Chair: Welcome all. Thank you for coming to give evidence to us this afternoon in our inquiry into the financial sustainability of social care and the quality of care provided. Before I come to you, I ask members of the Committee to put on record any particular interests they have of relevance to this inquiry. I am a vice-president of the Local Government Association.

David Mackintosh: I am a Northamptonshire county councillor.

Kevin Hollinrake: I employ a councillor in my office.

Helen Hayes: I also employ a councillor in my office.

Bob Blackman: I am a vice-president of the LGA.

Chair: We then come to you. Thank you for coming. Could you say who you are and the organisation that you represent?

Professor Wistow: Gerald Wistow, visiting professor at the LSE.

Jon Rouse: Jon Rouse, the chief officer of the Greater Manchester Health and Social Care Partnership.

Q198 Chair: Jon Rouse, I will begin by asking you about the situation in Manchester, which has attracted quite a lot of interest and publicity. The Committee went there a few months ago for the inquiry into devolution, because that is a particular aspect of devolution that is happening in Manchester and not many other places.

In terms of an individual—an older person—who is receiving supported help from both health and social care services in Manchester, by 2020, four years on, what benefits will they see from the greater integration of health and social care in the Manchester area?

Jon Rouse: They should be experiencing far more seamless and joined-up care than they experience today. Our starting point for that is to put the GP at the centre of that relationship again by really understanding their register and those who need help the most, and being equipped with all sorts of cool-off services that mean they can help to meet the needs of the people who have the greatest number of conditions or overall level of need. We do that by organising the other services around primary care. In North America, this is called the medical home model. Whatever we call it, it means that we need social care services, physios, OTs and other allied health professionals, district nursing, but also services that go wider than traditional health and social care—some of our local welfare services and housing—to be much more joined up around that primary relationship between the GP and the individual. Ultimately, that is our vision for what that care should look and feel like by 2021.

Q199 Chair: In other words, people do not get passed from one agency to another without each agency recognising that the other exists, which often seems to be the case.

Jon Rouse: Exactly, but also restoring the primacy and continuity of this relationship between the GP and the individual, and giving the GP enough time to proactively care for those who have the greatest needs.

Q200 Chair: That all sounds very good. Everyone in local government and the health service at present will say, “Integration? Yes, of course we are all in favour of it. Let us tick the box and say that we are doing it.” In practice, are local authorities and the NHS really working together to deliver joined-up services and to commission the services that are required?

Mark Lloyd: The honest answer is that the situation varies across the country. There are parts of the country where there is excellent good practice with councils and health bodies coming together to commission and deliver in a completely joined-up way. There are other parts of the country where the relationship is much less mature. We are trying, through our sector-led improvement work in local governments, to make sure that the best is signalled clearly and transferred across the rest of
the country. We have various guides around integration, the best one being called *Stepping Up to the Place*, which I am happy to leave with the Committee, which shares best practice with councils and health bodies in England.

**Professor Wistow:** It is absolutely right in terms of variability. We should not lose sight of the fact that we have been trying to develop better integration since at least 1960 and we still have a very chequered record. It is perhaps time for us to pause, reflect and decide whether the way in which we approach integration is the right one or whether we need to do something radically different.

Q201 **Chair:** It sometimes feels like if the chief executives of the local authority and of one of the health trusts do not get on together, nothing much happens. Is that a rather cynical view of the situation?

**Professor Wistow:** There is lots of research to say that personal relationships are immensely important. Certainly, if you have poor or untrusting relationships, or a huge turnover of staff so that they never build up those relationships, those are real problems in terms of getting through the task of integration. If you look at the model that we have adopted, we have tried to bridge two organisations—the NHS and local government—and they are two organisations that are fundamentally different. The truth about them is on the tin: one is a national organisation, centrally and hierarchically managed, that looks upwards and is not democratically accountable at the local level; the other is a local organisation that identifies with a particular place, has a range of services, is much better at horizontal relationships and does not look upwards to the same extent. Those contrasts are obviously overdrawn, but they are fundamentally the case. It is very difficult to get a horizontally and a vertically organised organisation working closely together at the local level.

Q202 **Kevin Hollinrake:** Those are the issues I would like to talk about: the barriers to that integration. You have mentioned one, which is that they are different types of organisation. Are you able to identify any other barriers that are stopping this from happening as effectively as it might?

**Jon Rouse:** There are a number of financial barriers. I will talk about money in absolute terms in a moment, but, before we even get to that, the misalignment of incentives in the system is a real issue. If you are rewarding acute hospitals for activity, you have a pull in the system that brings people into your most expensive type of care, which is acute provision. One of the things that we are therefore trying to do in Greater Manchester, through our accountable care organisations, is to make much greater use of what we call capitated or population budgets, whereby an organisation has to take responsibility for the overall health of the population from within a particular budget, rather than for example rewarding people for more non-elective admissions when that is the very thing that we are trying to reduce through good care in the community.
On the absolute money barrier, the deal that we did at the time of the last spending review in Greater Manchester had four planks to it, two of which NHS England met: they gave us transformation resources and front-end loaded it. We remain very grateful for that; it gives us a better chance than most. However, the other two planks were not solved: access to capital, because you have to invest in estates and digital if you want to move services around; and, most critically, the protection of the baseline for social care funding was not settled. We know in Greater Manchester how to deal with the NHS gap over the next four to five years, but we do not know how to close the social care funding gap.

**Mark Lloyd:** In terms of the challenges—and my fellow speakers have done a neat job of setting out some of them—from our perspective in the LGA they come down to: leadership and governance; the cultural differences that we have just heard about; regulatory and performance frameworks; outcome frameworks; payment systems, which have been touched upon; and information sharing.

I cannot resist the opportunity to build on Jon Rouse’s comments about the financial challenges. Local government, along with colleagues in the NHS, the health think-tanks, the provider network and charities, strongly believes that the oversight with regard to delivering extra funding to adult social care in the autumn statement last week was a mistake. It is an issue that we hope to come back to as we head to the local government finance settlement, probably next week.

**Professor Wistow:** When we were carrying out the early evaluation of the pioneers, one of the findings we produced was that, just at the time that it is more important for organisations to work together, the very conditions that make it necessary for them to work together, such as resource scarcity, also drive them apart. Unless you have the sort of mature relationships that you were talking about, the great incentives are to shunt the costs on to another organisation and argue about who is or is not responsible for particular parts of the care system. We talked about this integration paradox where, at the very moment that you need more integration in order to sustain the system, some of the incentives shift and make it more difficult to carry it through.

Q203 **Kevin Hollinrake:** Back to Mr Lloyd’s point about the funding challenges, to be clear, were you expecting more money in the autumn statement?

**Mark Lloyd:** The case is overwhelming. There is a crisis in social care, which the nation needs to address. The Local Government Association has assessed the financial challenges facing councils across the whole range of services through to 2019-2020. The deficit baked into their resources is £5.8 billion, of which £1.8 billion is children’s services and £1.3 billion is adult social care. It is a lesser number because we have factored in the councils’ ability to raise their precept, which takes some of the edge off. We have built that into our modelling.

That £5.8 billion assumes that everything is okay today, and it is not. If we were to even meet the fair funding criteria for care today, we would
need to add another £1.3 billion into the social care system. The foundations are therefore not solid and the future looks grim unless we get an injection of further resources.

**Q204 Kevin Hollinrake:** The former Secretary of State, at the time of the announcements of the precept and the Government investment of an extra £1.5 billion, took the position that they had given you everything you asked for. Is that not correct?

**Mark Lloyd:** The LGA, in the lead-up to the spending review, offered up a very conservative minimum intervention, necessary just to stop the system from falling over at that particular point. You are right that the Secretary of State made a commitment of £3.5 billion. That is made up of £2 billion through councils’ ability to exercise precept, and 144 of 152 councils exercised that precept this year, which raised £380 million towards the funding challenges that we have. It is optimistic to assume that it will generate £2 billion into the system.

Of the £1.5 billion balance that you referred to, £800 million is a redistribution of money within councils; it is the new homes bonus being redistributed. There is £700 million of extra resources. There is a desperate need for national action to inject further money. If you simply say to councils, “You can raise further money through increasing your precepting ability”, for those councils that it benefits the most, it will generate 2.1% of their adult social care budget. For those councils that it benefits the least, it will generate 0.6% of their adult social care budget. It is not distributed fairly across the country, because of councils’ different tax bases. We think there is a need for national action, yes.

