House of Commons

Committee of Public Accounts

Discharging older people from acute hospitals

Twelfth Report of Session 2016–17

HC 76

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The Committee of Public Accounts

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The current staff of the Committee are Dr Stephen McGinness (Clerk), Dr Mark Ewbank (Second Clerk), George James (Senior Committee Assistant), Sue Alexander and Ruby Radley (Committee Assistants), and Tim Bowden (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Committee of Public Accounts, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 4099; the Committee's email address is pubaccom@parliament.uk.

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Summary

Increasingly, older patients are experiencing delays in being discharged from hospital. Such delays are bad for their health and increase the level of care they may need after leaving hospital. Unnecessary delays are also bad for the financial sustainability of the NHS and local government and the National Audit Office (NAO) has estimated a gross cost of around £800 million a year for the NHS of older patients delayed in hospital when they no longer benefit from being there. While it is clear there have been improvements and many in the NHS and local government are putting in significant efforts, the Department of Health (the Department) and NHS England rely too easily on differing local circumstances as a catch-all excuse for not securing improvement in performance. They should be doing more to increase the pace of integration and make local accountability systems more effective. Those areas which are doing best are the ones where all the local system owns all of the problem but this practice is all too rare.

The Department, NHS England and NHS Improvement have failed to address long-standing barriers to the health and social care sectors sharing information and taking up good practice. The result is unacceptable variation in local performance. While we recognise there are significant pressures on adult social care and NHS funding, NHS England shows a striking poverty of ambition in believing that holding delays to the current inflated level would be a satisfactory achievement. Patients and the NHS have a right to expect better.

Introduction

Discharging older people from hospital involves not only hospitals, but also community health and social care services as many older people need some support in the short or longer term to allow them to live in their own homes or to take up a place in a care home. The number of older people (aged 65 and over) in England is increasing rapidly, by around a fifth every 10 years. Emergency admissions of older patients have gone up at an even faster rate—by 18% between 2010–11 and 2014–15. This rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems. Official figures show the number of delayed transfers for older people—that is where a patient remains in hospital after the clinicians and professionals involved in their care decide they are ready to leave—increased by 31% to 1.15 million bed days between 2013 and 2015.

Conclusions and recommendations

1. **There is a poor understanding of both the scale and cost of the problem of delays in discharging older patients from hospital.** The official data substantially under-estimate the range of delays and the number of older patients who are delayed. The NAO estimates that the number of hospital bed days occupied by older people who are no longer benefiting from acute care is approximately 2.7 million a year (higher than the official delayed transfer of care figure for all adult patients of 1.15 million), at an estimated gross cost of around £820 million. These estimates are in line with the recent Carter Review. The NAO also estimates that the public cost of providing out of hospital care for these patients may be around £180 million. NHS England estimated that the net costs could range from £0 to £640 million with a mid-range estimate of between £300 million and £400 million. If the NHS is serious about moving older patients of hospital as soon as they are ready, it needs to understand the true scale of the problem, and what resources are involved in caring for these patients in hospital or in alternative, more appropriate settings.

   Recommendation: ***NHS England should develop measures that fully capture the number of older people who are no longer benefiting from acute hospital care. Also, building on the initial work set out in the NAO report, NHS England should coordinate work to fully understand the cost to hospitals of delayed discharges and the costs, where these fall on the public purse, of caring for these people in the community.***

2. **There is unacceptable variation in local performance on discharging older patients.** As an indication of the variation across different areas, for the hospitals within the Committee member's constituencies, the number of officially recorded delayed transfers of care in 2015–16 ranged from 10 days in Northumbria to nearly 18,000 days in Lincolnshire. The Department agrees that there is unacceptable variation in the performance of local areas on discharge delays. It told us that there are 65 local authority areas (out of 152) whose current levels of delay have improved from their levels of two years ago. Out of the remaining 87, there are also 22 areas with rates of delay that are at least three times worse than the group of 65 authorities which have improved. The NAO report also shows significant variation between hospitals in the proportion of older people attending A&E who are then admitted to hospital from 37% to 61%.

   Recommendation: ***There are several contributory factors behind the variations in local performance. We expect the Department, NHS England and NHS Improvement to understand the reasons for the variations and address the further recommendations we make below.***

3. **The fragility of the adult social care provider market is clearly exacerbating the difficulties in discharging older patients from hospital.** NHS England believes the increasing pressure on adult social services will prevent significant progress being made in reducing the number of delayed discharges over the next five years. Local authority spending on adult social services has fallen by 10% in real terms between 2009–10 and 2014–15. This is putting pressure on local authorities to reduce fees which in turn puts pressure on care providers. The introduction of the national living wage is adding further to this pressure. Most home care and residential/nursing home

care is provided by private sector organisations who face significant issues with the recruitment and retention of home care workers and nurses in nursing homes, depending on other factors such as local employment markets and whether there is full employment. In some areas care providers are charging higher prices to people funding their own care compared to local authorities who benefit from bulk discounts.

Recommendation: ***Our report on personal budgets in adult social care recommended that the Department clarify its position as national steward of the social care market in its National Market Position Statement. Given the effect that serious funding pressures and market fragility are having on discharging patients, we re-iterate this recommendation. The Department should report back to us by January 2017 on progress in implementing the key elements of the Position Statement and what impact this is having.***

4. **While good practice on discharging patients from hospital is well understood, implementation is patchy across local areas.** Good practice in discharging older patients is well understood with some elements that all local areas should have. These include: avoiding older people being admitted to hospital unnecessarily; starting assessments and discharge planning early; maintaining the momentum of treatment while in hospital; joint/shared patient assessments between health and social care providers; and undertaking the assessment of patients long-term care needs in the most appropriate setting, whenever possible in their own home. While some local areas have made progress, overall take-up of good practice is slow. NHS Improvement's remit is to disseminate good practice across the NHS. Its model is to encourage organisations to go and look at other organisations that are doing it well and there are examples of where this is happening. However, this bottom-up approach does need to be balanced against the need to increase the pace of implementation.

Recommendation: ***NHS England and NHS Improvement should report back to us by January 2017 on what steps they have taken to increase the pace of good practice adoption.***

5. **The absence of widespread and effective sharing of patient information remains a significant barrier to the effective discharge of older patients.** The extent to which patient information is shared varies across local areas and difficulties in sharing patient information remain a significant issue. Patients and families often have to repeat information on their care history and current circumstances across different health and social care organisations. Northumbria Healthcare NHS Foundation Trust, which has an excellent record on reducing delayed discharges, regards the ability of its hospital staff to access GP patient records as a vital part of being able to plan patient's care and discharge. It also uses community matrons to facilitate the sharing of information, but the use of community matrons varies across other local areas.

Recommendation: ***NHS England, working with local government partners, should identify early lessons from the ongoing work on information sharing, so that health and social care providers can get a clear idea of what will work best in their local area. It should report back to us by January 2017 on what progress has been made on information sharing in local areas.***

6. **Current structures do not have an effective line of accountability, either nationally or locally, for what is at root a shared problem for health and social care systems of discharging older patients.** There is a fragmented accountability structure which makes it more difficult to implement and drive forward change. At a local area level, there is no single point of accountability for health and social care services. NHS England stated that system resilience group chairs are accountable to NHS England, but directors of adult social services that sit on these groups are not. At a national level, NHS England and NHS Improvement are responsible for improving services and the implementation of good practice across NHS organisations. However, they have no responsibility for, or control over, local authorities whose elected officials are accountable to their local electorate.

   Recommendation: ***As steward of the system, the Department of Health should set out in its accountability system statement how local health and social care systems will be held to account for areas of care that require a whole system approach, such as discharging older patients. This could, for example, involve strengthening the remit of the national Discharge Programme Board and local system resilience groups to hold the whole system to account.***

7. **Local health and social care organisations are too often not working together effectively, with organisational boundaries getting in the way of what should be a smooth and seamless process for the patient.** Patients and families often find it difficult to navigate the 'crazy paving' of local health and social care organisations and can find themselves caught up in delays, or passed back and forth, between different bodies. Some of the local areas that are performing best on discharging patients are those that are fully integrated, such as Northumbria where the NHS Foundation Trust controls acute and community health services and also adult social services. While a single top-down approach may not always be appropriate, different local circumstances should not be an excuse for lack of progress on effective joint working. Irrespective of local circumstances, strong leadership to bring local organisations together is important. System resilience groups have a remit to oversee the coordination and integration of services. However, these groups are not yet consistently effective. In 2016–17, NHS England and NHS Improvement will be leading a review and refocusing of system resilience groups.

   Recommendation: ***NHS England, working with local government partners, should clearly set out good practice models for integrated and closer working that they expect to be adopted by local health and social care systems, and report back to us by January 2017 on what steps they have taken to increase the pace of adoption of such models.***

8. **Financial incentives across local health and social care systems are not encouraging all organisations to work together to reduce delays.** Reducing the length of older patients' hospital stays will reduce their longer-term care needs and ultimately care costs. However, short-term financial incentives to discharge older patients as soon as possible from hospital are not aligned across local health and social care organisations. The Better Care Fund promotes closer joint working through a pooled budget for health and social care services, but most areas have not met their planned reductions in delayed discharges. Due to this lack of progress, the Department is requiring areas to put in place risk-sharing mechanisms to try and ensure incentives are aligned across the different health and social care organisations. Acute hospitals are able to fine local authorities if the authority is responsible for a delayed discharge. However, fines are not imposed by most hospitals—only 23% of authorities were fined in 2014–15 and the amount involved was minimal (around £2 million). Neither NHS Improvement or the Local Government Association saw fines as an effective way to improve incentives.

