



Health Committee

Oral evidence: Impact of the Comprehensive Spending Review on health and social care, HC 678

Monday 21 March 2016

[SALFORD]

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Written evidence from witnesses:

- [Local Government Association](#)
- [Care England](#)
- [Association of Directors of Adult Social Services](#)
- [Scope](#)
- [Mind](#)

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Julie Cooper; Dr James Davies; Emma Reynolds; Maggie Throup; Helen Whately.

Questions 194-294

Witnesses: **Sarah Pickup**, Deputy Chief Executive, Local Government Association, **Professor Martin Green**, Chief Executive, Care England, and **Ray James**, President, Association of Directors of Adult Social Services, gave evidence.

Q194 Chair: Good afternoon and, on behalf of the Health Committee, could I start by thanking Salford Royal for welcoming us here today? It has been a fantastic visit this morning and also to all the staff and voluntary groups who have met with the Committee, really appreciate all of their time. We are now moving on to the public session right now and it would be interesting for the panel to introduce themselves to those who are following from outside this room. This is our session on the impact of the comprehensive spending review into health and social care. Perhaps starting with Ray James.

Ray James: Hello, my name is Ray James. My day job is the Director of Health, Housing and Adult Social Care at Enfield Council in north London and this year I have the privilege of being the President of the Association of Directors of Adult Social Services.

Professor Green: Hello, everyone. I am Martin Green. I am the Chief Executive of Care England. We are a representative body of care providers, and I also have a role as the Independent Sector Dementia Champion at the Department of Health.

Sarah Pickup: Hello, I am Sarah Pickup. I am Deputy Chief Executive at the Local Government Association. I lead on finance and I also lead on adult social care.

Chair: Thank you and I come, first of all, to Emma.

Q195 Emma Reynolds: Could I ask all of you what the pressures on local government budgets have done to local authorities' ability to provide social care for their residents? How have these pressures manifested themselves in terms of local authorities' provisions?

Sarah Pickup: The first thing to say is that over the last spending review period about £5 million in total was taken out of social care budgets, not in a net cash reduction but that was the savings level that had to be achieved in order to accommodate those pressures you talked about. The biggest pressures in adult social care are demographic pressures and they are, in part, due to the rising number of older people in the population and their rising levels of needs. Martin talked about dementia and that is one of the aspects of rising levels of need. But what we must not forget is that the number and levels of many people with learning disabilities is as big a financial pressure on council budgets as older people. It is less talked about but having been a director of adult social care in a county council until recently, that was at least as big a financial pressure as older people.

Other pressures are those that fall on councils generally, such as national insurance increases, pension fund costs, things like the apprenticeship levy; all those things will fall on social care departments, the same as others. There are some specific things like deprivation of liberty safeguards and the cost of those and meeting those needs. The combined effect is very significant and of the £5 billion that had been saved, some of that would be through efficiency savings and service redesign, which you would expect us to do and we would have done anyway. Some of it was a reduction in people's ability to access the service or a reduction in the scale or type of service that individuals would get.

Q196 Emma Reynolds: Can you give us an idea of the proportion of that?

Sarah Pickup: Ray might have a better answer on that. The ADASS budget survey is covered by a lot of that.

Ray James: The ADASS budget survey, when it was published last year, shows that over the last five years there had been a 31% real-terms reduction in local councils' adult social care budgets, so that is making some prudent allowance for both additional demand and costs. If you wanted to do it in pure cash terms it was a 17% reduction in cash without the money that transferred from the NHS, and even allowing for the money that transferred from the NHS it was a 10% cash reduction. It is worth remembering that that 7% was counted in both the NHS budgets and in social care budgets. It can be used to better effect but the value is not necessarily counted twice.

Two other things to add from that, over the same period the proportion of councils' budgets spent on adult social care grew from 30% of the council budget to 35% of the council budget over the first four years but remained at 35% in the fifth year. That is suggestive of the fact that councils did all they could to protect adult social care for a

number of years but perhaps are reaching the end of the road in terms of their ability to continue to do that, instead of other services, given that it plateaued at 35% in the final year. In terms of the number of people receiving services over that period of time, it reduced by about 400,000. In essence, what we have probably seen is people with lower-level needs not being supported as much by councils because in addition to the additional demand that we experience we are definitely seeing that more people are living longer, which is clearly cause for celebration but they are often also doing so with more long-term conditions and more complex multiple needs. The complexity of need, as well as the volume of need, has been growing over that period as well.

Professor Green: Certainly, from a provider point of view, we have seen those pressures manifest in the amounts of money that are available within the system. Also, Sarah made a very important point about the difference in particular groups, so there is very much ageism in this system and older people are not getting the same access to resources and support as other groups. For example, that is manifest in things like care plans. I have pulled out some care plans for younger people with disabilities and some care plans for older people with dementia. The older people's ones tend to be focused on process, so they talked about getting people up, getting people washed, getting people dressed, giving them breakfast and doing them in half an hour. Younger people's ones talked about access to leisure, support to maintain family relationships—a whole raft of things that were much more about the quality of life. Given we have an Equality and Human Rights Act, some of those issues are about how the system tries to squeeze the resource, and the ageism aspect is a big factor within this system. If you took that out the system would be in collapse.

Q197 Emma Reynolds: Related to the general question about pressures, could you say a little bit more about the comprehensive spending review and the likely impact of that? I know Maggie is going to ask about this as well but I am interested in a significant pressure coming forward, which is the National Living Wage. I know the LGA, in a recent report, has said basically that the precept, if and when it is used—because obviously it is optional for local authorities—is in danger of being totally wiped out by the increase in the National Living Wage. That will obviously be different in different parts of the country but could you say something about more prosperous areas, which obviously are able to raise more in the precept than deprived areas? What kind of impact will that have overall on the provision of social care?

Sarah Pickup: If we look at the spending review as a whole and council budgets as a whole, because that is where social care is cited, the overall settlement for local government suggested just under flat cash, so real terms reduction in budgets over the four year spending review period. The adult social care provision is deemed to be £3.5 billion, of which £2 billion is deemed to be raised through council tax, but it is a bit less than that and £1.9 billion is the localised Better Care Fund increase. If you look at the social care increase in funding, assuming all councils took up the option to raise the precept, that goes some way, of course, to recognise the costs of social care but we have to sit social care within the councils in which it sits. If you are faced with a flat-cash or less budgets, so real-terms reduction in your budget and you have demographic increases and the fact that you are starting from a position where care is not properly funded, you have to meet all the things like the national living wage, the apprenticeship levy and national insurance increases and the deprivation of liberty safeguards. Going forward, the living wage is probably the biggest single issue going forward.

Every single one of those costs out of a council budget on average—councils are different—has to be met by a reduction in spending elsewhere because in a flat-cash or real-terms reduction scenario that is the case. Because some of it is council tax, you can't say there is £3.5 million potentially available for social care, therefore, the problem is solved. It is not even, in a sense, as good as suggesting that the increase will be wiped out by the living wage, it is worse than that because overall there has got to be a reduction somewhere else in the council to meet that living wage cost. The living wage cost could be anything, up to about £2 billion. I live in Hertfordshire, and I used to be a director in Hertfordshire, and I have my local newsletter through and I know 2% on the Hertfordshire Council tax raises £10 million. The estimated cost, in the public-facing newsletter, of the living wage next year is £20 million, so in some areas it wipes out that increase. Given that council tax can be raised more in some areas than others, the Government intended to equalise that in a different method by using the Better Care Fund. One of the problems is the new money for the Better Care Fund is not kicking in for two years and then it is only kicking in to a small extent. We have a big gap in funding in those first two years of the spending review. Because councils can raise different amounts in council tax, the Government stated its intention as being to take that into account in how the Better Care Fund is distributed, the new money, which means that some councils that can raise a lot of council tax will not get any new Better Care Fund money or very little because they are deemed to have their share of the £3.5 billion based on the current funding allocation formula because of the council's capacity to raise council tax. Of course, the current needs formula is quite out of date, and is particularly out of date in the nature of the population. As we know, the population has changed quite fast across the country, so there is some room for improvement there. We do know that as part of the settlement an urgent review of fair funding and the needs assessment has been put into play.

Ray James: A couple of things on that, if I may. To illustrate the issue around the distribution with the precept, in the most affluent areas you will raise about two-thirds of your council spend through the council tax. In the most deprived areas you will raise less than 20% of your council spend through the council tax, so 2% on two-thirds versus 2% or less than 20% is quite a marked difference. It is also perhaps not surprising that there is a very strong correlation between increased social care demand and high levels of deprivation. One of the distribution challenges with the precept is that it raises least money in areas of greatest need. As Sarah said, there is an attempt to counterbalance that with the distribution of the Better Care Fund when it comes to later Government but that is in the final two years of this Parliament. There are very real concerns about the sustainability of the sector over the next two years, the first two years of the Parliament, when the significant additional money doesn't come through the Better Care Fund and when the additional money that is available is through the precept and there is a real risk that that will not necessarily get to areas of greatest increased demand as a consequence of the distribution.

Professor Green: Yes, certainly from a provider point of view, we are in a space where only about a third of councils have identified what they are going to pay this year and the living wage is in in about 10 days' time. Of course, part of the challenge for both local authorities and providers is that this expenditure happens at 1 April and the cash is not coming in until the end of the Parliament in substantial part. We have this big challenge around cash flow.

Q198 Helen Whately: You have talked about the pressure on the funding and the challenge on cash flows, could any of you give me your view on what this will mean on the frontline and for people who are the recipients of social care? How is this going to play out? What will the impact be?

Professor Green: Certainly, from the provider point of view—and we did some work that we had validated by KPMG—we did some work that identified that in some areas about 50% of services would no longer be viable. One of the things that is worrying about this is that it is very geographical. In some areas, particularly those where there are large numbers of self-funders, we are getting the development of some new services. But when we look across other parts where we are dependent upon public funding, we see lots of services that are in danger of closing. What I think we will see is the demand and supply equation changing as a result of this. It will not happen immediately but it will happen over a period of probably a year to 18 months but it will definitely have an impact, so there will not be the services available in some areas. One of the challenges is that it will be very geographical and there will be some areas where more services will go down because they are reliant on public funding.

Q199 Helen Whately: What sort of services will not be available in those areas?

Professor Green: Certainly, residential services but also a lot of domiciliary care services are extremely fragile. In fact, my view is that I am probably more worried about domiciliary care services because they are tending to be smaller organisations, so they are very fragile. Because of the nature of them it is easier for them to exit the market very quickly and that creates enormous challenges for people who use services and also for our colleagues who commission them.

Ray James: I will try to illustrate that a little, at the moment the CQC rate 51% of nursing homes as either requiring improvement or being inadequate. Providers of nursing home care, which is among the most acute and complex that we commission, face very real challenges getting staff. There was a 32% turnover of nurses working in nursing homes. There is over a 20% turnover of staff working in the sector anyway. The announcement about the national living wage will be a welcome one. Who doesn't think, when we know what we expect of front-line care staff, that they deserve to be paid, trained and valued appropriately but that benefit will be available to the rest of jobs in the economy as well, so the difficulties in attracting staff are likely to continue.

As was said earlier, in different parts of the country it will be felt differently. In the north-east of the country about 90% of nursing-home beds are purchased by the state, either by the NHS or by councils in many of the urban areas, and in some of the home counties that is less than 20%. You can imagine that state-funded nursing home care in the north-east may well be one of those areas where we would have the greatest concerns. To illustrate Martin's point about domiciliary care or care at home, staffing is often most difficult in areas of low unemployment because you are simply unable to recruit staff. You will see quite wide-ranging variability in costs and prices in different parts of the country as a result of those market factors. But it will often be in rural areas where the costs are higher because of the travel that is involved in domiciliary care and in those where there may well be low unemployment where we will see some of the smaller providers, which Martin talked about, facing very real challenges in the next couple of years.

Sarah Pickup: The other thing I would like to mention is preventive services, ideally you want to invest in prevention to prevent those high costs coming later, but if you have to meet the statutory need you sometimes have no choice but to cut, for example, voluntary-sector spend. The very thing that could get you out of the hole later and prevent people's needs from escalating sometimes is the only place you have to turn. There is a real concern that preventive services will be reduced. The living wage should help with recruitment but it will apply to other industries equally and so recruitment is a real problem in the home-care sector in particular. I too am probably more worried about the home-care sector than the care-home sector, not that there are no worries there.

The particular impact will be things like the ability to keep people with complex needs at home and thinking about hospital discharge and people who are discharged from hospital with higher acuity, trying to get those more complex packages and care in place. There is some great stuff going on around the country and the danger is the great stuff is cut short because the investment is not available. There is core day-to-day services where people might get a bit less and you maybe have less capacity to recover because you are not getting the right enablement input at any one time or just generally packages are squeezed and your quality of life is reduced, whether it is for people with dementia or whether it is for younger adults with disabilities. The tighter the squeeze the less capacity there is for you to—you live your life. This is not about treatment, it is usually about living with a condition and it is likely to get harder.

Q200 Helen Whately: Will local authorities in these scenarios still be able to meet their statutory obligations if those scenarios play out, as you have described them?

Ray James: It will be increasingly difficult for local authorities to safely be able to do that. If you were to ask my judgment, the next two years will be the acid test of that. The additional money that it is in the latter two years of the Parliament gives local authorities some better opportunity to do that. It will still be difficult but the money that is available in the first two years of the Parliament simply does not meet the increased cost of the living wage and the increased demand for services. If we place that on top of the fragility of services at the moment the consequences for people who receive services for their families, their carers—and all too often the additional burden on the NHS as a consequence as well—will become more pronounced over the next couple of years. We have not heard yet of a local authority that you are saying is unable to meet its statutory duties on 1 April but the confidence of directors in being able to do so is significantly declined over the next couple of years.