**Jon Rouse:** Can I bring that to life? Greater Manchester is one of the areas where the precept is not a significant assist to us because of the low council tax base in most of the districts. Casting ahead to next year, we have budget pressures, just from national minimum wage increases, our living wage, demographic changes and an increase in pay and prices, of £55 million. We get from the precept and the extra better care fund resources, of which there is very little next year, £19.3 million. That gives you some idea of the gap that we are trying to find ways of filling. At the moment, this year, we are filling it mainly through reserves and underspends, but that of course cannot go on forever.

**Q205 David Mackintosh:** You talked about some authorities that have not taken up the offer of raising the precept. Is there any indication as to why they have not?

**Mark Lloyd:** Again, there is not one answer to that question—144 of 152 did, so that is the headline point. Those that did not may find themselves in a slightly different financial position. They may have made decisions about the basic council tax increase rather than the social care precept increase; they may have found themselves at a particular point in an electoral cycle that meant it was not a decision that they felt able to take at that particular moment. There will not be one answer.

**Q206 Kevin Hollinrake:** In terms of what we have learned from some of the
different pilots and models—integrated care pilots, integrated care pioneers and new care models—how are we going to distil the evidence and outcomes of those, learn from them and share them out more widely?

**Professor Wistow:** An important point that we have not learned, but need to, is how complex a task this is, and that the lead-in time is more substantial than we allow. If you look at the current policy round, it started in 2013 with the launch of the pioneer programme. The objective was for integrated care to be the norm, the ordinary way of doing things, throughout the country in five years; and there is no hope of that being the case. There are all kinds of reasons as to why that may not be the case, which may be particularly relevant to this period of time in terms of expenditure and other issues.

Broadly speaking, to be able to achieve large-scale cultural and systems change, you are looking at a minimum of five, and probably 10, years. If we set people unrealistic goals, we are almost setting them up to fail, at least by the terms of the policies that they have been asked to respond to.

That is a really important lesson for us to learn, and it applies just as much to the vanguards and the STPs. The nature of the task that they are being asked to engage in and the rapidity with which the policy agenda changes make it very difficult for people at the local level to get down, work, find new ways of working and embed those new ways of working before the next initiative comes along.

**Q207 Kevin Hollinrake:** It is an iterative process, isn’t it? There will be some early learning, with some people doing things well and other people doing things not so well. If you are constantly evaluating it, you have more chance of refining this into a model that works. One of the examples we have is Rutland Council, which has gone very well and is more or less on target with what the Government expected: a 3% reduction in A&E admissions. Is there an opportunity here to learn all the time and try to form thinking across the council network?

**Jon Rouse:** Yes, that is exactly our experience. Within Greater Manchester, we can learn from outside, but we have 10 districts. Wigan have been very advanced on this for years and have achieved a 5% reduction in non-elective admissions, while the national average has been a 9% increase. They have done that by embedding the Wigan deal, using an asset-based approach at the community level and really working very hard to change the nature of expectation of individuals away from a dependency relationship, towards one where they take more responsibility for their own health. One of the other products of that is that people in Wigan now live longer. They have in fact had the most significant decrease in mortality and morbidity rates in the country.

However, that has been hard-won. I want to back up Professor Wistow’s point that Wigan have been at this for five years. Sam Everington in Tower Hamlets probably has the best proactive primary care model in the
country. They have been working at that for 10 years. This is deep cultural change that we are embarked on, in order to get those sorts of benefits.

Q208 Kevin Hollinrake: The question around this is how you distil and then emanate that information across the country and not just in terms of Greater Manchester. Is there a mechanism for that?

Professor Wistow: There are quite a lot of mechanisms. Mark referred to some work that the LGA is doing at the moment, which is really important. We should not overestimate the extent to which things that work in one place naturally and fully transfer to other places, because the environment is often very different. If you have too ready an expectation that you can transfer a ready-made product that can be simply be locked into another system of care, that can be a bit of a misleading approach. It requires a bit more skill and subtlety to adapt and change in order to make change relevant to particular circumstances.

Mark Lloyd: To supplement that, we find ourselves in an unusual situation where bodies from the NHS and local government—so the NHS Confederation, NHS commissioners, together with the Local Government Association, or LGA, and the Association of Directors of Adult Social Services—have come together to capture what good looks like. We have shared this model. We have also developed a tool to help areas to move towards integration. There is no shortage of evidence about what works and how to share it. We then need to help areas make the step to the implementation in the way that we see it.

Q209 Kevin Hollinrake: What is that document called, for the record?

Mark Lloyd: Stepping Up to the Place.

Q210 Chair: We talked about the very big differences between the NHS and local government: one is national and one is local. Can you really get joined-up local integration, when NHS England has such an influence from the national level on what happens at the local level in the NHS?

Jon Rouse: In Greater Manchester, it is very different. I am employed by NHS England, but my accountability is to the partnership board. Every month, I have to give an account across finance, quality, system performance and the transformation journey, and we have a very clear assurance framework in which I do that. We have other mechanisms that help us in terms of governance and a clear accountability agreement with the national bodies that is only triggered when we fall below certain thresholds. Apart from that, they really let us get on with that place-based approach.

Q211 Chair: You are unusual, aren’t you?

Jon Rouse: We are, but, while it is early and we need to see what happens over time, there may be some clues there as to how you start joining things up at an STP level.
Mark Lloyd: The NHS’s adoption, on the back of the five-year forward view, of sustainability and transformation plans, or STPs—forgive all the titles—

Chair: We will come on to all those in detail later on, but yes.

Mark Lloyd: That is a symbol that our colleagues in the world of the NHS nationally recognise the wonderful contribution that local government makes at the community level and the tricks that it has pulled off to balance the budgets year upon year, and are trying to find a way of bringing those two sides together more effectively. I would like to talk more about STPs.

Professor Wistow: I absolutely endorse what Mark has just said about the record of local government in terms of managing the money and the potential lessons for the NHS. I can understand why they might want to look more closely at some local government practices. I am sorry if I sound a bit negative in this, but it is important that we remember what Jon just said about Manchester being different, and that in most parts of the country the amount of space that local leaders have to do their own deals is much more restricted. In those circumstances, a local organisation runs up against, as well as across, a national organisation.

Q212 Julian Knight: I want to drill down a bit in terms of measuring integration. Mr Lloyd, you spoke a moment ago about what good looks like and the 10 years taken to get this right. At this early stage, I wonder what precisely you are looking at. What indicators and measures are you using to see whether integration is progressing?

Jon Rouse: First, we have a balance scorecard, which I should send to you. We look at it every month, and it looks across outcomes, quality, finance, system performance and transformation. We should send you that. To give you a flavour of the types of metrics it has in there, it obviously has things like levels of non-elective admissions; readmission rates back into hospital, because if you have high readmission rates then that is a sign of poor rehabilitative services; the number of people who are dying in the place of their choice, which is a really good indicator of an integrated system that is abiding by people’s wishes; delayed transfers of care; people’s experiences of their GPs and primary care services and their ability to get a GP appointment in good time. Those are the types of indicators we have in there.

Professor Wistow: The Department of Health has commissioned quite a lot of evaluative activity. It has commissioned both an early evaluation and a long-term evaluation of the pioneer programme, and I should declare an interest as part of the team that is involved in that. It has commissioned an evaluation of the better care programme, and again I am involved in that. There is also a lot of evaluation commissioned under the new models of care programme and the vanguards. A lot of that is local, but there is going to be a national evaluation as well. There will also be a national evaluation of the integrated personal commissioning programme.
You have a lot of national evaluation that cuts right across the system, so there are opportunities to learn. The pioneer programme will run for about six years overall, which is very unusual in terms of a government evaluation. It is really the first time that we have had to take sustained and long-term look at how a policy in the field of integration beds down. A lot of the work that I have been involved with previously in national initiatives has been for two or three years at most, so that is important.

The other point that I want to make about evaluation and monitoring is that it depends upon what your objectives are. That dictates what it is that you are monitoring and evaluating. In the case of integration, it is important to remember that integration is a means to an end, and that the ends can be quite different. For example, the ends can be about ensuring that people have a much smoother experience of care; rebalancing investment between the acute sector, primary, community and social care; or promoting health and wellbeing, which involves a much wider range of organisations, as it is a much wider systems-based approach.

When you ask, “What are the objectives?” or, “How is it being evaluated?”, a lot of the evaluation is focused on the first of those objectives, the importance of getting joined-up seamless care, as we call it, and rather less on the wider systems change. If we are to make big transformations to the way in which our systems operate and really have an impact upon the number of people who go into institutional services because there is no alternative, we need to be thinking in a much broader way. Again, I am bound to say that that is exactly what the Manchester approach is.

