



Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 29 November 2016

10.15 am

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord McColl of Dulwich; Lord Lipsey; Baroness Redfern; Lord Ribeiro; Lord Turnberg; Lord Willis of Knaresborough.

Evidence Session No. 23

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Questions 224 -235

Witnesses

I: Nicky O'Connor, Chief Operating Officer, Greater Manchester Health and Social Care Partnership; Steve Wilson, Executive Lead, Finance and Investment, Greater Manchester Health and Social Care Partnership; Sir Howard Bernstein, Chief Executive, Greater Manchester City Council; Professor Kieran Walshe, Professor of Health Policy and Management, Manchester Business School, University of Manchester.

Examination of witnesses

Nicky O'Connor, Steve Wilson, Sir Howard Bernstein and Professor Kieran Walshe.

Q224 **The Chairman:** Good morning, lady and gentlemen. Thank you very much for coming to help us with our session today. I am sorry to have kept you waiting, but we had some private business to deal with. We are on live broadcast, so any conversation you might have may be picked up, and that applies to all of us. The members of the Committee, if they have not declared an interest before and it is specific to this session, will do so when they ask their question. The transcript of today's session will be available to you after the session. If you feel that there are any corrections to be made, please make so, but you cannot change it. Before we start, would you introduce yourselves from my left? If you wish to make a very short opening statement, please feel free to do so, and then we will get on to the questions.

Professor Kieran Walshe: I am Kieran Walshe. I am a professor of health policy and management at the University of Manchester with an interest at the moment in research on health and social care devolution, work that is being supported by the Health Foundation and the National Institute for Health Research. I will not take up time with an opening statement.

Sir Howard Bernstein: I am Howard Bernstein. I am chief executive of Manchester City Council. I am also head of the paid services of the Greater Manchester Combined Authority, and it is in that role that I have joint accounting responsibilities for the transformation fund that was negotiated for Greater Manchester health and devolution.

Steve Wilson: I am Steve Wilson. I am executive lead for finance and investment at the Greater Manchester Health and Social Care Partnership.

Nicky O'Connor: Good morning. I am Nicky O'Connor. I am the chief operating officer for the Greater Manchester Health and Social Care Partnership.

Q225 **The Chairman:** Let me kick off with the first question. We know that there is a devolution of health and social care to the Manchester area. This Committee is about the long-term sustainability of health and social care beyond 2025/2030, so the first question is: do you think the model of health and social care devolved to Manchester is the way forward in sustaining health and social care in the long term? How would we measure the success of that, and what happens if you fail?

Sir Howard Bernstein: When you start to address the requirement for place-based approaches to integrating health and social care services, it is inevitable that it can only be done at the locality level. All previous attempts through traditional national improvement programmes have, in my view, largely failed, so the whole question of fiscal and clinical sustainability is a fundamental part of how you develop locality

approaches. The whole approach in Greater Manchester has been to work through what works at the locality level and, more particularly, what works at GM level: what things you need to commission once rather than, in our case, 10 times. The overarching framework that we have developed gives us confidence that we are very much on the right lines on a whole range of programmes, which I am sure we can talk through as we go along.

I would identify two “buts” to this. One is that it has to be place based, not organisationally based, and it has to be how you place health and social care as part of the wider reform of public services underpinned by early help and early intervention. That is what we have been doing in Greater Manchester for some time. The other “but” is that you have to have the robust and mature partnerships to be able to deliver also at leadership level the scale of programmes that we are talking about.

The Chairman: Can you give us a picture of where you think social care, for example, is just now, what it looks like, and where you will be in 15 years’ time on the delivery of social care?

Sir Howard Bernstein: On social care in Manchester, one of the three pillars of our locality plans is single commissioning, a new independent care organisation and a single Manchester hospital service—priorities you could talk to anyone in Manchester about for the last 10 years. They have been identified as clear priorities for delivery, and within four or so months of devolution we are well on the way to establishing those priorities.

Social care, therefore, will form part of our independent care organisation, to be followed in 12 months’ time by our children’s services. We are seeking to join up community services with social care, mental health and primary care in order to provide the integrated offer that is necessary not only to support a transformation in our population’s health through prevention and early intervention but in effect to reduce the demand for services in our hospitals. That is how we see this strategy. Of course, there are particular pressures in social care at the moment, which I am sure Steve can take you through.