Professor Green: Also, I do want to make the point about the level of dependency of people in residential care and nursing care. In your own constituency, Ms Whately, the minimum hourly rate that is being charged is £3.50 an hour to look after people who 20 years ago would have been in an acute hospital surrounded by doctors, nurses and other medical professionals. If you compare that with a cost to be in a hospital, which is about £18 an hour, you see that the level of dependency is pretty much the same but the resourcing package is not. We have taken people out of the acute sector and we want to do that more but we have not shifted resources and it is becoming unsustainable.

Sarah Pickup: In terms of statutory responsibilities, it is not a nailed-down and black and white thing. You can give people a bit less and a bit less and a bit less and still say you are meeting their need but you are not meeting their need, if you think about the requirements

under the Care Act, of fulfilling lives for people with learning disabilities. The idea is not just to keep people alive and barely able to eat and drink, the idea is that people can live a life. A lot of people live a long time with a condition, a disability or a long-term condition and it is to be able to live that life. There is also a duty in the Care Act to provide preventive services. It is not defined in any way, so it is hard to say when you do or don't meet it. I suppose if you have none they are not meeting it but if you have any then maybe you are okay, so it is all a question of degree.

Q201 Chair: In the last Parliament this Committee heard quite a lot of evidence around cross-subsidy in the care-home sector, how much is that still an issue, despite it being outlawed? Perhaps, Martin Green, you would like to start with that.

Professor Green: It is not cross-subsidy, it is about some people who are self-funders paying the true costs of care and in other areas because of obviously commissioning they are not paying the true costs of care. Over the course of the organisation's budget, of course, you do have that issue about the fact that the only way the organisation sustains itself is by having self-funders. But one of the problems that is going to happen in the future is that care providers are going to stop doing that and one of the reasons is that they are getting an increasing kickback from their self-funders who are very angry that they are paying significantly more and getting the same service. Of course, in a regulated service you cannot differentiate how you provide the service and, in my view, you shouldn't. Good quality care should be everybody's right but increasingly what we will see is providers going out of publicly funded provision.

Q202 Chair: Because if you are charging much higher rates to people who are self-funders when they are not receiving a distinctively different service, in effect that is a cross-subsidy. It is often dressed up as being a single-room charge or what have you but it is the way the organisation is staying viable, therefore, you could say it is still a cross-subsidy. How often do you feel that is happening?

Professor Green: It happens a lot. What happens, particularly in corporate providers who may, for example, find their portfolios are only sustainable because of the provision in more affluent areas, if they subsidise services in less affluent areas where the level of public funding is much higher.

Chair: Right, so the cross-subsidy will happen across a region within a provider, as well as within a single organisation.

Professor Green: A region, as well as across an organisation, indeed.

Q203 Chair: Do you have any evidence to the extent that that is happening? You may wish to write to the Committee afterwards.

Professor Green: I will write to the Committee afterwards about that but it is becoming more and more significant. Given some of the figures that I have just given to Ms Whately, you can see that it would be impossible to deliver very much just on that publicly funded amount of whatever, £400 a week.

Q204 Maggie Throup: We have already discussed where you think the precept that is being raised will be spent in the next few years, in your opinion, are there any unforeseen consequences of local authorities having the power to raise a social care precept?

Sarah Pickup: Unforeseen consequences, the LGA's view is that local councils should be free to set the precept, should be free to set their local council tax at the level that suits their population to meet their needs. Over the last few years what the local government has been faced with is no means of raising additional income to meet the rising demand. All they have been able to do is reduce costs. The business rate has been set nationally—and I know that is changing, it is still going to be capped—and the council tax has been capped. We welcome the flexibility to raise the council tax for social care but we do think it should be very much up to local areas because the cost pressures are different in different places, the capacity to raise council tax is different.

In terms of unforeseen consequences, I suppose you could argue that once you have broken the thing that says you can have a hypothecated amount of council tax, could that then be argued for other things? Does it make a nonsense of the referendum limit? Why flex here but keep tight there? There is devolution but it is devolution by trickle of delegation. It is not real devolution because the power is still not local. That 2% was counted in all the Chancellor's figures about how much money was available. From a position where councils were, in a sense, not quite punished but put on the naughty step if they put their council tax up, we are now in a position where it is a good thing to do it, you are supposed to do it and indeed it is counted in the figures. The mainstream rise and also the social care rise is now a good thing. If you are an elected council who has been telling your citizens what a good job you have been doing by keeping the council tax down and some people put it in their manifestos that they will keep it down, now it is counted in the figures for it to go up. It is quite a difficult position. This is not about politics, it is just about your population messages and a change of policy and a change of tack. Is it unforeseen? It is unforeseen as a consequence I think.

Q205 Maggie Throup: Do you think then local authorities should be allowed to set their own level of the precept?

Sarah Pickup: Yes, they should be able to set their own council tax because they are the ones that are delivering local services. They are elected by their population. Their population can vote them out if they don't like the council tax that they set.

Ray James: Ultimately, you want a fair system where resources are allocated so that there is a degree of consistency about people who, after all, represent relatively substantial needs if you are going to be eligible for state-funded social care now. I would have no difficulty with local taxation playing a legitimate part in that. But you would want to see it within the context of some kind of assurance that there is a fair distribution of state resources to make sure that it gets to people who need it and that there is not an over-reliance on local taxation alone because of the difficulties that we described with the precept earlier.

Professor Green: One of the problems with it is that as far as the general public—who are not very well sighted on these issues—are concerned, they will have heard the Chancellor say 2% precept will go to social care and their expectation will be that the local authority will have the money to deliver a good quality service in line with the Care Act responsibilities and that is not necessarily the case all over the country.

Maggie Throup: I was going to ask about the Better Care Fund transformation, but I think that has been previously answered.

Q206 Dr Davies: In view of the financial pressures that we have heard about in the social care sector, to what extent do you think there is a real risk of providers withdrawing from contracts or collapsing?

Professor Green: It is already happening. We have seen people withdrawing from contracts. We have seen it in the domiciliary care sector. Certainly, some organisations are saying, “We are no longer going to develop services in particular areas” and it will not be long before they start saying, “It is not viable and we are going to close in certain areas”. We have already seen in Northern Ireland the impact of what is going on there with their budgetary constraints where eight care homes were closed by an operator because the operation was not viable.

We should also remind ourselves that it is not only about the current services but, as Sarah and Ray have said in their evidence, there is a significant need heading our way and also we are trying to develop new innovative, creative, higher-quality services. If you are in an area where it is not sustainable currently, nobody is going to invest in that area. You are not only going to perhaps lose some of the current provision but you are not going to get development of new innovative provision that will deliver on the aspirations of the Care Act.

Sarah Pickup: There is already evidence that some providers are moving out of the local authority market. Obviously, in areas where the vast majority of carers is funded by the local authority, moving out of the market means you are going out of business, on the whole. There is still a market there, but there is a real risk that even if you have providers, providers cannot deliver the capacity that you need, so you might still retain providers in the market, but their capacity to expand to meet rising demand will be limited. That is particularly so in areas, I think as Ray said earlier, of high employment. It is really difficult to recruit home care workers and in many areas it is not for want of budget, although budgets are tight, that people are not being discharged in a timely way, it is because you cannot get enough care workers to do double-up care four times a day in a village that people have to go backwards and forwards to. It is that capacity to recruit. Yes, it is whole providers and there are some real risks around whole providers, small and large, but there are also risks that existing providers cannot either expand or they end up contracting because of the access to the workforce.

Ray James: If you think about this in classic market terms, it is probably one of the few industries or service areas where you could be pretty confident about there being likely to be a very substantial underlying growth in demand. The rate at which the population is ageing, we will see a doubling in the number of older people aged 85-plus, we will see a doubling of the prevalence of dementia over the next couple of decades and what we said earlier about people living longer with more complex conditions. On the one hand, it is a sector where demand is definitely going to grow. Our experience, however, is that the new investment is almost exclusively in the self-funder market, so it will be in areas where those services are being marketed to people with the means to purchase them themselves and not in terms of the state-funded market. So there is a growing risk of what some people have described as two-tier provision in terms of the differences that may exist there.

But it is absolutely true to say that we have already seen some people exiting the market. The UK Homecare Association published a survey, and I think the stats were suggesting

that over two-thirds of their operators were considering market exit. Now, that is a fairly open question, to ask the question “considering”, but still an alarmingly high figure in terms of the risk. The rate at which we see it, the nature of it, we will probably see some of the smaller providers potentially first and we may see it from some of the larger providers in a more geographically-based way, where they are reviewing their portfolios, looking at what they consider to be viable and taking decisions based on that.

Professor Martin: Certainly in domiciliary care, we have seen a lot of people exit the market. Large charities like Anchor went about five years ago, because they did not feel it was sustainable and they could not deliver the services to the quality that they thought their citizens should expect.

Q207 Dr Davies: Do you have an innovative solutions as to how to tackle this shortage of money, other than the Treasury obviously finding it?

Ray James: With the work that has happened around personalisation in recent years, we have sought to give individuals as much choice and control over how the money is spent as possible. People know what matters to their quality of life, their loved ones, their families do, so I think that has made a real difference. If you think about what we have said about the funding reductions of the last five years for people receiving social care services, the last national data satisfaction was at 91%. That is a remarkable tribute to front-line social care staff and their commitment and dedication, I think. So personalisation has provided one opportunity and there will be more that can be done with technology as we move forward, but we need to remember that social care is 70% to 80% labour costs, so very often this will be somebody coming to visit you in your home, helping you get up, washed, dressed, toileted, so the potential for technological or other efficiency innovations over and above those that have already been achieved, while they exist, is not going to be as profound as it might be in some other sectors. We need to remember that any efficiency gains secured through that will need to counter the rising costs that we have already talked about as well.

In overall terms, many, many places—and I know Salford is one of those—are trying to work better together across health, social care and other public services and plan services at a system level and try to make sure that public money is used to best effect in that way. But I think we need to remember that that will probably help to stem the rate of demand that we get and it will help to prevent, but given the underlying population characteristics, there is no evidence anywhere in the world that integration alone will meet the fiscal challenges that we face. It is absolutely part of the solution, but it does not solve the financial problem on its own.

Sarah Pickup: I would say three things. One is I would never say there is no more room for efficiency because there always is, but I think in some cases they have pretty much gone nearly as far as they can go. Integration is not the answer to the problem, but I think if we all looked around us across health and social care in the public sector and said, “Are we using every public pound to best effect?” we could probably not put our hand on heart and say yes, so I think we could make better use of resources. While there are things we could prevent, we are not doing that, so the real risk of the reductions in public health budgets, for example, and the real focus on funding the acute trusts is that we are not stemming the tide, of course. We often talk about preventing hospital admission and facilitating hospital discharge, but what about preventing people from having an ongoing

need, the enablement, picking the people with long-term conditions before they get to the point of needing the hospital trip and then social care?

So social care is valuable in its own right, not only because of the fact that it funds health, which leads me just to the final point, which is about the quantum and about the different assumptions and reasoning that is given. Social care is means-tested; most healthcare is not currently means-tested. Healthcare, under the previous Government—the one before last—had Agenda for Change and it looked at the terms and conditions of staff, because they were having trouble recruiting nurses. Where is the Agenda for Change for social care staff? Because they are in the independent sector, it does not happen and we do not get it. A priority was set, it was decided it was a good thing to spend national money on, and the same thing with the frontloaded real terms increase in funding for the NHS into this free at the point of delivery system. The backloaded insufficient funding for social care is means-tested and people have to contribute, and yet without really the will to resolve it, even in a way that might require citizens to contribute differently, but through a sort of fairer insurance-style system.

There have been proposals over the years that could have brought more money into the system, but no one has ever been able to agree that those should be implemented. There is just a different mindset around the NHS compared to social care. Both are valuable in their own right, the one supports the other and the huge difference in treatment. Although it is easy to say, “How can we solve it? We cannot all talk about the cake, we cannot have a bigger cake”. Well, when people want to have a bigger cake, they have a bigger cake, and social care needs a bigger cake.

Q208 Emma Reynolds: Before we move on, can I pick up on that, on the costs of social care? Obviously the Government quietly dropped its manifesto commitment to capping care costs in July of last year. They have now said they will introduce that cap in 2020. All things being equal, given what we have heard this afternoon and what we have read and we know, unless there is significant new investment, does it seem unlikely that that cap could feasibly come in?

Sarah Pickup: It could not be implemented without more funding. Funding was set aside to do it and has now been used for other purposes, so if that care cap comes in, there will need to be funding for it. That care cap was about protecting people’s property assets and capping the amount that they would have to pay. It did not bring any more money into care, it was just a different way of distributing the costs. It is not a wrong thing to do, but its objective was not to solve the funding problem, it was to solve that problem of inequity, in a sense at the top end of home ownership.

Professor Martin: Certainly I would absolutely agree with everything that Sarah has said, and particularly about the differential funding between health and social care. We have a funding settlement that is based on a 1948 model, which is you diagnose, you intervene, you cure. The reality of the 21st century is long-term conditions and how people live well with a long-term condition. If we were starting to develop our system from this point, we would not develop it in the way it has developed at the moment, so we have to get much more clarity about the settlement and where the money goes. If there is no more money in the pot, then we are going to have to do something tough about reappportionment, because we have lots of people who are living with long-term conditions and they need support to live well. I remind people that it is not necessarily us or citizens that have said, “This is the

vision for social care”, it is politicians. It is rather ridiculous to create expectations that you are not prepared to resource.