   Recommendation: ***NHS England and NHS Improvement, working with local government partners, should seek to understand which contracting and payment mechanisms, including targeted use of fines, offer the best incentives for community health providers and local authorities to integrate and co-ordinate their activities better and accept patients as quickly as possible.***

1 Performance

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), NHS England, NHS Improvement and the Local Government Association.[1] We also took evidence from the Association of Directors of Adult Social Services, Northumbria Healthcare NHS Foundation Trust and Independent Age.

2. For older people, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. They can also lose their ability to do everyday tasks such as bathing and dressing and are more likely to acquire hospital infections.[2] Once discharged from hospital, some may need short- or long-term support from their local authority or community health services. This may involve either living at home with some support or living in a care home.[3]

3. The number of older people (aged 65 and over) in England rose by 20% between 2004 and 2014 (compared with 8% for all age groups) and is projected to increase by a further 20% between 2014 and 2024. The number of older people admitted to hospital is rising: between 2010–11 and 2014–15 the number of patients aged 65 and over with an emergency admission to hospital increased by 18% (compared with a 12% increase overall). Both the NHS and adult social care sectors are under pressure with the combination of rising demand for services and restricted or reduced funding. Nationally, while NHS spending has grown by 5% in real terms between 2010–11 and 2014–15, local authority spending on adult social care has fallen by 10% in real terms between 2009–10 and 2014–15.[4]

Understanding the scale and cost of the problem

4. The Department acknowledged that the level of delayed discharges had increased significantly over the last two years. The official data records that delayed transfers of care (where a patient remains in hospital after the clinicians and professionals involved in their care decide they are ready to leave) have increased substantially over the past two years. This data show an increase of 270,000 (31%) bed days taken up by patients (aged 18 and over) in acute hospitals with a delayed transfer of care, from 0.87 million days in 2013 to 1.15 million days in 2015. Around 85% of those days were for patients aged 65 and over. Two reasons account for most of this increase: the number of days spent waiting for a package of home care; and waiting for a nursing home placement or availability.[5]

5. We heard that the official data on delayed transfers of care do not capture all the delays that a patient might experience.[6] The definition of delayed transfers of care excludes any delays that occur before clinicians and other health professionals make the assessment that a patient is ready for discharge. The NAO estimated that the actual number of hospital bed days occupied by older people who are no longer benefiting from acute care is approximately 2.7 million a year. The NAO further estimated that the gross costs to

1 C&AG's Report, *Discharging older patients from hospital*, Session 2016–17, HC 18, 26 May 2016
2 Throughout this report, by 'hospital', we mean acute hospitals which focus on the treatment of a patient's immediate medical care needs as opposed to community hospitals, which are more focused on rehabilitation.
3 C&AG's Report, paras 1.2, 1.6
4 C&AG's Report, para, 1.1, 3.3
5 Q 66, C&AG's Report, paras 1.9–10
6 Q 50

the NHS of delayed discharge for older people was in the region of £820 million and that caring for older people who no longer need to be in hospital in other settings could result in annual costs of around £180 million for other parts of the health and social care system, principally for NHS community health care and nursing care. As set out in the NAO report, there are limitations to the available data and the NAO's estimates are sensitive to a number of assumptions.[7]

6. NHS England stated that it did not agree with the NAO cost estimates. Although it did not offer an alternative in the C&AG's report, in the hearing it told us it considered that the net costs of delayed discharges could range from £0 to £640 million with a mid-range estimate of between £300 million and £400 million. The NAO estimates are in line with the recent review by Lord Carter which estimated the gross cost to the NHS of delays across all age groups was £900 million.[8]

Variation in performance

7. As an indication of the variation across different areas, for the hospitals within the Committee members constituencies, the number of officially recorded delayed transfers of care in 2015–16 ranged from 10 days in Northumbria to nearly 18,000 days in Lincolnshire (see **Figure 1**). **Figure 2** shows the variation in acute delayed transfers of care across those hospitals reporting an acute delay between March 2015 and February 2016. The **Appendix** to this report provides data for individual trusts. Monthly data on delayed transfers of care are available on the NHS England website.[9] The NAO report also shows significant variation across a number of indicators of patient flow within hospitals. For example, there was variation between hospitals in the proportion of older patients attending A&E who are then admitted, ranging from 37% to 61%, and in the average length of stay in hospital for older in-patients ranging from 10.4 days to 14.1 days.[10]

Figure 1: Levels of delayed transfer of care across Committee members constituencies

Constituency	Acute hospital trust	Delayed transfers of care (days)
Sleaford and North Hykeham	United Lincolnshire Hospitals NHS Trust	17,932
Bristol South	University Hospitals Bristol NHS Foundation Trust	15,632
Peterborough	Peterborough & Stamford Hospitals NHS Foundation Trust	14,020
South Norfolk	Norfolk & Norwich University Hospitals NHS Foundation Trust	13,659
Amber Valley	Derby Hospitals NHS Foundation Trust	6,552
Shoreditch and Hackney South	Homerton University Hospital NHS Foundation Trust	4,709

7 C&AG's report, para 1.11, 3.10;
8 Qq 47–52; C&AG's Report para 3.10.
9 NHS England, *Delayed transfers of care*
10 C&AG's report, Figure 6. The numbers reported are those between the 10th and 90th percentiles of each distribution. These can be used to highlight variation between hospitals, as they are not unduly affected by extreme (very low or very high) cases, which could be driven by atypical or specific local factors. (The 10th percentile is the value for which 10% of the data points are lower; the 90th percentile is the value for which 10% of the data points are higher.)

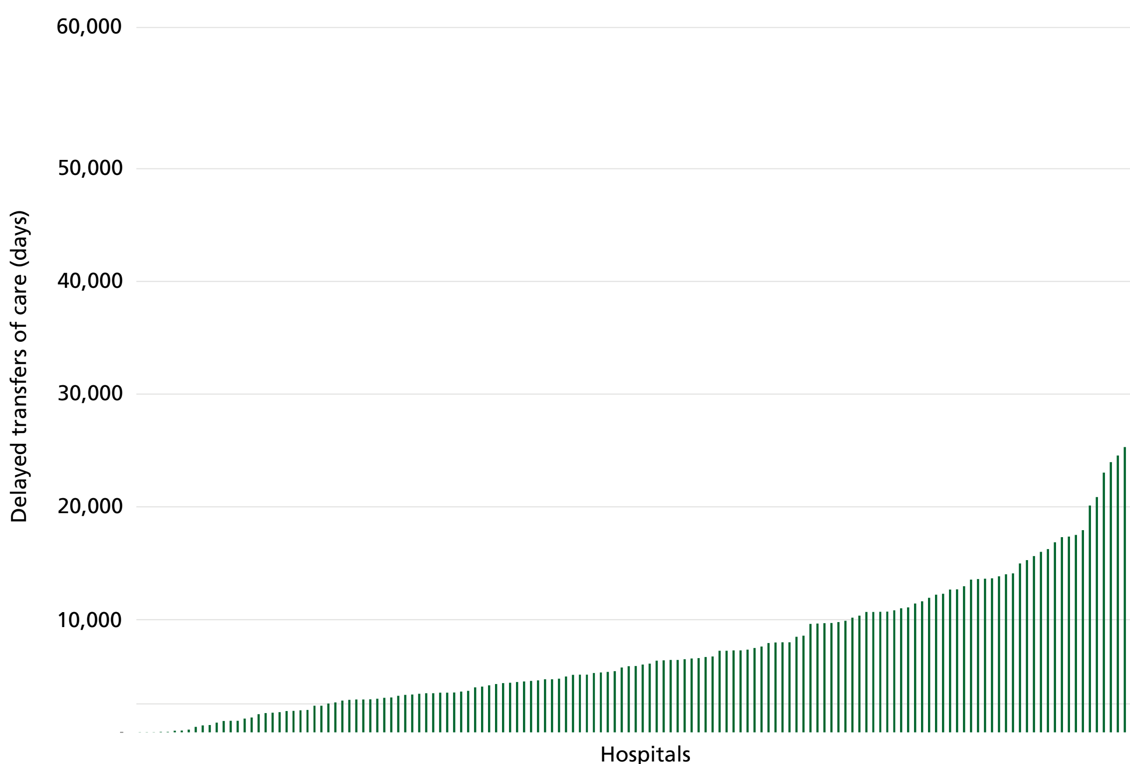
Constituency	Acute hospital trust	Delayed transfers of care (days)
Don Valley	Doncaster & Bassetlaw Hospitals NHS Foundation Trust	2,551
Houghton and Sunderland South	City Hospitals Sunderland NHS Foundation Trust	1,219
Southport	Southport and Ormskirk Hospital NHS Trust	1,027
Torbay	South Devon Healthcare NHS Foundation Trust	1,002
Berwick-upon-Tweed	Northumbria Healthcare NHS Foundation Trust	10
Warrington South	Warrington and Halton Hospitals NHS Foundation Trust	Not available—did not submit data in Jan–Feb 16

Notes

- Data is for the year March 2015 to February 2016

Source: NHS England, Delayed transfers of care data.