The Chairman: To answer my question, where do you think you are just now, and where will you be in 15 years in the delivery of social care?

Steve Wilson: In the wider sense, the devolution platform has been a real enabler for making change happen locally, which is about integrating social care, healthcare, physical health and mental health care within localities and communities. Within the 10 localities across Greater Manchester, there are individual plans to deliver that. The original plan for Greater Manchester to close the financial and clinical sustainability gap over the next five years was based on social care funding being protected. There is a risk to delivering those plans at the moment because we have a gap of about £176 million at the end of our five-year planning period for delivering social care. There is a real risk in that, because the transformation that we need to deliver over the coming five

years will be the key to that vision in 15 years' time of social care integrated with mental and physical healthcare.

The Chairman: My two subsidiary questions earlier on were: how will we know what success will look like, and what will happen if you fail? What happens to your five-year plan if you cannot deliver it in the first five years?

Steve Wilson: I think the risk is that, unless we are able to use the transformation funding that we have available in Greater Manchester at the moment to transform services now—that is what all our local plans and our submissions to our local transformation fund are all about—we will not be able to deliver those integrated services of the future that will deliver clinically and financially-sustainable services for the 10 localities within Greater Manchester. Success looks like a system that is clinically and financially sustainable over the medium and long term, and that is what we are using the transformation fund to deliver, but there will be real challenges in delivering that.

Baroness Blackstone: Is that understood by NHS England, the Department of Health and, indeed, the Treasury? A huge amount hangs on this. It is, in a sense, a kind of pilot for what the future might look like, or you could describe yourselves as a role model for other big metropolitan authorities taking a similar approach to the one that you are taking. Are you communicating with these people at the centre who hold the purse strings?

Sir Howard Bernstein: Yes. Jon Rouse, who is the chief officer for delegation, Lord Peter Smith, who chairs the Health and Social Care Partnership, and I wrote a joint letter to the Secretary of State for Health, copied to the Chancellor and elsewhere, particularly to Simon Stevens, explaining our particular challenges in social care funding, which, unless resolved, will gnaw away at our capability to create the sustainable funding platform that we have committed ourselves to within the next five years.

The Chairman: Was this a private communication?

Sir Howard Bernstein: No.

The Chairman: Can you supply us with a copy?

Sir Howard Bernstein: Certainly.

Baroness Blackstone: Can you demonstrate what the long-term savings might be if you have adequate funding for social care? Presumably, there will be substantial savings in relation to NHS funding for hospitals with geriatric wards?

Sir Howard Bernstein: Yes, exactly.

Baroness Blackstone: You can demonstrate that, can you?

Steve Wilson: Yes. Our financial strategy over the next five years demonstrates that, and that was set out before STPs came along. We presented our Taking Charge financial strategy in December 2015, which identified a gap of around £2 billion for Greater Manchester health and social care. We have identified solutions, which will not be easy to deliver, but they will, through the transformation activities we have described, release efficiencies across the system. They will move care closer to home and they will build care around the patient in integrated local services, which will deliver about £880 million of savings across the system. That, combined with the extra income that we are getting through our share of the £8 billion investment plus some social care precept funding and better care funding, will close most of that gap and, with the protection of social care, would present a strategy that enabled us to close the financial gap.

Baroness Redfern: Is that embedded in the STP?

Sir Howard Bernstein: Yes.

Steve Wilson: Yes.

Q226 **Baroness Redfern:** There will be savings from your acute sector that will be moved into health and social care across those 10 localities. Are the CCGs also picking that up, and are they in agreement with that?

Steve Wilson: Yes. All our 10 localities have their own locality plan. That is shared between health commissioners, local authority commissioners, as a single commissioner for health and social care, and all the providers within those localities: the acute provider, the community service provider and mental health provider. They are all signed up to those locality plans. It is those locality plans, working with some of the additional savings that we can lever across the whole of Greater Manchester, as Howard said delivering local savings and looking at things that need to be delivered pan-GM around standardising approaches and particularly around acute services, where they will deliver those savings, if they are delivered. None of that is easy, and devolution is not a magic bullet that enables that to happen, but it is enabling the conversation to happen through a place-based approach, with all parts of the local economy working together rather than individual organisations.

