question as well? I am not accusing you of it, but there seems to be a bit of a feeling within the health service that joint arrangements are okay, because really the NHS remains in the driving seat and local government can come to the table and say a few things that might or might not be taken notice of, but devolution looks a little bit more like the NHS having to cede some power and responsibility to local councils. Therefore, there is an added resistance to it from the NHS.

Rob Webster: I don't think there is added resistance from anybody. What we see across the country is health and wellbeing arrangements, which have been in place for a couple of years. There is a requirement for people to work together differently and understand each other. If you talk to local government about what it thinks of the NHS and vice versa, you get some quite interesting conversations at a local level. What we see across the country, in places like Brighton, Blackpool, Hampshire, Leeds and Sheffield, is a much greater understanding and actually sharing of budgets, accountability and responsibility.

It seems to me that there is a much greater understanding, which is borne out in some of the progress that has been made, that there is a symbiotic relationship between local government and health. The vast majority of things that impact on somebody's health are linked to place, and they are about the environment, their education, their employment and their housing, alongside the health sector. There is a great deal of support for much greater local working, much greater support for and understanding of where devolution could help and a much greater understanding of where it might not be for other people.

Q103 Jo Cox: Who is ultimately responsible for capturing best practice and then disseminating it nationwide? Given the diversity of issues being tried, I just wonder where best practice is being gathered and then disseminated out to regions trying various ideas and initiatives.

Rob Webster: On devolution?

Jo Cox: On how we get better care and integration ultimately. With all the different diverse elements being tried, how are we making sure we are capturing best practice and then disseminating it to relevant players?

Linda Thomas: Through the LGA and the health and wellbeing boards, we have had a programme of support and a lot of peer review, where officers and councillors have been invited into towns, and have gone and looked at what health and wellbeing boards have done, and come up with priorities. We have given them good practice to consider. We have done regional events, where we have tried to share good practice, and we have done a guide for health and wellbeing boards. This has gone out to all health and wellbeing boards' chairs and leaders.

In Greater Manchester, we have always had a health and wellbeing board, almost like a commission. Under the new governance structures, what will happen is that each health and wellbeing board chair will be part of a governing body of health and wellbeing board overview, with all the 12 CCGs. I am quite sure that Ian will make sure that all the good practice that comes up will be disseminated, because that is the whole point of this, but will also know the risks and the pitfalls as well.

From the previous question, you were talking about process. One of the things that is very difficult for everybody to understand and is difficult for the NHS is the fragmentation of the commissioning. If you are telling us to integrate, integrate. This is why it is a real opportunity in Greater Manchester to pool the budget because, at the moment, nobody really understands where the money for the NHS comes from. It is NHS England; it is GP commissioning; it is adult social care commissioning; it is public health money. It is all over the place. That will help bring everything together as one. I think things like the acute sector being regulated by Monitor and adult social care being regulated by the CCG are not helpful. While you are still encouraging hospitals to be income generators because of tariffs, it is a barrier to devolution. That is something that we hope the Government would look at.

Rob Webster: The question of best practice is interesting. There is a snowstorm of stuff that you can access around best practice. We contribute to that through documents like this, so working with the Local Government Association, NHS clinical commissioners and the confederation, we publish guides for local government and the NHS around integration and best practice, and we help support a leadership group for local government health and wellbeing board chairs and vice chairs, which are NHS and local government people. NHS Improvement, the new body that replaces Monitor and the Trust Development Authority, has a role in sharing best practice. The 15 academic health science networks across the country have a role in

sharing best practice, and then think-tanks and others share best practice, and you still have organisations like Horizon and The Edge linked to the old NHS Improving Quality, which share best practice.

One of the things we would like to see is a much greater structure and consolidation of how best practice gets shared and disseminated across the health and care system, so that we have a bit more clarity. At the moment, there is lots of really great practice and fantastic things going on in the service and local government, but sometimes it is difficult to see it very clearly.

Q104 Jo Cox: Can I just follow up on that? Do you have a proposal on the structure that you think would be most valid?

Rob Webster: We would suggest that there are two big things that are currently happening that will really help. The first is the creation of NHS Improvement, which is the successor body to Monitor and TDA. We are waiting with interest to see how that emerges and how it refocuses its role on improvement, rather than regulation and performance management. Alongside that is a big review going on at the moment called the Accelerated Access Review, which is co-sponsored by BIS and DH, which is looking at how you adopt and disseminate clinical and cost-effective service and treatment in the health and care system. That is due to report in March-April time. At the moment, it is testing what a new infrastructure should look like around sharing good practice, so that it gets adopted by everybody.

Q105 Mr Mark Prisk: Briefly, on the integration of services, which you have all referred to as being one of the critical benefits, and which many of us as constituency members would recognise when we have had battles for individual constituents between two budget lines—one called health, the other called social care—we have all had those battles with different bureaucracies. Do you envisage that GPs will remain the principal gateway for patients? Does that mean that, therefore, their aegis will stretch now to a new integrated service of clinical and social care?

Rob Webster: The first thing to say is that there is a significant amount of progress on joining up care at local levels and integration. We saw that with the number of people who came forward to be integration pioneers two or three years ago. 111 parts of the country said they wanted to be involved in that, because they were really pushing forward how to join up care for people with multiple conditions and older people. Those models tend to have somebody who is a care co-ordinator and somebody who is a case manager, and sometimes that is the same person.

What we find with joined-up care is that there needs to be somebody in the system who has the authority to direct resources, and say, "I am not just referring this person; I am actually directing you to support and treat them," and there needs to be somebody who understands where all of the care is, so that they can work around what the team is for that individual. That does not have to be the GP, but it has to be somebody. In different parts of the country, there are different models.

Ultimately, it comes back to one of the points that Linda talked about. We are in an environment where the commissioning of services, so how they are designed, how you engage with people and how they are paid for, is a joint endeavour. If you are frail and old, the issues that affect you are as much to do with care as they are to do with what the NHS does. The boundary between these two is quite a grey area, so we have to have a joined-up view of how we are spending care and NHS money together on those patients. Either individual GPs will make decisions based on a set of commissioning arrangements that allow them to access health and care together, because services are joined-up, so they just refer somebody to a service that treats them and gives them health and care, or there will be a different arrangement that allows that to happen. Ultimately, what we have to do is join up the commissioning of services, if we are going to join up the delivery of services.

Q106 Mr Mark Prisk: Do you therefore recognise that it is important that, if it is not the GP, the patient knows who that decision-maker is?

Rob Webster: Certainly, and that is one of the biggest things. In my experience, what patients say is quite simple. If you ask them what they want, what they say is that they want "somebody who knows me, who treats me with respect and dignity, and who is part of a team, and the team know each other and they have information. They know who I am and I have one person generally coming down the garden path, and I get treated at home. If I cannot be treated at home, I want to go somewhere nearby. If I have to go to the hospital, I want to be able to get the bus there or park my car." That is pretty much it.

We have to respond to that by saying we can put all those things in place by creating teams that make sense to the individual, with a single point of contact, a care co-ordinator or a case manager, who they can talk to if things are not working or if they want to change them. Moving beyond that, if you look at integrated personal health and care budgets, they might even be able to design that themselves.

Q107 Mary Robinson: Rob, you mentioned earlier the reasons behind this, and these are big changes. You said the reason was to deliver better outcomes for people. Just looking at that, would you be able to expand on it and say what differences people using health and social care services in Greater Manchester would see?

Rob Webster: Ian might want to start with this, because he is responsible for it.