**Mark Lloyd:** That is absolutely right. We need to make sure that we are looking at the wider determinants of health, not just focusing on health and social care. You are getting deafening agreement from your panel this afternoon. The overall goal is of course to ensure that services are organised and delivered to get the best possible health and wellbeing outcome for the individual. It is not about the institutions. We should hold on to that.

Mr Rouse talked about the measures that we are using at the moment to measure. He is right. Within the better care fund, we explicitly talk about issues around delayed transfers of care as one of the measures, as Mr Rouse mentioned. It is important to put on the record that delayed transfers of care are at the moment becoming a proxy for the funding crisis in social care. Not all delayed transfers of care are down to the social care system. In fact, I made sure that I dug out the most recent stats on this, and just a fraction over one-third of delayed transfers of care are down to failings in the social care system.

**Julian Knight:** I can buy that, effectively, it is in the round, but in terms of trying to hook on to something, what can we expect to see move first? What is the thing about which we can say, “Okay, we can see an improvement in this particular area”?
Jon Rouse: Readmissions are a really good lead early indicator of whether an integrated system is beginning to take effect because, putting aside the problems with delayed discharges, and they are significant, when a team gets somebody home—whether into a care home or into their own home—whether they operate together properly as a team will be the biggest determinant of whether that person ends up coming back to hospital, beyond any underlying medical conditions, obviously. All the evidence suggests that if you get that integrated team working right, you will see a significant reduction in your readmissions rate. I would expect that, as an early sign of an integrated system beginning to take effect and make a difference, you would see a reduction in unnecessary readmissions.

Q214 Julian Knight: Would you agree with that?

Professor Wistow: Yes, readmission is the absolute key. You probably know the quote from Joe Biden, who said, “Do not tell me what you value. Show me your budget and I will tell you what you value.” One of the issues that we have not sufficiently carefully monitored or acted upon is whether we are changing the balance of investment between different kinds of activities. In practice, successive Governments have advocated more priority for primary care, community services and social care, but those priorities are not reflected in the figures. Some much more intensive monitoring of the balance of investment, understanding what that means and following it up would be both an early indicator of the success or failure of integrated care, and something that you could begin to focus on and deal with.

Q215 David Mackintosh: Does closer working between the NHS and social care partners lead to reductions in costs and better patient and carer outcomes?

Jon Rouse: All the evidence, not just here but from abroad, is that if done well it can lead to a higher quality of patient experience and potentially contribute to a better outcome as well. The jury is out in terms of whether it will save the level of money that we hope it does. The jury is out for a really good reason, which is that very few places have done systemic, place-based integration over a long enough period of time to know whether that is true, which is why the Greater Manchester experiment is such an important test and why it is being watched both nationally and internationally. Just a couple of weeks ago we had a team from Harvard across, because they are as interested as we are in whether this can make a financial as well as a qualitative difference, and whether it can shift long-term health outcomes.

One of the reasons why we do not know the answer to that question is that, in order to take money out of the system, it is not only a case of investing in community services; you have to achieve real cashable cost savings in the acute sector. That is incredibly hard to do because that is people and beds—that is what it means—or at least assets and infrastructure, in order to take out savings. You have to shift care over time from acute and into the community. If you do not do that, it cannot
save money. You do that by reducing demand for those services, which means that it is then safe to turn down some of that supply. You have to choose really carefully which of those services in which locations you turn down in terms of the supply. That is why it is so hard, because it has to lead to reduced costs within the acute system.

**Mark Lloyd:** To supplement that, we have been doing some work on the exact points that Mr Rouse described in a number of councils. The research, which we are happy to share with you, shows that, if decisions are made in a timely manner by the right provider and people are put on the right pathways at an earlier point, it can deliver efficiency savings in the system of something like 10%. That of course needs extracting from the system as a cashable saving, and that is where the real challenge lies.

The largest area for savings is in avoiding admissions to acute hospital, and our research shows that something like 26% of acute hospital admissions could have been avoided if people had been put on the right care pathway earlier. The evidence is saying that this works if you integrate, but my colleagues are right that we then need to get to the point of proving that we can take cash out of the system.

**Professor Wistow:** To add one other point, which is implicit in what Jon said, the methodologies we use tend to focus on evaluating individual initiatives as a proxy, in effect, for trying to establish whether systemic change will produce better outcomes and save costs. By definition, you are not going to do that. You will say something about the contribution of an individual intervention to a system, but you will not be saying very much about the system as a whole, and you will not necessarily have information that gives you sufficient confidence to know whether, in a different system with a different set of services, that intervention would make the same contribution.

**Jon Rouse:** One of the things that is so undermining about the reductions in social care finance, in terms of the integration objectives, is the knock-on effect on the NHS’s cost base. The research suggests that, for every pound you take out of social care, there is a 25 to 35 pence impact on the NHS in terms of them picking up additional costs. At the same time that you are trying to reduce costs and pressures on the system, you have this additional pressure coming because of the underfunding of social care.

**David Mackintosh:** Following up on that, you talked about people coming to Greater Manchester to look at what is happening and the LGA taking a very keen interest. I certainly know that, in my constituency, my local authority is looking very closely at what is happening. Do you have a process in place to share that information with both local authorities and also central Government that is set up and designed to disseminate it to people?

**Jon Rouse:** We need to do more than we are doing; that is the first thing to say. We have a very live website and social media presence where we
put all our documents. We aim to be really transparent in the way that we go about our work. I gave a webcast six-month review on Friday. That report, on our first six months of devolution, will be available on the website in the next few days and we can send that to you. We have bilateral visits, because we can learn from counterparties as well. Recently we hosted Suffolk and we are planning visits with Glasgow and south-east London, so we certainly do that.

I am sure that we could do more in terms of disseminating our learning, because we are going to get things wrong as well as right, and there are things that we are not doing that other people are doing brilliantly. If you want to look at integrated mental health crisis care, do not come to Greater Manchester, because we are not that good at it. Go to Bradford; they are fantastic.

Q217 **David Mackintosh:** I would ask the same question to the LGA, but there is an issue that we have uncovered as we have looked at different types of authorities, particularly with devolution. Greater Manchester is a series of unitary authorities. In areas like mine where there are two-tier authorities, there is an extra pressure on trying to work together. How can you take the learning from Greater Manchester and filter it to help other types of authorities to learn from it?

**Mark Lloyd:** We are a collaborator in the descriptions that we have just heard from Greater Manchester. We are equally keen to bottle and distribute the things that are happening. In the parts of the country where there are two tiers of local government, it is important to recognise that district councils make a very big contribution to wellbeing. The activities that they lead around planning, housing, sport and leisure, and recreation all contribute to wellbeing. Indeed, the District Councils’ Network, which brings district councils together nationally, did a piece of evaluation to ascertain the value of district councils’ contribution to public health and wellbeing, and it is significant.

We need to make sure that they are full and active partners in the work that goes on at health and wellbeing boards, in the general work of councils around improving positive outcomes for people, and in the sustainability and transformation plans, where district council involvement has been particularly weak, if I may say so.

Q218 **Helen Hayes:** I have a few questions about the better care fund. I wondered if we could start by asking how the better care fund is now being used to promote closer working between the NHS and local authorities.

**Jon Rouse:** From the perspective of Greater Manchester, it is virtually irrelevant; I have to be honest with you. That is not to say that it was not a useful mechanism, and in some places it may still be, for those who are in the early foothills of this integration journey, concentrating minds, buying in partnerships and so on. In Greater Manchester, we do not really talk about it, to be honest. In terms of the level of integration on both the commissioning and the provider side, we are well beyond the minimum
requirements anticipated by the better care fund. The metrics that the BCF measures, we measure anyway. They are part of our balance scorecard and we look at them all the time. They are really important metrics, but we do not need a national BCF now to tell us to do that.

To be honest, it was a really important national policy and mechanism. It instigated a lot of joint action. I wonder whether we are getting to the point where we are beyond the better care fund in a lot of localities and the levels of integration and partnership have moved beyond that. I know that is true in Greater Manchester, anyway.

**Mark Lloyd:** It is an issue that we try to understand across the country. In a 2015-2016 survey of councils, 90% agreed that the better care fund had a positive impact on the integration of health and social care; 91% agreed that it was leading to improved joint working; and 76% felt that the pooled budgets had led to a more joined-up approach to health and social care provision. Those are positives. I agree that it was a necessary intervention to stimulate change. Most areas are now striving to “graduate” from the better care fund, so that this becomes simply a local initiative bringing health and social care together in the way that we have just heard from Greater Manchester.