Baroness Redfern: Would you have more flexibility if you had fewer locality plans so that you could integrate across?

Sir Howard Bernstein: The fact that we are working within 10 local authority areas is important.

Baroness Redfern: I know that local authorities do work together sometimes.

Sir Howard Bernstein: Exactly right, which is why, for example, within the Pennine footprint area, you will see Oldham, Rochdale and Bury particularly working in commissioning together.

The Chairman: Are the leaders in the acute sector in agreement that they could deliver these savings to you?

Steve Wilson: The locality plans that are submitted are signed up to collectively by all the leaders—by providers and commissioners. They form the basis of the bids for the transformation fund to do the enabling work to make that happen, to pump-prime and to double-run services so that that can shift.

- Q227 **Lord Willis of Knaresborough:** The complex organisation of 12 clinical commissioning groups is not of your making. Do you have plans to apply for those to be made into one commissioning group, and how quickly does that need to happen?

The Chairman: A quick answer, please.

Sir Howard Bernstein: In Manchester, we have three and are moving to one voluntarily. All three commissioning groups have agreed that in order to underpin our single commissioning arrangements they need to become a single commissioning focus. We will be doing some work with our commissioning colleagues over the coming months to do a further analysis of the overall effectiveness of commissioning arrangements. My view, without pre-empting the outcome of that work, is that there will be fewer commissioners. Whether or not we want to move to a single commissioning group for the whole of Greater Manchester is not something that I think we could support, certainly at this time, but I think that the trend towards integrating commissioning will mean fewer commissioning foci.

- Q228 **Lord Bradley:** I am pleased to hear that the locality plans are based not only on the integration of health and social care but on physical and mental care, but is there a tension between what you are trying to achieve through devolution and controls that are put on you from central government regarding financial and efficiency savings that you need to make through the acute sector, which makes the transfer of money in the social care system more difficult? Have you profiled that shortfall in social care over the planning period of five years, and are you planning how that integration and the financial underpinning of it over the longer term leads to a sustainable position for Greater Manchester?

Steve Wilson: The social care gap that remains in our plans is profiled across the individual localities and over those periods. There are a number of things that we would seek to get more flexibility on as we move into 2017-18, and some of that relates to some of the business rules operated by NHS England and NHS Improvement. It is not enormously significant, but, taking a reasonably evolutionary approach to that, there are things we would want to ask for in 2017-18, such as flexibility in control totals for foundation trusts and NHS trusts and between providers and commissioners, and how we can look at Greater Manchester as a whole. A lot of that is doable within the current system. We just need to ask.

Lord Bradley: That is clear?

Steve Wilson: It is all based on a system control total, which is the way business rules are evolving; it is not about looking at individual organisations in isolation. I think we are ahead of others in the way we are looking at that. The locality plans are a good example of that, and we offer ourselves as a test bed nationally to do that sort of work.

Sir Howard Bernstein: When we did the devolution agreement and the delegation instrument, which was executed on 1 April, it was always intended that there would be regular reviews of those arrangements. We are at a point, as Steve has said, where we want to start engaging our colleagues at NHS England about the next iteration of that agreement in order to improve efficiency and to deliver the flexibility the team needs to manage both performance and finance.

Lord Bradley: Are you able to start planning 10 or 15 years down the line, or are you very much concentrating on getting sustainability and some transformation over the next three or four years?

Sir Howard Bernstein: It is three or four years. Certainly that is where our primary focus is.

Q229 **Lord Willis of Knaresborough:** Can I come on to the workforce? I am very excited by the Manchester proposals; I think there is a huge opportunity here. What worries me is that the workforce arrangements and working practices, which tend to be silo-based and focused very much on individual professions, are very hard to shift. What advantage do you feel the Manchester model has in effectively planning for the workforce of 10 or 15 years ahead? In particular, where are the system barriers to changing the workforce and its practices that we could point up in our report?