Figure 2: Acute delayed transfers of care across hospitals (March 2015 to February 2016)



Notes

- The appendix to this report provides data for each individual trust.
- Data is for the year March 2015 to February 2016.

- Figure shows all trusts that reported an acute delayed transfer of care between March 2015 and February 2016.
- A number of trusts have been excluded as, although they reported delays for some months, they did not submit data for at least one month between March 2015 to February 2016. These trusts are: Warrington and Halton Hospitals NHS Foundation Trust; Sheffield Teaching Hospitals NHS Foundation Trust; Surrey and Borders Partnership NHS Foundation Trust; Norfolk and Suffolk NHS Foundation Trust; Berkshire Healthcare NHS Foundation Trust; and South Tees NHS Foundation Trust.
- The NAO report generally used the 10th and 90th percentiles to show variation as these are not unduly affected by extreme (very low or very high) cases, which could be driven by atypical or specific local factors. The 10th percentile tells you the value for which 10% of the data points are lower. The 90th percentile tells you the value for which 10% of the data points are higher. For delayed transfers of care, these are around 1,100 and 16,000 days respectively.

Source: NHS England, Delayed transfers of care data.

8. The Department agreed that there was unacceptable variation in the performance of local areas on discharge delays. It told us that there are 65 local authority areas (out of the 152 local authorities with responsibility for adult social care, approximately 43%) whose current levels of delay have improved from their levels of two years ago. Out of the remaining 87, there are also 22 areas with rates of delay that are at least three times worse than the group of 65 authorities which have improved. These 22 areas make up approximately 15% of all local authorities, but are responsible for around a third of all officially recorded delays.[11]

Adult social care provider markets

9. Local authority spending on adult social care has fallen by 10% in real terms between 2009–10 (£16.3 billion) and 2014–15 (£14.6 billion). The Association of Directors of Adult Social Services and the Local Government Association said that the funding cuts were increasing the pressure on local authorities and providers. As set out in the NAO report, commissioners of adult social care are under pressure to keep the fees they pay to providers as low as possible, which is in turn putting pressure on providers. The report also highlighted a 2015 survey by the Association of Directors of Adult Social Services where 56% of directors thought service providers were facing financial difficulty. The Association of Directors of Adult Social Services also cited the introduction of the national living wage as a factor increasing the pressure further on funding and providers.[12] NHS England said that the pressure on local authority funding would see a widening gap between the availability of, and the demand for, adult social care over the next few years. It stated that this would impact on the NHS, showing up as delayed discharges, and would prevent significant progress being made in reducing delays over the next five years.[13]

11 Qq 63, 64, 152
12 Qq 2–3, 83, 108; C&AG's Report, paras 3.3–3.5
13 Qq 68, 74, 110, 116

10. The Association of Directors of Adult Social Services noted that there was no correlation between the size of local authority funding cuts and performance on delayed discharges, citing Northumbria Healthcare NHS Foundation Trust where significant funding cuts had not impacted on its performance on delays.[14] However, the Association of Directors of Adult Social Services and the Local Government Association said that funding cuts were having a significant impact on the adult social care market. Most providers of care were private sector organisations, which were having difficulties in the recruitment and retention of home care workers and nurses in nursing homes. The Department said that factors such as local employment markets and whether the local area has full employment also impact on the local markets. The NAO report highlighted the variation in vacancy rates across the country for residential and home care workers and also high staff turnover rates in these areas.[15]

11. The Local Government Association recognised that local authorities and individuals funding their own care were paying different prices for care, with local authorities benefiting from bulk purchase discounts. Where fees for individuals were significantly higher, the Local Government Association said that individuals should be asking providers what they were getting for the money. It also said that, where fees were very high for individuals funding their own care, this made it more difficult for local authorities to negotiate adequate supply from care providers. The Department confirmed that it had recently written to every local authority reminding them of their duties under the Care Act to promote a sustainable market including diversity and choice.[16]

14 Qq 2, 8

15 Qq 2, 3, 10–12, 83, 108, 151; C&AG's Report, figure 13

16 Qq 160–161

2 Good practice

Adoption of good practice

12. Both the Department and NHS England agreed that there was a good understanding of good practice in discharging older patients from hospital.[17] This includes: avoiding older people being admitted to hospital unnecessarily (for example, through setting up frailty units);[18] starting assessments and discharge planning early; maintaining the momentum of treatment while in hospital, for example increasing the level of discharges before midday and at the weekend; joint/shared patient assessments between health and social care providers ('trusted assessors');[19] and undertaking the assessment of patients long-term care needs in the most appropriate setting, whenever possible in their own home ('discharge to assess').[20] NHS England confirmed there have been a series of publications with organisations such as the Local Government Association and the Association of Directors of Adult Social Services setting out good practice in this area.[21]

13. Both the Department and the Association of Directors of Adult Social Series stated that there were examples where good practice was being implemented. NHS England cited the examples of Northumbria and other vanguard areas that have been set up as part of its Five Year Forward View programme. These areas were demonstrating what can be done in implementing good practice and the impact this can have.[22] The Local Government Association stated that changing the culture across organisations was vital. It cited the example of Leicester where the cultural change has been across all of the organisations with every person asking the question "Why not home, and why not today?". The Association stated that it was important to get every person focusing on what is right for each individual patient.[23]

14. NHS England confirmed that not all hospitals were implementing good practice. NHS Improvement said that, in a number of areas of good practice highlighted in the NAO report, it would expect to see widespread implementation such as trusted/joint assessment and 'discharge to assess' schemes.[24] The NAO report shows that only 49% of hospitals had 'trusted'/joint assessment arrangements in place with their local authority and 52% had discharge to assess schemes in place where the assessment of a patient's future care needs is done outside hospital. The Department also stated that there are some essential elements of good practice that every place should have and that over the next year there should be a systematic approach to making sure they are in place.[25]

17 Qq 53–54, 104, 151

18 Frailty units are dedicated teams of specialist doctors, nurses, therapists or social workers operating in A&E and short stay units to carry out early assessment of older patients' needs.

19 Under trusted assessor arrangements, health and social care professionals complete a single assessment of patients' needs, which can be shared, reducing duplication.

20 Under 'discharge to assess' schemes, planning, assessment and arranging ongoing care takes place in the patient's home rather than hospital, as soon as their acute treatment is complete.

21 Qq 2, 4, 54

22 Qq 2, 18, 64, 68

23 Q 109

24 Qq 110, 130–133, 148–150

25 Q 151; C&AG's Report, figure 10

15. NHS England and NHS Improvement confirmed that NHS Improvement was responsible for ensuring the spread of good practice across the NHS. NHS Improvement set out its model for the dissemination of good practice which is to encourage organisations to go and look at other organisations that are doing it well. It cited the example of the quality improvement programme it has set up at Leeds Teaching Hospitals which had resulted in a 30% reduction in delayed discharges. This is being rolled out as a pilot across the North of England with plans to take the good practice and use it across the NHS.[26] Northumbria Healthcare NHS Foundation Trust said that over 50 trusts had visited to look at its systems. The Department stated that there are advantages to a bottom-up approach as you get local ownership. However, it also said that this approach needed to be balanced against the need for more pace in implementing good practice and the degree to which the centre prescribes what local areas should do.[27]

Sharing patient information

16. The NAO report showed that the sharing of patient information is a barrier to the smooth transition of patients into and out of hospital. This includes both the information provided to hospitals when people are admitted and also the information provided to ongoing care services (community health and adult social care) following discharge from hospital. Independent Age said that hospitals often relied on family members to provide information on a patient's circumstances outside hospital. It said that families often have to repeat background information, such as current medication, across different people and organisations they encounter. Independent Age had concerns about how information was provided for those patients who did not have people to represent them.[28]

17. Northumbria Healthcare NHS Foundation Trust said that in an acute hospital setting they are often dealing with patients they have never seen before. The Trust recognised the importance of its hospital staff being able to access patient information and, in particular, its ability to interrogate GP patient records. It described the IT system it had recently put in place which allows hospital staff, community nurses and social workers to access appropriate parts of the GP record. This information helped them to: avoid stopping care packages; ensure that adequate support is in place when patients leave hospital; and highlight to community nurses areas that may require further monitoring and assessment.[29]

18. Northumbria Healthcare NHS Foundation Trust also highlighted the important role played by community matrons in sharing patient information and ensuring continuity of care for patients. The Association of Directors of Adult Social Services said that there was local variation in the extent to which community matrons are used and patient information is shared.[30] The NAO report showed that the numbers of nurses working in community services had fallen by 13% between 2009 and 2015.[31]

26 Qq 68, 71, 75, 101–102
27 Qq 9, 147
28 Q 32, C&AG's Report, para 3.20
29 Qq 20–23
30 Qq 30–31
31 C&AG's Report, para 3.7

3 Accountability and integration

Accountability

19. NHS England acknowledged that there was fragmentation in the care system following the Health and Social Care Act 2012. It said there are a range of organisations with different statutory accountabilities, with some organisations within the NHS and others such as local authorities outside. It went on to say that this accountability structure was making it more difficult to drive forward change and it was doing its best to work around this structure.[32]