Ian Williamson: I am happy to, thank you. That is exactly the point: we need to be able to demonstrate, over a period of time, that there are significant improvements in the health of the population throughout Greater Manchester. I have described some of the challenges we face now around life expectancy, early diagnosis of cancer and poor outcomes. In our experience, talking to people about what is often the fairly opaque subject of devolution is not the best way to engage with a population. What they are interested in is us demonstrating how services will improve and how outcomes can improve.

In the recent months, we have described, announced and started to implement changes around primary care access seven days a week. We have also signed a memorandum of understanding with Public Health England, which is intended to make sure that we can have access to the best possible national and international evidence around prevention and, within that, link the health and social care world, as colleagues have mentioned, to the real world of employment and jobs. For example, we know that there are lots of people who fall out of employment because of mental health problems—depression, anxiety. Too often, they then wait a long time for treatment, appointments and care, and one of our ambitions is to make sure that people can either get into employment or return to employment more quickly, so they can be economically active and therefore healthier.

Also in the last few months, we demonstrated how we can improve outcomes in hospital. Through a programme that we have led, we can describe how we should achieve 300 saved lives per year around emergency surgery. We have also done some work on dementia and people with learning difficulties, which are tangible examples.

Looking forward briefly, we will be setting out in our strategic plan in December some of the outcomes that we are aiming to achieve over the next four or five years. Hopefully, we will have some access to a transformation fund, which will enable us to implement those changes. They are real changes on the ground for people, for example people with long-term conditions being cared for in their own home, rather than ping-ponging in and out of hospital; people with dementia feeling as if they have a wraparound set of support services for them. It is absolutely

in those areas. Some will be relatively fast. A lot of them will take longer to evaluate.

Q108 Mary Robinson: Will it be the case that people see that processes are easier, in terms of their healthcare when they engage, together with those measurable targets? To what extent is there going to be more of a feeling that it is working better and less of the targets, or is it a balance between the two?

Linda Thomas: Can I perhaps speak about my own locality plan to demonstrate? Obviously the Better Care Fund and now devolution are almost a catalyst to encouraging people to work more closely together, and there is the setting up of integrated teams. On the previous question about whether the GP should be the key worker, if you like, or the main person, what we have done is create integrated teams around GP practices. We have put in a unit there and we are already seeing, after about six months, 100 more people than there were this time last year being cared for in their own homes, which we think is great progress, considering we have only been doing it for about six months.

Ultimately, those people do not end up in very expensive beds, which are not always appropriate. Obviously the age group that we are really concerned about is 85-plus, because they are the ones who inevitably end up in hospital and, because of pressures on hospitals, do not always get the care that is required. If you went round the other nine local authorities, you would find this kind of operation being duplicated everywhere.

Rob Webster: Those sorts of developments are really important, in terms of thinking about how the outcomes deliver social value, so people are in employment or education. They cover the whole spectrum, so children and adults. Often we focus on older people, but there is a lot of benefit from joining up services for children. The individual outcomes for people and the individual difference that it makes are significant. If one of the biggest risks that affects older people is loneliness, the fact that you can socially prescribe in many places now for access to activities, luncheon clubs, knitting and natter or whatever it is, which improves people's health, their outcomes, their outlook and their mental health, is fantastic. What we need to see is how we join up the voluntary sector, social care and the NHS in a place to make that a reality.

Q109 Mary Robinson: There are some big changes going on. Recently we held a session in Manchester, and invited members of the public to come along and listen, but also to give their views. It seemed

that a lot of people were unsure of what was actually happening. Do the public and the workforce understand what health devolution is and are they on board?

Ian Williamson: Shall I start that again from a Greater Manchester perspective? Our experience so far is that there is a tremendous enthusiasm and interest in health and social care devolution in Greater Manchester, which has been demonstrated through all sorts of work by the local media and engagement with staff groups on the ground. As I said earlier, I do not think that going to ask about devolution per se is of great interest to people; what they are interested in is changes in services. The changes that I have described, for example, have been widely disseminated. We have had something like 260 individual pieces of media coverage in Greater Manchester—local, regional and national coverage—in the last six months, which are describing the sorts of changes we are bringing about. We have a strong presence on social media and a website.

I expect that, once we have developed our strategic plan in December, we will be doing even more engagement with the Greater Manchester population, I hope largely through existing arrangements in each borough—so in Bolton, Bury, Wigan, Salford, etc. That is where the primary responsibility lies for engagement with the public. Where things are of a Greater Manchester relevance, we will be telling the Greater Manchester story in a co-ordinated way as well.

Q110 Mary Robinson: This is building on things that have gone before, such as vanguard and the integration Pioneer sites. Could you explain to me how this health devolution will fit in with those existing models?

Ian Williamson: Yes. We have a number of vanguards in Greater Manchester. In Salford and in Stockport they are pursuing the new models of care that came out of the five-year forward view. In Salford and Wigan, they are pursuing acute sector closer working, and the Christie Hospital has a vanguard to try to disseminate best practice and identify cancers earlier within the Greater Manchester region. All of those vanguards are closely working with us in the devolution programme and I expect will be the sorts of things that we will demonstrate as exemplars, which should then be able to be replicated and built on, throughout Greater Manchester.

Given the challenges we have, both clinically and financially, we cannot afford to reinvent everything ourselves. We have to have that question of spreading best practice that was raised earlier, and we think that a population of nearly 3 million, which is about 5% of England's NHS, is a

significant enough sized footprint to enable that dissemination to take place, because something over 95% of our population receives all of their health and social care within Greater Manchester. We are a fairly well self-contained population, so there is an opportunity for us to learn from each other and work together on that basis.

Rob Webster: Can I just add something about the public? We did some work earlier this year about public attitudes to change in service, because the public is interested in service, not the bureaucracy of the NHS. More than three quarters of people said that they would support services if they could be demonstrably better—"If you are making changes because we are going to get something better, then we will support it." We then asked people if they knew enough to get involved in the debate, and only 40% of people said they knew enough or understood enough about the NHS to get involved in the conversation. We are starting from a position where we always need to communicate clearly and well, and engage with people over time.

The second thing I want to say about this is that it is essential that we do it for the reasons that I described earlier. If this is about driving better outcomes, having clinical leadership and support for change, and being accountable to the local public, then we need to make sure that those tests are passed in all the changes that we make. The third thing I would say is, if you look at the next wave of developments, places like the north-east and Liverpool are having bigger conversations with the public, as they get into what they want to achieve with all of this, which I think is a positive step.

Q111 Mary Robinson: Thank you for that. It has led nicely on to my next question, which is about Greater Manchester health devolution as a model for other areas. Is it a model for other areas?

Rob Webster: There are some themes that we would see very clearly from the confederation. Clearly it provides some themes and learning, but it is not a model for everywhere. Colleagues have described how the Greater Manchester organisation has been working together since 1986. The footprints are different in terms of service from other places. Relationships are different. The financial and population issues are different. Cornwall is different from Manchester. Manchester is different from Middlesbrough. It is different from Maidstone.

What we need is some enabling legislation that allows people to design things that make their own mind up. Some of the principles about whether you have strong leadership, whether you have effective governance, what kinds of outcomes and service you want to adopt,

how you are going to meet the standards and principles in the NHS constitution—some of those things we can significantly learn from.

Q112 Mary Robinson: Would it be a model for cities, perhaps?

Rob Webster: Again, not everywhere. If you look at Sheffield and Leeds, they have both said that they do not necessarily want to include health and social care as part of the model. Leeds is at the forefront of integration of health and social care. Sheffield, for the reasons I described earlier, is saying it can push this far enough without having further devolution of powers. It has good arrangements in place already to make decisions. Manchester is fundamentally different, so it depends on the city and depends on the infrastructure.