Nicky O'Connor: There are probably three advantages in our current arrangements. We have clarity of ambition through our Greater Manchester strategic plan, which enables the 10 localities to plan their workforce needs around that ambition, which we can then aggregate up, as we need to, at a Greater Manchester level. We have clarity about our operational requirements, which enables us to have Greater Manchester-wide recruitment campaigns for shortage specialities. At the moment, we have some work going on around urgent and emergency care consultants particularly, which is a shortage speciality across the country, and we can use the aggregated power of all the Greater Manchester authorities to do that. We are also able to use our funding to create apprentice roles, nurse associate roles, et cetera. We also have a single leadership board on the workforce, which is chaired by one of our acute sector chief executives but has health and social care senior representatives on it. We are in discussion with Health Education England about devolving the resources from them to a Greater Manchester level so that we can use that to plan our workforce for the future on a locality and Greater Manchester basis.

Potentially, some of the risks that we have are to do with the reductions in health education funding coming forward—these are risks to Greater

Manchester as well as to other parts of the country—but the power that we have between us probably enables us to mitigate those risks, unlike perhaps in other places. One of our plans is to create a centre of excellence that brings together the university sector in Greater Manchester, all the employers, Skills for Care and Skills for Health in one place so that we can plan our workforce for the future with all that knowledge and skill around the table.

Sir Howard Bernstein: Can I add one particular point, which Nicky has mentioned, which relates to the whole culture? What we are seeing, interestingly—not at the front line as much nowadays, because front-line workers see the frailties and the inadequacies of the existing system on a day-by-day basis—is huge excitement, I think, across the public sector for the sort of cultural and organisational development process that is required to get us to start working as integrated teams. It has not been easy in the NHS, but I think it will become a lot easier at the front line.

What we have to do, and Nicky is part of that, is create the leadership structures that will be seen to drive that cultural change. That is a particular focus of mine in Manchester at the moment with the new independent care organisation; we are looking to put so many different services together, working in a holistic, focused and targeted away in all parts of Manchester, which is a big cultural as well as organisational development.

Lord Willis of Knaresborough: You have an ability, given your population size and budget, to develop a bespoke workforce for your population. Are there any barriers to your creating new roles and being able to develop those specialisms within an integrated sector?

Sir Howard Bernstein: We are looking at that. We do not want home care or social care; we want care assistants. We want to address how we introduce apprenticeships as part of the developing nature of wider health and social care provision. We have a fantastic working relationship with our trade union staff representatives, who are working with us in similar ways. Of course, there are constraints. I want to see a greater level of devolution to Greater Manchester to enable us to plan more effectively for the skills requirements we have within our services over the next five years.

Lord Willis of Knaresborough: Devolution of what?

Sir Howard Bernstein: Health education spend. They spend, I think, £70 million to 80 million, from memory, or is it less than that now?

Nicky O'Connor: The totality of the budget for Greater Manchester, which includes the medical and dental education budget, is £271 million.

Lord Willis of Knaresborough: Is most of that on medics?

Nicky O'Connor: Probably about half of it is on medical and dental education.

Sir Howard Bernstein: Building on our key assets of Manchester University, Manchester Metropolitan and our colleges of further education, we have the capability to develop very integrated and strong pathways that are very much linked to all our institutions in Greater Manchester, which is what we want the ability to do.

Nicky O'Connor: On the cultural aspects of where Greater Manchester has got to, one thing that I have been very struck by is how we have integrated the GP workforce into everything that we do. That has been a powerful voice to help us in all our efforts, and particularly around workforce models for the future. We also have a greater ability to grow our own workforce, which has significant social benefits alongside benefits to the NHS and social care system in terms of getting people back into work.

Q230 **Lord Ribeiro:** One of the things that has come out of the STPs so far is the lack of engagement of patients and clinicians in the process early on. Clearly, you came ahead of STPs, and I would like to think that you did that, but one of the things that concerns me about how you are going to organise your training programmes for doctors, et cetera, is that currently these are at a national level and placements are usually done on a national basis. How are you going to make this work for you in Manchester, mindful of the national profile of training research?

Lord Willis of Knaresborough: People may need to move.