Ray James: In the longer term, to use the 1948 example, I think I am right in saying that there were about 14 people of taxpaying age for every one person post-taxpaying age in 1948. We are not very far away, certainly in the next couple of decades, from that ratio being something like 3:1. If you think about both that tax-raising potential and what we know about the demography, there is absolutely a need for a longer-term public consensus about the way in which social care should be funded in terms of what is the contribution of individuals and what is the contribution of the state. That has proven difficult for successive Governments to find a solution to, but the need for it gets ever more compelling with the way in which the population is ageing. My one caveat on that is that there is a very real funding problem over the next couple of years and I am fearful that that much-needed public debate might be a diversion from the need to address funding in the short term, which needs to be done alongside the public debate around consensus for the longer term.

Q209 Maggie Throup: I want to now move on to the CSR and public health funding, so it is probably questions aimed at Ray and Sarah, if that is okay. I am just wondering, what are your opinions on the likely effect of the CSR settlement on the ambition of the five-year forward view to deliver a radical upgrade in prevention in public health? I do not know if you want to start, Ray.

Ray James: Inevitably there is a risk. I think when public health funding was devolved to local authorities, it was done based on existing spend, so there is quite considerable inequity in the distribution. That existing spend often mirrored areas that were particularly challenged or faced greater demands previously, so a possible compound effect there. Public health spending is sometimes thought to be entirely about preventive services, where there are a number of essential drug treatments, sexual health and other services that local authorities commission from within their public health spending budgets. I think it is inevitable that the reductions in public health funding will put our ability to develop prevention at greater risk.

When we did the ADASS budget survey—so this is Directors of Adult Social Care, not Directors of Public Health—we asked directors what their main plans were and the two things they most wanted to do was more on integration and more on prevention, yet in the same survey, it revealed a 6% reduction in spend on prevention by the council. That was simply as a result of the statutory pressures they were facing and that was before the decisions about the reductions in public health budgets. So if we are to preserve those kind of mandated services, which will form a large part of the public health budgets, it will reduce the resource that is available for prevention in other ways. But again, we will need to look across health and social care, plan together and see what sort of whole system prevention we can do there. Hopefully in the best of places, they will be willing to use the public pound effectively across health and social care, as opposed to saying perhaps, “No, the local authority needs to fund that now that they have the public health budget”. I think we will only succeed if we are willing to look across the whole system and consider where investment might be making savings to the NHS as well as where it might be making savings in social care.

Q210 Maggie Throup: Have you any thoughts as to how you break down those silos that exist?

Ray James: One of the other things that the spending reviews did was to require us to all ensure that we have plans for full integration by 2020. We need to submit those plans by 2017. The work around sustainability and transformation plans is going on already, so I think in many parts of the country, already very good work is going on to develop those plans. The challenge will be can we be confident that that good work will happen everywhere, particularly in the areas that face the greatest challenges in terms of their health inequalities? Because if those challenges around health inequalities are compounding the difficulties, for example, in social care funding, as we talked about earlier, it is going to make the challenge harder. But ultimately I very much believe that place-based approaches with local people, with local leaders central to them, people who understand, care about and have their investment in their local communities will be the best chance to trying to develop those sorts of plans and to work across those silos, to use your words.

Sarah Pickup: I suppose what has happened in public health is local government's worst fears realised, isn't it? A service is transferred and then it is reduced. We have certainly said in the LGA that it is a false economy to cut the public health budgets. Some of the key services that are funded from public health traditionally even are things around tackling obesity and tackling smoking cessation, which are things that lead to long-term costs in the health service. But the hope with public health in local government is that it moves beyond those things as well and starts looking at some of that risk stratification, picking people out before they get to the higher level of need, helping people support, do self-care and so on. Obviously the tighter budgets get squeezed, the less capacity there is to do those things at the edges that might just trigger change and create synergy in a system to move forward. So it is the new things that are at risk, but even some of the core things are at risk, when we are about to see a national childhood obesity strategy published and so on. It does not feel like the right thing to do to deliver the five-year forward vision.

Q211 Maggie Throup: Public Health England have stated that there is enough within the system to fund the public health ambitions of the five-year forward view. Do you share their confidence?

Sarah Pickup: I would go back to what I said earlier about how well do you fulfil your statutory responsibilities? There will be enough money to do public health functions, but it is whether you are going to make a difference. Maybe you can tread water, but what we need is public health functions to be starting to address those high-end needs of the future. If you want any room for manoeuvre anywhere in the system, for me it has to be at that preventive end and the community services end. If you take money out of that end of the system, you inevitably end up with costs at the other end. What we always seem to do is wait for costs to drop out of the top to put them in the bottom. It is not going to happen. We need that front investment at the community and preventative level to change that high-needs level.

Q212 Maggie Throup: We have also heard from Public Health Directors, who are very positive about the changes.

Sarah Pickup: About the cuts?

Maggie Throup: No, about how they could change the services and still deliver.

Sarah Pickup: There is great stuff going on, but the reduction in funding, £200 million and then a further £300 million, will not assist in making the change. Of course we all try to do the best we can with the money we have. Local government always try to innovate, I wouldn't say it is famous for it, but it is what we do, because we have to set balanced budgets, so we always try to create and do service redesign, but the less funding you have, your hands are tied. Of course Public Health Directors will do their best to deliver a good service with the money they have, but that is not to say they could not have done more if they had more. It is not new money they were looking for, it is retention of existing money.

Ray James: I think as the evidence base grows and we start to understand where the potential for preventive investments might make a difference, the areas that would make most difference in terms of probably both health and social care, but certainly social spend, would be around managing heart risk and dementia risk—and there is a relationship between the two of those in terms of physical activity and other things as well—and probably around managing diabetes risk as well. I think we are seeing good interventions, we are seeing a better understanding of that, so the potential in terms of knowing what the right things to do are and being better connected with local government and its unique access into its local communities do help to create the conditions. But it is inevitable that if you are hard-pressed to fund statutory demand from people who have care and support needs now that you are going to be able to invest as much as you might like to, because the kind of return on investment for many of those initiatives, some of them are shorter term, but some of them are over many years. That is a difficult choice for local health and social care economies to feel that they have the financial flexibility to be able to make that additional investment now, given the pressure on demand as well.

Chair: Thank you very much. Unless other members of the Committee have any final points, thank you very much indeed for coming this afternoon.

Examination of Witnesses

Witnesses: **Lord Smith**, Leader, Wigan Metropolitan Borough Council, Greater Manchester Combined Authority, **Sir Howard Bernstein**, Head of Paid Service, Greater Manchester Combined Authority, and **David Slack**, Managing Director, Somerset Clinical Commissioning Group, gave evidence.

Q213 Chair: For those following from outside this room, could I ask you to introduce yourselves? Just as a reminder, we are examining the implications of the spending review on health and social care. Starting with yourself, David Slack.

David Slack: Yes, I am David Slack. I am the Managing Director and accountable officer for the Somerset Clinical Commissioning Group.

Sir Howard Bernstein: I am Howard Bernstein. I am Chief Executive of Manchester City Council, and also for this purpose, Head of Paid Service for the Greater Manchester Combined Authority.

Lord Smith: I am Peter Smith and I am Leader of Wigan Council, but I am here as the Chair of the Manchester Strategic Partnership Board.

Q214 Chair: Thank you. Very interested to hear your views this afternoon. Perhaps I could start with you, David Slack, looking at what has been happening in Somerset and the proposal to move to outcome-based commissioning. For those who are following from outside this room, do you want to just give a quick overview of what that means in terms of having capitated budget for a population, just very briefly?

David Slack: Thank you, Chair, I am happy to do that. We have a programme in Somerset called Somerset Together and a key component of that is to introduce outcome-based contracts. We are looking to do that across a broad spectrum of services, as many services as possible, including health, and originally it was going to be social care, although they have now decided they cannot participate in the procurement process in the way in which we are setting those up. It is certainly most of the health services, including primary care services to a degree, and the aim is to establish these contracts from April 2017. We have a population of about 500,000 and our thought is at this stage we will have two contracts, one for the west and one for the east. I guess what we are trying to do through those contracts is to get a focus on prevention, a focus on joining up services and a focus on making better use of resources.

Some of the key distinctive features of those type of contracts are that the payment will be based on a per capita basis or per head of population rather than an activity-basis. The length of contract will be considerably longer, so we are looking at a contract length of five to 10 years, and we looking to contract with a couple of what we are calling accountable joint ventures, so bringing organisations together into those accountable joint ventures so that there is a common set of outcomes that all organisations are focused on delivering and improving for the population.

Q215 Chair: Can I ask, are you planning to bring in the voluntary sector? We heard earlier today from voluntary sector partners from across the UK here in Manchester and their frustration, that they feel they are often excluded, although they can add enormous value for both individuals and for costs within the system.

David Slack: Yes, very much we are intending to try to include the voluntary sector. We are in the first capability assessment, which is based on inviting a range of organisations to come together and consider how they might work together and how they might come and form an accountable joint venture. We have invited the voluntary sector to be part of those early discussions, so what role they end up playing is not yet determined. The nature of the voluntary sector, with the large number of organisations, in many ways this is quite parallel to primary care with large numbers of practices, so there is some detail to work through about how they participate, but they are certainly around the table having those early discussions. We see that some of the ideas and approaches that they can bring is some of the innovation that we need.

Q216 Chair: Presumably it is a huge disappointment to you that social care is no longer going to be part of this, because that integrated model was, as I understand it, part of how you were hoping to deliver savings for the whole of the health and social care system.

David Slack: It is a disappointment to us that social care felt that they were not able to participate in the procurement route that we are using to establish the contracts. We did not want to set up a competitive process, because the whole ethos is to get organisations working together better and so we are using the Most Capable Provider process. The legal advice to the council was they could not participate in that. That does not mean they are not participating in the wider Somerset Together programme, and indeed, social care as a provider is in the room, if you like, having those discussions about what role they might play with the accountable joint venture, even if they cannot be a full member of it and even if we cannot jointly commission bringing social care and health budgets together in the way we originally envisaged.

Q217 Chair: Was their legal advice about the risk pooling or what was it about, the barrier that stopped them from being part of it?

David Slack: My understanding of the legal advice that they had was that they needed to follow a competitive procurement process potentially if they were going to include all their social care contracts within these arrangements, so they took a view that they were not prepared or did not believe they had the ability to participate in an MCP process. I have to say that was different to the original advice that we had, which was the basis of the paper that I think we shared with you back from July, but when we got to the decision point, the council felt that it was too big of a risk for them to be participating in the MCP process.

Q218 Chair: When do you expect to start seeing the savings from this approach? Because sometimes the problem with integration is people expect the savings to come on board sooner than they can be delivered.

David Slack: Yes. I think the savings will take a significant period of time. Of course time is not on our side, so we are taking some steps to try to and promote organisations to work together during the transitional period to try to get some of those benefits for the population and some of those savings. Within part of Somerset, we have a vanguard around Yeovil Hospital, working with the GPs. We have tried to spread that to some of the areas of Somerset through Test and Learn pilots and we are also looking to set common CQUINs, which is the quality incentive element of the contracts in this forthcoming year. So we hope to get some of the benefits during this transitional period, but we see it as a long-term project and we think it will take five years to get many of those benefits out in terms of the integration.

Q219 Chair: Primarily the benefits from integration seem to be to meet an unmet need. Is that your plan? How are you going to be using this to make sure that you are keeping people out of the acute sector if they do not need to be there?

David Slack: That does happen and we recognise that. We recognise the evidence base for integration on its own producing large savings is not there in any strength. When we look at what has happened internationally through outcome-based commissioning, there is a wide range of savings that have been delivered. Our business case was the same, between 5% and 29%. I guess my expectation would be at the lower end of that and it all depends where different communities have started from. It is certainly challenging to get those benefits and I think we would see the benefits from integration coming through a number of strands. When you talk to patients and clients, they have a very fragmented experience

of care often and there is huge amounts of duplication, there is huge amounts of wastage, with people lying in hospital beds just waiting for things to happen. If we can eliminate some of that duplication and reduce some of that waiting, we do believe there are savings to be had.

Q220 Chair: So you are integrating around the person to improve the experience of users, rather than it being an organisational issue? You are very clear about that, are you, or not?

David Slack: We are very clear about that. That is one of the problems with the term “integration”, isn’t it? Most people think about integration from their own perspective and if they are working with a service, they can see how wonderful it would be if everybody else integrated and organised themselves around them. That is not what we are trying to do, as you have articulated. It is about person-centred care and joining up services around the person and what their individual wants and needs are, and not making an assumption that we know what they need and want, having that as part of the consultation early on, having those care plans that clearly set out what it is that is important to individuals. That may be some sort of social activities that they want to be able to re-engage in, rather than necessarily a full medical cure.

Q221 Mr Bradshaw: Can I just pursue this issue of the legal advice, because you hear this often, don’t you, that two different organisations get conflicting legal advice? It is normally often a political reluctance, because could you not have referred this up to a higher body or organisation to resolve this dispute about legal advice? It seems absurd that we cannot do sensible integration.

David Slack: Unfortunately, I go back to the point that time is not on our side, so we spent a number of months doing that. Our understanding of the Most Capable Provider process is that that is not available to NHS organisations after April, so it was important that we started the process, so that is the decision we took. We have a commitment with the council to have an ongoing dialogue to explore how it is that they will engage with the outcome-based commissioning process. As I say, although they are not fully engaged in the contract, they have not walked away from the programme in its entirety.

Q222 Mr Bradshaw: You think that was a genuine reason, that it wasn’t a political reluctance that was preventing them from—

David Slack: It is always difficult. If you are in an organisation and you have that legal advice, it is then about what risks you are prepared to take and how you are asking the questions, isn’t it? That is the decision that they came to. I was disappointed, but at the end of the day we have to respect them, it is their risk and their legal advice.

Q223 Chair: Can I just ask you to go further? You said the Most Capable Provider is not available to NHS organisations after April, so nobody else around the country would be able to do what you are doing after April?