Q113 Mary Robinson: It is something that is going to be taken forward around the country, we suspect. Are there any lessons that could be learned from the Greater Manchester health devolution experience?

Ian Williamson: Briefly on the previous question, I would add that NHS England has published, through a board paper, a set of criteria that they will apply in judging the opportunity to support other parts of the country. That includes the sorts of issues that Rob has described.

In terms of lessons for other parts of the country, it is not for us to impose or even promote our model as the only model. There are some lessons that have been described. The additional one that I would add is that many, if not all, parts of the country have similar challenges to those that we have. The approach that we have taken is to say that our strong preference is to try to take responsibility for those challenges and come up with the solutions ourselves, even if those mean making difficult decisions. Everywhere is facing challenging times. The alternative to taking responsibility is, in a sense, possibly having change done to you. That is far less attractive than taking responsibility. One of the key lessons for me is that there is an energy and positivity about trying to find solutions in Greater Manchester, which has been very palpable.

Linda Thomas: Can I just add that it is about trust and responsibility? As I said at the beginning, at the LGA we do not say that one size fits all. It is about understanding what each can bring to the table. We have said for many years in local government that we can bring the accountability. We are good at consulting. We are not clinicians and do not profess to be. It is about knowing what each other's strengths are, being grown-up about it and bringing them to the table.

Q114 Chair: I want to pass on to Julian but, very simply, if we can do all these things, why do we need more enabling legislation?

Rob Webster: There are differences in different parts of the country.

Chair: They can do all these things anywhere.

Rob Webster: If you look at the arrangements and the geographies I have described, and the relationships, it might be that the legislation just forces the conversations and the accountabilities to change, at a local level. One of the things about the Health and Social Care Act and the way that the NHS and care system works today is that, if you look at places like Leeds and Sheffield, often the progress has been about leaders locally making the right choices despite the system. We currently have a system where individual organisations are held to account for their contribution to people's health and care, which often means that they are penalised for issues outside of their control. In some places, they have decided to work together almost to work around that, I would say, and stand together to say, "If this is going to work in Hampshire, Leeds or Sheffield, we are going to do it together." The system currently does not force them to do that.

Q115 Chair: Could you do us a note on that? I think it is an interesting area, but we do not have time to explore it in more detail. Could you do a note explaining what you think might be appropriate and beneficial?

Rob Webster: Yes.

Q116 Julian Knight: Mr Williamson, if something goes wrong with the NHS in Manchester, who does the patient or relative go to? Where does the buck stop?

Ian Williamson: Post April 2016, which is when we go live, accountability will remain with the existing organisations so, if there is a problem in the NHS, then the accountability will remain within the NHS. The chief officer for devolution, which is the post that I am currently holding, will be an employee of NHS England, and therefore the line of accountability will flow up through NHS England to the Department of Health and to Parliament in that way.

Q117 Julian Knight: Will the instinct of people be to go to the mayor, to the figurehead, to the office?

Ian Williamson: The interim mayor and the elected mayor, when in post, will have no formal responsibility or accountability for health and social care.

Q118 Julian Knight: They may not have any formal accountability, but that is the figurehead of the combined authority of Greater Manchester. The concerns are that that office will be effectively swamped by any issue to do with the NHS, rather than knowing to go to NHS England, which is the current way in which you do things.

Ian Williamson: It is very important, therefore, that we communicate clearly about exactly how these arrangements will work. We think that the arrangements add to transparency and accountability at a local level. For example, holding meetings of our new strategic partnership board with all the 37 organisations in public will aid that accountability and transparency, so that will be one way in which we will explain the system to people better and of course we will have to redirect complaints, if they go to the wrong place, for example, to make sure that they are handled appropriately.

My hope is that ultimately there will be fewer complaints, because the systems and services are more joined up, but that we will be able to explain and resolve problems, because health and social care are working more closely together, and there is not the fragmentation that exists and people experience at the moment.

Q119 Julian Knight: I am conscious of time, Chair, but I want to go into a particular area to do with specialised services. I understand that £1 in every £7 in the NHS is spent on these services, and they can cover anything that is not mainstream, for example HIV treatment or spinal injuries, and that sort of thing. It has been expressed to me by patient groups that they are concerned that, in the devolution process, these services become a slightly Cinderella service. Because at present they are centrally dictated in the resource allocation, their concerns are that, under devolution, you may favour treatments in areas that are economically impactful, rather than precisely what is actually needed. I wonder whether you have any thoughts on that, Mr Williamson.

Ian Williamson: We are very pleased that we have agreed with NHS England that the specialised services budget will be within the responsibility of the GM devolution arrangements. We believe that, by having all the budgets available to us, we can then make more sensible joined-up decisions and, for example, ensure that patients are treated at the earliest point on a pathway, rather than their condition deteriorating and then having to endure very difficult, more

complicated services. We are very clear as well that there will be some nationally commissioned services that we will not take full responsibility for, because it would be inappropriate to do so. There are some rare conditions where I would expect NHS England nationally or regionally to continue to take that responsibility.

Q120 Julian Knight: Is there anything in the guidance in terms of which services you will be taking and which you will leave centrally guided?

Ian Williamson: We are working through that list with NHS England at the moment. I expect that to be available soon.

Rob Webster: Can I just make a point? One of the great things that comes out of the conversation in Greater Manchester is a realisation that the biggest spend on specialised services is cancer, but the second biggest is mental health. That starts to open up conversations locally about how we are making sure that we deliver the best services around mental health in area, for children and adults.

The big step in commissioning for specialised services that is happening anyway is that clinical commissioning groups will co-commission them in the future. They will not just be nationally commissioned; they will be locally commissioned. The 10 CCGs in Greater Manchester already have a formal role, or will do, in commissioning those services. Where there is a very small number of nationally commissioned services, because they are very rare, people will have to engage, but it is mental health, cancer and other specialised services that will be at the heart of this. What needs to happen is that their voice around the table is heard really well. I do not think I have ever heard them described as Cinderella services before.

Q121 Julian Knight: The patient group said that services were treated as Cinderella services when this was not nationally dictated. I am a little bit concerned to hear you just focus on, for example, cancer and mental health services, and refer to other ones as little ones. It sounds to me, frankly, as if you are going to focus on those very major treatment areas and the others are going to have to scrap around for any resources that are going. Many of these people are very vulnerable.

Rob Webster: I do not think that will be the case at all. Once something is prescribed as a specialised service, it has to be commissioned. If you look at the spectrum of services and treatments that are clinical and cost-effective, and must be delivered, and emerging services and treatments, which are at the forefront of

development, the great thing about devolution in Manchester is that you can start to harness all the resources of industry, the great universities that exist locally, the academic health science network and the research within NHS organisations to say where we want to pitch for global developments in these sorts of treatments and how we are going to make sure that they are resourced. That is quite an exciting conversation to be having.

The risks you describe have to be taken seriously. What Ian, Linda and others are doing is saying how they fit within the governance arrangements that we have and how we make sure that all of our respective citizens, in and out of area, get the right support for these treatments.

Q122 Julian Knight: I am going to request that they explain a bit more in writing, particularly the time when they decide which services precisely are going to allow central diktat to take control.

Chair: Perhaps you could do a note for us on this particular area and where the balance is for things to be totally devolved, in terms of commissioning, and the ones that have a central requirement. Thanks.