Q219 **Helen Hayes:** There has been a great deal of call in recent weeks, and I should say that I have been one of those voices, for the promised increase in the better care fund, which is currently back-loaded, to be brought forward. Those calls are in part a recognition of the crisis situation that has been described today in terms of social care. Given your answers to that question, I suppose there are two further things. What would it be used for if the increase was brought forward and not back-loaded? Is it in fact the right thing at all, or should the Government be announcing something that moves on from the better care fund and delivers the same resource, if not an increased resource, but in a slightly different way?

**Mark Lloyd:** I would echo your plea for the tail-end-loaded resource to be injected earlier. Yes, please; the more voices that are saying that, the better. What would it be spent on? A very short and simple answer: social care. My colleagues may have a different view, but it cannot be spread across a whole range of interventions locally that are currently wrapped up in the better care fund agreements. It needs to be injected into social care. It is as simple as that.

**Jon Rouse:** I completely agree with Mr Lloyd. It would go into the fundamentals. It is the right thing to do. We would like BCF graduation, but frankly we would keep BCF if it meant extra money for social care because the need is urgent.

To try to bring this home, if you take the last seven years, we have had a 20%-plus reduction in the number of people in residential and nursing care in Greater Manchester, and a 25% reduction in the number receiving domiciliary care. All those people are still out there. It is just that they are placing significant pressure on the NHS, because they are not having
their needs met. This is only going to increase next year, given the gap that we are facing. We are seeing the impact of that in terms of delayed transfers of care, certainly, and reduced quality of care in terms of CQC ratings of care homes and domiciliary care provision.

We are also seeing it, not in Greater Manchester, but in some other areas, as creating an artificial barrier in terms of NHS bodies’ willingness to truly risk-share with social care, because of the anxiety about those cost pressures coming straight on to the NHS. In GM, we are risk sharing anyway, but we need that social care gap dealt with.

Q220 **Helen Hayes:** That is all interesting and clear. Do the current conditions on the use of and access to the better care fund place limitations on a local authority, when a straightforward injection and increase in funding that you can spend on care is required, and is there an issue there?

**Jon Rouse:** We would prefer a straightforward injection of that resource brought forward from the end of the spending review period into 2017-2018, but if the price of getting that money was continued BCF strictures we would put up with them.

**Mark Lloyd:** In putting up with them, we would work with our colleagues in the Department of Health and the NHS to try to ensure that there were fewer national conditions and a lighter-touch assurance process to relieve the burden that councils face.

**Professor Wistow:** We certainly found, in our evaluation of the early period of the pioneers, two things that confirm what has just been said. First, most of the people we interviewed were positive about the overall impact of the BCF, but thought that the conditions associated with accessing the money were somewhat limiting; secondly, the bureaucratic demand that was created by the way in which the assurance process operated they found extremely excessive for the amount of money involved.

It is really important that we remember that the better care fund’s predecessor was called a transfer of NHS funds to social care. The reason for it being established was in recognition that it really made very little sense to protect the NHS and at the same time to make it impossible for social care to play its part in delivering the amount of health service activity that was being protected. It was an attempt to square a circle. It is an imperfect mechanism, but in the current situation there has to be some way of aligning NHS activity and social care funding, so it can do its part of the job with the NHS.

Q221 **Bob Blackman:** Mr Rouse, you just mentioned the reduction in the numbers of people in Greater Manchester being assisted. How have you achieved that? Have you raised the bar by which people have to be in a greater need before they will get care, or have you reduced the time they have?

**Jon Rouse:** The bar is now statutory, since the Care Act, so it is a substantial level of need. Prior to the Care Act and when resources were
not as tight, we would have provided a much fuller range of preventative services for people before they reached that threshold. That is a really good investment for obvious reasons because, if you can put in place preventative support and do it at scale, some of those people will never reach the statutory thresholds. We know that, if you do not do that, they tend to deteriorate more quickly, hit the statutory thresholds earlier and potentially end up being more expensive, so it is a false economy. In an ideal world, if we had additional social care resources, we would be restoring some of those preventative services, as well as making sure that we could continue to deliver statutory services.

**Professor Wistow:** That is where the current conditions are somewhat restrictive, because they put much more emphasis on the direct avoidance of hospital admission than on early intervention to prevent people getting to that position.

**Melanie Onn:** Mr Lloyd, you were excited about the opportunity to talk about sustainability and transformation funds, so this is your opportunity to wax lyrical and entertain the gallery. NHS England diverted 86% of the sustainability and transformation fund for 2016 to 2017 to hospitals facing significant financial challenges. Are the STPs really driving closer working between local authorities and NHS partners?

**Mark Lloyd:** They have the potential to; that has to be my opening line. As we look across the 44 sustainability and transformation plan areas in the country, we have outstanding practice, and areas where local government and the NHS are simply not collaborating and councils are refusing to be involved with or support the plans as they are being published. We have the whole spectrum.

If we step away from today’s name, “sustainability and transformation plans”, the principle of place-based leadership around health and social care has to be right. If we have a health service that is facing very substantial efficiency savings as part of the five-year forward view, responsible local leaders of place—councillors—want to have a say on the right way of reshaping and reforming the health service in the context of social care and their wider interest in wellbeing.

The principles that led to the STPs have been longstanding, as we have heard from Professor Wistow and others, and they could make a big difference where councils and the NHS collaborate effectively. Where they have not worked are where plans have been produced in secret, where communities have not been engaged in having an understanding of the problem, and where politicians are not at the table and part of the negotiation of solutions. In some areas, as a consequence of those failures, plans will just meet opposition as they are made public.

In places where local government has been inside, communities have been involved and plans have been involved in a way that is right for a local circumstance, it will make a big difference to solving the dilemmas that we face in social care, health and wellbeing more generally.
Jon Rouse: He is right.

Professor Wistow: Absolutely.

Jon Rouse: Out of fairness, on the sustainability and transformation plans, Mr Lloyd is absolutely right and I hope that that is what we are trying to exemplify in Greater Manchester. On the sustainability and transformation fund, which is obviously a slightly different thing that you also raised, it was perfectly legitimate for a large amount of that resource to go into the acute side in 2016-2017. The reason is this: we must not lose track of the fact that we need to save money in a number of ways across health and social care and there is still a big efficiency and productivity dividend available to us in the acute sector sitting alongside integration, and we need to do both.

The key for me is that localities should be making the decisions about that balance. In Greater Manchester, we need to be able to make the judgments about how much of our resource goes into integrating community care and how much goes into driving efficiency and productivity in the acute sector. Those decisions about the balance of how resources are invested should not be being made nationally.

Professor Wistow: The frontloading of extra funding in the NHS and the back-loading of extra funding in social care makes very little sense in that context, because both services need to have the funds at the same time in order to manage the transition from a hospital-based system to one that has a bigger role for community services. The gap in between that we have now possibly makes sense from the point of view of the Treasury managing the flow of money overall, but it makes very little service sense.

Q223 Melanie Onn: It is a transformation fund. Is it transforming and, if it is not, why is it not and where is it not?

Jon Rouse: If we are being honest, in 2016-2017 the emphasis has been more on sustainability than on transformation in terms of those resources going into the acute sector. We got to realise what the level of deficit was in the acute sector, and what we were therefore dealing with, last year. There is no question that, over time, we need the balance of the way that that resource is working to move more towards transformation. The only way to do that, and this is what Professor Wistow was pointing towards, is: to make the decisions about the allocation of resources place-based; but also to make sure that the sustainability and transformation fund is working with the other incentive mechanisms that we have, whether those are incentives in terms of the commissioning system or on the hospitals themselves. The whole thing has to work as a piece and the only way you can resolve that is at a locality level.

Professor Wistow: That is quite right. The STPs, as they are currently set up, are not a single budget to cover the full range of expenditure across the locality. Equally, there is not a single point of accountability for the expenditure or for the plan. The accountability processes in STPs are
incredibly opaque and very difficult to manage. When I said at the beginning that we need to think about something much more radical, it is about finding a single point of responsibility for a place-based plan. We have lost a huge opportunity over the last five years by not making anything out of health and wellbeing boards, simply because they were not given the ability to make decisions about the allocation of commissioning budgets. Had we done what the original proposal was five years ago, we would have had a much better basis on which to build the STPs now. Unless we focus on this single point of accountability and the single budgets, we are not going to make the most of the resources that we have.

**Mark Lloyd:** The clue to sustainability and transformation plans, as we heard earlier, is in the name. It is a planning arrangement at the moment. It is not about implementation or operationalisation, and there is a potential in each area to decide on the most appropriate way of working. Taking into account the current infrastructure and the lack of interest in going through statutory changes to things like clinical commissioning groups, is there a way that we can bring stronger democratic leadership to each place around a plan for health, wellbeing and social care, driving growth, tackling housing issues, etc? The STPs are at least a start on that journey where we could democratise place-based leadership for health and social care. We should recognise that it is just a start, but it nudges us in the right direction towards a solution that would be more sustainable long-term.