David Slack: That is our understanding, that they will not be able to do what we have done.

Q224 Chair: Who has said that to you, sorry?

David Slack: It is in discussions with Monitor, principally, and our understanding is that Monitor are required to set out a process that may well prove to be similar, but the details of that certainly I am not aware of at this point in time.

Q225 Chair: Do you have that in the form of a letter from Monitor—or now NHS Improvement—to set that out, to tell you that?

David Slack: I think we do have it a letter, yes.

Chair: It would be helpful if you would not mind letting us see that.

David Slack: Yes, we can share that.

Chair: That would be great. Sorry, Ben, I probably cut you off mid-flow. Emma, I know you had a follow-up.

Q226 Emma Reynolds: How confident are you that the new model will create incentives? You were talking about moving to a payment per capita system rather than an activity basis. Are these incentives—and are there others—to move people from the acute sector to the community? Obviously you have said that there are people stuck in hospital beds when they do not necessarily need to be. How confident are you that your new system will move patients to home or to a community setting rather than the acute sector?

David Slack: We are reasonably confident. We have been doing a lot of work looking at what are the outcomes and how we are going to link them to the reward framework. It is important that that is reasonable, meaningful, achievable and so on for providers, but we believe we can get that right. We think that having longer-term contracts will mean that providers potentially benefit from investment in prevention.

Reflecting back on the earlier discussion around public health, what I would say is we need to all be engaged in the public health agenda in its most widest sense in terms of influencing people's lifestyle choices, which is what is so often influencing their longer-term health and the extent to which they develop long-term conditions. Yes, we have a degree of confidence that we can achieve a change. It will not happen overnight, because at the end of the day this is going to be about influencing the behaviour of thousands of staff and also changing patient expectations, so it is a big cultural change within here as well, so it will take some time. But we think by creating a better incentive framework, we can act as a catalyst for doing that, as well as doing a set of other things to change clinical views and behaviour.

Q227 Helen Whately: I am going to bring us on to Greater Manchester, questions for Sir Howard and Lord Smith. First, could you talk about how you are going about integration and what is happening in Greater Manchester that is different as a result of the devolution deal?

Lord Smith: Perhaps if I could, Chair, just describe what we are up to and then put the question in context. What we are doing in health is part of a devolution package in Greater Manchester and it is not to be seen in isolation. Particularly I think the concept of public service reform is something that we are applying not just to health but across the piece as well, so in a sense it is linking in with all of that work too. About 13 months ago we received the memorandum of understanding with the NHS England to develop this thing. We have done it in two ways. Obviously we have developed the implementation, which is

taking place in 10 days' time, so we need to be ready for that, but we have also thought about making short-term gains, so in a sense, by working together across the piece, we have thought of things that we can be doing on the way, so seven-day access to GPs. We think now it happens across Greater Manchester and that was not available before. We have worked on dementia, which clearly, in a sense, if you think about the partners that we have in our organisation, it affects all of us in different ways, so we have set up Dementia United, where we are going to be clearly working with carers through to acute hospitals on how we do that. We even have something that is called Health Innovation Manchester, which is using the fact that we have some fantastic universities in Greater Manchester, some fantastic hospitals, so we can link the two and be at that cutting edge of health change. So that is some of the work that we are doing together, which we were not doing before. This is all examples of integration.

Then to develop the strategy, there are 10 local authorities across Greater Manchester, and we started off with a sort of basic building point of 10 locality plans, because the issues in my authority in Wigan are not going to be the same as in Oldham, so we needed to make sure that whatever we are doing in integration reflected what needed to happen on the ground. Then we did the Greater Manchester part of the strategy, which a document came out in December called "Taking Charge", if you want to see that. I think we sent the Chair a copy some time ago. So this puts into the Greater Manchester context where we are working. Some things across the conurbation, obviously a lot of specialist services are not run in tender for the authority, but run across the conurbation, so that what it is. The title, "Taking Charge" in a sense has a double-edged meaning, because it means that we are taking charge, the partnership in Manchester is taking charge overall, but we want to get back to that concept of people taking charge more of their lives and not simply thinking the NHS has a solution, whatever their lifestyle is.

Way back in August, I think, we appointed a Director of Public Health for Greater Manchester with a real ambition of changing population health across Greater Manchester, because if we look at the figures, we are not a very healthy population, a lot of deprivation in Manchester and obviously health stats and deprivation stats are highly correlated, so there are quite a lot of issues there. We think we have done a lot of integration work together. On the partnership board we have 37 different organisations. That is what we have to co-ordinate and I chair it. It has been remarkably easy, I think, because the spirit across the different sectors of health and social care is that what we all want is improvement in health for the people of Greater Manchester. That is the prize that we are going to go for.

Sir Howard Bernstein: Would it just help if I summarised the key framework that is embodied in that health and social care plan, which Lord Smith has talked about? From February, as has been said, to effectively today, we have spent an enormous amount of time to create that strategic framework, which will bind the 37 stakeholders to the delivery of a collective set of priorities. They fall broadly into five programme areas. One, as has already been mentioned, is how we drive radical changes in improvements in population health, which is a real shift in the focus, but linking not just around the public health programme, but a wider public sector reform, a behavioural change programme for Greater Manchester.

Then the second programme area is about how we transform community-based care, with a real focus on how we shift the demand away from acute hospitals into community settings. Thirdly, it is about how we standardise acute care itself and how we move increasingly to more collaborative service models around particular localities. Certainly within Manchester we are working towards an integrated hospital service being provided by, at the present time, three distinct organisations, and also how we standardise clinical support and back office services, which plays very much into the wider work that has been done by a variety of people over the last several months, all underpinned by the fifth programme, which is the enablers, how we drive state reconfiguration, how we describe new commissioning models, how we drive the maximum efficiencies into the system.

All of that is embodied within that broad framework, so within those 10 locality plans you will see single commissioning models for each locality, which is not just around health and social care, it will embrace the public sector services generally. You will see the development of individual locality platforms, ICOs, where providers, working with local authorities, working with primary care, working with other commissioners actually coalesce. Certainly in Manchester our locality plan involves us to second a significant proportion of our adult social care staff to work within single teams within neighbourhoods in a joined-up way and the overall approach. The key is that over the next five years, we have to get pretty close to delivering financial sustainability, and that was the basis upon which we made our ask to Government around a transformation fund and the transformation fund will be designed to support the delivery of those five key priorities.

Q228 Helen Whately: Thank you, that was very helpful. If I am right, you decided or agreed to pool £2.7 billion of the total £6 billion health and social care budget for the area. Could you explain how you got to that figure? How did you reach that decision?

Sir Howard Bernstein: What we did not want to do is change the funding flows of existing organisations. I think we would have still been talking about that 11, 12 months after the MOU was signed. So the whole framework we are bringing forward, the overall model, is fundamentally respecting the existing statutory responsibilities, organisations like CCGs, like local authorities. What goes to local authorities now through adult social care plus the top-up, what is going through CCGs in the ordinary way will continue to go to local authorities and CCGs, but through our collective leadership structures, what they have to do is join those up. They have to join those up at locality level. What comes to GM, as GM falls especially in specialist commissioning, as an example, will continue to come to GM as specialist commissioning and parts of our job will be to ensure that specialist commissioning strategy is aligned with detailed locality plans.

Q229 Helen Whately: You mentioned earlier about finding efficiencies so you will get close to sustainability. What sort of efficiencies, what level of efficiencies have you been able to identify and what sort of areas will drive that?

Lord Smith: I think it is partly integration, some of the stuff you were talking about earlier. In a sense, too many people spend too long a time in hospital, a very expensive way of treating them and we aim to use our collective activity to keep them out of hospitals for longer by supporting them in the community and making sure, if they have finished their medical treatment in hospital, there is somewhere appropriate for them to

move on to so they can free the beds. What we want to do is to see the size of hospitals shrink, quite frankly, in that area and the money released into community support.

I think we are fortunate in that a lot of hospitals, acute hospitals, chief executives understand that is the way we are going forward. It is hospitals themselves working together is another way we are going to find efficiencies, that in a sense we have all the acute hospitals across Greater Manchester offering duplicating services and so on. If they can start to work in a more collaborative way, rather than seeing themselves in competition, some of the office services, some of the support services can be done once rather than a number of different times and that can reduce costs as well. We think there are things that we can do collectively to start to save money and this is both our challenge and our opportunity. I think the fact that we are working together gives us a chance to do it more than places that are still working in separate silos.

Q230 Helen Whately: You are sounding reasonably confident that this will add up financially, except possibly there is still a slight gap. Did I read that from what you said?

Sir Howard Bernstein: Since we produced our ask last September, we have learnt a little bit more about the finances of the system and it is dynamic, isn't it? Based on the programmes we have developed, we are not going to be far short and our objective is financial as well as clinical sustainability, obviously.

Q231 Helen Whately: This may be a very long answer, but to the best that you can, what difference will this make to the population of Greater Manchester? What will the outcomes be for patients as a result of the partnership?

Lord Smith: The first thing we obviously hope is that people do take much greater care of their own bodies, understand what creates health and ill health and you start to see people getting engaged in physical activity at all levels. We are not to be too ambitious about this, certainly in my view they are not going to suddenly start going to the gym three times a week, but we need to start to find those small steps that get people moving. In Wigan, we are funding community activities where in the locality people might just go and do a bit of tai chi or whatever it is, whatever age, get kids engaged. There is a great sporting tradition across Greater Manchester and I think we want to use that to inspire young people to keep fit and understand if you are a professional sportsperson, whatever sport it is, then you keep that going, so I think it is going to be about people themselves being fit, but also our health institutions working better.

We have some wonderful hospitals in Greater Manchester, but some are not. We want the standards to be raised so that we get better outcomes for people who have to go into hospital, obviously there are going to be some of those, and we want to make sure that when you are ready to come out of hospital, we have the supporting system in place that we can move you on to. I did a tour around my own local hospital on the Friday afternoon when the medical director is trying to decide which of his patients who have finished treatment can be moved on and it was a very illuminating thing, because clearly a lot of the people are elderly, that in a sense whatever caused them to go in, their confidence has probably taken a knock, but also the confidence of the families has taken a knock. So it is not just a question of what the individual wants, it is persuading the families that they are ready to go home or ready to go into a care home or whatever it is, or maybe we need an intermediate place where they can be given that extra support for a period of time. So we

have to plan all those out, and as I say, the funding of that is to take money out of the acute sector.

Sir Howard Bernstein: Within the plan, which we will share with you, we have very clear outcomes for what we describe as, “Starting Well”, numbers of young children turning up for school, about being ready for development; “Living Well” which talks around how GM families will be more economically active, how we will prevent this disease and that disease, and also, “Ageing Well” as Peter has said, and how we will support increasing numbers of people with specific outcomes, about being to live in their own home longer, so a whole range of outcomes.

Lord Smith: We had Simon Stevens talking to us a couple of weeks ago and I think he said that one of the attractions of Greater Manchester was it was not simply a health plan, it was the whole holistic plan of thinking about people’s lives, because, clearly, if we can get more people into employment, it is not only good to create wealth across Greater Manchester, that itself will keep people healthy, because people in work tend to be healthier than people not in work. A lot of the barriers for a large number of unemployed people in Greater Manchester are health barriers, whether it is mental health or physical health barriers, so if we can start to overcome those, then again getting more people into work is good.

As Howard said, we want more kids to be school ready. In a sense, that may be a long-term change, but as you know, if kids are not at the age of five ready to get to school, then probably their life chances are affected from that point.

Helen Whately: I should probably allow someone else to ask some questions.

Chair: Ben, you had a supplementary.

Q232 Mr Bradshaw: Yes. First, why have you not faced the same legal obstacles that Somerset has in your integration?

Secondly, we have heard from the hospital chief executive here of his vision for the future of care for a 2 million population with hospitals clustered significantly for service reconfiguration. You have already talked about that. I assume your plans are all aligned as one. How will you persuade those communities and those hospitals that will inevitably face losing some services or those services being changed to swallow that?

Lord Smith: Let me take the last one first. We went through that earlier this year with this process called “Healthier Together”, where what we needed to do is identify hospitals across Greater Manchester that will be more specialist and take patients who need real specialist care. Clearly there was some argument against that, but overall I think we countered those arguments. It is about services for people, rather than buildings, and I certainly used the model of our specialist cancer hospital, Christie, which obviously has a worldwide reputation. We said, “If a member of your family needed cancer treatment, where would you want them to go to? If they could go to Christie or could go to their local, where would you want?” and we said, “Yes, go to Christie and then back-up treatment locally”. That is what Christie is doing, they are franchising one of the chemotherapists at local hospitals so people do not have the inconvenience of travelling to

the site, but if they need the specialist treatment, they can get it from there. So we worked on that.

Hopefully we are aligned with what we are trying to do and obviously some people's ambitions are more than others and you have to take it overall. It is very hard when you come from a local authority background to get into health, the idea that somehow you get in a deficit at the end of the day and somebody would say, "That is all right". It is a very interesting concept and we would like that perhaps in local government in the future.

Howard talked about we have this transformation fund and the question that kept coming from one or two places was, "What is my allocation?" because the assumption was if so much money comes into the health service in Manchester that everyone receives a bit. I keep saying, "No, on the tin it says transformation. It is to help us make a real difference to the way we serve the people of Greater Manchester. If you come up with a transformation scheme, of course we will consider it and try to fund it, but if it is just doing the same or thinking of paying wages out of it, it is not for that".