Sir Howard Bernstein: We want to be co-commissioners. It is the same sort of arrangement, I think, that is in our minds, and it is not about where we will assume direct responsibility for every penny. We want the ability at a place level to join up with Health Education England and say, "These are the particular posts and skills that need to be provided in Greater Manchester over the next five years or so. How do we secure support and co-operation to deliver those skills outcomes, and how can we help you by organising our education and skills provider sector in Greater Manchester to support those outcomes?" Rather than a national delivery model, which is almost blind to place, we are saying that we want a clearer focus on place through a co-commissioning model with Health Education England.

Professor Kieran Walshe: We all know that the history of Health Education England is relatively recent and that the hollowing out of regional governance in the NHS as a result of the Health and Social Care Act 2012 has created, in many ways, the fiscal and financial crisis and the governance crisis in the NHS that you now see playing out in STPs. What is most interesting about health and social care devolution in Greater Manchester is that it is providing an opportunity partly to reinvent some structures that existed in the past—the North West Deanery, the Greater Manchester Workforce Development Confederation and things like that, but what is really different is the engagement and the role of local government.

Baroness Redfern: Nicky, can you give me a workforce example of

sharing back-office staff? Have you started with that, or where are you?

Nicky O'Connor: Absolutely. Perhaps my colleague would be best to answer that in the first instance.

Baroness Redfern: Your faces lit up when I asked that.

Steve Wilson: One of our transformational themes relates to clinical support services and the corporate function, and there is a whole piece of work going on on a number of different work streams. On the clinical support service side, work is being done on radiology, pathology and pharmacy services across Greater Manchester, led by individuals within organisations on behalf of Greater Manchester, and how can we best deliver those support functions.

Baroness Redfern: Are you working with other local authorities or other organisations not just within the NHS?

Steve Wilson: Absolutely. Particularly on the clinical side, obviously there is more focus on the NHS. On the corporate support side, we are looking at working across health and social care. All that is happening already at a local level. We are seeing social care commissioning coming together with local authority commissioning, but there is a whole extra tier we can look at in Greater Manchester. We now have a Greater Manchester support service that delivers all the business and back-office support for CCGs, and we want to see how that can work with what is coming out of the work done by the combined authority and what comes out of the local authorities. We have a particular focus on things like IM&T and estates, where there is such an additional benefit in working across not just social care but wider government. We have examples on estates in Wigan where you have the co-location of PCSOs with healthcare services, which is not only delivering a better service but is much more efficient, because you can utilise buildings better. So getting the right level of shared function across GM for corporate functions and clinical support is absolutely key.

Baroness Redfern: So you will save a substantial amount of money, will you?

Steve Wilson: An element of savings will be delivered through that, yes.

Baroness Redfern: Revenue and capital?

Steve Wilson: Certainly revenue, and it will reduce our capital requirements. As you will know, one of the constraints on STPs is the availability of capital. One of the solutions is not finding extra access to funding but about making sure that you utilise buildings across the wider public sector.

Q231 **Bishop of Carlisle:** You have all spoken very interestingly and encouragingly about the way in which you are attempting to integrate just about everything, including health and social care, especially in localities and with good leadership and so on. Could I focus our

discussion a little on the whole issue of prevention? What difference is what you are doing making to prevention, how do you see that working out in the future, and what are the chief obstacles to it?

Sir Howard Bernstein: One of the key areas or programmes is how we radically upgrade our population health and new models of leadership for public health across Greater Manchester. We are designed to deliver a much bigger impact to reduce need at the point of crisis.

Picking up the point we have already discussed, it is also about how we develop a much stronger integrated role for early years and mental health and, crucially, make the link between health and social care services generally, how we tackle worklessness and how we integrate a comprehensive public service offer that is designed to support people and families in communities to move on. That is the whole approach that we are taking to that particular issue, which I think is very distinctive.

Bishop of Carlisle: Can you see that working in practice already, or is that still an aspiration?

Sir Howard Bernstein: We have done lots of pilots across different parts of Greater Manchester, that is true. Through that better investment and better sequencing of services in early years, we have demonstrated that we can have an impact on the lives of young people, certainly on their school readiness. Through our health and work programmes, we have seen how we are achieving far better outcomes in getting people into work than what has been delivered through traditional programmes. What we have never done, because nobody has, is attempt this at the scale that we have throughout Greater Manchester, but that is what we are determined to do and that is what we will do through each of our locality plans.