**Professor Wistow:** It is quite interesting that, in the study of STPs recently published by the King’s Fund, they had four case studies, in one of which the leadership was with a local authority, a senior officer. That was the one where they found that they were planning on a wider basis and drawing in a wide range of services. For example, they talk about a task group on environmental health and housing. That is really rare. In my experience of STPs, they are much more narrowly focused on the health service and the interface of the hospital with community services.

**Jon Rouse:** Contrasting STPs with Greater Manchester, we published our plan last December before STPs were really conceived in the terms that they are today. Because of the local political influence in terms of the planning, from MPs as well as councils, leaders of councils and portfolio leaders, we have a much richer population health approach. It is about work and health; it is about early years. Last week, we had a big conference on mental health in schools and colleges. We had an enormous turnout from schools and colleges that want to build resilience into their curricular approach within Greater Manchester schools. You get that richness by the exposure to local democracy and local democratic influences, and we are the richer for it in terms of the GM approach.

**Julian Knight:** Mr Lloyd, I would like to pick something up. You have been talking about the need for consultation and democratisation, not just now, but down the line. I completely agree with you and wish it was happening in my area. Where it is not happening and there are instances
of this democratic deficit, is that because of politicians effectively standing back from the process so that they can grandstand, or is it more to do with healthcare professionals, frankly, saying, “We have to get on with this rather than being involved in the to and fro of politics”?

**Mark Lloyd:** Again, there is not one answer. The situation varies across the country. Being honest, we had a difficult start, in that sustainability and transformation plans were announced as part of the five-year forward view without proper engagement with local government. The geography was imposed. In some places, the geography is perfect—I quote Greater Manchester, because it works on the combined authority areas and brings them together—but in others the geography means that, in the worst cases, councils are working into three STPs, and they just do not know how that works in terms of the kinds of approaches that we have been talking about today.

Where councils have been involved from the very outset and where there has been political and community engagement, councils in the main feel ownership of the plan are getting behind them. Where those conditions do not apply, they are more likely to be oppositional, and it is not just for political purposes.

**Q225 Julian Knight:** Where the councils are engaged, is that not normally just officers, rather than councillors, going through the normal processes? The officers get together with the CCGs and say, “This is what we need: X, Y and Z.”

**Mark Lloyd:** Again, different places have different starting points. There are some places where health and wellbeing boards were involved from the very beginning. There are places where that has been built in later on. Most success has been achieved where they were involved from the beginning.

**Chair:** Thank you all very much for coming to give evidence this afternoon. That is appreciated. Thank you.

**Examination of Witnesses**

Witnesses: Alison Rogan, Karen Kibblewhite and Alex Fox.

**Q226 Chair:** We move on to our second panel. Thank you very much for joining us this afternoon. For the record, could you say who you are and the organisation that you represent?

**Alex Fox:** I am Alex Fox. I am chief executive of Shared Lives Plus.

**Alison Rogan:** I am Alison Rogan. I am external affairs director at Tunstall Healthcare.

**Karen Kibblewhite:** I am Karen Kibblewhite. I am head of commissioning for health and wellbeing at Rutland County Council.
Q227 Chair: Thank you all for coming to talk to us about innovations in adult social care, which we are trying to explore. Starting with technological innovations, it could be helpful if you, Alison Rogan, could say what evidence there is that these innovations lead to better outcomes. Could you explain one or two of the most common ones and how you think they are helping?

Alison Rogan: The innovations in technology-enabled care started off with something called telecare, which you may be familiar with. Telecare consists of a number of sensors around someone’s home to enable risks to people’s independence to be monitored by a 24-hour response centre. The evidence base for telecare is very strong, because it has been around a long time, so historic evidence has been quite strong. Very recently, the LGA did a report on efficiency opportunities through health and social care integration, which listed a number of examples of where telecare was making a difference, particularly to hospital admissions.

ADASS, the Association of Directors of Adult Social Services, did an online survey with their members. Twenty eight people responded to that, so we have a good selection of examples from Brighton to Bury, across England.

More widely, we have a national study that FACE did a number of years ago, which pointed out that between £3 million and £7.6 million could be saved by a typical council, which at the time was 7% to 19% of their total social care budget. In the response that I sent through, there was a really good example from the London Borough of Havering. They had a longitudinal analysis comparing homecare with people who had telecare and homecare—the first of its kind that I am aware of. Over a long period of time, I think 18 months, they compared the cohort with homecare and telecare against those who only had homecare, and they found a reduction in general hospital admissions of about 25%. When you dig a little deeper into the reasons for the hospital admission, if you look at hospital admissions due to falls, there was a 44% reduction in admissions compared with 2011. If you worked out indicative savings, that would be about £2.2 million. The residential and nursing care admissions also reduced within the two cohorts by around 6%. That is telecare.

Telehealth is a little different. It has been around for 10 to 15 years, as opposed to 50 years for telecare. Telehealth is all about managing people’s long-term conditions, or trend monitoring if you like, and enabling people to self-care and be more confident in their conditions such as lung disease, respiratory disease and diabetes. A good example of the evidence base on the telehealth side is the study that we have done with Calderdale. Calderdale CCG, the council, the care homes and the foundation trust got together, and around 25 of their care homes have been equipped with both telecare and telehealth, as well as a multidisciplinary team. Nobody is claiming that it is the technology alone that makes the difference.

They found that, for two years, hospital bed days were decreased by 30% year-on-year for the care homes that had the technology and the MDT in
place, compared with the care homes that did not. There was also a 33% reduction in emergency admissions.

Q228 Chair: They have been around for a long time. Is there anything new and exciting being introduced or on the horizon that we ought to be aware of?

Alison Rogan: People like exciting stuff and there is a bit of an obsession with apps. We know that apps are good for some people, but it depends on the cohort of the individual. If they are used to having smart technology, that is brilliant, but you also have to think about what the technology is used for.

We have some great examples—not just Tunstall, but everywhere. There are good examples of GPS technology enabling people who have dementia to walk their dog again, after perhaps being afraid of getting lost; you can see where they are on a map and assist them if necessary. Voice activated controls: has anyone bought the Amazon Echo yet? This could be the future technology that individuals in their own homes can get. You just speak out: “I need help” or whatever, and the help comes. A lot of this stuff consists of Wi-Fi and broadband technology, which we know is not in everybody’s home, but there are some very exciting things out there today, for the people who can use them, of course. However, the evidence base is very slim.

Q229 Chair: There is one area where I wonder whether any progress has been made at all. The Committee has seen the Dispatches programme about the problems of people getting care in the home and actually whether they get it at all or whether someone turns up. If they do turn up, are they giving them medicines? Are they giving them a meal? Is there anything to monitor that? Are we getting anywhere with that sort of problem and getting feedback on it?

Alison Rogan: Yes, we are getting a little way towards that. It is better in Scandinavia, where we do a lot of work. Do you want to know about care homes specifically?

Chair: That was people in their own homes.

Alison Rogan: We have a large response centre in Doncaster and there are several of them around the country. We get a lot of calls from people who have memory problems, who ring us up to say, “I need to have something to eat” or “My carer has not been today.” The beauty of this type of technology is that we can liaise with all the agencies involved. We have very personal information about their data and their care provider, so we are able to co-ordinate that care, as long as we know about it. If somebody has not been into that home when we know they should have been, we know about it, through certain sensors in the home.

Q230 Chair: How? If the person themselves has dementia, they do not know whether anyone has been either. How would technology help with that?

Alison Rogan: Say somebody has not done what they said they have done. For example, we would know if the kettle had been boiled or the fridge door had been opened, or if somebody had been through their
front door. This stuff is available today, but it has to be done in a clever way, because anyone could be coming through the front door. In Scandinavia, we have a particular system whereby you can use your mobile phone, which links with a system to indicate that you have now entered the building, you have done the tasks that you have been provided and you then log out again. Unfortunately, it is not quite as clever here just yet.

**Q231 Bob Blackman:** What sort of involvement would older people have in setting this technology up, or in determining what it looks at or does not look at? Some people are more able to handle mobile phones than others, and there are some people who are physically disabled, but very able to do things with mobile telephones. Others may have dementia or other problems. What is the involvement of the individual in setting this up?