20. At a local area level, NHS England said there was no single person or organisation with overall responsibility for delayed discharges across the local health and social care systems. It cited the example of 'system resilience groups' where it said the group chairs are accountable to NHS England, but the directors of adult social services, that sit on these groups, are not.[33]

21. NHS England set out that, at a national level, NHS England and NHS Improvement are responsible for improving services and the implementation of good practice across NHS organisations. However, they have not got responsibility for, or control over, local authorities, who are accountable to their local electorate.[34]

22. The Association of Directors of Adult Social Services and the Local Government Association emphasised that, irrespective of the local organisational structures in place, strong leadership was a vital part of improving the way local health and social care organisations work together.[35] NHS England has established system resilience groups as the key local forum for planning capacity and overseeing the coordination and integration of local services. The Local Government Association cited the example of Oxfordshire where strong leadership within the system resilience group had resulted in a significant improvement in relationships across local organisations and this was starting to improve the performance on delayed discharges. However, both the Association of Directors of Adult Social Services and NHS England said that there was variability in the effectiveness of system resilience groups across the country. NHS Improvement stated that, during 2016–17, it would be jointly leading with NHS England a review and refocusing of system resilience groups with the aim of improving their effectiveness.[36]

Integration of local health and social care organisations

23. Witnesses highlighted the challenges that organisational boundaries pose for patients. Independent Age talked about the 'crazy paving' of health and social care services across the country which makes it more difficult to advise patients and families about issues such as who is responsible for services and who to contact about the choices available. In its casework, Independent Age has seen examples of: delays due to conflicts about funding between the NHS and local authorities; poor co-ordination in assessing care needs

32 Qq 75, 77, 139
33 Qq 72–78,
34 Qq 75, 139, 145–146; C&AG's Report, para 3.26, figure 19
35 Qq 24, 57
36 Qq 38, 53, 57–58, 71; C&AG's report. Para 3.11

which result in older patients receiving the wrong care and ultimately being readmitted to hospital; and a lack of co-ordination in the provision of equipment and re-ablement services (care aimed at maximising people's independence).[37]

24. The Department stated that some of the systems that are doing the best in reducing delayed discharges were those that are fully integrated—where local providers have come together so that 'all the system owns all of the problem'.[38] One example of this is Northumbria Healthcare NHS Foundation Trust which has very few delayed discharges (see **Figure 1**). The Trust manages both the acute and community hospitals in Northumbria. In addition, since September 2013, it has managed the adult social services for Northumberland County Council. The Trust set out its experience of working across traditional organisational boundaries and the benefits of doing so. It cited the example of its seven-day working across physiotherapists, occupational therapists, speech and language therapists and social workers within its multidisciplinary teams. The whole multidisciplinary team are coordinated, monitored and actively managed.[39]

25. There are other areas that have introduced a similar structure to that of Northumbria, such as Salford and Torbay, and the Department stated it had a growing interest in this approach. It said that the number of areas where an NHS trust was running adult social services was currently in single figures and this was likely to grow to about 20 based on those areas that were currently making preparations for such an approach.[40] However, the Department, NHS England and the Local Government Association explained that this model may not be replicable across all areas and therefore it was not appropriate to impose a single top-down approach. NHS England added that it was not in favour of new legislation or a statutory reorganisation of health and social care. The Department explained that some health organisations were not ready to take on the control of adult social services. NHS England and the Local Government Association stated that the proportion of individuals funding their own care, as opposed to local authority funding, would also influence the appropriateness of the local organisational structure.[41]

26. The Better Care Fund promotes closer joint working through a pooled budget for health and social care services with individual areas having plans to reduce delayed discharges. The Department said that, in the first six months, only 40% of local authority areas had achieved their planned reduction in delayed transfers of care.[42] The Department said that one of the things the Better Care Fund has struggled with is a lack of alignment of incentives between the different local organisations. It stated that, due to the lack of progress to date on delayed discharges, it was taking a tougher approach in 2016–17 and requiring organisations to put in place risk-share mechanisms so that there is a joint and agreed responsibility for delayed discharges.[43]

37 Qq 1, 28
38 Qq 58, 106
39 Qq 4, 6–8
40 Qq 58, 84–88
41 Qq 55–61, 78
42 Q 117; C&AG's Report, para 3.18–3.19
43 Qq 111, 117

Incentive mechanisms

27. NHS England stated that in some places there was a disconnect between hospitals and community health services in terms of incentives and the availability of community services. It also agreed with the NAO report that many local authorities do not have response time standards in their contracts with care home providers and this was an important part of making the system work more effectively. The Local Government Association said that there was no incentive for local authorities to leave people in hospital for longer than was needed as the longer older people stay in hospital the more their mobility and ability to perform everyday tasks will deteriorate; increasing their long-term care needs and therefore the costs.[44]

28. As outlined in the NAO report, short-term financial incentives to discharge older patients as soon as possible from hospital are not aligned across local health and social care systems. The report found that hospitals have financial incentives to minimise the length of stay for emergency attendances and keep space free for elective procedures for patients. However, community health providers and local authorities are not incentivised financially to speed up receiving patients discharged from hospital. Most of the community health providers the NAO spoke to were on a block contract without any activity-based payments.[45]

29. The Department confirmed that there is a statutory mechanism for acute hospitals to fine, on a discretionary basis, local authorities if the authority is responsible for a delayed discharge. NHS England said that the level of fining was minimal. The NAO report showed that only 23% of local authorities were fined in 2014–15: for a total of around £2 million. The Local Government Association said there was a lot of evidence that, where a fining system was in place, local authorities had to put money aside to pay fines rather than invest to improve services such as home care.[46]

30. NHS Improvement thought that there were better ways to improve incentives than the use of fines. It cited the example of some vanguard sites, set up under NHS England's Five Year Forward View, that were looking at establishing 'whole-population' budgets. NHS Improvement also said that, rather than using fines in a punitive way, local agreements should be made on using the money to invest in initiatives to help reduce delayed discharges.[47]

44 Qq 54, 118
45 C&AG's Report, para 3.23
46 Qq 112–113, 118; C&AG's Report, para 3.25
47 Qq 114–115

Appendix

Acute delayed transfers of care (DTOC) across hospitals (March 2015 to February 2016)

Provider Code	Name	Number of DTOC days between Mar 15–Feb 16
RQY	South West London And St George's Mental Health NHS Trust	1
RJ8	Cornwall Partnership NHS Foundation Trust	8
RTF	Northumbria Healthcare NHS Foundation Trust	10
RRF	Wrightington, Wigan And Leigh NHS Foundation Trust	41
RPC	Queen Victoria Hospital NHS Foundation Trust	43
RP6	Moorfields Eye Hospital NHS Foundation Trust	142
RGM	Papworth Hospital NHS Foundation Trust	160
RPY	The Royal Marsden NHS Foundation Trust	234
RBV	The Christie NHS Foundation Trust	484
RAS	The Hillingdon Hospitals NHS Foundation Trust	619
RT3	Royal Brompton & Harefield NHS Foundation Trust	651
RFF	Barnsley Hospital NHS Foundation Trust	855
RA9	South Devon Healthcare NHS Foundation Trust	1,002
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	1,026
RVY	Southport And Ormskirk Hospital NHS Trust	1,027
RLN	City Hospitals Sunderland NHS Foundation Trust	1,219
RLQ	Wye Valley NHS Trust	1,310
RBL	Wirral University Teaching Hospital NHS Foundation Trust	1,609
R1F	Isle Of Wight NHS Trust	1,710
RL1	The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1,734
RE9	South Tyneside NHS Foundation Trust	1,791
RBK	Walsall Healthcare NHS Trust	1,884
RET	The Walton Centre NHS Foundation Trust	1,909
RKE	The Whittington Hospital NHS Trust	1,948
RXP	County Durham And Darlington NHS Foundation Trust	1,988
RFS	Chesterfield Royal Hospital NHS Foundation Trust	2,354
RBQ	Liverpool Heart And Chest Hospital NHS Foundation Trust	2,367

Provider Code	Name	Number of DTOC days between Mar 15–Feb 16
RP5	Doncaster And Bassetlaw Hospitals NHS Foundation Trust	2,551
RCF	Airedale NHS Foundation Trust	2,650
RA2	Royal Surrey County Hospital NHS Foundation Trust	2,819
RWH	East And North Hertfordshire NHS Trust	2,876
RBN	St Helens And Knowsley Hospitals NHS Trust	2,909
RCD	Harrogate And District NHS Foundation Trust	2,922
RQ6	Royal Liverpool And Broadgreen University Hospitals NHS Trust	2,936
RC1	Bedford Hospital NHS Trust	2,981
RDD	Basildon And Thurrock University Hospitals NHS Foundation Trust	3,062
RAE	Bradford Teaching Hospitals NHS Foundation Trust	3,102
RR7	Gateshead Health NHS Foundation Trust	3,246
RJZ	King’s College Hospital NHS Foundation Trust	3,329
RXQ	Buckinghamshire Healthcare NHS Trust	3,348
RVW	North Tees And Hartlepool NHS Foundation Trust	3,422
RA3	Weston Area Health NHS Trust	3,464
RD1	Royal United Hospitals Bath NHS Foundation Trust	3,477
RJ6	Croydon Health Services NHS Trust	3,518
RFR	The Rotherham NHS Foundation Trust	3,526
RJ2	Lewisham And Greenwich NHS Trust	3,531
RAP	North Middlesex University Hospital NHS Trust	3,620
RN7	Dartford And Gravesham NHS Trust	3,683
RC9	Luton And Dunstable University Hospital NHS Foundation Trust	3,986
RJ7	St George’s University Hospitals NHS Foundation Trust	4,050
RQM	Chelsea And Westminster Hospital NHS Foundation Trust	4,169
RCX	The Queen Elizabeth Hospital, King’s Lynn, NHS Foundation Trust	4,277
RLT	George Eliot Hospital NHS Trust	4,373
RJR	Countess Of Chester Hospital NHS Foundation Trust	4,395
RTK	Ashford And St Peter’s Hospitals NHS Foundation Trust	4,468
RBZ	Northern Devon Healthcare NHS Trust	4,520
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	4,567
RAJ	Southend University Hospital NHS Foundation Trust	4,619