Nicky O'Connor: To illustrate that a bit, Tameside is one of our localities, and it is one of the areas that decided early on to bring health and social care together through a joint leadership structure, so the CCG and the local authority are led by the same individual. Through their preventive programmes and the integration they have managed to achieve, they have already reduced their teenage pregnancy rate by half, which was very high in that particular borough. They have also had reductions in infant mortality, they have really good rates of immunisation, and their healthy life expectancy has already improved by 2.2 years over the last year or so just through the preventive work that they have been able to focus on.

Bishop of Carlisle: For you, what are the chief obstacles to continuing down this track?

Sir Howard Bernstein: The social care spend must be a constraint, if we are being frank. We will not be able to deliver the scale of change that we all want to deliver if we do not provide the full level of service that we need to support vulnerable members of the community. That is almost

the single biggest challenge that we face in Greater Manchester at present.

Q232 Lord McColl of Dulwich: On the preventive side, as you know we are in the middle of the worst epidemic for 97 years, the obesity epidemic. How successful are you in coping with that?

Sir Howard Bernstein: It is one of our priorities, and we will see greater awareness. We want to create a movement for social change and a much stronger capability for early help. Early intervention through our enablers, and a focus on childhood obesity in particular, will be a fundamental part of that strategy.

Professor Kieran Walshe: I would add a slight note of caution and say that it is about influencing the shape of the future demand curve and not necessarily bending it downwards. Ever since Wanless, there has been a received wisdom that doing prevention-related things will change people's future use of health services, but we also know that we not only perhaps influence people to use health services more effectively, more wisely and more economically but we uncover lots of unmet need when we do this, and you have to think hard about that.

The difference with devolution is perhaps that, traditionally, trade-offs between health and other sectors were rather difficult to make real because of the siloing of financial flows. What devolution perhaps offers is an opportunity to see those trade-offs made more real between, in the example you gave, health and worklessness. If you think about the spend in the social security budget against the spend in the health budget and the opportunities that might emerge in the future, you start to see greater place-based thinking about issues such as worklessness, health, and school readiness, which opens up opportunities that people have talked about for a long time.

Baroness Redfern: Could I just come back on Lord McColl's question about obesity? Sir Howard, you did not really answer that particular question. Have you set targets for when you want to achieve those things by, or the number?

Sir Howard Bernstein: We are currently in the development of our final population health and we have not set targets.

Baroness Redfern: So it is too early to say?

Sir Howard Bernstein: I think the report is promised early in the new year.

Nicky O'Connor: It is due in January, so we have a whole stream of work on population health and prevention, and obesity will form part of that.

Lord Kakkar: I just want to be clear about what you consider to be the limitations to the devolution settlement that you have for health and social care at the moment, and what changes you would suggest are

implemented in the overall opportunities that you are being given to overcome those limitations. If you are unable to overcome those limitations, what do you think the consequences will be for your ability to deliver on your ambitions?

Sir Howard Bernstein: The point was made earlier that the existing devolution instrument is not cast in stone; it is subject to review. Steve has already given a number of examples of how we would wish to see that devolution flexed certainly in time for next year, including co-commissioning on health education and specialist commissioning services and additional commissioning responsibilities. I think that will be important to us. The most important requirement, which I keep emphasising, but I think it is true, is a settled, stable pattern of social care spend starting from next year, because it is absolutely pivotal, in my view, to making the sorts of transformational changes that we need to make to create a sustainable system within the five-year period.

Lord Kakkar: If you were not to have devolution of the Health Education England function in a way that you could utilise effectively for what you want to achieve in workforce development, and if you did not have a stable settlement with regard to social care, would that mean that what you have projected as your current devolution settlement being the bridge to longer-term sustainability of the NHS and social care for your devolved area would not be delivered, and that in the long term it will not happen?

Sir Howard Bernstein: We have already said that very clearly. We are looking already at a difference of £190 million over the five years, and £176 million of that difference is attributable to social care spend within Greater Manchester over that five-year period. We will not be able to deliver our target of financial sustainability within the five years if that position remains.