Q123 Liz Kendall: You will all know that the biggest issue at the moment, both in the NHS and in local government, is money. The NHS is predicted to be £2 billion in deficit by the end of the year, with 90% of trusts saying they are going to be reporting deficits. Local government has had 37% of its budget cut and, just this week, Lord Porter was talking about how, if the proposed reductions in the DCLG are passed on to local government, it will lead to £16.5 billion-worth of funding reductions and increased cost pressures. What difference will devolution make to any of that?

Ian Williamson: I would say that, at its most basic level, we have to believe that taking responsibility, ownership and accountability will enable us to spend the £6.2 billion or £6.3 billion, which is the Greater Manchester proportion of NHS and social care spending in England, to best effect. We have to believe, and do believe, that we can make the best use of the money available. It is not necessarily for me to argue the case politically for more money. Of course we would like more money, and that is why, for example, we are advocating a transformation fund through the spending review, which will enable us to invest in some of the more preventative services, so that we can start to rebalance the economy as well. Social care is a large aspect of that because of the particular focus that there has been on social care spending in the last few years. My job, and our job, is to make best use of the resources that we have available.

Linda Thomas: I am a politician, so I do not have to be as cautious as Ian. You referred to specialisms as being a Cinderella service. If anything is a Cinderella service, it is adult social care. That is absolutely key to supporting the NHS. We have to do much more on much less. Hopefully we can under devolution, but it would be wrong of us just to take the amount that the Government have given us and say that we can do everything. We cannot; we need some additional funding.

Local government very much feel like the poor relations. We come to the table to integrate and be part of devolution, but we come with very little resources. Over the years, we have tried to prop up our adult social care. We decimated other services in order to do this, but there comes a point when even the cut in adult social care is going to have a detrimental effect on the NHS. Although we have the Better Care Fund, it feels a bit like the scraps from the table. This is not new money; this is money we are taking away.

This is not an argument to take more money away from the NHS. We just need to be realistic. Our people are living a lot longer with co-morbidities. It is a lot more difficult. If you talk to any GP now, the vast number of visits they do now are 85-plus. Ten years ago, it would have been 75-plus. I make no apologies for saying that we need additional revenue for adult social care so that we can play a really active part in this devolution; otherwise we are going to be robbing Peter to pay Paul. It would be a great pity at the end of it if we got blamed for not delivering, because we did not have the correct finances to do that at the beginning.

Rob Webster: The fundamental point is that devolution will not deliver all the savings that are required in the next five years in health and care. If the settlement from the spending review does not back the five-year forward view, then we cannot deliver the five-year forward view. It seems to me that, if you read what backing the Stevens plan means, it means delivering the £8 billion that has been promised for the NHS and doing that in a way that is front-loaded, so more of the money is given in the first couple of years to address the kinds of points that you have made about the current financial position. Social care is backed; that was a fundamental principle. The level of social care is supported to be maintained or increased, and it has since declined. There is a major upgrade in public health and prevention, and we have seen reductions in public health budgets.

What we believe, and our chair has written to the Chancellor about it, is that we are in danger of having not just bad social policy but bad economic policy. What you are doing is disinvesting in the things that

both prevent people from becoming sicker, which is the fundamental issue that we should be dealing with, and increase costs. That is bad social policy and bad economic policy. Devolution could help, if we get the conditions right, to make sure that we are dealing with prevention and public health, and the wider determinants, that we have joined-up health and social care, and that we are building a new network of hospitals and specialised services that make sense, which is exactly what is happening in Manchester, but we cannot do that without resources.

Q124 Liz Kendall: It is interesting that this is all supposed to be about joining up the budgets and the resources, but you specifically referred to NHS and social care. Is it the time to stop thinking about these budgets separately and do one deal, across the NHS and social care, a proper five-year plan for funding across both? Is that not what we would like to see in the spending review?

Rob Webster: That is exactly what we would like to see, and it goes beyond that to include public health and prevention, too. In the latest leadership survey that we did, the biggest one of NHS leaders, chairs and chief executives, 76% of them said there should be a ring-fenced deal for health and care over the next five years. 99% also said that reductions in social care spending were having an impact on their organisation or the NHS.

Q125 Liz Kendall: I understand that NHS England, in its submission to the Treasury for the spending review, has asked for the transfers from the Better Care Fund to local government to be stopped, because they are so concerned about pressure on NHS budgets. Do you know if that is true and, if so, what do you think of it?

Rob Webster: I have not seen the NHS England submission.

Q126 Liz Kendall: I have one final question, which is linked to finance and its impact on integration. Some people have argued that charging for social care services, whereas the NHS is free at the point of use, is a barrier to integration. Do you think that that is true or false?

Rob Webster: Patently it is false, if we have parts of the country where health and social care is integrated.

Linda Thomas: It would be an ideal world, would it not, if we could fund adult social care? We know that the Dilnot proposals, which would have supported more of adult social care, have been put back until 2020. Yes in an ideal world, but I debate whether we could actually get any Government to implement that, at this time. But it would be good. Why should dementia be treated any differently from cancer? It is not

an illness that you choose to have and yet it is very often something that you end up having to pay for through residential care. That is our brave new world, is it not?

Q127 Liz Kendall: I hope the Chair will forgive me just asking this, as you mentioned Dilnot. They had promised to have a cap on care costs. It has now been moved back. Could you update us on when that is? What are your estimates of the spending that local councils have had to make in making sure Dilnot works, and is that a good use of public funding when people are struggling so much with social care?

Linda Thomas: It is a pity that it had to be put back but, to be honest, the situation in local government was so dire that we actually, through the Local Government Association, asked if it could be put on hold while we help and support adult social care continuing in the vein that it is at the moment. We asked for that because there was no new money for us and we have lots of other pressures, like DoLS and things like that, which are really impacting on adult social care departments. It is partly from our requesting it, but we understand that, by 2020, at the next election, it will be an election pledge. We are hopeful that the money that should have been allocated to that will come back to local government for us to spend on increasing our support for adult social care, because of the rising demographics. I cannot tell you any more than that.

Q128 Chair: I have just two final points to Linda Thomas; I just want to be clear where the LGA stands. Rob Webster just talked about ring-fencing health and social care budgets. The LGA is actually against ring-fencing in principle. Public health is ring-fenced. Where does the LGA stand on social care being ring-fenced, very briefly?

Linda Thomas: We have always opposed ring-fencing health for all services. There was some sort of talk about it, but I really do not think that we could get consensus on ring-fencing for adult social care at this moment in time. You know we operate on consensus.

Q129 Chair: You are obviously a Greater Manchester councillor as well. One or two local government colleagues in other areas have looked at the Manchester deal and thought, "We're not going there." They have mentioned what has been described to me rather appropriately as a hospital pass being given to you—you are being made responsible for impossible decisions with inadequate money to deliver health and social care.

Linda Thomas: Is that, "Discuss"? The thing is, in local government for many years, across all local government, we have asked for devolved powers. It would be very churlish of any local authorities to turn around, once they were offered them, and say we do not want them now. As I have said today, we want them under the right conditions. We are very clear that we want it to be funded adequately, and we will say if it is not funded adequately at the 11th hour and we feel we are being short-changed, but it is an opportunity. As we work in other areas across Greater Manchester—we have children's services coming together now and we are doing planning together—it seems an ideal opportunity to at least make an attempt, because it is about the people of Greater Manchester, and we are hopeful that we can improve the outcomes. The health inequalities in that region are just at the top of our priority list.

Chair: On that positive note, we will end this evidence session. Thank you very much indeed for coming in to give evidence to us.

Examination of Witnesses

Witnesses: **Councillor Paul Carter**, Chair, County Councils Network, **Councillor John Pollard**, Leader, Cornwall Council, **Councillor Alan Rhodes**, Leader, Nottinghamshire County Council, gave evidence.