Sir Howard Bernstein: I would just like to pick up Peter's point, because the ultimate question will always be how do you absolutely satisfy yourself that you secure the system changes your strategy says are necessary? Most of us would recognise that, I think, given what we all know about health and social care at the present time. The answer to that is you will not get the transformation fund you say you need to deliver clinical and fiscal sustainability within each locality unless you do sign up to a contract that says, "You will pool this level of resource in your locality; you will develop these new pathways; you will work with your provider to develop and deliver these particular configurations of hospital services, but if you do not sign up contractually that is what you are going to do, you are not going to get any money". That is how we change the behaviours and how we start to address the accountability arrangements working within the existing statutory regime, which as I have said before, we are loathe to change—certainly in our first year—into something that gives accountability, through Peter as Chair of the Strategic Partnership Board, to the rest of the partnership.

Q233 Chair: Can I just slightly press though on Ben's point, which is why haven't you come across the same barriers about Most Capable Provider no longer being an available option in April—obviously we are looking forward to seeing the letter in detail—or the issues around competition when it comes to local authority commissioning?

Sir Howard Bernstein: We have a joint commissioning board that is established, involving all commissioners, including local authorities. We have a commissioning strategy that has been overseen by our procurement specialists. We are very happy to share information, but certainly in my experience, we have not encountered—

Q234 Chair: So as far as you are concerned, you have not come across any of those barriers?

Sir Howard Bernstein: But the circumstances might be entirely different. What we are doing is how we procure specialist hospital services, alongside how we procure at GM level specialist social care services, because what we have decided is we only want to do something once rather than 10 times, wherever that is feasible. At a locality level, through

the pooling arrangement, we are satisfied and have satisfied ourselves that within the existing procurement operations that is all perfectly feasible.

Q235 Mr Bradshaw: Wouldn't it be sensible for someone in Government or somewhere to be able to show other people your model to help them overcome the sort of legal obstacles we heard about earlier?

Lord Smith: It is not for us. We want to get on with doing with what we have to get on with and obviously we work with NHS England and so on.

Sir Howard Bernstein: This has been in the public domain since December.

Q236 Chair: Clearly this is something we will need to raise with the Secretary of State and Simon Stevens when they come before us, but interesting that you have not come across that.

Sir Howard Bernstein: There might well be particular issues that made the comparison not as straightforward. That is all I would say.

Q237 Maggie Throup: But as an add-on to that, I am just wondering what lessons you have learnt for Greater Manchester from other areas in efforts to integrate health and social care. Have you looked around?

Sir Howard Bernstein: We have not only looked within the UK, we have looked beyond as well. We have tried to secure access to the best examples and I think the overall judgment that we have come to is that while there are lots of very, very good examples, they have tended to be in particular places around particular programmes and that what we have to do is develop our capability to do this at scale along the lines of our five programmes. Quite frankly, it did dawn on us, it has to be said—towards the end of last year in particular—there are no real examples where this has been done at this scale, certainly in this country and if not in other places in Europe.

Q238 Maggie Throup: Have you been able to pick bits from different parts?

Sir Howard Bernstein: Little bits.

Q239 Maggie Throup: Anywhere in the UK in particular or has it all come from other places?

Sir Howard Bernstein: There have been some in the UK, I think some of the stuff that has been done around single commissioning. We have always understood the theory behind single commissioning. I can remember within my own authority, and I know the same applied in Wigan, there was always an understanding that we needed to join up our commissioning capability at a local level, but it was often local authorities who were articulating the case for that change, whereas many of our partners did not necessarily have the incentive to come and join those programmes. I think those incentives have changed, not just the Government support for this devolution programme, but also, if I am being frank, the fiscal challenges that lie ahead for our social care over the next few years.

Q240 Maggie Throup: We heard from a large number of representatives from the voluntary sector in our evidence-gathering today. They have expressed their concerns about their relationship with these statutory bodies and they feel that they are very much on the periphery of decision-making and contribution rather than being an equal partner. I suppose it is a

question for all of you: how do you see the voluntary sector, how do you work with them and do you feel that they can contribute more and you want them to contribute more?

Lord Smith: The answer to that is obviously yes. I think there is a danger that sometimes we can over-medicalise problems, which are often not really medical problems but social problems. What did we say, 40% of GP patient load is probably not medical, but it is people who may have problems with housing, problems with unemployment and no wonder they are not sleeping, so in a sense we can deal with that. We can get support groups. Some mental health issues can be perhaps tackled at a very early stage by developing mentoring.

I will give an example, that we have one of these youth zones in Wigan and a young girl, a 17 year-old, spoke to the patrons—which are all older people, like me—and she had come there 12 months earlier at 16. She was 16 stone and had been bullied for her size, clearly was in danger of becoming a diabetic and had a severe problem. Just by talking to people, she got herself on an exercise programme, had lost over a stone and got the self-confidence so she could talk to a big audience. I think that was a great result of the voluntary sector helping to get a young person to get back to health. You can imagine that had she not come across that, that contact, she could well be an expensive person for the future for all sorts of health reasons. So I think we can do more of that. The partnership board, a couple of days ago, we had a guy who is very prominent in Greater Manchester pushing this, Michael Oglesby, and we have signed up to that concept that community groups, support groups, are needed to work in relation to health. If we are honest I suppose we had a pretty short time to get this plan up and running so in a sense it was eyes-down and pushing to do that. When we got the plan published in December, that is when we were out to public reaction, public response. We want these community groups to come back to us and show how they can get engaged in delivering some of these outcomes we want. So they are certainly not excluded.

Sir Howard Bernstein: To add to that, I think it is important to differentiate what can realistically be done at Greater Manchester level—2.8, 2.9 million people—and what needs to be done at individual locality level.

We would see ourselves at GM level as being the focus, the platform, for the strategic framework development where we would be engaging GM-wide stakeholders to satisfy all the boards that our direction of travel was appropriate but that is not any substitute really for detail work taking place at locality level within Manchester, within Salford, the other boroughs of Greater Manchester, where quite frankly day-to-day involvement with the third sector is critical to the effective delivery of those locality plans.

David Slack: To add from Somerset's perspective, the council have pulled together a forum for the voluntary and community sector and funded a co-ordinator and we have offered some funding for a couple of nominations to come and participate in the Somerset Together programme. I think some of that seed funding, if you like, to help with the communication and co-ordination is important but I am sure you could find voluntary sectors in Somerset who would express similar frustrations as well.

Q241 Maggie Throup: I think it also comes down to how they can contribute and at what stage they can contribute. That was a lot of their concern.

The other concern they had, they felt very much that their services were being procured rather than commissioned and I would see procurement being as procuring widgets; it comes down to the lowest possible price and their expertise not being valued.

How do you perceive the voluntary sector? Do you procure services from the voluntary sector or do you commission them?

David Slack: We commission.

Sir Howard Bernstein: We would commission. I am not sure I would use the terms in that way but I get the point you are making about the added value and developing a meaningful partnership rather than just buying a standard product or expecting a kind of free contribution. I think it needs to be meaningful in terms of the relationship.

Lord Smith: As Howard said, a lot of that is done at a local authority level across Greater Manchester and certainly in Wigan we are investing more money into the community sector now than we used to. This myth that it has all been cut, it is not true. The last few years we have put 5 million in and another 2 million is going in in the budget that we have just approved and in a sense we invite them to say, “How can you help support the outcomes that we have as an authority?” because we understand that if we are going to continue to live with the public service reform we have to work with communities supporting individuals. They can do that a lot better, often, than public services could in the past.

Q242 Maggie Throup: I think also they were saying that they provide the added extras so what you invest in the voluntary sector is worth an awful lot more. How can you evaluate their contribution? For every pound spent in the voluntary sector, do you evaluate how much it saves elsewhere?

Lord Smith: With the financial pressures on local authorities, we need to do it in a financial sense, but I think we recognise the impact that those individuals have. After I have finished with you, we have something called the Wigan Deal and part of it is that I go round to the different communities in my borough and talk to people and at one of them we had the other week with two elderly ladies stood up, and they had husbands with dementia so they were representing dementia carers and the contribution they made, very simple contribution but helping other carers to think about the issues. You can’t measure that in any sense really but it shows that the funding that we give, small amount that it was, to support this group was having benefits right across.

David Slack: I think you always measure the counterfactual—what would have happened if you had not put it in—but nevertheless you can draw parallels. Social isolation is a big issue over a large rural county and we see huge benefits from some of the projects such as Village Agents and Health Coaching and Living Well, which Age UK are involved in, and you can clearly demonstrate those benefits on those individual projects for sure.

Q243 Chair: One of the issues they raised was that they often do not know who to communicate with so it was interesting, David Slack, that you say you have a specific coordinator. They felt it needed to be somebody at strategic level. So taking your point that you thought it should happen at local level, they felt it needed to be somebody quite senior within the organisation to stress the importance of it.

Sir Howard Bernstein: They do write to me a lot, yes, in Manchester. I can assure you of that.

Lord Smith: Nice having a chief executive appearing in our local communities where they can come and ask us questions and they will make a contribution and we make contact and obviously if there are issues we take them up.

Q244 Chair: Right. So you would say that as you move forward you are going to recognise—

Lord Smith: Oh yes.

Sir Howard Bernstein: Oh, absolutely.

Q245 Chair: Thank you. That is helpful in terms of being able to feed back.

The other issue they raised was that there needed to be more than just one year at a time because there are examples of people still not knowing even a week before the next financial year whether their contracts are in place. Is that an issue for Manchester? I know that was more raised at a national level.

Lord Smith: I hope not. Those who are long in the tooth will remember the section 48 agreement after the abolition of the metropolitan counties with funding a number of arts and other organisations, in Greater Manchester we certainly consider making sure people have—I am not going to say, a long term—the pot has been shrunk a bit but nevertheless we are not telling people now that their funding is stopping on 1 April.

Q246 Chair: You are moving towards longer budgets. On that issue—

Lord Smith: Yes. We have done three year settlements.

Chair: Yes.

Sir Howard Bernstein: In principle Greater Manchester said as part of the overall settlement this year, because of the 2% supplement through council tax for social care, what Greater Manchester wants, and we all want to do that together, we want to create that platform for social-care investment on a GM-wide base, which I think is a very important step forward. Implicit in that was an acceptance, too, that we were minded to accept the Government's offer to agree the four-year settlement opportunity, which we felt was very important to underpin the stability of our transformation plan. There was an announcement last week around business rates where Greater Manchester will be one of the pathfinders for relocation of business rates from 1 April 2017, which is three years earlier than in other places. I think Manchester, London, and possibly Liverpool might be some of the other pathfinders. So of course what that gives us over the next few months is the opportunity to understand what the practical impact of that deal should be in order to underpin the stable health and social funding plan that we need to deliver.

Q247 Chair: Thank you. Can I return to a point that you just touched on a minute ago, Sir Howard, and that would be the reduction in budgets? Can you expand a bit more on how the reduction in the public health budget is going to possibly, or not, impact on your ambition for public health for Greater Manchester?

Sir Howard Bernstein: Well, it won't help. I think that much is absolutely clear. As I think I overheard one of the previous presenters or witnesses say earlier, local government does have a reasonable track record of being able to react innovatively even to in-house cuts, which of course happened to the public health grant last year. But I go back to the point Lord Smith made earlier, that when we talk about public health I think it is absolutely essential that we do not just look at one aspect of the public health funding. If we are going to deliver the outcomes, certainly where our population health improvement is concerned, we have to look at the entire public-sector spend within Greater Manchester; how we are funding our targeted services; how we are funding our universal services; whether or not the priorities that we are aligning on those universal and targeted services are reflective of how other public-service providers in our area are driving. So for us the public reform programme is absolutely key to changing fundamentally behaviours not just around health and social care but in the context of demand for high dependency services generally.

Q248 Chair: There is one very specific area where we heard that services have been decommissioned and that was in the smoking-cessation services in Greater Manchester. Is that something that concerns you or you have plans to reinstate?

Sir Howard Bernstein: I think we are looking at those things afresh. Until next year we have not done things as one GM, so there has been a tendency certainly 18 months ago to look at things 10 times with individual authorities looking at their own priorities. What we now have the opportunity to do is reassess those priorities in the context of our wider transformation programmes.

Q249 Mr Bradshaw: Wouldn't smoking cessation always be a priority in public policy?

Lord Smith: I think what we also need to do is reassess the programmes but I am not sure all of the smoking cessation programmes are effective. So I would say do we need to do it 10 times whence we can do it once across Greater Manchester? When public health was being passed down to local authorities we did make some inquiries about whether we should then have a single public health service across Greater Manchester and certainly we were discouraged from doing such a thing. So in a sense we are now tenderers of public health across the authorities and so on. So we need to look to see how we can deliver services more effectively. Obviously smoking is still a major problem here but I think probably there are more things to do about obesity that we do not do well enough and so on. I think we have responsibilities as local authorities, as planning authorities, as well as simply public health services in the area. If the local school has a mobile chip shop arriving at lunchtimes to service kids it is not really a good part of our public health strategy, is it? So we need to think how we can change behaviours by changing opportunities.

Q250 Julie Cooper: What would you say was the single most important lesson from the experience of your area for the wider health and social care system if you were to point to one single thing for us to take away?

Sir Howard Bernstein: Resilience.

Julie Cooper: Resilience.

Lord Smith: Encouragement. Decide what you want to do and persuade people that is the objective. I think we have done that. As Howard said earlier, I think the incentive is partly to—everyone has joined to improve health outcomes for the public but I think as well there is increasing financial incentives, that people recognise if we can work together and do it more efficiently and effectively then that is a good lesson for all of us.

Sir Howard Bernstein: I think there is also another point and that is understanding the interdependencies around system change. If we are looking at health social care in the way we have described it then we need to address rightly the impact of it, how we can create pathways that build on their inherent strengths but equally start to address those programmes that are not as connected to the health and social care process like estate configuration. Because unless we can access the resources in order to support our colleagues to reconfigure their estate—and there will be an element of double-running associated with that—there will be a requirement to access capital, whether from the public sector or the private sector. We have to join all of this up in a very clear way. Without that then we are only going to be looking at things from one end of the telescope.