**Alison Rogan:** It varies. All the things that you have said are quite correct. I know a lady whose mother is fantastic; she can use a tablet and search the internet, whereas her mother-in-law would not go anywhere near a tablet because she has no idea what one is. First of all, you need to know what you need. Using the word “technology” is often a put-off in the first place. You have to work it round the individual’s personal circumstances. It tends to rely a bit on carers and family members, maybe a spouse or a grandchild, to help with all those things if you are talking about with tablets and mobile phones.

However, with the traditional telecare stuff—let us face it: there are a lot of people out there with it, at least 1.7 million—you do not have to have any involvement. If you wish to wear the pendant on your wrist or clothing, you know that you will be provided with support should you fall when you are nowhere near the main unit, for example. It rather depends on the need.

The sensors are almost just in the background doing their job. It is like a circle of care. You do not have to do anything with them. There are all sorts of things that you can do, depending on the individual need.

**Q232 Bob Blackman:** Ms Kibblewhite, what is the impact of what you are doing in your local authority in Rutland, in terms of both the users and the benefits for the council?

**Karen Kibblewhite:** It is an interesting one. There is a real balance around using some of this technology. We have been using the better care fund to support rolling out more assistive technology in Rutland. Alison is absolutely right that it can really help to reduce admissions into residential care, and increases the number of people who are able to maintain their independence in their own home, which is fantastic. It does not always lead to cost savings, because some of it is in addition to the homecare that we put in to help people, so it is more of an ethical choice. It is about helping people to stay at home, where the only other option without the technology would have been to go into care homes.
We tend to find that it is often about reassurance, an additional level of support to either that individual service user or their carers. You referred to it as a circle of care, and I quite like that phrase. It is about providing that reassurance and sense of safety. We have found that traditional assistive technology is very well taken up. Rutland, as you may well know, is quite rural and we have worked very hard to get over 90% broadband coverage, but the more rural areas are going to struggle to roll out some of the new telehealth that is available, because it relies on Wi-Fi and broadband.

Q233 **Bob Blackman:** Have you been able to quantify a period of time over which people can stay in their own homes for longer? Is it one, two or three years? What is the timeframe? That is obviously a big impact on the individuals.

**Karen Kibblewhite:** We have not measured it in that way, because so many different factors affect it. We know that our residential care admissions have dropped year-on-year for the past three years, and we know that, since we have been rolling out the assistive technology with the support of the better care fund, it has had a massive impact. I cannot quantify that in terms of how many years it has led to people staying for.

Q234 **Bob Blackman:** How many people fall into help and assistance from the local authority through this compared to, say, three years ago?

**Karen Kibblewhite:** Interestingly, we have taken a view in Rutland that we will support some self-funders to help access assistive technology, on the basis that we have a very large proportion of self-funders in Rutland. Again, it is quite difficult to quantify, because you do not necessarily know that they are all there. We have found that, for some people, a very small piece of assistive technology can help them and reassure them to the point that they are not reaching crises where they become eligible for social care services, so that makes a big difference for us as well.

**Alison Rogan:** In terms of the evidence, on the number of months people have been able to stay at home as opposed to going into residential care, it was a long time ago but West Lothian did a really large study, which I will send you the link for. In the first year of doing their evaluation, they gave quite a lot of people, around 3,000 individuals, a series of sensors in their own homes. They found in the first year that the reduction in the length of stay in residential care was 12 months, and in the second year—or perhaps the third year, but I will clarify for you—the reduction in the length of stay was 18 months. That means people were going into residential care later on in life and spending less time in because they were more ill. In the study I mentioned earlier by Havering, they found a delay of three months, so it varies.

Q235 **Julian Knight:** Specifically to Rutland, I was reading something about the Pi tool. How does that work and what are the advantages and limitations?

**Karen Kibblewhite:** The Pi tracking tool is essentially a data platform. We are part of the Leicester, Leicestershire and Rutland health footprint,
so it is working across LLR, as it is known locally. Essentially, it draws in data from a number of different sources and pulls it together by NHS number. It is pseudonymised so that we cannot see which specific individual it relates to, but we are able to see individuals’ journeys through the health and social care system.

We are in the very early days with this at the moment, but it is quite exciting. Hopefully, touch wood, as we develop it and get more data drawn into it, it will allow us to identify flows of individuals through systems. That will tell us things like how our hospital bed use is changing. It will identify those people who are going through social care, into hospital, into care homes, and coming back out again. It will give us an opportunity to identify our areas of most need and to potentially identify some gaps by looking at the service user journeys. That will enable us to target our resources more effectively.

It also means that, going forward, we will be able to think about how we commission services differently. At the moment, we have an integrated team within Rutland, which is our local NHS trust provider and our social care provider. By using the data flows, we will be able to see whether there are other people who should be a part of that integrated team, and whether there are other ways that we can target our resources to make that more effective.

Q236 Julian Knight: Has it led to greater integration? Is there greater working together between you and your NHS partners?

Karen Kibblewhite: That is an interesting one. We have ploughed on with integration regardless. In the previous session, you were talking about STP plans and the BCF, and we have put that integrated team together anyway. This will support our understanding of where we are targeting that integrated team. The only caveat around it for Rutland, for us, is that, because of where we are geographically sited, we have a very large proportion of people who go out of county for the hospital. Around half the people who live in Rutland go into Leicestershire hospitals and half go into Peterborough or Northamptonshire hospitals. At the moment, we only have the data on our health footprint, which is Leicester, Leicestershire and Rutland, so we are missing data on some individuals, which means that it will not be entirely accurate in terms of the data flow.

Q237 Julian Knight: Ms Rogan, how can assistive technology, like we have just heard, be used with data tools like this? How do you integrate the two?

Alison Rogan: Over a number of years, we have realised that it is not a good idea to be proprietary. You have to integrate with things that you need to integrate with. Over a number of years, we have been integrating GP systems, with Adastra, TPP and all that sort of thing. The social care side of integration is, I have to say, less advanced. We have tried and will continue to work with partners like Liquidlogic.

Pi is very new, as you have mentioned. Can we do it? The short answer is, “Yes, we can.” There is always some programming work that will need
to be done, but we have ways and means of extracting the data that is required, in a data warehouse, and then enabling third parties to get that information. It is all doable.

Q238 Melanie Onn: How likely is it that commissioners will reinvest in or pursue any kind of innovation, given that their budgets are so tight?

Alison Rogan: It is an interesting question, because where we have seen great innovation is where we have had some of the worst possible financial situations. It is not just the funding that enables local authorities to do something really fantastic with innovation. I have to say that funding is a driver, but we also have the demographic challenges and of course the costly service options. There are three others that often get forgotten. They are deprivation, i.e. “Why are people living longer in some parts of my county than others?”; safeguarding, so the big quality issues that you mentioned, like the Dispatches programme; and the lack of co-ordination of services out there. Funding is absolutely a driver, but that does not mean that it is the only driver.

Let us park that and ask, “Why have some of our best examples done it?” It is because they have looked to the future and realised that they just cannot cope with the demographics and all those things that I have described. They do not have enough nursing homes or enough capacity within their system. They have had to change their model of care in order to cope with their future demand, and that has been a massive driver. Funding is obviously a very big part of that.

Alex Fox: I would agree with that. There are areas, we find, that are able to take risks with innovation that they would not have done in happier times. There was perhaps a belief during the boom years that, as long as we invested enough in public services and organised them well enough, we would be okay. In all that time, the demographic change was catching up on us. Now we are in a time when budgets have been very dramatically cut in a lot of areas and that has created two different approaches.

There are areas that have said, “We just need to do things differently now”. I also meet commissioners who have very little capacity to change, so there are areas that are more in panic mode. The downward pressure on what commissioners can do is not just about the money that they have to spend, but also about their own capacity as a commissioning team. I talk to commissioners who are clearly very interested in Shared Lives, Homeshare and other asset-based approaches, but I do not really expect to hear from them ever again. We have had a warm conversation, but they have just told me that they are commissioning 20 or 30 entirely unrelated things at the moment, so they do not have the capacity to do something that will require quite a significant change in the way that their team thinks, and sometimes in the way that the economics of what they are trying to do in social care work.

Q239 Melanie Onn: Would that be your experience, as we have heard it, in terms of commissioning?
Karen Kibblewhite: It is a real balance for local authorities. I would certainly agree that you get to a point where you have the authorities that say, “Do you know what? There is nothing else to do but be completely radical and do something different”; and you have the ones that say, “Things are so tight now that we have to batten down the hatches.”

One of the lessons that we have learned in Rutland from looking at other authorities is that often, when people try to be really innovative, it is brilliant if it works, but if it does not then you can cause a lot more problems. At times when we have limited resources, it is quite difficult to run a twin-track approach, which is what you really need to do: to start the innovation, while keeping something else going on in the background just in case it does not work how you envisage.