Q130 Chair: We move on now to our second panel of witnesses. Thank you very much for coming. Could you just say who you are and the organisation you represent?

John Pollard: Certainly. I am John Pollard. I am the Leader of Cornwall Council.

Paul Carter: Paul Carter, the Leader of Kent County Council and Chairman of the County Councils Network.

Alan Rhodes: Good morning. I am Alan Rhodes. I am Leader of Nottinghamshire County Council.

Chair: Thank you very much for coming. I am going to begin by passing over to David Mackintosh to start the questions.

Q131 David Mackintosh: Thanks very much for coming today. The Government are talking about city regions as natural candidates for devolution deals. Do you think we should forget about devolution to counties like Cornwall? How do you feel about that city region idea?

Paul Carter: I think that is probably coming my way, Chairman. I am very excited about the opportunity. Two-tier areas—county unitaries—have to make the case for devolution, and we relish the opportunity to have greater reach and influence in the delivery of not just local government services but the broader public services that are delivered within our areas. The devil is in the detail. We have to look at the conditions that will be attached to devolution deals, but counties have already shown their ambition in the early submissions on 4 September for devolution propositions to their areas.

My own county is working on one that will be with the Secretary of State by the end of February. We are taking the time to put that together in the most intelligent way. We hope that what has started in the cities will roll out sometime very soon to the county shires of this country, which represent 48% of the populace of England and are responsible for 41% of the GVA of this country. They need to raise their profile and hopefully receive intelligent devolution packages, against good business cases affecting the public services that we deliver in our areas.

John Pollard: Can I just say, I have to be very careful here? Cornwall obviously has a deal, and we are not a county—we are actually a duchy. I will just get that one in.

Chair: I thought you were a country.

John Pollard: Obviously as a unitary authority based on a county region originally, we see this as a wonderful opportunity, and we are using our deal as a wonderful opportunity to spread the ability to make decisions to all parts of our community. The strength of counties is that they are a community. Clearly we have parishes—we have two tiers—and therefore we can engage in double devolution, making sure that local decisions are made as locally as they can be.

Alan Rhodes: Can I just add something? I agree with you that it is a wonderful opportunity. I would argue that devolution of centrally held powers, funding streams, responsibilities and functions is as important to shire counties as it is to metro areas and city regions. There is a tremendous opportunity here.

I am here this morning representing Nottinghamshire and Derbyshire, and we have been working jointly, as 19 authorities, 15 districts, two cities and two counties to put our deal together. We have already had sight of a first draft, and there is another meeting with Ministers tomorrow. We are selling this hard, simply because we think that there are opportunities for our market towns, villages and rural communities

in devolved powers, particularly around the economic development and growth potential in shire counties.

Q132 David Mackintosh: Going back to Cornwall, you are unusual in being a single unitary authority. Can you tell us how the deal came about and how it was delivered?

John Pollard: By all means. We managed to be the first non-metropolitan area to secure a deal, because we were actually ready for it. We had been working for some 12 months before on fairer funding projects and trying to look at the funding of Cornwall in relation to the funding of other areas. We had a member and an officer group doing that, and clearly our officers had been working for many months in trying to develop new ideas for how we could deliver services more effectively.

Once the Scottish devolution referendum had happened, we were ready, and I got full council backing to do two things. The first was to prepare the case for Cornwall, and we have put together a very full and detailed case of the things we feel need to be devolved down to Cornwall for Cornwall to be most effective. The idea was—and the council backed the idea—that we would present the case for Cornwall in its broadest terms to all politicians before the general election, and we would then negotiate with the new Government coming in, so that we would have a clear set of proposals before the summer recess.

What actually happened was that when we worked with civil servants—the Government very kindly gave some civil servant time to us during purdah—we realised and they realised that we had some really solid ideas developed here that could be implemented. The Chancellor told us, "Let's see if we can do the deal before the summer recess," which I must say was a bit of a shock to some of our officers, who had to produce a lot of detail, a lot of documentation, a lot of negotiation, in very short order, but we managed to do that. Therefore, at the end of July, we signed our deal.

Q133 David Mackintosh: Thank you very much. Turning to Nottinghamshire, you were the first two-tier area to put forward devolution proposals. Do you think the Government were surprised?

Alan Rhodes: The Government have been very supportive, actually. We took a view early on that there were opportunities here. We talked to the leaders in both counties and there was clearly an appetite for it; this is 12 months ago now, so quite a long time before the election. We could see the potential, but I do not think, in fairness, we realised the

amount of work that both we and more so our officers would have to do, but it is something that we felt we would like to be a frontrunner on, if you like a pioneer, for the county areas and, so far, we have been very pleased with the support we have received and encouragement received from Government on this, although clearly there are issues.

Q134 David Mackintosh: Thank you. Can you tell us a bit more about how the two-tier is working? Is everybody working together well?

Alan Rhodes: One of the great positives around this has been the way that everyone has worked together. You will appreciate that there are 19 authorities from very different areas geographically and demographically, with different political persuasions, and it has been an extremely businesslike process. People have left their politics at the door, if I can say that, and we have been working towards a common purpose. That in itself has been very rewarding and refreshing. I think everyone who has been involved in the process would say that.

I would not try to suggest to you that there are not concerns and that there have not been differences between us. That would clearly be nonsense, but there has been a sense of a common purpose among the 19 leaders. Getting 19 local authority leaders and their members through the departure gate at the same time is an extremely challenging thing to try to do, but I think we are getting there.

Q135 David Mackintosh: For the County Councils Network in particular, are you worried that devolution is becoming a two-speed process? There are many counties that are not necessarily in the same place as Greater Manchester, obviously with the exception of Cornwall, which is a duchy.

Paul Carter: There is a danger, but it is up to the Government to empower two-tier areas through exciting devolution agreements, against the ambitions that are delivered predominantly through combined authorities going forward. I am a great believer that coterminosity of boundaries is really important, and the Government need to work on the scale and size of a devolved package to a population grouping of—what?—there is much talk about 1.5 million to 2 million, but Cornwall very much breaks the rule on that front.

In my view, ignore county boundaries at your peril. I think that the counties have an identity and a history. Residents identify with their county, their town and their district, which is very important to me. I am not too hung up about the size and scale. We are lucky in Kent and Medway, having a populace of about 1.65 million, with 12 districts and

one unitary. The directly elected mayor is a big issue, I can tell you that now. The relationships are building around combined authorities. Everybody is questioning if the prize is going to be worth the energy and the effort of pulling together combined authorities, in the ability of Government and Whitehall to actually let go and really empower our local government, but our track record from the last five or six years, or 15 or 20 years, has been second to none in local government.

As I started by saying, if we can really have influence in our reach to the totality of public service expenditure in our area, and bring to the table what we have learned from the last five or six years, we really can make things hum and sing in a very different way, in my view.

Q136 David Mackintosh: Do you think the issue of elected mayors is around the directly elected office or do you think the title of "mayor" is also an issue in a county?

Paul Carter: We are in danger of having four tiers of government. We have towns and parishes; we have districts and boroughs; and we have the county. Do we need another tier of governance on top of that, through a directly elected mayor's office? I do not think we do. When you look at the Conservative Party manifesto, it talked about directly elected mayors for cities, but then went on to talk about further devolution packages to other areas. It did not have the condition of directly elected mayors to those other areas of the country, which I think is really significant and important. Hopefully the vast majority of the members of the County Councils Network are very concerned about having directly elected mayors imposed upon them.

Q137 David Mackintosh: Is that an issue in Cornwall?