Q251 Julie Cooper: Did you want to add to that?

David Slack: Yes. It is a bit early to draw lessons but I suppose the principle we would say is trying to make the right thing the easy thing for people to do, both whether it is individuals making lifestyle choices or staff or clinical teams or organisations thinking about the health of the population they serve; so getting that environment and those incentives right.

Q252 Helen Whately: It is very good to be having what feels like a very positive conversation, because as a Committee we do not always have such positive conversations with our witnesses. It was very good to hear you say earlier that you believe you can pretty much close the gap. Reading the document you mention there was around 2 billion envisaged for the health and social care economy but post CSR you believe you can pretty much close that. I would be interested to know whether you feel that could have been done without devolution. What aspects of devolution have enabled you to tackle this? What is it about the devolution set up?

Lord Smith: I think it is the place base. We think we understand, both Greater Manchester better as a whole but also within each of the authorities' understanding, those areas much better than is done centrally. So the more flexibility we have over resources coming into the area then we can work with health colleagues to get better outcomes. So I think it is really important that places do have that opportunity. We can then link it up with other bits of public service reform. We don't see health here in isolation. It is seen as part of that wider package. You will see the objectives; there are objectives about getting people back to work as part of our outcome. It is seen to be part of that wider concept.

Q253 Helen Whately: Sir Howard, you may have more to say on this but I want to push you on that. So it is possible for organisations to work together and look at things on a place-based basis without having a devolution deal arguably?

Sir Howard Bernstein: Yes.

Q254 Helen Whately: So what is it that enables you to work together on a place basis particularly because of devolution? What is it about devolution?

Lord Smith: It is the ability for the 6 billion total fund to be used, not entirely, but be used for the benefits of Greater Manchester that we would see rather than it being done on a central basis. I think that is just—

Q255 Helen Whately: The taking control of that pot of money?

Lord Smith: Taking control of the money; organisations thinking they can have that influence. We were told from the beginning there would be no structural changes and we accepted that. So if you are chairing a meeting of 37 organisations it is quite a fascinating exercise. Most of them like to bring a friend.

Sir Howard Bernstein: I think there are three elements to this. The first is leadership; national delivery models have no spatial focus. What we can provide is a spatial focus around Greater Manchester and the Greater Manchester health economy. I think that is absolutely essential and that comes from Peter and his political colleagues right across the political divide in Greater Manchester alongside other NHS stakeholders. That is point one.

Point number two is the transformation fund. There will always be the temptation, I am sure, for people to agree a strategy and then go away and blissfully ignore it. What we have to do is make absolutely certain, and I think Peter has made this very clear and it is very much at the heart of the criteria that will be deployed in order to determine what secures access for funding and frankly what does not, is that this has to be transformation; it has to involve system change and there have to be a number of common indicators about levels of productivity, what constitutes a single commissioning hub, all that sort of stuff, because without that we will not secure the consistency and the radicalism we need throughout Greater Manchester.

Thirdly, I think it is really about the breadth of the vision. It is not just enthusing people—because there are huge numbers of people who work in the National Health Service and public service generally who recognise the need for change—it is the real opportunity to align the health and social care changes with the wider public sector reform programme, which goes right to the heart of our other devolution deals as well. So we link health and social care with different housing offers, particularly in or near hospital estates; we are able to look at mental health and work programmes in a different way but as a result of supporting people to getting to work; we are able to access health services generally to support our skills and our other growth programmes. It is that unique opportunity we provide, which has provided, I think, the opportunity to enthuse so many of our leaders in Greater Manchester.

Q256 Helen Whately: Thank you. I don't know, David, whether you might have a perspective on that?

David Slack: Yes. I have not made quite such a bold claim and I would describe it as still work in progress in terms of our plans to deliver sustainability over a five-year period. We have various components. So the Vanguard scheme in South Somerset based around Yeovil Hospital and the GPs come together; they have a plan that brings sustainability to

that part of the county. I think we can replicate a lot of that, but that is about targeting the resources jointly across organisations on the different segments of the population that we have looked at, so co-ordinating care through hubs on those most needy parts of the population, enhancing primary and community-care teams on those whose conditions are in danger of exacerbating and then focusing on prevention for the wider part of the population. I would absolutely agree with Sir Howard that leadership is pivotal in delivering this and getting that common focus around an agreed set of objectives.

Lord Smith: Just to come back on something that Howard said, I think we also have to enthuse the staff. From 1 April it is going to be different. It is not like it was the day before. So all of the partners have joined together in constructing a letter that will go to the staff across Greater Manchester whether they work for local authorities or in hospital organisations or CCGs talking about the changes that are coming into place, trying to enthuse them that this is their opportunity to work with us all to achieve these desirable outcomes for the population of Greater Manchester because, you know, it is good for us to talk at this higher levels but we need to get the staff enthused, get them behind us, working well with the changes and we recognise their value.

Q257 Chair: You are pooling a figure of 2.7 billion out of a 6 billion total. How much control will you have over the spending of the remainder of that 6 billion in terms of things like tariffs and other incentives within the system, that tend to suck activity into secondary care? Are you going to have much more freedom to control those payment mechanisms?

Sir Howard Bernstein: We will do in time, not from 1 April. It is one of the key workstreams, which is being led here in Salford on behalf of Greater Manchester, looking at the whole tariff system. What we want is certainly to be in a position of trialling something within the next six months.

Q258 Chair: That allows you to move activity elsewhere.

Sir Howard Bernstein: Absolutely.

Q259 Chair: Of course there are some issues here for the local community. We are here in one of only two trusts in the country that has an outstanding rating from the CQC. Do you have any concern that you could upset that delicate balance, given that obviously things are going very well in terms of the CQC rating? Is that something you have looked at?

Sir Howard Bernstein: We have not looked at that directly and that is clearly one of the impacts. Obviously we do not want to undermine in any way at all where the system works effectively.

Q260 Chair: If it ain't broke, don't fix it?

Sir Howard Bernstein: Equally what we also have to address is that the system at GM level is not particularly effective.

Q261 Chair: Yes. So in other words you want to spread the best elsewhere.

Lord Smith: Inverse of your question, if I may say so. We want to learn really what makes Salford so good and we can pass on that good practice to the other acute hospitals.

Q262 Chair: When we look at the Sustainability and Transformation Fund, to give it its full title, most of it is going on the sustainability element; to, as you said, write a cheque because they have not balanced the books within the NHS, and so a relatively small amount within the transformation element of it. Are you confident that you are going to have enough within that transformation part of it to achieve your ambitions?

Sir Howard Bernstein: One of the proposals we agreed on Friday, which had been the subject of discussion for some time, with Jim Mackey and NHS England Improvement, is the appointment of relationship manager representing Monitor-NHS Improvement who work within the devolution team in Greater Manchester who would ensure that the way in which those conditions, those functions, as a result of the deployment of that funding to individual providers fairly and accurately reflects the ambitions within our GM plan.

Q263 Chair: What I am hearing is, do you feel that Greater Manchester is going to have special treatment over and above other areas of the country?

Sir Howard Bernstein: No, it will not have special treatment, unfortunately.

Lord Smith: Maybe different.

Sir Howard Bernstein: What it will have—we want—

Chair: I am just asking the question because—

Sir Howard Bernstein: What we are trying to do is move away from this culture of rewarding failure. Part of what we want to do is not judge individual stakeholders and providers in particular on the back of continuing to run up deficits and the delivery of the NHS fund but also how it contributes to fiscal sustainability as embodied in our own GM plan as well. Monitor-NHS Improvement see the inherent worth of that strategy and why we are working with them so closely.

Q264 Chair: A final question from me. You sound like you are reasonably confident that you will have the transformation funding you need. But it is not just about funding; it is about having the levers. If we are going to talk about transforming services sometimes we are referring to closing down a service that might be very valued by a local community even if perhaps it is not best for the wider health economy. Do you feel you have the levers you need to put in place those transformations? They can be very difficult.

Sir Howard Bernstein: I think the answer to that is yes. If you build on the Healthier Together success, which was led by my colleague behind, what we found with that was providing you provided the evidence to justify service changes then by and large people got behind them and understood them. We were able to show on Healthier Together that we would save, what was it, 360 more lives a year, we would be able to achieve these outcomes within different localities, all of which were positive. By and large the National Health community supported those changes. There will be no substitute for building on my platform and going ahead and doing that but so long as we act in the context of where the evidence tells us we will achieve the maximum impact for the benefit of people who live in Greater Manchester then I will be confident of being able to make those decisions and to see them through.

Lord Smith: About a third of the way I suppose into the Healthier Together process, which up to that point had largely been issue led, we isolated—people brought it before us, the argument, to the Greater Manchester authority—we reviewed it for the first time and we said, “We can’t support the work you have done so far; what we want to do is exactly what I said; we want to know evidence; we want to know the benefits for patients. If we get that right we will support you”. So in a sense it changed the workstream from that point. We got the right evidence. So in a sense the local authorities supported the changes that were being put. We had a judicial review of that outcome a few months ago. One of the hospitals decided it was not too happy with the outcome but again the strength of the local authority in maintaining that this was better for patient outcomes and so on meant the hospital was quite isolated and was seen to be pursuing organisational benefit rather than public benefit. We bring it to the table as local authorities, that kind of democratic connection.

Q265 Mr Bradshaw: Which hospital and which service was that?

Lord Smith: Wythenshawe.

Chair: So, no more questions. I will say thank you very much for coming this afternoon. It has been very interesting hearing your evidence. Thank you.

Examination of Witnesses

Witnesses: **Neil Tester**, Director of Policy and Communications, Healthwatch, **Elliott Dunster**, Interim Group Head of Public Affairs, Policy and Research, Scope, and **Geoff Heyes**, Policy and Campaigns Manager (Mental Health Services), Mind, gave evidence.

Q266 Chair: Welcome to our final panel of the afternoon looking at the impact of the comprehensive spending review on health and social care. Could you please introduce yourselves to those following from outside the room, perhaps starting with you, Neil Tester?

Neil Tester: I am Neil Tester. I am Director of Policy and Communications at Healthwatch England, which is the consumer champion for health and social care and supports the network of 152 local Healthwatch across England.

Elliott Dunster: I am Elliott Dunster. I am Head of Policy Research and Public Affairs at disability charity, Scope. We are also a member of the Care and Support Alliance.

Geoff Heyes: I am Geoff Heyes. I am Policy and Campaigns Manager at Mind, the mental health charity.

Chair: Thank you. We are going to start off with Ben.

Q267 Mr Bradshaw: Mr Tester, do you think that the current levels of health spending in the CSR are sufficient to meet the expectations of patients and the public?

Neil Tester: People have spoken very clearly to local Healthwatch and to us about their expectations. What they have not done in those conversations is put cash numbers on it so apologies if I cannot answer that bit of your question directly but what I would say is that both when they are looking at specific examples of service change, specific local policy decisions, and when they are given the chance to think more broadly in the way that Anna

Bradley described to you last year in your primary care inquiry, people absolutely acknowledged the resource pressures. They absolutely see a role for themselves and the changes they can make in their own lifestyle and behaviour but also the way they interact with the services in being part of that solution. But they are presenting a challenge to the system because they are saying, “You need to engage with us; you need to involve us properly for us to feel that you are getting the best value out of the money that we as citizens are putting into our resource-pressed system”.

Q268 Mr Bradshaw: So you as an organisation do not have a view or take a view as to whether we as a country are spending enough on health.

Neil Tester: No, we do not take a view on that but what we do is listen out for and amplify the voices of people experiencing the impact of policy decisions taken within those resource envelopes. Sometimes that leads to either local or national decision makers rethinking particular resource-allocation decisions and sometimes it leads to a different, a more creative approach based on listening to people about how to deliver the best outcomes with the money that has been allocated.

Q269 Mr Bradshaw: Within the money that has been allocated are there particular areas given constraints that you feel should be prioritised?

Neil Tester: Yes. People have been very clear with local Healthwatch and the network have been very clear with us about those priorities so the top five issues come through really strongly.

Every year we ask local Healthwatch how they have prioritised their work programmes for the coming year and they do that based on issues that people are raising formally with them, issues that are coming up through individual members of the public turning to the local Healthwatch with a problem or as part of the information and signposting role that local Healthwatch have, and also in reaction to issues that are emerging across their local health and care economy.

So top of the list for the coming year most of the network has said that mental health and particularly the development of provision of lower-level interventions—more flexible access to counselling-type services, peer-support services, that sort of thing—that has come through incredibly strongly.

Access to primary care, so GP services but also dentistry and pharmacy in that mix, was the top of the list the year before. It has dropped to number two but actually more local Healthwatch are programming that into their workstream.

Then there were also some very interesting things people are saying about the need to focus on social care provision but also to focus on the integration of services, which I know is something your Committee is very interested in.

Q270 Mr Bradshaw: We are going to come on to mental health in a bit more detail in a second but on access to primary care what is it exactly? Is it that people are finding it more difficult to get to see a GP? Or at a time convenient to them? What is a bit more detail on the picture.

Neil Tester: There is a whole range of issues and it does vary depending on which part of the country you are in. So you are absolutely right that sometimes it is about the availability of appointments. Some of the issues are being explored through the PM's Challenge Fund pilots. It is also about the variable take-up of online initiatives like Patient Online, so where that is available people are often making very effective use of it and finding it very positive. Some of the challenges that people are identifying elsewhere mirror that. We found that there have certainly been in the past a number of issues in some practices of physical access to services; some fairly basic issues around things like wheelchair ramps, interpretation services for people who are deaf or hard of hearing, and occasionally language interpretation services can come up as an issue. So a whole range of issues. There is no single access issue that is coming through at every single local Healthwatch.