Lord Kakkar: More broadly, workforce sustainability is another very important aspect that has been drawn to the attention of this Committee in repeated evidence sessions. Are you saying in addition that what you need to do beyond funding for social care will not be deliverable if you do not have further changes to your devolution settlement?

Sir Howard Bernstein: I would not go so far as to say that we would not make significant progress, given the enormous commitment of staff throughout the system to make this work—and I really mean that. I think it would be harder. It is more to do with the cultural requirements that are needed—not just at the front line, I hasten to add, but at the leadership levels and senior management levels within organisations. Being able to create the right sort of template for training for the skills that we need in Greater Manchester and the reform programmes that we are delivering is, I think, a massive part of the challenge that we have to face.

Lord Kakkar: Just to be clear about your view with regard to regulation more generally and the multiple regulators that you have to deal with, do

you believe that there are any changes that would be required to ensure that the approach that you mentioned—place-based care—would be better delivered with some changes, and are there limitations in that area?

Sir Howard Bernstein: Steve can come in in a minute, but I would place on record the co-operation that we have received from NHS Improvement and the CQC. NHS Improvement has the senior relationship manager, we are working with Nicky, Steve and John in their team day by day, and I think other agencies have promised the same. I think everyone is starting to recognise the significance of a place-based system approach. The particular task we have to perform, and we show all the signs of being able to deliver this, is how we integrate the functional responsibilities of NHS Improvement as part of our transformation plan without necessarily undermining the legitimacy of discharging separate statutory responsibilities. There is a balance to be struck there, but I think that so far we are very comfortable with the way that balance has been struck.

Steve Wilson: I would echo that. We are on a journey and I think those relationships will need to evolve, but at the moment, within the current national structures for NHS Improvement for example, we are able to create a place-based approach.

On the issue of locality assurance, we now have a single assurance meeting, so it is not NHS Improvement having an assurance meeting with an FT or NHS England having an assurance meeting with a CCG; we have a single assurance meeting. On our side of the table, if you like, we have NHS Improvement representatives, and, as Howard said, one of our senior management team is embedded from NHS Improvement. On the locality side, they will have the local authority, the CCG and one or two local providers, a mental health provider and a physical health provider. We are doing all that within the current structures and the current national requirements.

As we go forward, they will need to evolve, but what we are doing on locality assurance is likely to be followed by most other areas, because, as we said right at the start, the only real way to deliver the challenge ahead is to work on a place basis, and you can assure only in that way.

Lord Kakkar: Do you have any observations, fully accepting that it is working well at the moment on this journey, on how it might change, in order to make sure that, in the future, regulation does not inadvertently undermine the ability to deliver place-based care effectively, not only in your own devolution but in relation to lessons that might be learned for the rest of the country?

Sir Howard Bernstein: I think we are going to find out over the next six to nine months. A number of big transactional processes will be under way, particularly around the creation of our single hospital service. We will be very much in the detail of that in March and April next year and we will find out whether those will become fundamental constraints. We

believe not. Based on all the work and discussions that we have undertaken and all the analysis that we have produced, we believe that those transactional changes can be delivered efficiently in the way that we would want.

Professor Kieran Walshe: I would turn the question around. It is a question for government, because all that has been done so far has essentially been done without statutory change. As you said, it is a process of delegation really rather than devolution, which has some real advantages. In Greater Manchester and elsewhere, increasingly the structures and facts on the ground look less and less like the legislative provisions of the Health and Social Care Act 2012. Therefore, the question for government and Parliament will be at what point they think something needs to be done to align the statutory provisions and the legislative responsibilities, which apply and will continue to apply until they are changed to foundation trusts, to NHS trusts, to CCGs and others, to make those things fit for the present and the future.

Steve Wilson: One of the risks is whether, if individual areas hit difficulties, there is a retraction to the centre of some of things, because a lot of that is being delivered through relationships and cultural change and not embedding in statute.

Lord Kakkar: I think those are fundamental points. Beyond regulation, do you have concerns that competition law might have an impact on what you are trying to do?

Sir Howard Bernstein: In a nutshell, again we will find out the answer about our ability to navigate those processes with the development of our single hospital service over the next six months, so we will be putting all our views through the most robust tests feasible. We think we have a way through all that.