Provider Code	Name	Number of DTOC days between Mar 15–Feb 16
RQX	Homerton University Hospital NHS Foundation Trust	4,709
RYJ	Imperial College Healthcare NHS Trust	4,714
RWJ	Stockport NHS Foundation Trust	4,755
RBT	Mid Cheshire Hospitals NHS Foundation Trust	4,952
RK5	Sherwood Forest Hospitals NHS Foundation Trust	5,094
RBD	Dorset County Hospital NHS Foundation Trust	5,109
RVR	Epsom And St Helier University Hospitals NHS Trust	5,112
RF4	Barking, Havering And Redbridge University Hospitals NHS Trust	5,258
REM	Aintree University Hospital NHS Foundation Trust	5,309
RJ1	Guy’s And St Thomas’ NHS Foundation Trust	5,366
RQ8	Mid Essex Hospital Services NHS Trust	5,428
RGR	West Suffolk NHS Foundation Trust	5,760
RQQ	Hinchingbrooke Health Care NHS Trust	5,869
RWA	Hull And East Yorkshire Hospitals NHS Trust	5,890
RDE	Colchester Hospital University NHS Foundation Trust	6,012
RA4	Yeovil District Hospital NHS Foundation Trust	6,097
RXK	Sandwell And West Birmingham Hospitals NHS Trust	6,355
RTP	Surrey And Sussex Healthcare NHS Trust	6,392
RNZ	Salisbury NHS Foundation Trust	6,424
RRV	University College London Hospitals NHS Foundation Trust	6,428
RJL	Northern Lincolnshire And Goole NHS Foundation Trust	6,488
RTG	Derby Teaching Hospitals NHS Foundation Trust	6,552
RXR	East Lancashire Hospitals NHS Trust	6,577
RGP	James Paget University Hospitals NHS Foundation Trust	6,685
RW6	Pennine Acute Hospitals NHS Trust	6,736
RW3	Central Manchester University Hospitals NHS Foundation Trust	7,234
RWE	University Hospitals Of Leicester NHS Trust	7,240
RM3	Salford Royal NHS Foundation Trust	7,267
RJF	Burton Hospitals NHS Foundation Trust	7,268
RHU	Portsmouth Hospitals NHS Trust	7,338
RDZ	The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	7,478

Provider Code	Name	Number of DTOC days between Mar 15–Feb 16
RJC	South Warwickshire NHS Foundation Trust	7,607
RN3	Great Western Hospitals NHS Foundation Trust	7,928
RAX	Kingston Hospital NHS Foundation Trust	7,976
RMC	Bolton NHS Foundation Trust	7,988
RAL	Royal Free London NHS Foundation Trust	7,991
RJN	East Cheshire NHS Trust	8,481
RPA	Medway NHS Foundation Trust	8,580
RWY	Calderdale And Huddersfield NHS Foundation Trust	9,618
RCB	York Teaching Hospital NHS Foundation Trust	9,652
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	9,688
RD3	Poole Hospital NHS Foundation Trust	9,704
RK9	Plymouth Hospitals NHS Trust	9,777
RGQ	Ipswich Hospital NHS Trust	9,898
RHW	Royal Berkshire NHS Foundation Trust	10,175
RQW	The Princess Alexandra Hospital NHS Trust	10,353
RYR	Western Sussex Hospitals NHS Foundation Trust	10,670
RVV	East Kent Hospitals University NHS Foundation Trust	10,679
RTX	University Hospitals Of Morecambe Bay NHS Foundation Trust	10,700
RJE	University Hospitals Of North Midlands NHS Trust	10,713
RXH	Brighton And Sussex University Hospitals NHS Trust	10,821
RTE	Gloucestershire Hospitals NHS Foundation Trust	11,007
RMP	Tameside Hospital NHS Foundation Trust	11,086
RWG	West Hertfordshire Hospitals NHS Trust	11,431
RBA	Taunton And Somerset NHS Foundation Trust	11,620
RXW	Shrewsbury And Telford Hospital NHS Trust	11,933
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	12,214
RNA	The Dudley Group NHS Foundation Trust	12,285
RNQ	Kettering General Hospital NHS Foundation Trust	12,669
RL4	The Royal Wolverhampton NHS Trust	12,676
RXF	Mid Yorkshire Hospitals NHS Trust	12,965
RM2	University Hospital Of South Manchester NHS Foundation Trust	13,541
RD8	Milton Keynes Hospital NHS Foundation Trust	13,596

Provider Code	Name	Number of DTOC days between Mar 15–Feb 16
RXC	East Sussex Healthcare NHS Trust	13,622
RM1	Norfolk And Norwich University Hospitals NHS Foundation Trust	13,659
RRK	University Hospitals Birmingham NHS Foundation Trust	13,843
RGN	Peterborough And Stamford Hospitals NHS Foundation Trust	14,020
RNL	North Cumbria University Hospitals NHS Trust	14,106
RWF	Maidstone And Tunbridge Wells NHS Trust	14,986
RDU	Frimley Health NHS Foundation Trust	15,285
RA7	University Hospitals Bristol NHS Foundation Trust	15,632
RWP	Worcestershire Acute Hospitals NHS Trust	16,007
RVJ	North Bristol NHS Trust	16,250
RX1	Nottingham University Hospitals NHS Trust	16,859
R1H	Barts Health NHS Trust	17,321
RGT	Cambridge University Hospitals NHS Foundation Trust	17,358
REF	Royal Cornwall Hospitals NHS Trust	17,507
RWD	United Lincolnshire Hospitals NHS Trust	17,932
RH8	Royal Devon And Exeter NHS Foundation Trust	20,127
RNS	Northampton General Hospital NHS Trust	20,868
RR1	Heart Of England NHS Foundation Trust	23,034
RN5	Hampshire Hospitals NHS Foundation Trust	23,977
RHM	University Hospital Southampton NHS Foundation Trust	24,554
RKB	University Hospitals Coventry And Warwickshire NHS Trust	25,305
RR8	Leeds Teaching Hospitals NHS Trust	29,803
RTH	Oxford University Hospitals NHS Trust	50,256

Notes:

- Data is for the year March 2015 to February 2016.
- Figure shows all trusts that reported an acute delayed transfer of care between March 2015 and February 2016.
- A number of trusts have been excluded as, although they reported delays for some months, they did not submit data for at least one month between March 2015 to February 2016. These trusts are: Warrington and Halton Hospitals NHS Foundation Trust; Sheffield Teaching Hospitals NHS Foundation Trust; Surrey and Borders Partnership NHS Foundation Trust; Norfolk and Suffolk NHS Foundation Trust; Berkshire Healthcare NHS Foundation Trust; and South Tees NHS Foundation Trust

Source: NHS England, Delayed transfers of care data.

Formal Minutes

Wednesday 13 July 2016

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon	Nigel Mills
Deidre Brock	David Mowat
Chris Evans	Karin Smyth
Kevin Foster	Mrs Anne-Marie Trevelyan
Mr Stewart Jackson	

Draft Report (*Discharging older people from acute hospitals*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 30 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Appendix agreed to.

Summary agreed to.

Resolved, That the Report be the Twelfth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 18 July 2016 at 3.30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 6 June 2016

Question number

Harold Bodmer, President, Association of Directors of Adult Social Services, and Executive Director of Adult Social Services, Norfolk County Council, **David Evans**, Chief Executive, Northumbria Healthcare NHS Foundation Trust, and **Janet Morrison**, Chief Executive, Independent Age — Q1–42

Simon Stevens, Chief Executive, NHS England, **Dr Kathy McLean**, Executive Medical Director, NHS Improvement, **Sarah Mitchell**, Director, Social Care Improvement, Local Government Association, and **Jon Rouse**, Director General, Social Care, Local Government and Care Partnerships, Department of Health — Q43–175

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

ADA numbers are generated by the evidence processing system and so may not be complete.

1 ADASS (ACH0015)

2 Age UK (ACH0010)

3 Anchor (ACH0006)

4 British Red Cross (ACH0001)

5 College of Occupational Therapists (ACH0003)

6 David Halpin (ACH0017)

7 Department of Health (ACH0014)

8 The Health Foundation (ACH0016)

9 Healthwatch England (ACH0007)

10 Local Government Association (ACH0013)

11 Marie Curie (ACH0002)

12 NHS Improvement (ACH0012)

13 One Housing (ACH0008)

14 Parkinson's UK (ACH0004)

15 Royal College of Nursing (ACH0009)

16 Royal College of Physicians (ACH0005)

List of Reports from the Committee during the current session

All publications from the Committee are available on the publications page of the Committee's website.