Q271 Mr Bradshaw: In this context, what is your view of the Government's proposals on the seven-day care?

Neil Tester: What we have heard from our network and what they in turn have heard from their local communities will probably be quite familiar to you from the way that most of the evaluation of things like the Challenge Fund pilots and I think NHS England and the Government's position has now ended up, namely, that people very clearly want more flexibility. They very clearly see the need for greater ability to use GP services further into the evenings. Opportunities like Saturday mornings are very popular and well-used. There does not seem, in the evidence that has been brought to us, to be a particular demand for use of time on Sundays for routine appointments. People obviously think quite differently when you are talking about low-level but fairly urgent issues, the sorts of things that if provided through a GP or primary-care framework avoid you having to go to A&E.

Q272 Mr Bradshaw: Are you able to quantify from your surveys whether you think people's satisfaction with their ability to access GP services is deteriorating or getting worse or better or staying the same?

Neil Tester: We have not done survey work on that nationally but the work that the NAO recently undertook for the Public Accounts Committee and other NHS England indicators of satisfaction suggest that while satisfaction with GP services still remains very high it has started to decline. I think that is one of the reasons why everybody is focusing such attention on the issue at the moment.

Q273 Julie Cooper: Turning back to the subject of mental health could I ask you, Mr Heyes, to start us off by saying what you think the mental health taskforce are telling us about the Government's promise to deliver parity of provision for mental health? How far have they delivered on this promise?

Geoff Heyes: I would characterise it as we have come a long way in terms of Government and public attitude towards mental health, understanding that there is a real issue there and it needs to be sorted out. The mental health taskforce is a plan of action, going back to some of the conversations earlier, for the transformation of services so that parity can be achieved. It has priority actions across the board tackling things like access to crisis care, which we know is a real challenge; access to therapy; prioritisation of prevention services. So it covers the whole scope of mental health provision and it sets out what the priority areas are. I do not think it suggests that in five years' time in the delivery of this plan that

parity will have been achieved but it does say this is part of a longer journey and these are the urgent things that need to happen.

Q274 Julie Cooper: What effect do you think the comprehensive spending review might have on this delivery? It is good that now at last the area has a spotlight shining on it and that is a very good start but going forward to turn those plans into deliverable actions, what effect do you think the spending review will have?

Geoff Heyes: It was pleasing that the Chancellor mentioned mental health for the first time specifically, and that commitment. Then the commitment to funds, the £1 billion that the mental health taskforce—these are the recommendation of the taskforce, they have been costed as costing £1 billion. The Government has said that money is there. The organisations that are involved through NHS England, the arms and the bodies, have all committed to doing those recommendations. So in that sense the CSR is kind of saying, “Here’s the money that you have said you needed to be delivered”.

I understand in previous sessions you have had discussions around to what extent are those commitments achievable given the pressures on the system and the deficit sucking money back. I would emphasise one of the key parts of the taskforce is around transparency, so that is transparency of outcomes, which in mental health we just have not had the data on or it has not been standardised across the system to understand what actually is happening, what interventions are working most effectively, so local areas can say, “We are going to invest in this”. It is also about transparency around funding. Since 2013 we have not heard any detail about what is being spent locally on mental health so being able to match up rhetoric about this is all the money that is going to be put into mental health and seeing it delivered is a real key step and I think that is a really important part of the mental health taskforce.

Q275 Julie Cooper: That is our view because for too long mental health has been the poor relation, over many years, hasn’t it? So to see some development I suppose is the proof of the pudding. We will see later.

What impact do you think the pressures on public health and social care budgets has had on mental health in the community? Do you think it has added to demand for services? Are you aware of extra demand?

Geoff Heyes: I am not so sure about adding to demand. What I would say is that we at Mind are disappointed at the cuts to public health. Just echoing the conversation again, the focus of the “Five Year Forward View” and of the mental health taskforce was this is really important; prevention is a key part of this so we can try to prevent more people from becoming so unwell that they have more expensive care. That is a fundamental part of the Five Year Forward View and really important for people themselves, public health has a really important part to play in that in terms of mental health. Mind has done quite a bit of work in this area in terms of trying to understand what local authorities are spending on that. We had to FOI all the local authorities to get the figure that 1% of the public health budget is being spent on mental health. Now for us, we are obviously campaigning to make sure that changes in local areas and trying to support local areas to understand how they can use their public health budgets to support mental health and that they should be doing this.

We are really pleased the Government has now changed how it categorised it, how it asks local authorities to report the public mental health spend. It used to be stuck underneath miscellaneous along with fluoridation of water supplies and things like that. Mental health is more important than that—I am not denigrating fluoridation of water supplies—so we are disappointed that there are going to be cuts to public health because the reality of local government and the funding at the moment is that it is even harder to get people to focus on mental health when they are having to cut back. As we heard earlier they are looking at their statutory obligations first and then the nice stuff around that, they are looking at what they can cut back. But it is kind of short term, is how I feel.

Q276 Julie Cooper: It is interesting that Mr Tester was just saying that Healthwatch have identified that as a top priority but a perception that mental health is an issue that needs to be addressed as top priority. Did you want to comment on that at all further?

Neil Tester: It might just be helpful to add that in the deliberative work we undertook last year looking at people's future expectations of better non-hospital care in the round firstly it was very striking how quickly people got straight into talking unprompted about mental health in a way that five or 10 years ago nobody would have wanted to be the person in the room that brought the subject up. So it is very heartening to see that and people talking about their own experiences and their friends' and families' and colleagues' experiences but also a very sophisticated view. People really have been thinking hard about this issue, and probably more than the system gives them credit for, about the interrelationship between different services and the role that for example voluntary-sector services can play as part of a mix of provisions to enable people to get the flexibility they need within the resource constraints they know are there.

Chair: Thank you. So if we come on next to James.

Q277 Dr Davies: How do you think the comprehensive spending review's statement, or settlement I should say, will affect services for the disabled community?

Elliott Dunster: I was fortunate enough to be here for the first session and I do not really want to go over the same ground as your brilliant, excellent witnesses did around the broader spending review but in terms of for disabled people the one thing that I would pick up is that it is really important to remember that a third of social care users are working-age disabled people. They are not older people. It is a third and half of the social care spend is on that group of people. It is often forgotten as I think the representative from the LGA said earlier today that the demographic pressures that we are seeing in the system are around services for working age disabled people, and the outcomes that they are looking for are very much about independent living and they are very much about living their own independent lives—as is brilliantly articulated in the Care Act, in the very first clause of the Care Act, around the well-being principle—and that is important.

We did a lot of research, which we have submitted to the Committee, and of which there is much more around disabled people's experience of the care system. Unfortunately the funding pressures we are seeing in the care system and in local government are translating into the types of services that disabled people are receiving. We found that only 18% of social care users say that their services consistently support them to live as independently as possible. Just over half, 55%, said that their social care never supports their independence.

We will probably come on to this a bit later in the session but perhaps also concerning is that a third of users said they are not getting the standard of care agreed in their care plans. I know in the written evidence submitted by the LGA to the inquiry, they talk about where those efficiencies that councils are making are going to come and it is quite clear that they are saying some of those efficiencies are going to come in the sufficiency of the services delivered. That is the background and the bit that we are worried about.

The good bit is—I would echo Geoff’s points about the spending review—having a very clear recognition from the Chancellor around the precept is important and they sent a good message that social care is a priority and it is important. We recognise the funding pressures. The next step is to work out where responsibility for delivering social care services lies, because there are huge opportunities in devolution, as we heard in the last session. But people still expect some kind of responsibility from central government around the services that enable disabled people to live independently. I do not know where that balance is and we will see that over the coming Parliament.

Q278 Dr Davies: How would you rate the Better Care Fund in terms of its ability to assist disabled people?

Elliot Dunster: We are very supportive of the Better Care Fund. Integration, if purely seen as a cost-saving measure, is probably not particularly helpful. The helpful bit can radically transform the services that disabled people get as well as other people to live independent lives. Where services do not join up and they do not work properly disabled people do fall between the gaps and they do not get that support. The Better Care Fund is a way of helping join up those services.

I can think of a man that we spoke to as part of our recent policy work where he was on a housing waiting list for 12 years. He wanted to live independently. He was a man in his late 30s living with his parents, working, and he was on a waiting list and a flat came up. It was fantastic and he contacted his council and said, “I need to be assessed for social care support” and they assessed him and they said, “Well, you can have one hour’s support a day in the morning to get up, none at the weekend, and that is your care package.” He needs to go to work and he needs a bit more help than that so he said, “I cannot live independently”. So he was pushed on to the NHS and the NHS said, “We cannot fund your support either, you need to go and speak to your local authority”. He went back to his local authority. This whole process took a year where he was paying rent on a flat which he never slept in.

It is those types of things we have to get to the bottom of and make sure that there is an incentive around supporting disabled people to live independently across the board. To do that, the one thing that we would change around the Better Care Fund is, include some metrics that are about disabled people living independently and not purely around older people and hospital admissions. We have some suggestions, which we have put in our written evidence to you, and we think if we can tweak some of the outcome frameworks there for the Better Care Fund we might drive better outcomes for disabled people around living independently. We did a review of the Better Care Fund plans that were put forward and it was just 14 of 91 had schemes that were designed for working age disabled.

When I come back to my first point, a third of the population using social care are working age disabled people and half of the spend—we are certainly not going to drive any savings

in the system unless we focus on the full range of social care users. That would be the message around the Better Care Fund; really good but how can we make sure the outcomes drive best practice to support disabled people to live independently?

Q279 Dr Davies: If we are looking at improving health and social care services, clearly that is one suggestion. Do you have other suggestions that you would wish us to highlight or is it just down to money, do you think?

Elliot Dunster: It is difficult to get away from the money question. Again I do not want to take up the Committee's time with it, because the points were made excellently in the first session today and I hopefully have given some colour around what that means for disabled people. There is lots more of that. People being restricted to taking two or fewer baths a week. People that can only go to the toilet once a day because that is all their care package allows. That is what it means for people. People told us they get yeast infections because they cannot wash regularly enough. It is those type of things that are happening to people. That is what it means for people.

In the longer term, and hopefully that is something the Committee will look at, if there is a single outcomes framework developed across public health, health and social care, that might help to drive some behaviour, which improves the situation. That has to have independent living at its heart for disabled people. If I may be a bit bold, and it was in our written evidence, an interesting area for the Committee to explore would be to have an inquiry around independent living for disabled people because we are seeing lots of information come through about how independent living is perhaps—we have a lot further to go and Government-owned statistics say there has been a bit of regression here.

We have just come on from the closure of the Independent Living Fund and we would like to see what is going to happen to the 19,000 previous recipients of the Independent Living Fund and what that has meant for their care package. We have a welcome commitment from Government about halving the disability employment gap. What is the role for social care around that? Supporting disabled people into work and halving that gap. We are obviously a year on now from the Care Act as well. So there are lots of different things here, which it would be timely for the Committee to look at an inquiry about what is happening to independent living for disabled people and how can we drive that forward through the care system and integration.

Dr Davies: Interesting. Thank you.

Q280 Chair: Obviously very topical at the moment is the issue of the PIP payments and how that all fits into it. Although PIP is not our remit as a Committee, it does have a knock-on effect. Looking at the consultation, do you feel there is an argument to focus payments on people who have greater levels of need or do you wish to make a comment on that today on behalf of Scope?

Elliot Dunster: Two things, it is important to remember what all these different bits of the system do, and in the debates over the last week some of that has got a bit lost. Personal independence payment is about meeting or helping to meet or to contribute towards the extra cost of disability. We need to think about what that means. Ensuring that people have those extra costs met is important in terms of them living an independent life, and that is part of it.

The social care system is something different. That is about the support that disabled people need to get out, get washed, get dressed, get out of the house, and they are slightly different things. I can understand in the eyes of the public and many others those two things can get conflated.

Chair: That is why it is helpful to have you set out your views on it.

Elliot Dunster: I hope I can be helpful.

Chair: We have some time to hear your views in detail on that.

Elliot Dunster: It is helpful to think about what the purpose of it is. One thing that I would like to think about—and it might be something the Committee could think about in their inquiry on independent living for disabled people, that I very much hope you do—would be the numbers of people falling out of the care system. Those people do not stop needing some kind of support. Some of it is picked up with informal support. People have an unmet need and then later on it becomes truly urgent need and they go into residential care at a time when they just need a little bit of support. I can think of lots of cases of people that we have spoken to. A deaf and blind lady who was not eligible for care from her local authority was living alone, and she was completely deaf and blind, she could not tell if her food was safe to eat and she was getting no care support. I have not caught up with this particular lady's case recently but I can certainly imagine that her needs will escalate to the point that she will probably have extremely high needs and the local authority will then have to intervene at a later day.

Q281 Chair: Is that because she was self-funding—I do not want anyone to feel identified—or was it more an issue that it was not the capacity—

Elliot Dunster: She did not meet the eligibility criteria for care.

Chair: So she did not meet the criteria?

Elliot Dunster: They are the types of people that we are talking about here. I wonder if those people are also going to be pushed on to—not “pushed on”, that is the wrong way of putting it. But I wonder if people are being signposted more towards personal independence payment as a result of the care system because there is an interaction there. We just need to unpick it a bit and understand it. But I would like to clarify for the Committee, they do two different things, they serve two different purposes. Personal independent payment does something different to the care system and that is important.

Q282 Emma Reynolds: Any comments on the current debate around PIP? You are here before us and there is nothing else in the news, to be honest, other than that.

Elliot Dunster: It has been a busy week. I assume this statement is going on in the House of Commons at the moment, and we very much welcome the Government's decision to relook at the proposals. There are a number of decisions around support that disabled people receive that have been taken in the last few weeks, in the last few months, and our position on those things is clear and on record. We very much hope that the current debates provide an opportunity to relook at the assessment process, which is extremely challenging for disabled people. Both the work capability assessment for ESA, as well as

the assessment for the personal independence payment. We are here, as ever, to work with Government to make sure that we can get that right.