John Pollard: It is clearly not an issue for us, in that there is no appetite for it anywhere. That is very clear. For me, the wish of Government to have an elected mayor must be to do with clarity of governance. I believe we have that. We have a strong leader model. I am elected annually by full council, so I am more accountable in that way than an elected mayor would be. Therefore, in terms of the future, we are trying to make sure we develop that role and the governance structures to reflect that accountability and that ability to make decisions. We did not go down the avenue of an elected mayor, although we were warned that, if we want further parts of the deal, which we do, we need to address our governance. We are doing that now and I can explain that later, if you wish. The fact is that our model, of a strong leader, a cabinet and accountability to full council, full council being the sovereign body, works.

Q138 David Mackintosh: Lots of county councils and indeed unitary authorities have huge social care pressures. Do you think that health devolution will go some way to addressing those concerns?

Paul Carter: I think there are massive opportunities. I was gagging to get involved in the last debate with Manchester, where the health and social care support and preventative agenda are absolutely crucial to delivering better use of the National Health Service pound and better use of the social care pound. If we can really deliver really good community health, primary care and social care, deliver the team around the patient and the team around the GP practice, in my view, we really can make a massive difference to the admissions into acute hospitals and the utilisation of the National Health Service pound, and get that money better spent in good primary community health preventative services, which in some cases are accessible seven days a week, 24 hours a day. That will reduce hospitalisation enormously, but I could bang on about it for a long time. Kent is very privileged in having one of the most advanced vanguard practices and a pioneer authority as well. It is something that we have been working on for many years and will be a significant part of our devolution submission.

Q139 Mr Mark Prisk: Just turning to some of the practicalities of delivering service, what would Cornwall and Nottinghamshire, in this case, see as being the principal challenge of the delivery of a public service to what is a more diverse and spread-out population of town and rural areas? I know that in Cornwall, for example, a bus service is obviously very important. How do you make sure that both St Ives and Saltash, at different ends of the county—sorry, the duchy, you are quite correct, and I should know that—are being satisfied?

John Pollard: As a unitary authority since 2009, we have been wrestling with those issues anyway. What we have done in the last five or six years is to establish the unitary authority in people's minds, and it is accepted, but we are struggling to, as you say, deliver services to different areas with different backgrounds. It is very difficult. We keep looking at the practicalities. If you take the devolution deal, that can only help us, in my view.

For the integration of health, for instance, we are a pioneer authority. We have models that are working extremely well, which are based on shared budgets. If we can integrate that budget and have one service, one management and one delivery, we will do the business, and that is our challenge under devolution. We need to have a joint business plan that reflects that by next April. In terms of the delivery, devolving the

authority—the ability—to local level can only help. We will have control of the bus network. We will not be reliant on a national network. We will need it and will use it, but we can adapt for the needs of a rural remote area like Lizard and a more populated area like Truro. As you know, it is 100 miles from one end to the other. Those are the challenges we have to deal with anyway. We believe that devolution helps us.

Q140 Mr Mark Prisk: Just before I come to Nottinghamshire, you mentioned double devolution specifically. In that context, do you envisage an enhanced role for the rural parishes, as well as the town councils?

John Pollard: Absolutely, and we are encouraging our towns and our rural parishes to come up with what we call a deal, a package or a plan of the kinds of things they would like to adopt, the kinds of ways in which they can work with Cornwall Council to deliver services in a much more reactive and local manner. That is happening, and it is a growing movement. The problem there is that we cannot resource all the demands, but we are working hard to do that. It is a growing phenomenon, this ability of towns not to just accept something we cannot deal with any longer, but to work with us to plan the future. It is working well.

Alan Rhodes: We are clearly going to have to focus more on the co-ordination of our limited transport resources, greater leverage over bus operators, integrated ticketing and local infrastructure prioritisation. Ours is a deal based around economic development and growth.

Clearly connectivity is key to growth. We are very fortunate in Nottinghamshire and Derbyshire to have the M1 corridor and A1 corridor, and HS2 coming in. One of the hubs has been identified as Toton in Nottinghamshire. The Midland Main Line electrification has recently been unpaused, and we have the East Coast Main Line. We have great connectivity north to south, but do not have great connectivity east to west. We need to deal with that too, but there is a will to do this and a recognition among all the partners in the agreement that transport connectivity has to be a priority for us.

Q141 Mr Mark Prisk: You mentioned earlier the fact that you had to get 19 local authorities through the gate. I think you said 19; is that right? There are 19 units within the team. In the delivery of services, does this make it far more complicated than perhaps Mr Pollard's unitary authority?

Alan Rhodes: Undoubtedly. We are all aware of the complications of working with 19 different authorities, all with their own very different demands, all with their own clear identity, keen to ensure that they get a good deal for their areas as well. One thing that has been developed over the many months that we have been working together is the recognition that it is not just about your own area; there is the big picture here around Notts, Derbyshire and what we can do through working together and what we can achieve. That has been the message that has come through in our many deliberations.

Q142 Mr Mark Prisk: On a similar tone, clearly it must be simpler as a unitary authority. One of the challenges here is getting everybody to agree that, in making a devolution deal, not everyone is going to benefit equally. Not every town or village is going to see exactly the same. There are the economic differences between Saltash, which would look to Plymouth, whereas the west would look to perhaps Truro and Falmouth, and the industrial towns of Camborne and Redruth. Do you feel, Mr Pollard, that your double devolution deal is a way of embracing and getting those communities to participate and engage? You do not have the same problem as a two-tier authority. Is that your solution to engagement?

John Pollard: In terms of engagement, we have been very clear that the devolution deal that we secured was not for Cornwall Council, but for Cornwall, and therefore it was a deal that came about by partnership. We do have advantages in terms of being one very clear geographical area. We have one coterminous LEP. Our NHS management is Cornwall-wide and no further, so we have been working for a long time on those partnerships.

It seems to me the partnership that will actually deliver double devolution is the partnership between all those partners, and the towns and parishes as well. Different areas will have a different impetus, really. If you take the east, they are part of the Plymouth city deal. There are advantages that come to Cornwall there, because a lot of the employment for the south-east is in Plymouth. In terms of the local enterprise partnership, they are very clear that we are trying to make sure that we focus the resources of the growth deal where they can be delivered, so we are looking to Bodmin for food and different areas for different aspects. It is a matter not of equity, but equality, really—the equality of opportunity for areas to develop what they need in the way in which they can deliver it.

Q143 Mr Mark Prisk: Lastly, Mr Carter, looking at the picture as a whole, we have certainly seen some evidence and some commentary that two-tier authority areas naturally have a greater struggle to get to the gate of devolution. What can be done to change that so that there is a more unified approach to this? Do you see two-tier as a particular hurdle in the way in which devolution is being offered as deals?

Paul Carter: Everybody would agree that two-tier areas have their challenges, but you would need to look at the track record of working together. Let us look at the public service agreements and the local area agreements that were carved out however many years ago it was—10 years ago or whatever—when local government came together with other public service providers to deliver better and improved outcomes for our residents. The troubled families programme would be another example of where, despite some of the wailing and gnashing of teeth, two-tier has got on, done the job and delivered. For the local enterprise partnership and local growth fund submissions in prioritising schemes, we have all had to work together in a mature way to put the proposition, if we are to get the prize from Government in devolution arrangements, to prove that we can work well together and deliver governance arrangements with a clear decision-making process.