I would also agree with Alex that some of it is about capacity. While you are still doing your day job of commissioning everything that you have going on, you need the space and resources to step back, have a proper look and say, “Let us be really innovative. What can we do that is different?” As a local authority, you often do not have that luxury.

Alex Fox: There is also something about the extent to which some areas have been investing for some time in their communities, whereas other areas have not, so they do not have that resource, that trust or those relationships to fall back on if they want to talk about doing things quite differently. I am currently independent chair of a review of the role of charities and community social enterprises in health and care. We did quite a wide consultation with areas about how they work with their VCSE sector organisations, which are often some of the real engine rooms of innovation, because they are doing things very differently.

We found a huge difference between areas. Some saw that people like us do not have the answers. The commissioners by themselves did not have the new ideas; if they did, they would probably be doing it already. It was a lot to do with the extent to which they were able to work with people who used services and their families, to design new ways and new approaches. If you talk to people, they do not necessarily want to carry on doing what we have been doing, or a bit less of what we have been doing. People are willing to think quite differently, so long as you have the right starting point, which is often, “What does a good life look like to you and what do you want to do to get there?”, and they are not constrained by thinking about what has already been on offer.

Q240 Helen Hayes: Mr Fox, could you explain to the Committee how Shared Lives works?

Alex Fox: People from all backgrounds are recruited by their local Shared Lives scheme. They go through a really rigorous approval process, which can last three to six months. Once you are approved as a Shared Lives carer, you are then introduced to local adults who need support: typically people with learning disabilities, but also people with mental health problems; older people with dementia; and others with a wide range of
support needs. The idea of that is to find a match of people who will not only be able to support each other, but will get on and want to share their family and community life, which is what the model is based on.

About half of the 13,500 people using Shared Lives across the UK have moved in with their chosen Shared Lives carer and live as part of the family. They do that either as a stepping stone to getting their own place or sometimes as a place to settle down and belong—for instance, as an alternative to living in a care home. The other half visit that household regularly for short breaks or day support.

I can give you a couple of examples of that, to bring it to life. James is a guy with a learning disability and previously, in other kinds of social care services, his life revolved around mental health crises and frequent admissions to hospital because he also has some significant mental health problems. He now lives with a Shared Lives carer called Phil, as part of Phil’s household. From time to time, his mental health does decline, but Phil knows him well enough, probably better than people did in other services, to be able to spot the signs and get the right support in place. Most of the time, their lives revolve around the sorts of things that you or I would want our lives to revolve around: the things that they both enjoy doing, taking part in the community, volunteering, work and so on.

To give another example, Lynne is a family carer. Her father is called Harold, who has dementia and she cares for Harold full time. She was looking for short breaks so that she could take a break from caring. Their Shared Lives scheme matched Harold with a Shared Lives carer called Karen, so Harold now visits Karen regularly rather than visiting a care home for his respite or short breaks. What Lynne says about that arrangement is that before, when Harold went into respite, he would come back having lost something of himself, and often something that he never really regained. That experience was quite distressing for them and it was not really the break that Lynne needed. Now, because he is matched with Karen, it is a familiar visit and just feels like a family visit, really. They do things together that they enjoy, like short walks, watching old musicals and things. Lynne says that he fits back into his old life as if he has never been away.

It is a model that does something really unusual in regulated social care. It combines what people find valuable and what they love about family and community with the resources, infrastructure and training of a CQC-regulated care service. In England, there are 120 local Shared Lives schemes, all registered with CQC, which inspects them and consistently says that they outperform all other forms of social care for safety and quality.

It is also a model in which people have a very different experience of what they can achieve. For instance, everybody in a recent survey said that they had made friends through Shared Lives. One-third of them said that they had made five or more friends. There are many services out there that are called community services, but do not really have any theory of community and do not help people form those kinds of
relationships that we all rely upon to live well. It is also much lower cost than alternatives. An independent report found that on average, if somebody with a mild to moderate learning disability moves out of another form of care and into Shared Lives, the saving is £26,000 per person, regardless of any additional savings from the better outcomes that they might achieve.

Q241 Helen Hayes: In terms of the continuity of those relationships, how successful are the relationships in being sustained? What happens if a relationship is not able to work out?

Alex Fox: That is a really key role for the local scheme, and one of the things that it is inspected on is that continuity of care. It varies enormously. I can think of a young woman with a very mild learning disability who is a parent, and she needed support when her baby was born. She was not looking for long-term support, but it has probably turned into a slightly longer-term arrangement because she does need some ongoing support and may do for some time. For some people, it is a stepping stone to getting their own place, not just to get the practical support with living independently, but also to put down roots in the community, because you have a household around you who are going to introduce you to your friends and social networks.

I also meet people who have lived together for 40 years and intend to live together forever because it is their place. If you talk to these people, they say that he or she is just part of the family and they cannot imagine a reason why they would not want to live together. You get the good things about family life, and also some of the messiness of family life. Unexpected things like health crises happen, and the Shared Lives scheme is there to provide support and to make sure that there is continuity of care if that happens.

If you talk to the people involved in Shared Lives, there is a much lower turnover of people involved, much lower rates of safeguarding alerts, concerns and other forms of social care, which leads to greater continuity. That is all based on the investment in recruiting people very carefully, putting them through the approval process and getting to know them at a much deeper level than you would during a normal recruitment process. It is investing in recruiting the right people, rather than spending a lot of money, which a lot of services do, to deal with the fact that there are issues with the staff that they have.

Q242 Helen Hayes: You have spoken quite a bit about the outcomes and the cost savings that are achieved by Shared Lives. What are the barriers to expanding that scheme to support more people? Is there a limitation in that it requires a very special type of person to want to participate? Is there a limitation in terms of the level of support and the intensity of investment that goes into establishing those relationships? Are there other constraints?

Alex Fox: We feel that we are a very long way from finding the ceiling. Over the last two years, it has grown by about 27% in England, at a time
when the rest of social care has declined by about 7%. There are areas now that already have hundreds of Shared Lives carers, and there are many areas that only have a handful. That has happened without the general public really being aware that they have a local scheme, that they could become a Shared Lives carer as a paid form of work and that they could be using Shared Lives. There has been a lot of growth despite all that.

In the areas that are using Shared Lives the most, it is only about 1.5% of social care provision. I was in British Columbia recently. Their version of Shared Lives is over 50% of live-in learning disability support, so there is huge potential. If all areas caught up with those, like Lancashire for instance, that are making the best use of Shared Lives, the number in England would go from 11,500 to over 30,000, and the saving gets into hundreds of millions of pounds.

There is huge potential. Our big ask to Government at the moment is about not money, but awareness. We are now at the stage where there is a scheme in pretty much every area, and we need a national recruitment and awareness-raising campaign to back the local organisations that are delivering this.

Q243 **Chair:** Are there any payments involved?

**Alex Fox:** Yes, you are trained and paid to become a Shared Lives carer. For some people, it is their sole source of income, and there is a specific tax regime around it. The average age of a Shared Lives carer is about 55, so, for lots of people, they have worked in health and care, they have perhaps got a bit fed up of working in a way that can involve lots of form-filling and so on, they have a couple of spare rooms, perhaps because their kids have moved out, and they are looking for something that is more part-time and less of a traditional job.

Q244 **Chair:** Are the payments decided at the national level or are they more of a local decision?

**Alex Fox:** No, they are locally decided. Shared Lives Plus is a membership body, and we work very closely with all the organisations, 5,500 of the Shared Lives carers and the regulator to develop a whole set of policies and procedures, but they are locally decided. There are some elements of Shared Lives where the guidance and regulations say things like, “You cannot support more than three people at any one time”, for instance.

Q245 **Melanie Onn:** It sounds like an absolutely fantastic scheme and it is fascinating. My concern is this: despite all the vetting, does it not leave some incredibly vulnerable people even more vulnerable if they are absorbed into somebody else’s family? Do they not go off the radar a bit?

**Alex Fox:** The scheme’s role is not just matching people; it is also monitoring and supporting that arrangement. They do not just leave people to it; they carry on having contact with those people, who should also have advocacy involved, although that is diminishing across the
whole of social care at the moment. CQC’s data suggest that the safety record is very good and, while there are occasional safeguarding incidents, which as a sector we obviously take very seriously, there are some protective factors to living out there in the community with a whole range of friends and family around you.