Q283 Chair: Any further comments you would like to make on it?

Elliot Dunster: I do not think so, no, if that is okay. I think that is okay, thank you.

Q284 Chair: Can I return to the issue of seven day urgency? We have covered the issue about that as regards primary care. Can I return to that as regards hospital care and perhaps, Neil, would you like to set out where you feel we are with seven day services in the hospital setting? Is that something we should prioritise or do you feel there should be other priorities? Do you want to express a view on that?

Neil Tester: It is not something that people have raised with local Healthwatch as an overriding priority as a general issue of principle. There are some areas though where it has come through in different pieces of work. So the most obvious example that leaps to mind is in the work that we did around discharge; last year when we produced our safety home report looking at poor and unsafe discharge particularly for older people, people with mental health conditions and people experiencing homelessness. Particularly in the mental health strand of that inquiry there was a real issue around—and it came out time after time in the stories that people told us—either an inability to get hold of crisis support out of hours or if people could get through they were told, “You will need to wait” or, “Can you just hang on until the morning?” That is probably the most substantial bit of non-primary care related evidence we have of issues of specialist support not being available within the standard hours.

Interestingly, I have combed back through the report because I expected to find a bit more of people perhaps talking about the fact that a lot of the other services that might support this charge wind down at the weekend; so occupational therapy, physiotherapy, those sorts of services. That did not come through. It is possible that that may have been because given that there is not a seven day social care operation to receive people that were getting those weekend assessments it may not have necessarily presented itself to people telling us their stories of delayed discharge as being a factor.

We certainly have not had demand coming through or expressed to local Healthwatch or to us about, you know, pop in and see the phlebotomist and have a blood test on a Sunday. That has not come through as an area of demand. Where there have been issues where local Healthwatch have been part of shedding or shining a light on individual institutions, where there have been concerns about outcomes or quality of services, that has been part of a broader discussion in that local health economy typically where there will also have been CQC inspection activity, concerns expressed in health and well-being boards, and so on.

I would say that the two areas where people have shared their views and experiences most prominently with us and our network around seven day services has been in primary care and in that mental health crisis space.

Q285 Emma Reynolds: Is there some confusion about what the Government means by seven day services?

Neil Tester: There almost certainly is a degree of confusion there. In primary care it has taken quite a long time to unpick and unpack that debate for everybody now to be talking

about the same set of potential service changes. No two people would have exactly the same experience in a hospital of there being a seven day service available or not, depending on individual circumstances. To come back to the point about the discharge, the current controversy around junior doctors has not related to the discharge issues because the only potential barrier there, in terms of somebody being ready for discharge, barring a few final steps in the process, would be at the consultant end because that is where the control is in the process.

Geoff Heyes: Can I just add on the point about crisis care? This is one of the main things of the mental health taskforce is about making sure there are 24/7 crisis teams available to people because we hear too many stories about people at weekends where there is a higher chance of being in a crisis situation where they cannot get help and they have to wait until Monday. It is obviously fundamentally not good enough. That is one of the key strands of the mental health taskforce is to make sure that in every local area there are 24/7 crisis support options available to people.

Q286 Helen Whately: Could I just follow up with you on the funding for mental health, and you welcomed the additional money that has been sent in the direction of mental health? Do you have a view on the timing of that funding and, first, whether there is enough transparency on that and, to the extent there is, whether the timing looks in line with what is recommended by the taskforce?

Geoff Heyes: I do not know the details of the timing because it has not been published and I am not part of the taskforce. Even though my chief executive is part of the taskforce, I am not.

In terms of the timing, my view on it is that it is like the five-year plan and the £8 billion, we are trying to pump-prime the transition in the system, so the earlier you can get that the more impact it is going to have. The sooner the better from my point of view. In terms of some of the aspects, some of the taskforce is about changing levers and enabling data to be seen to be transparent. It is not just about the money, which is important to increase access to Talking Therapies, it is to make sure there are adequate resources with crisis teams everywhere, to recognise those things take time but we would rather see those things sooner than later. But it is not all about the money. It is about changing the system so that mental health is seen as equally important as physical health, so when decisions are made when people review services they are thinking about mental health as well. Similar to what I was saying about public health. It is going to the point where we do not have to mention that public mental health is an important aspect of public health, but we do have to mention that at the moment.

Helen Whately: Thank you for flagging the importance of transparency. I agree with you.

Q287 Emma Reynolds: You have been very positive about the taskforce and very diplomatic. Is it not quite appalling that one of the findings was that three in four people who need mental health care of some kind are not getting access to it? We are in a pretty bad state, aren't we?

Geoff Heyes: Yes, it is appalling. It affects one in four of us and a quarter of those people currently are not getting treatment. Part of that is about the services available and the

resources available for mental health. Part of it is about public attitudes as well and feeling confident to talk about mental health and being able to get support and when they seek support for the support to be there. Again, that goes back to the public health funding. There is public health in mental health to support people with mental health conditions, if you are living with them and helping them stay well so they do not get it again, but there is also population public health; public mental health initiatives and initiatives that are targeted at population groups that we know are more likely to suffer mental health problems. It is important, yes.

Q288 Chair: I will say before I ask a question on mental health that I have a personal conflict in that I am married to a consultant psychiatrist and a registrar of the Royal College of Psychiatrists. Do you feel there is any unfinished business from the mental health taskforce that has not been funded adequately?

Geoff Heyes: Going back to the last point, I do not think the mental health taskforce is going to mean that in five years' time everything is hunky dory, and there is no need for Mind because everyone is getting exactly the care they need. The mental health taskforce is about transition and making sure that we are turning the NHS around so it is thinking about mental health when it should be, on an equal par with physical health. I would not characterise it as it is left out. These are the urgent first steps that need to be taken.

Q289 Emma Reynolds: Can I ask specifically about suicide prevention because obviously we know that suicide among young men is the biggest killer and, according to statistics—you will correct me if I am wrong—there has also been an increase in the number of young women committing suicide. Can you tell us a little bit more about what you think the Government should do on that because it clearly is a very worrying problem and one that seems to be getting worse?

Geoff Heyes: It is not my field of expertise, and I do not know the details around why there has been that increase in women. It is obviously very worrying but I do not know all the details around that. On suicide, the fundamental point for us is that every local area is meant to have a suicide prevention plan and they are meant to be doing stuff on it, and I do not think that is the case at the moment. It should be a priority for every local area. Around suicide people know the at risk groups and they know the kind of support that can help those groups. Every local area should have a plan and those plans should be real and they should be doing something about them.

Q290 Chair: Any further questions from the Committee? Are there any areas that you feel you would like to raise with the Committee today before you go on the comprehensive spending review?

Geoff Heyes: Can I just add one point about local authorities again? Obviously we have done a lot of work on public health but it provides all sorts of services. The representatives from the LGA talked about this. That lots of different services, some of them are provided by voluntary sector organisations, some of them are as simple as helping people deal with their finances and providing advice and support maybe on benefits, maybe on legal issues, and they can often be the easiest thing to cut in those circumstances because they are not the big statutory service they have to provide. Just to say that they really support people and they can often be the difference between someone being well and living with their condition, as we were talking about earlier, and not be well. The difference in terms of if

somebody becomes more unwell going into hospital, it is much more expensive. It seems very short term for a local authority to be put in that position where they are having to cut those services, which are relatively cheap and make a big difference to people.

Q291 Chair: That point was made very powerfully to us by the voluntary sector groups we met earlier today as well, but thank you for reminding us.

Elliot Dunster: To add to that and continue on that theme; I drew the point out earlier about eligibility for social care and where that sat and understanding the longer-term savings that come out of the system for disabled people is a bit more difficult than it is for older people. People can understand a bit more clearly the idea that if you have an older person who has a fall and needs a hip replacement, as a result that is very expensive and people understand that. But it is a bit more difficult to understand the journey that disabled people go through and the interactions between the health and care system for working age disabled people. It is a bit more difficult to understand and the data is not there to help us do it. It is very difficult to understand but it is there.

Anecdotally, for example, I can think of someone with a learning disability who might just need a little bit of care support to help them manage their finances. Without that, if they become not eligible for that social care support, what happens is they might become in debt, have a big mental health crisis as well on top of their learning disability, lose the job that they have, and they might be then categorised as being in need of urgent crisis care. That could have been prevented by someone doing intervention, so the same arguments play out for working age disabled with a variety of conditions that are permanent. The other thing that I would also like to add, given the opportunity, is the point around how the Better Care Fund will be used to equalise the differences in the precept. This underlines the importance of the point I am making about the outcomes being right and making sure the Better Care Fund outcomes are right for working age disabled people. Because if we have the Better Care Fund trying to even out those funding discrepancies but we are only looking at half of the funding that local authorities are spending—and only a third of people—it is probably not going to do a very good job of that for disabled people. It is just to understand a bit about the demographics of the different areas. It is absolutely right that each local area does what is right for them but they also need to be rewarded for delivering care that supports disabled people to live independently and not just focus on preventing admissions to hospital, which might not be the most relevant thing to a disabled person who needs social care. They are not sick. They do not need to be fixed. They do not need to go into hospital. They just need a bit of care and support to get up in the morning, get washed, get dressed and get out of the house. That is not very well understood at the moment, I do not think.

Q292 Emma Reynolds: One of our first witnesses said in terms of social care for people it was ageist, that somehow older people are getting a poorer deal than the younger or middle-aged people in the system. Would you disagree with that?

Elliot Dunster: I was here for that session and I do not think it is particularly helpful to trade different views. From the plans that we have looked at, if you are an 18 year-old who has just finished school and goes to college you probably want something different from your life than you do if you are an 85 year-old. Obviously the principle surrounding independence is important but we have spoken to young people who have finished residential college, they have gone to their local authority and they have gone to the NHS

and said, “I want to go and live with my friends now, live independently. I had a great time at college. They have tried to teach me the skills to live independently. I would like to go and maybe try to get a job one day and try to live like a normal 20 year-old” and what they are told is, “You can move into this old people’s home or you can move back with your parents”. That is a different thing and people need different outcomes. The system needs to be flexible enough to deliver different things. That would be my starting point, starting with the individual, what they want from their care package and what that looks like. Someone who wants to, at 20, go and live with their friends and try to start a career and have a job, they need something a bit different and we need the systems and structures to enable that to happen.

Q293 Chair: Thank you. Neil, did you have any final points you would like to make?

Neil Tester: I did, yes. There are just a couple of things that have not come up naturally in questioning. The first of which is about the need for people not to rush from shifting eligibility criteria for things just from one position straight to another position and hope that that will work for everybody. Just thinking back to one of the examples we heard in the discharge special inquiry. There was a woman in her 80s who was a carer for her husband who had dementia and Raynaud’s Disease. In 2011 she had one hip replaced, she was given six weeks of reablement; she felt she needed a fortnight, but that six weeks was paid for and delivered. When she had the second hip done in 2013 the eligibility criteria had changed and she was given nothing, and she felt she probably could still have done with that fortnight and told us a very powerful story of how she was literally left standing on her crutches as the ambulance drove away with no clue about what she was going to do. So a more sophisticated approach to getting a package that would have suited her would have saved money previously but would still deliver a service to her now. So criteria needs to be looked at in a sophisticated way.

Secondly, just to touch on the capital money that will be provided through the CSR settlement for improved use of technology across health. Importantly, and I think differently from some of the previous attempts for the system to deal with this, the fact that that is now trying to deal with the integration agenda with social care. So we are now involved with the work of the National Information Board and there are a number of opportunities there, if—what are always very tricky management and technical issues—they are sorted out properly there is a lot of opportunity to provide the kind of flexibility and the ability to empower people to do things for themselves and get themselves through the system without constantly going back for repeat GP consultations. The eyes need to stem the price there. That is a potential positive.

Also I do not want to come across as though we are a Dr Panglossian organisation. We are there both to look for opportunities and challenges that can be resolved by the opportunities, and to get engagement right and think differently about it in these new and different discussions about integration that have been forced on everybody by the resource challenges. There is something massive for people to gain as patients and as citizens in that.

I know you had a witness earlier from Cumbria from the Success regime, a good experience there of them working very effectively with Healthwatch Cumbria to do—

Q294 Chair: Unfortunately they were not able to make it. It was very disappointing. They submitted excellent written evidence but unfortunately the person who was due to come was not very well today so it is a shame.

Neil Tester: I am glad I flagged it. Certainly I know the experience Healthwatch Cumbria have had of working with them on public engagement in what could have been, and will still be, a very tricky set of decisions but there is definitely a qualitative difference in people's experience of engagement there. But also thinking about the vanguards. Some of the most creative, most forward thinking vanguards have worked very effectively right from the start. Even at the stage where they were bidding to be vanguards, to work with local Healthwatch, to get engagement of people at the start and throughout rather than as a tick box exercise at the end. We would say, very clearly based on the evidence right across the network, that investment of time and a little bit of resource at the start of major change projects like that pays dividends because you know that you are going to deliver the right set of services that people will need and will use rather than having to continue to tinker with the system with all of the costs that that has. The challenge is for people who are not in high profile programmes, either because it is a success ratio or because it is a vanguard, to apply the same kind of thinking and get the same kind of benefits in terms of their own integration efforts but more importantly for the population that they are serving.

Chair: That is an important note to end on, involving patients right at the start and all the way through the process. It gives you better results in the end and saves you money as well, so thank you for very much for that, Neil. To all of our panel, and in closing finally again to thank Salford for welcoming us here today. It has been a fantastic visit so thank you very much to everyone who has been involved. Thank you. And to our witnesses who have come to watch proceedings as well, thank you.