There is a lot of mystery around what a combined authority constitutes and what it does not constitute. In a metropolitan area, a combined authority is very different from a combined authority in a two-tier area, and one needs to accept that the responsibilities of districts, boroughs and counties are very different from metropolitan authorities. Therefore, for the governance arrangements and working together, we should not try to find the same solutions for both. I hope that we can arrive at a different solution in the counties.

Q144 Mr Mark Prisk: Just briefly on this, what would you therefore say is the single thing that helps a two-tier area engage with this process? What is the exemplar that you would look at to say, "This factor is the thing that helps two-tier areas to succeed"?

Paul Carter: Hopefully if we get the submission right, the prize is worth the energy and effort in delivering additional responsibility shared between all tiers of local government, in our areas. There is a real appetite not to miss the boat and, where there are those strong relationships, to work together across other parts of the public sector as well as within the family of local government. We have come into local government to try to make a difference and make a change. If we can have influence and reach in how the totality of the £7.5 billion is spent in the Kent area, how exciting is that? It is not necessarily for

fiscal devolution, but real influence in shaping the delivery of that public expenditure in our area. It is place-based budgeting.

Alan Rhodes: What is important in two-tier area working is the strength and quality of the partnerships. It is important for a district leader to feel that he or she had just as relevant and important a contribution to make as any upper-tier authority. We have four upper-tier authorities, two cities and two counties, and 15 districts. What has been challenging is keeping everybody focused and engaged because, as we all know in the council these days, it is extremely challenging and time-consuming. It is very easy to be distracted doing the day job, but it is important that this is seen as a partnership of equals, if I can put it that way, and that people feel that they have a relevant role around the table, that they can speak frankly and openly with each other, and that we are working in partnership in a serious way, and it is not perceived to be driven by the upper-tier authorities.

There is always a danger of that because, very often, for purely practical reasons, I suspect, Government tend to communicate more easily and freely with upper-tier authorities. The channels of communication tend to be more regular and more open than they perhaps are with the other district authorities. That can sometimes be challenging in itself, because then people start to feel as if they are being excluded or that it is not an equal partnership. We have had all of these things to deal with in the past 12 months. We are still meeting. There is still a sense of purpose around it. We have ironed out our various problems as they have arisen, but the strength and the quality of the partnership is key to taking it forward in a two-tier area.

Q145 Chair: Can I just follow on from that? It seems to me Cornwall is fairly straightforward; you have one council, so that is a clear method of governance. In Kent you have two tiers, but you are looking to do a devolution approach based on your county and district relationship. Nottinghamshire and Derbyshire have a more interesting conundrum, have they not? You have districts, counties and then a combined authority on top. Do you think the public is going to wear another tier of governance—three tiers of government in one area? There are parishes as well, of course, if you throw those in. You have quite a few of those as well. Does it make it very complicated?

Alan Rhodes: It is not an easy sell, is it? This is the conundrum that we have. It is another tier of local government, and we are going to have to ensure that the deal that comes from Government is good enough to be able to sell the concept of a devo deal and an elected mayor.

Q146 Chair: That is four tiers then, if you have an elected mayor as well.

Alan Rhodes: You are absolutely right. Unless the deal is good enough, it is going to be an almost impossible thing to sell, so the deal has to be good and we have to be able to talk to our communities about the benefits of what we have done and the deal we have achieved.

Q147 Chair: Is that not a slight nudge towards unitaries and changing the whole structure of local government? Would you want to do this as a combined authority?

Alan Rhodes: If I had a crystal ball, which I do not, I would not be at all surprised if unitaries were on the agenda at some point, although they are not at the moment of course. In the future, who knows? If somebody had said 10 years ago that devolution would be on the agenda now, I would have said that that was unlikely.

Q148 Chair: I know that Paul wants to come in, but I just want to raise another issue within this, which is the issue of consent in the legislation. One person's consent is another person's veto. Cornwall has a nice easy job, because you can agree with yourselves. You are one council. For Paul, it is slightly more challenging, because you have to get the districts and counties together. For Nottinghamshire and Derbyshire, there are districts and counties, and some concerns around some of the north Derbyshire and north Nottinghamshire districts looking towards Sheffield. The county veto what the districts want to do and the districts veto what the county wants to do. Is that really a sensible position to get to, in terms of trying to reach a conclusion to this?

Alan Rhodes: I do not think it is. We need to find a way through it. The districts involved are Bassetlaw and four north Derbyshire districts—Chesterfield, North East Derbyshire, Bolsover and Derbyshire Dales. I actually live in Bassetlaw. I am a Bassetlaw district councillor, as well as a member of Nottinghamshire County Council. It is an issue. Bassetlaw clearly faces north. I can only talk about Bassetlaw; I cannot really talk about the four Derbyshire authorities, but Bassetlaw clearly faces north, although it has to be said that, in terms of travel to work, the most recent study showed that the vast majority of Bassetlaw residents said they lived and worked in Bassetlaw. The travel to work argument is actually fairly flimsy, but we need to recognise that there are geographic issues involved. I do agree with Paul that neither this

Government nor any other Government should start to break up the shire counties, because that is not necessarily a good thing.

Of course, the other thing we need to remember is that districts are big places. It depends where you live in Bassetlaw: if you live in Harworth or where I live, you might well think that Sheffield is not too far away; if you live in the south of the district, you might think that Sheffield is a very long way away. It is not quite as simple as it seems, but the challenge for us—and this is the important point—is that we find a way to ensure that Bassetlaw can continue to have the benefits of its involvement as a non-constituent member of the Sheffield city deal and, at the same time, is fully engaged as a constituent member in Nottinghamshire, where it is based geographically.

Q149 Chair: I want to bring in Paul. I just want to say that you cannot have a district that, in the end, is involved in electing two mayors in different places, can you? That is going to force the issue as to where the district actually wants to—

Alan Rhodes: Sure, but of course, Bassetlaw will not be involved in electing the mayor in South Yorkshire. It is not a constituent member.

Q150 Chair: That is the interesting argument about what the legislation allows. Paul, do you want to pick up on this?

Paul Carter: It comes back to my earlier point about the size and scale of the population. How critical is it to have the 1.52 million? Clearly it is not in Cornwall, and there are significant parts of the county landscape that do not need to merge with others. Some will. Just coming back to the conversation we were having about unitaries, if you look at the evidence, there are some small unitaries, and for their viability and sustainability financially size does matter in building up a populace in excess of 500,000 to sustain sensible unitary counties. It is absolutely essential. It is the small ones that, from my knowledge, are really struggling in their viability as it becomes ever tighter.

Coming back to the debate about whether or not counties could all become unitaries, you could not run Kent as one big county. The diversity and the needs of east Kent and other parts of the county are totally different, from very prosperous west Kent to extraordinary poverty in the east of the county. You would have to reinvent area-based governance arrangements, and this, that and the other. My view is that the pain is not worth the gain. Make two-tier really hum and sing in the most efficient and effective way to deliver the very best

public services to the populace. I know that it is easily said, but delivering it is a challenge.

Q151 Chair: I have one question, then, and Jo has one final question as well. To come back to the health and social care issues, this is important. I heard how positive you were about this, Paul. Is there still a sense that, in talking about joint working and trying to deliver services together on a holistic basis, the NHS really does not want to let go? I know we have had a chance to look at paragraph 19 of the Bill. It is essentially saying that, in the end, health spending goes back and is accountable to the Secretary of State, and nothing changes there. Do you think this is still a rigid point of view that is ultimately a problem and an obstacle to this joined-up approach that you want to see?