Session 2016–17

First Report	Efficiency in the criminal justice system	HC 72
Second Report	Personal budgets in social care	HC 74
Third Report	Training new teachers	HC 73
Fourth Report	Entitlement to free early education and childcare	HC 224
Fifth Report	Capital investment in science projects	HC 126
Sixth Report	Cities and local growth	HC 296
Seventh Report	Confiscations orders: progress review	HC 124
Eighth Report	BBC critical projects	HC 75
Ninth Report	Service family accommodation	HC 77
Tenth Report	NHS specialised services	HC 387
Eleventh Report	Household energy efficiency measures	HC 125

Public Accounts Committee

Oral evidence: Discharging older people from acute hospitals HC 76

Monday 06 June 2016

Ordered by the House of Commons to be published on 06 June 2016

Watch the meeting: http://www.parliamentlive.tv/Event/Index/91550dd5-1776-458e-8bb3-c9243d9d3ed8

Members present: Meg Hillier (Chair), Mr Richard Bacon, Deidre Brock, Chris Evans, Caroline Flint, Mr Stewart Jackson, Nigel Mills, David Mowat, Stephen Phillips, John Pugh, Karin Smyth, Mrs Anne-Marie Trevelyan

Sir Amyas Morse, Comptroller and Auditor General, National Audit Office, Adrian Jenner, Director of Parliamentary Relations, NAO, Ashley McDougall, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Harold Bodmer, President, Association of Directors of Adult Social Services, and Executive Director of Adult Social Services, Norfolk County Council, David Evans, Chief Executive, Northumbria Healthcare NHS Foundation Trust, and Janet Morrison, Chief Executive, Independent Age, gave evidence.

Chair: Good afternoon and welcome to the Public Accounts Committee on Monday 6 June 2016. Apologies for starting 15 minutes late; we had a lively pre-session in private. We are here today to discuss the NAO Report, "Discharging older patients from hospital". In the last two years we have seen delays for older patients in hospitals rise to record levels, but Richard Bacon—who is deputy Chair of the Committee—reminded us that 13 years ago there was a Report on a similar subject, and it was not good news then. It is not rocket science, and it is not new that there is an issue here, but there are real concerns that this Report pulls out. Of course, this is against the backdrop of major cuts to social services and the tightening and squeezing of spending in the national health service. We are keen to hear from our first panel about their experiences on the ground and what it is like, and then from a second panel of people who are responsible for funding and managing this at a national level.

We are delighted to welcome David Evans, chief executive of the Northumbria Healthcare NHS Foundation Trust, which has one of the best records on discharging older people anywhere in the country—I am sure we will hear that again from David's local MP. We are pleased to welcome Harold Bodmer, who is the president of the Association of Directors of Adult Social Services and the executive director of adult social services at Norfolk County Council, which is where Richard Bacon is

an MP. Janet Morrison, who is the chief executive of Independent Age, does not have an MP representing her here, but I am sure we all saw her article today on PoliticsHome. Thank you for coming along, and welcome to you all.

Our hashtag today is #olderpeople for anyone following us on Twitter. I will hand straight over to Anne-Marie Trevelyan.

Q1 Mrs Trevelyan: Thank you, Chair. To start, it would be interesting to hear your views on what you think the main reasons are for not only the level of delays, but the increase in delays?

Janet Morrison: Thank you for inviting me to give evidence today. I am speaking from the viewpoint of an organisation that provides information and advice to older people and their families, particularly when they are trying to navigate a crisis. A large number of questions and cases that come to us regarding social care are often brought by family members, not the older people themselves. Our experience is therefore not of the positive but of the negative; the delays and challenges. I will draw out a couple of themes from the kinds of cases that we deal with in order to give you a flavour of where I think the pressure points are.

One of the key areas is people contacting us who are nervous about imminent discharge, when they feel either that their relative isn't fit enough to be discharged or that there isn't adequate care in place for them. That raises a general concern about those people who don't have someone to advocate for them when they are in that situation. Some of the themes that we see are a feeling from the families that there is not an embedded culture of communication and consultation in the hospitals prior to discharge, and the feeling that things are done to patients, rather than them actually being involved in the plans for their care.

The theme of lack of integration in health and social care is particularly identified in some of the cases we deal with where there is a conflict between the decision about whether they are going to be local authority-funded or whether they are going to be funded under continuing care. That can cause considerable delays and some disputes. On the way that people are actually handled, we have seen cases where people have had a local authority social worker who has been very involved in their needs, but they have then been passed back to a broker of beds who hasn't understood them, and therefore they have been sent to or offered inappropriate placements that have resulted in them going into temporary placements and, ultimately, readmission.

On the lack of co-ordination, a lot of the cases that we deal with are not just about finding home care or residential nursing care, but about co-ordination in the provision of equipment and re-ablement services. People are really struggling with the wait for those services to be available—evidence, of course, of the challenges in social care funding.

Finally, some of the cases that we see concern not having long-term plans for discharge, so people are being given temporary solutions, perhaps to relieve pressure on bed spaces. We had a case of a lady with vascular dementia who was assessed to move back home; she could not move home and was put into temporary care home accommodation, but then she was sent home and ended up back in hospital, and again went to a care home. The reality was that at each point there was not a long-term plan or assessment; it was a short-term plan.

Those are some of the themes that you will see across the board and in the evidence from the NAO.

Q2 Mrs Trevelyan: Thank you. That is very helpful. Mr Bodmer, there is a strong sense that it is in the externals beyond the NHS and the hospital framework where the problems are. Would you agree with that?

Harold Bodmer: I would agree with that to some extent.

I want to make three points on behalf of the Association of Directors of Adult Social Services. We are a charity that represents all 152 local authority adult social services departments. First, if we are to make an impact on delayed transfers of care, we need to look at emergency admissions. The Report shows that emergency admissions have gone up by 18%. Unless we stop people going into hospital—particularly older people who do not need to be there, and that is either at the front door of the hospital or with much stronger community health and social care services—we will always have this problem. That is my first point.

Secondly, you would expect me to say something about the reduction in adult social services budgets. Of course that is an issue, but there is no direct correlation, as David will demonstrate, between a big reduction in social services spend and delayed transfers; what there is, over time, given that we are now into the sixth year of reductions in adult social care spend, is a real impact on the social care market. The thing that our members and I are most concerned about is the home care market and the sustainability of domiciliary care. It is no surprise to us that the NAO Report illustrated the availability of home care and of nursing care as the two major issues for the increase in social care delays.

There are regional variations in that—it is not a straightforward picture—and in areas with high employment it is really difficult to recruit home carers. There is also the whole issue of the national living wage; welcome as it is, its big impact has been in how it is funded. The area is not one in which private providers feel it is profitable to be, and we have not necessarily got the join-up we need between private domiciliary care agencies and the NHS. I think we would go so far as to say that the fragility of that market undermines the whole fabric of health and social care community provision; it is not just about discharge. That is one of our biggest concerns.

With nursing care, it is about the availability of qualified nurses in nursing homes. There is a real issue about recruiting and retaining nurses. Nursing homes are sometimes seen as the solution, and they absolutely are, where they are part of a discharge through an assessed process that is properly managed. That is absolutely right, but they cannot be seen as a block solution, because otherwise the examples that Janet talked about—people moving from place to place—are emphasised. Also, they create dependency.

My third and final point is that the best examples of where really good practice is happening—and some really good practice is happening—is where services are integrated and there is a whole-system approach. Yes, of course emphasise that we need to get the accounting right—we need to make sure that we are accounting for all the delays, and we need to have a system—but if we are going to have a new system of accounting, we would really press not to have something that forces systems to create arguments between different sectors.

Q3 John Pugh: May I press you on a point you just made? You are talking partly about market failure in the adult social care market, rather than non-delivery of adult social care services. Social services departments can obviously do something about one of those, but rather less about

the other. If you were to take a view of the delays you see that are caused by the failure to provide adult social care in a timely way, when you say market failure, how much of it is because of shortage of the right people or the right accommodation and how much of it is simply because of the local authority not doing its job sufficiently well or with sufficient resources?

Harold Bodmer: I think the Report itself says that the main reason for social care delays is the availability of domiciliary care services. Of course there are delays in process—I wouldn't pretend that there were not—but the systems that are working well are doing it quickly. They are planning discharge as early as they possibly can. Once you have gone through that process, though, you have to have people in the community who are available to manage the needs we are now seeing. We are seeing an increase in acuity. We are seeing people whose needs are much greater and more dependent than they were even five years ago.

Chair: I should add that on Wednesday we are publishing our Report on the social care market, in which we touch on some of these issues. It is interesting that the matter has come up so firmly in this Report as well.

Q4 Mrs Trevelyan: Mr Evans, in Northumbria you have spent the past 10 years building what is, judging by the Report, a fairly unique model, so it will be helpful for us to hear you views on where the delays are and how you have cracked it in Northumbria.

David Evans: We have been at it for a lot longer than 10 years. It goes back to the mid-90s, when Northumberland was one of the pilot combined care trusts, and North Tyneside, the bottom part of our patch, was one of the acute community trusts. We have had a long experience of working across traditional boundaries and realising the benefits of integration.