I was talking to a Shared Lives carer the other day, for instance, and if he goes out and about without the guy that he supports, everybody asks him where he is. He is often at work or volunteering, but people want to know where he is because he has become a visible member of the community. If you contrast that with Winterbourne View, where there was a horrendous care scandal, it was on the face of it a very safe environment. People were in nurse’s uniforms; there were locked doors; it had a huge amount of regulation; and it was costing thousands of pounds per week. They were out of sight on a light industrial estate and were entirely reliant on paid people in their lives to protect them, a long way from their families. If you talk to the families of people using Shared Lives, they say that it is a bit like extending your own family: “We feel like we are now a team of two families.” Those are protective factors.

Q246 Melanie Onn: Likening it to foster care situations with children, what if there is a fall out? Relationships do not always work out. Does it mean that a service user will potentially be passed from family to family to family?

Alex Fox: We do not see that happening very often, and certainly not from family to family to family. We see some arrangements break down. As I say, the schemes are very good at matching people very carefully, so it is not a question of chucking two strangers together and hoping for the best. It is about people gradually getting to know each other and both parties, and their families if they are involved, taking a really considered decision that this match is going to work, and being able to review that and change their mind if it is not working out for them. It is absolutely crucial that schemes are properly resourced to do the recruitment and approval, so that is not compressed too much; that the matching is allowed to take time so that as a Shared Lives carer and as an individual you feel like you have really got to know people and made a real choice; and that there is enough resource put into monitoring. We have suggested ratios around the number of people working in the scheme to how many households they can safely support, because they have to be in reasonably frequent contact with people.

Q247 Melanie Onn: Is that something that Rutland Council would consider, rather than looking at innovative technology or solutions, or would that not be attractive?

Karen Kibblewhite: It is quite interesting. I have been in post for about two years and I looked about 12 months ago at Shared Lives for Rutland. The difficulty we have is that, being such a small county, the costs of setting these types of schemes up, fantastic though they are, sometimes make it quite difficult to do that, in terms of costs, volume and benefit. One of the things that we need to consider, with Shared Lives and similar
schemes, is that often it is about local authorities looking at where else they can join up with. For example, it would become viable for us if we joined with Leicestershire, which I know already has Shared Lives and is running it very successfully.

There is an awful lot of innovation around, as Alex mentioned, in the voluntary sector, and as local authorities we should not be risk-averse to that. That does not necessarily mean that it all fits well with every local authority, depending on your own patch, demographics and needs.

Q248 **Chair:** As to the payments that are made, presumably there are restrictions on those payments being made to close family members. Is there a framework in which some people can be paid and others cannot?

**Alex Fox:** Yes. The Government have spotted that one. There are 6 million unpaid family carers. There are restrictions, some of which are locally decided, because if you are in a Shared Lives arrangement, although it will often feel—if you visit one in your constituency—like sitting in anyone else’s kitchen seeing family life, there is a formality to it. There are contracts and regulations involved, which you cannot really put into an existing close family arrangement.

One thing I did want to flag in terms of how it is being developed is that NHS England have recently invested £1.75 million in five areas, and the CCGs in those areas have invested another £500,000. In those areas Shared Lives will be developed as a healthcare intervention, which can include getting people with learning disabilities out of medical institutions, but also things like stroke rehabilitation and home from hospital care.

Q249 **Chair:** That was my further question for the three of you, on health and social care. We talked a bit about data before and the importance of it. How far are the problems with sharing data between health and social care an obstacle to you doing what you do? There are often quite strict rules on health data and passing it around to different systems.

**Alex Fox:** For us, the problem would be more about the cultural differences. In some areas, there is still quite a medicalised health system that would look on Shared Lives or other asset-based community approaches askance and would not necessarily recognise the same sorts of outcomes in terms of what they would expect to commission for and measure. Kent University have developed an outcome measuring tool, which is being rolled out across the sector. We need to add some health modules into that, but the intention is that any local scheme can get its local data, and we get anonymised national data, so we can start to build up some of those data sets.

Q250 **Chair:** Do you have that information about the effect of the schemes and whether they stop people getting into the need for more and more expensive care later on?

**Alex Fox:** Not yet. The outcome measuring tool is relatively new, but in six months to one year we will start to have proper data at various time points. There is a bit of an evidence trap affecting innovation across the
piece: the big research budgets are in the big-ticket services, so approaches, like Shared Lives, that are currently small-scale attract small-scale research budgets. You have endless pilots where everybody agrees that it looks promising, but we do not have enough numbers to be sure, and we need to break that.

Q251 Chair: Alison, is the current issue of data-sharing a problem for you?

Alison Rogan: NHS Digital and the NIB, the National Information Board, are doing a great deal of work in terms of data-sharing, and we comply with everything that comes out of those bodies. There are a lot of things that have come out; we are part of the techUK Interoperability Charter. The technologists are on it. As Alex says, sometimes people are the biggest difficulty. In our world, we are not at that scalability with health and social care integration at all. I do not know anywhere that is, to be fair, apart from Spain, where we are doing some fantastic work and supporting 250,000 people with health and social care. We have a long way to go, but it is very early days and we are waiting for the NIB to make its final reports.

Karen Kibblewhite: We have seen a real shift in information-sharing over the past couple of years. It has improved tenfold between social care and health, but I say “health” with a bit of a caveat because of course, when we talk about “health”, there is health data that sits within hospitals, CCGs, GP surgeries, acute trusts—and I could go on. We have a tendency to say “health data” and put it all together. The data-sharing with CCGs and hospitals, and with NHS trusts, has improved tremendously.

GP data-sharing is still a bit of sticky issue. That is not necessarily because GPs do not want to share, but because you are talking at a much lower level. You are often talking at the GP practice level, which then means that you are talking about working across a lot more individuals to get to the data, to get the information-sharing to get back.

Q252 Chair: Alison has already told us about the figures that she has to demonstrate the impact of the various schemes that she has been dealing with. Alex was saying that you are working on getting the data to show what impact you have. Do you have any specific evidence that what you are doing is beneficial in terms of preventing people from needing more expensive care, admission to hospital and that sort of thing?

Karen Kibblewhite: Yes. I did not bring specific numbers with me today. I can share some of those with you afterwards.

Chair: If you could, that would be helpful, yes.

Karen Kibblewhite: We chose within Rutland, unusually, to spend a proportion of our better care funding on prevention. We recognise that within Rutland we have an ageing population—as we do in a lot of places in England, but it is disproportionately so in Rutland. We do not necessarily need people to live longer; we need them to live more healthily while they are living longer. We shifted our focus from looking
after those people who already needed social care and were already at those thresholds. We still provide the care to them, as we do statutorily under the Care Act, but we started to think about how we could spot those individuals earlier, support people earlier and reduce the likelihood of them only coming to social care when they are in crisis, which then means that they need a lot more intensive interventions and they are a lot more expensive.

We have taken a view that it is more cost effective long term, we would hope—we will see the outcomes of it in five to 10 years’ time—to start working with people who are under the social care threshold, putting in support for those people at a much lower level, shorter-term and less intensive, which will stop them escalating.

Q253 Chair: How can you afford to do that when many councils say that they only have enough money, and probably not enough money, to deal with the people with the highest needs?

Karen Kibblewhite: In the previous session, someone was saying, “The better care fund would be great if we could spend it more on prevention.” I was sat at the back thinking that that is exactly what we did in Rutland. We took a view that, if we are to reduce residential admissions and hospital admissions in the long term, we need to start much earlier in the day. We used a good chunk of the better care fund to do that and to focus on the prevention, knowing that we will not see the results until three, five or 10 years down the line. If we do not start that shift, we will never be able to make that shift. We use the better care fund, because why not? In our understanding, that was what the better care fund was for. It was about integration, innovation and preventing those high-level needs.

Chair: Alex, do you have a final point?

Alex Fox: On that prevention point, people often see prevention as being about what happens longer-term and things that you cannot measure, on the basis that it is the stuff that did not happen. You can turn that on its head slightly in terms of how interventions can build resilience, which is preventative. Some of those things affect people now, or almost now; they are short-term. In particular, a good measure of resilience is how connected people are to those around them. Approaches like Shared Lives and Homeshare connect people and support their resilience. You can do that for people through things like local area co-ordination, where you are looking at people who are below the eligibility threshold, but are getting disconnected from their community.

We need to start building some of those ideas around resilience, connection and confidence not just into our early-end community stuff, which is almost impossible to invest in for many areas at the moment, for the reasons that we have heard, but throughout the system. Any intervention that we do in health and social care can connect or disconnect people depending on the way that we do it.
Karen Kibblewhite: You talk about local area co-ordination. That is one of the things that we have spent our better care fund on in Rutland, as part of prevention: co-ordination to support the building of community capacity.

Chair: Thank you all very much for coming to give evidence to us from a whole variety of different innovations. That has been appreciated by the Committee. Thank you very much indeed.