Q233 **Lord Willis of Knaresborough:** I am a little concerned—and I declare an interest as a consultant for Health Education England—that you seem to feel that there is a pot of gold in Health Education England that will resolve your staff and workforce problems. Clearly, as Lord Ribeiro has illustrated, the fact that we are delivering particularly medics and dentists, et cetera, on a GB-wide basis is a different thing, and they have no responsibility for social care. What has surprised me is the fact that you have not seemed to include the 0.5% of your payroll across the whole of Greater Manchester and your organisation, which will be massive with the training levy, as the major driver for workforce in-work development, which is currently one of the biggest problems; not the people coming in but the people who are already there who have to be transformed to deliver. Why have you not included that sum of money, which is massive as far as your training budget, rather than on Health Education England?

Nicky O'Connor: That is perhaps because we did not have a chance to cover it before.

Lord Willis of Knaresborough: This is your opportunity.

Nicky O'Connor: We are in discussion with all our organisations about how we make the best use of that training levy, because, as you quite rightly say, that is a big opportunity for us to both create and grow our workforce in the right areas. In conjunction with Health Education England, we are looking at how we can pool those budgets so that we can maximise the benefits of what we have across Greater Manchester rather than in individual organisations. This is definitely part of our plans.

Q234 **Baroness Blackstone:** In many ways, this is one of the most interesting and challenging changes to the delivery of health and social care for a very long time. I wonder whether there is an independent evaluation going on to monitor how the implementation of this is going and to identify some of the barriers that Lord Kakkar was talking about. Is somebody doing this work and, if not, why not?

Sir Howard Bernstein: There is an independent evaluation project, which is largely led by Manchester University, and there are conversations going on with Harvard and Manchester University. Harvard is very interested in the work that we are doing in Greater Manchester, because of its wider application, so I can assure you that the work will be independently validated.

Baroness Blackstone: It is happening. That is good.

The Chairman: Before I come to the last question of Lady Blackstone's, from reading the information sheets and the evidence that you have given before, the budget that is devolved to you is £6 billion, which is for a population of what size?

Nicky O'Connor: Some 2.8 million.

The Chairman: The plans have identified seven population-based outcomes, none of which is in social care or prevention health, but there are 1,300 fewer people dying from cancer, 600 fewer people dying from cardiovascular disease and from respiratory disease, et cetera. Are these targets any more ambitious than nationally the health service is required to deliver on?

Sir Howard Bernstein: When we produce all the locality plans, I think you will find that those targets will be exceeded in the context of the benefits that will be generated as a result. What we saw there, if I may say so, was an analysis about a point in time. It was before we got into the absolute detail, the fine grain of locality planning, which is generating significant additional benefits that will be captured, and we will bring that forward as part of our review of our plans in the early part of next year.

The Chairman: When do we know if you are succeeding or failing?

Sir Howard Bernstein: We are monitoring ourselves on a monthly basis. One important thing, which I do not think we have mentioned, is that when locality plans are approved and transformation funding is

provided, there will be an investment agreement between our colleagues at the Greater Manchester level and individual localities. That will bind the system in those localities to deliver certain outcomes about how the money will be used and what particular care models will be driven forward. It is through those investment agreements that we have changed or varied the accountable relationships between place and the holders of the transformation fund. I think that is possibly one of the most exciting things that we have brought forward and done.

Q235 **Baroness Blackstone:** Could you each say which key suggestion for change the Committee might want to recommend to support the sustainability of the NHS?

Sir Howard Bernstein: Funding for adult social care, really.

Professor Kieran Walshe: I would say that it is a combination of financial stability and organisational stability—so the issues I raised in relation to thinking about the legislative framework and how it serves the interests of the system rather than acting as a barrier to it and thinking about the longer-term financial stability. I think the arguments that you have heard advanced that Greater Manchester, because of the change in governance, will be better placed to respond to the financial challenge are probably true, but that does not diminish the financial challenge, which is unprecedented.

The Chairman: Thank you very much for coming today. I know that you had a fairly long journey to come and assist us today and we appreciate it very much, so thank you very much indeed.