The key word from the Report is "momentum". It is about managing people actively and recognising that, first of all, the key thing is avoiding the need for people to come into hospital in the first place. That has undoubtedly been an important part of what we have done. We have had seven-day working by consultants in our emergency stream since 2004. We didn't make a shout about it, we didn't have to employ a lot of extra people and we didn't have to pay a lot of extra money; we did it because there was a recognition that it was the right thing to do and that by doing it we could improve the passage of patients through our service and avoid unnecessary admissions.

Although the Report deals with the back end, if you like, to me the most active management we can do to benefit older people is to avoid their having to come into hospital in the first place, because without doubt people get trapped in the system, and then there is all the stuff about losing muscle strength, becoming confused and being exposed to infections. If we can avoid an admission, and if that means having consultants working an extended working day, seven days a week, to avoid the need for people to come into hospital, that is where an acute provider can really focus their effort.

If somebody is in the system, planning for discharge from the time they come into the system is key. Again, it is about the momentum that you maintain. In Northumbria, in the best Geordie tradition, we have a thing called your "Ticket Home", which is a checklist that everybody—the family and the individual—takes part in. It is a simple aide-mémoire of what needs to be in place to help this person get home. That is started as soon as they are in our system. We have a "hospital to home" team that actively manages everyone who is destined to go home. It is a multidisciplinary team that draws on all the agencies.

The key thing for us is that since September 2013 we have managed the adult social services for Northumberland County Council, which is our biggest area. Within 72 hours of our taking on that responsibility you could see a change in the graph of our ability to move people through our system. It seems to me that every time you remove an organisational boundary, you can gain a benefit for that older person. We have seven-day working by our physiotherapists, our occupational therapists, our speech and language therapists and our social workers, so that the whole multidisciplinary team is there all the way through. It is co-ordinated, monitored and very actively managed.

The other thing that is unusual about Northumbria is that we also manage our six community hospitals; so, again, moving people through the system to their benefit is something that is in our control.

Q5 Chair: Mr Evans, can I just ask about the issue raised by Mr Bodmer, which was the ability to recruit domiciliary care and other care workers? Is that an issue?

David Evans: In the north-east of England that is not an issue.

Q6 Stephen Phillips: Mr Evans, what you have just described—the figures are frankly breathtaking. You have essentially got 0% delayed transfer of care days per 100 beds. If I look at ULHT in Lincolnshire, it is 5%. You really described two things in your answer. You described having different structures in place and having different processes in place, possibly as a result of having responsibility, or combined responsibility, for the hospitals and also for the domiciliary care. Which is more important: the structures or the processes?

David Evans: For us it was a sequence. We put the structure in place. We put seven-day working in place and we were able to see the benefits very quickly. We then refined the process and actively managed people through the system so it was a natural sequence.

Q7 Stephen Phillips: The suggestion from that answer would be that if everybody got the right structures in place, so that there was, if you like, combined hospital care and combined responsibility for adult social care in every area, then the processes would drop into place and the worry which emerges from this Report about how many days are being lost as a result of delayed transfers would simply evaporate. Would that be fair?

David Evans: You could look at it that way. For us, a lot of what we have changed was driven by our geography. We cover 2,500 square miles. We have patients in 10 different hospitals.

Stephen Phillips: That is not largely different from Lincolnshire, yet you are doing incredibly well. ULHT, the main trust in Lincolnshire, is doing incredibly badly.

Q8 David Mowat: The other feature in Northumberland is that you have had larger cuts in the adult social care budget than the average; so, to Mr Phillips's point, it sort of exacerbates the result. It is almost extraordinary. You have had the most significant cuts in adult social care budget, yet you have got, stand out, the best results by loads.

David Evans: I think we have managed that collaboratively, because we work together with our local authority. We managed the social services contract and we had those structures in place, which allowed us to weather that.

Q9 David Mowat: So I would expect you to be touring the country now, telling everybody else what to do, so that that could be rolled out as best practice everywhere, because it just seems too good to be true—or a fantastic achievement—and that the NHS should be using that everywhere.

David Evans: We have had over 50 trusts—51 trusts, now—visit us to look at the system, and we are certainly happy to share what we have done. It is applicable in some parts, but not for everyone. Again—I go back to what we said—it is our geography that has driven a lot of the changes we have made.

Chair: I will bring in Mr Bodmer for his perspective on this, and then I am going to bring in Nigel Mills after that.

Harold Bodmer: We would argue that process is really important. Structures may be less important, but clearly what is important is the combined working. I wouldn't underestimate the impact of the differential effect on the social care market in different parts of the country, because there isn't a domiciliary care problem in the north-east, but there is in parts of Hertfordshire, Oxfordshire and Norfolk. It is really difficult to get domiciliary care in north Norfolk. So there is something about making sure that we see the whole picture in terms of the—

Q10Mr Bacon: When you say the differential impact on the domiciliary care market in different parts of the country, are you referring to the availability of staff or the availability of physical homes, or what?

Harold Bodmer: I am talking about the availability of staff, Mr Bacon. Social care in this country is provided by the private sector pretty much exclusively, except, usually, for re-ablement services, which are often provided in-house. So almost all of this is outsourced, and therefore it is very much dependent on local employment markets.

So what you see—I think it is figure 13 in the Report that has the turnover—is that the turnover in domiciliary care is very significant. Certainly in my own authority, that turnover is not always people leaving the domiciliary care service, but it is people moving from one provider to another. That is because if you are on the national living wage, a 10p difference in the hourly rate makes a big difference, so you are going to move somewhere else. What that does is it creates a disruption in the whole system. People don't get continuity of care and it creates an uncertainty around this.

Q11 Mr Bacon: Can I just pursue this point for a second? You say that they are provided by the private sector. In most cases, they are paid for by you, are they not?

Harold Bodmer: They are.

Q12 Mr Bacon: Yes, so just as the Department for Communities and Local Government announced it was going to commission directly the building of 13,000 houses because the supply of houses was not rising to meet demand, wouldn't a natural response of a social services department facing the problems you describe be to start providing these services itself?

Harold Bodmer: There is a variety of difference. Some local authorities are looking at doing that. We have a clear responsibility under the Care Act to understand the market in which we are working and to make sure an efficient market is available. Some authorities are using directly-owned companies or outsourced but Teckal-compliant companies to do this, but there are other examples. Even if you do that and offer well above the national living wage, you are competing with private employers who can pay more.

I haven't got a solution and I'm not just saying this. It is a funding issue and a workforce issue, and it is about how we collectively plan the health and social care workforce together.

Chair: Absolutely. As I say, we will be publishing our report on this on Wednesday.

I must advise witnesses that if they can be a little quicker with their answers, we will get a few more questions in. We very much appreciate what you are providing, but we want to get through more material.

Q13 Nigel Mills: Mr Evans, can I come back to the way you have got the number of delay days down to practically zero? There is some suggestion in the NAO Report and perhaps my local trust that there are different ways of measuring this delay around the country. Is some of what you have achieved down to different measurement?

David Evans: Given that we manage community beds so that people who move into a community hospital are still on our books and given that we don't have a hospice system so people in the palliative care stream are still on our books, if anything that detracts from our figures. We have checked our methodology and we believe we are doing it absolutely correctly and that we have a system that allows us actively to manage people through, and we control parts of the system that allow us to do that.

Q14 Nigel Mills: Looking at the data we got from all our constituencies, which showed you were perhaps slightly higher in the number of bed days for over-65s proportionately, in length of stay and in length of over-seven-day stay, I was wondering whether you were starting the clock at a slightly later point for some very good reason.

David Evans: No; that reflects the fact that people who will stay in a community hospital for several weeks will still go into that dataset. I do not believe that the dataset that is managed nationally reflects the way a trust like ours works. A lot is said in the Report about what could be the standard dataset to allow comparison.

Q15 Nigel Mills: I suppose I am trying to understand what the trigger point should be. I think I am right that the current one is when a consultant says a patient no longer has any need for acute care. They should then leave the acute hospital, in effect. Quite rightly, they would be moving into one of your other community hospitals. Is that a measure you take? It is hard to believe you

wouldn't have any patient or relative choice problems, or other continuous assessment problems and that you could get down literally to zero.

David Evans: The patients who feature in delayed discharge are almost all patients with a family who need some support to make a decision about where their relative would be placed.

Q16 Nigel Mills: So you think that if it is done right, everywhere can get down to practically zero on this. That is what I am trying to work out: whether there is a base level that we can never get below. You think you can get almost to zero if you get it right?

David Evans: If you want to push it further, it would sometimes mean two moves. Your relative may be ready for discharge and be discharged to a setting which may not be your choice for their long-term care, so they would be in that setting until you make a choice on where their long-term care will be and they will move again. I think that is a bad thing for the individual—very confusing and disruptive. If you want to get it down to zero, it would mean two moves in some cases.

Q17 Chris Evans: In May there was another report by Dame Julie Mellor, the Parliamentary and Health Service Ombudsman. I think you will be very au fait with that. It seems that the huge problem with a number of the complaints—221 complaints across the NHS—is related to patients with dementia. The NAO has had several Reports on dementia strategy. I wondered how, on the ground, that affects delayed discharge.