Paul Carter: Yes, there is evidence of enormous reluctance to change, but I have great faith in the direction that Simon Stevens is setting out in his five-year plan, with the acceptance that there has to be change at pace and scale—and fast. Those vanguard projects and pioneer authorities that can really cut the mustard and be empowered to deliver the concept into practice will start to deliver real transformational change, but it does have to involve pooled resource between social care and health budgets in CCG areas and boundaries.

One should not discount the problem of the self-funders and the state funders, which you started on earlier. If you take Kent, probably 25% of the elderly populace is entitled to free social care provision. That is about £500 million-worth of services. The National Health Service budget is about £2.4 billion in Kent, but you then have the 75% or more who are paying for their own social care packages. The totality of the social care expenditure in Kent is approaching similar to the National Health Service budget. How do you make sure that you have equity and fairness for those services that are free at the point of delivery and those that have to be means-tested? It is a horrible complexity that gets in the way of trying to marry together pooled resources and pooled funds. We have to find a way through it, and the Care Act and the Dilnot implementation would have made some of that stuff easier, which now cannot take place until 2020.

Q152 Chair: John, you are obviously doing health and social care under your devolution deal. Do you want to say a little bit about this issue of accountability and the NHS role there?

John Pollard: It will be difficult. There are stones along the way but, at the end of the day, the health service in Cornwall needs to do integration just as much as the council needs to do integration,

otherwise we will not be able to deliver the services to an ageing population in the way in which we need to. Therefore, that is the impetus. The glory of the deal for us is that we have Government backing, so that we can make sure that the NHS is at the table with the same willingness as the council and the other partners, because we have an obligation to the Government to produce an integrated business plan within the next six months. For me, that gives the structure, as long as we can maintain good relationships and the willingness.

Q153 Chair: Do you not worry, though, that in the end, you are going to be the one who is blamed for everything that goes wrong in the NHS, because the public will now see that it is all devolved to the council?

John Pollard: Frankly, Cornwall Council is blamed for anything anyway, so there is nothing new there. The fact is that this is not about blame; this is about delivery. This is what the client on the ground, the patient, the elderly person, or the person in need of support actually gets, and we have to forget about the blame. Obviously we are all accountable, but that is the prime motivator for what we are trying to do: to deliver a better service in straitened times.

Q154 Jo Cox: I have one last question on overview and scrutiny. How are you all going to adapt the overview and scrutiny framework, as set out in the Bill, for your quite different areas?

John Pollard: Most of that is designed for combined authorities in how the interface between the different elements will work. In terms of our deal, we are making sure that there is a lot of scrutiny and overview involved. Clearly since the signing of the deal, we have been developing our structures for implementation and particularly for monitoring. We have a monitoring board, which is representatives of the NHS, representatives of the LEP and representatives of the Isles of Scilly, which are obviously involved although not part of the deal. Our MPs are there, as well as the council, as overarching monitoring. Within the council, we have a health and social care scrutiny committee, which has co-opted partners from outside the council. That will function, as it has before, as an overview with a policy scrutiny element. I am quite comfortable that there is scrutiny in place.

What we are doing now is looking at strengthening the governance and scrutiny element within the governance. For instance, we are talking to the Boundary Commission to make sure that we have got the representation right and that all those elements are in place. We have the Centre for Public Scrutiny coming and supporting us in what we are doing

to make sure that that is fit for purpose as well. We are looking at what Cornwall or any local government will look like in five years' time and, looking ahead, making sure that our devolved powers help us to be fit for purpose for the delivery of the services. There is a lot still going on in terms of thinking and development, and giving that assurance that what we do has some overview and scrutiny to it.

Paul Carter: A lot will depend on what devolved packages areas get to make sure they do have the right oversight and scrutiny arrangements. My answer would be totally in line with John. That is the way the County Councils Network is thinking.

One point I would like to make is that there is bespoke devolution, but there has to be generic devolution with commercial rates and the other £12 billion coming our way sometime soon. We spend an awful lot of time talking about the potential devolution around bespoke deals, but have to start to get up to speed about what generic devolution would look like, with that £12 billion coming to local government with a load of responsibilities and hopefully the adequate amount of finance and funding to support that responsibility. That is going to be a massive challenge for local government, and we need to get out heads together, working with central Government, as to what that could be and how that could look.

Alan Rhodes: For us it is work in progress. We have set up a governance group and we are discussing the creation of an overview and scrutiny framework with Nottinghamshire and Derbyshire colleagues. We have to reflect the political balance and the different types of authorities that are involved as well. We are still working on it; it is work in progress. It will have to be properly scrutinised as well. We cannot allow that not to happen. Government will demand that anyway.

Q155 Alison Thewliss: I just wanted to pick up on the external scrutiny. You mentioned the Centre for Public Scrutiny, so I just wondered how each of you were looking to involve the public in this process, so that they have an understanding of devolution and some kind of involvement, so that there is some sort of public accountability there, rather than just political accountability.

John Pollard: That is a very interesting dynamic really, because we have created a devolution deal for Cornwall, and therefore it is important that Cornwall understands what is happening and is signed up to it. Obviously the council does a lot of work in that line. At the minute, I am halfway through a series of public meetings across Cornwall, and have one in Launceston tonight, so I have to dash back, trying to make sure we explain and have that focus. Clearly all the

members of the council are publicly accountable through the electoral system, so that is another element and, if we are working with our town and parish councils, that gives another interface and another level of accountability.

Alan Rhodes: We have already started talking about it in the media, but unfortunately they seem to be transfixed with the prospect of an elected mayor, rather than interested in talking about what the possible benefits might be for their readers and for our communities. That is frustrating, it is fair to say.

Once the deal is agreed, there will have to be a period of public consultation, when we will have the opportunity to talk about what is on the table and what the benefits are. There will also have to be stakeholder consultation. Business is obviously very interested in this. We had a good discussion about it at the local enterprise partnership on Thursday, and of course there are others. The police and crime commissioners of both counties are extremely interested in what is happening, as are the chief constables and other public sector bodies as well. There will be a hugely important consultation to take place.

At the moment, we have very little to consult on because, as I said earlier about another matter, the deal is a work in progress. We have tried to get the message out via the media, but it is very difficult. It is a very complex, rather narrow discussion that we are having at the moment anyway. If you are not involved in the public sector at a senior level or in local government in some way, it is not really a conversation that you need to have at the moment, but there certainly will be a need for that eventually. Going back to an earlier discussion, how we are going to explain and sell the idea of an elected mayor as another level of governance is certainly going to be challenging.

Q156 Bob Blackman: Just very briefly, John, you mentioned that you are involving MPs in your structure. How are you involving MPs?

John Pollard: We have a monitoring board, and there are six MPs. They are all Conservative. They are sending representation on to that monitoring board.

Bob Blackman: They are not all going.

John Pollard: No, I think there will probably be three of them. We are trying to develop a system where MPs take on an area to champion. Certainly the history of what has happened in Cornwall is that has been the case. One or two have got heavily involved in transport, and it is the same thing in health. In terms of the overall scrutiny, the

monitoring board is at the executive level, so all those areas that are involved as partners, including the MPs. They are very important to us; they are our voice here in London.

Q157 Bob Blackman: Turning to you, Alan, have you considered using MPs in a similar guise to what is going on in Cornwall?

Alan Rhodes: We have had some very interesting discussions with our parliamentary colleagues. As you would imagine, there are voices that are not necessarily in favour of the proposal that we are pursuing, and there are others who are very much in favour. The minority are actually somewhere in between, and they are rather waiting for more detail, which is where quite a lot of elected councillors are as well. They want to see more detail before they can commit one way or the other, at this stage, from our perspective.

Chair: Thank you very much indeed for coming to give evidence this afternoon. That has been really helpful to us, thank you.