In Dame Julie's report, there were nine harrowing cases and many of those related to dementia. I am interested to hear you relate how you think the dementia strategy is working and why we are in a situation where hospitals are discharging people. There is one example from Chesterfield in front of me reported in the *Derbyshire Times*. It says that 1,571 patients were released from hospital between the hours of 11 pm and 6 am. That is an absolute disgrace—a national disgrace. What are your thoughts on that?

Chair: Janet Morrison, would you like to kick off on that, as I think you mentioned that in your article?

Janet Morrison: Yes. We certainly have cases coming to us where people are consulted but without their mental capacity being effectively taken into account or the home circumstances they are going back to considered. We have certainly dealt with people who are going back to their home setting with no or very inadequate care, which has meant that they have just bounced back into the hospital system.

There is also an issue about finding the right kind of residential nursing care. I do not think that families feel they get sufficient choice in terms of the information and advice they have about exercising that choice. Again, I think that causes considerable delays, because if they refuse a placement they could in some cases get eviction notices or whatever. I do not think the actual marketplace in terms of dementia care and support is taken into account adequately.

Harold Bodmer: Our take on that report was that it absolutely reflected a system under huge strain. Decisions were being made quickly and inappropriately, and the harrowing cases that were set out were really good examples of that.

You have to question whether anybody should go to residential care who has not been in a residential home before that, straight from an acute hospital bed. There are some places that absolutely do not do that. That goes back to our first point about keeping people out of hospital, and alternative ways of doing that, particularly for that increasing group of people with dementia. It is about finding ways of providing as much care at home or near to home as we possibly can.

Q18 Chair: In a previous hearing, we were looking at GP services and the challenges there, where a GP can see their own patient and make an assessment. That is particularly important in dementia. Is that something that you recognise and are there good examples of where that is working well around the country in your experiences? I will come back to David Evans in a moment.

Harold Bodmer: There are good examples of where work is centred around primary care, and lots of the work that is going on in the models for the new Five Year Forward View centre around that. I think there is some interesting work.

Q19 Chair: Can you name any examples? If you cannot now, can you write to us?

Harold Bodmer: I can certainly send you some examples.

Q20 Chair: Please, if you could that would be great. David Evans on the main point.

David Evans: Primary care has a key role in this because they manage patients long term; they know and recognise changes in behaviour, often the early signs of dementia. In an acute setting, we are dealing with somebody we have never met before. What has helped us is our ability to interrogate GP records and get more information through some technology that was on the back of our PACS vanguard, and that will help us in the future. Certainly, that is also helpful because we can avoid turning off a care package; we can ensure that adequate support is in place; we can highlight concerns to community nurses for further monitoring and assessment and liaison with primary care.

Q21 Chair: You mentioned sharing records. How, in your situation, do people check records? Do people carry their own? Is there an electronic method?

David Evans: It is four weeks in and it hasn’t crashed yet, but we have just got a thing called the medical interoperability gateway.

Q22 Chair: I love these titles. Please explain in ordinary English what that is.

David Evans: It’s a MIG. It is on a server somewhere and it means that using SystmOne—one of the commonest GP systems—GPs, hospital care, community nursing and social services can gain access to appropriate parts of the master GP record.

Q23 Chair: So, if someone is in someone's home in a domiciliary setting or that person is in a nursing home, can they access that information?

David Evans: Yes, it's on a tablet. And in A&E.

Chair: Mr Chris Evans, did you have anything else? Too many Mr Evanses today. No. Karin Smyth.

Q24 Karin Smyth: Mr Bodmer, can I come back to something you said about structure and process? I would not disagree, but in Bristol we have got two large acute hospitals and we have been an outlier in this area for a number of years. There are two different community providers, we do not have community beds and there are two different social services organisations, and one hospital has 50% of its admissions from each of those two different areas.

Mr Bodmer, will you talk a little bit about the different structural problems faced across the country and how that mitigates some of the successes? Mr Evans, as you take over the world as a provider, where are your commissioners in driving some of this work?

Harold Bodmer: We have got a very complex health and social care landscape, and I think we have all seen examples where we have had integrated services that have not felt very integrated. I would argue that the key—and I am certain that this is the key to David's success here—is leadership. So in a sense, the issue is how you lead across the services, rather than the structure in the first place. Structures can get in the way, and sometimes our structures do get in the way, but actually if you have a combined willingness and a leadership to work across, you can do that. I suppose I was arguing that the solution is not always a major structural one.

Q25 Mr Bacon: Mr Bodmer, did Mr Evans not tell us that he runs the Northumbria social services department? He is in charge of it. He has a contract with the county that he runs adult social services. Mr Bodmer, of course we are familiar with each other because you are my local social services director, but in your previous answer you could be accused of talking your own book, because if the model—

Chair: Not that you ever do that.

Mr Bacon: No, I am not going to go there. It is very good—

Chair: Sorry, that is an in-joke. Mr Bacon has written an excellent book—

Mr Bacon: Thank you. If we were running Norfolk on the same model as Mr Evans is running Northumbria, social services would be run as part of one NHS trust rather than by Norfolk County Council, and you might not have a job.

Harold Bodmer: I don't think structures are as important as the process and the leadership—I suppose that is simply my point. You are absolutely right—of course that would be the case, but I am not answering that question because I would be worried about not having a job. I think genuinely that we could spend an awful lot of time in a mass of reorganisation of health and social care, when actually what we need to do is ensure we have the right leadership in place—

Q26 Mr Bacon: Well, I am slightly sympathetic to that. I remember having a conversation with Simon Stevens about the fact that there were too many clinical commissioning groups and he was very concerned that the NHS not obsess itself with yet more reorganisation, which is a fair point.

The interesting word Mr Evans used was "control"—in fact, control of a system. Part of it is about process and part of it is about organisation. Of course you always need good leadership, but, since this is plainly a systemic problem, you need a system that is working as one system and it sounds like you have got several systems interacting not particularly well—Janet Morrison is nodding at this point. Given the available evidence, do you not think that we could learn more from Northumbria? Mr Evans took a question out of my mouth when he said, "We've had 51 visitors to Northumbria." Do you not think we could all learn more from Northumbria than Northumbria could learn from elsewhere?

Harold Bodmer: I am absolutely certain that that is the case. Of course we could learn from Northumbria and should be doing that. I think there are different ways of having control; I am just arguing against a massive reorganisation of health and social care.

Q27 Chair: It is worth highlighting that adult social care is not just about older people in hospital.

Harold Bodmer: No, that is a key point. It is not just about discharge.

Q28 Mr Bacon: Janet Morrison, you were nodding when I said this is a systemic problem.

Janet Morrison: I was nodding. I think everyone is sympathetic to further structural reform. The issues of underfunding are still there, but we know that processes do not work very effectively and structures are one good excuse why they will not work effectively.

From our point of view, when we are trying to advise people to navigate the system, it is like crazy paving across the UK. To try to explain to someone where responsibility lies, who will be able to advise you and give you choice, and how you will have control about your future independence and the way you want to live is very difficult because every area is different. I think we do need to think about how we create greater integration and better processes, and leadership and funding are essential to those as well.

Q29 Karin Smyth: Can I be clear that, having been through two reorganisations, which I think have caused us a number of problems, I am absolutely not in favour of another structural reform. My point really is that the structural reforms have mitigated the integration—however you define integration—of the systems. I think your earlier point about going through from the '90s as a care trust is interesting. Picking up on the point about the Five Year Forward View, I am interested in how, in that patch in Northumbria—I understand you have two clinical commissioning groups—you have kept that leadership and drive for 20 years?

David Evans: I think there was a collective memory that things were better when we were working in that way. We then had to withdraw from that, and everybody in the system was keen to get back to that way of working. On your earlier question about the role of our commissioners in this, commissioners are there to commission high-quality care. We were able to demonstrate, by these changes, that the quality of the care that we were providing was improving, so our commissioners have been very supportive of the changes we have made. I am proud to say that we have driven all of our changes on safety and quality; not on money, not on systems and not on process, but on the safety and quality of the care we provide for patients.

Q30 Caroline Flint: Figure 18 on page 43 of the NAO Report and the paragraph beneath it talk about the lack of sharing information. That is why it was interesting to hear what you said, Mr Evans, about the sharing of appropriate amounts of patient information by different people who are involved. What are you doing in Northumbria on the personal touch on this? In Doncaster we used to have community matrons who had a case load of 50 patients—not all were older people, but most were. The matrons were a sort of human linchpin between the community-based services, and they also worked with social services. If one of their patients turned up at an A&E, there would be a call from the consultant to the community matron as soon as possible, so they could start thinking about whether it was appropriate for that patient to come in and how quickly they should be settled in a more suitable form of support until they got better. How do you manage that human interaction and continuity in your area?

David Evans: That is key, and the community matrons have a key role in that. We use our community matrons in a lot of different ways. We use our community matrons to provide training to care assistants and matrons in nursing and care homes about what support can be given and what "good" looks like. Our community matrons come into our community hospitals to take part in the consultant ward rounds, to make sure that the packages that need to be in place when somebody is moving back into a home or into a different setting are in place. We also use our community staff in our "hospital to home" management teams, so that those people are providing expertise.

The thing you said about the collective knowledge of their case group is vital. There used to be a phone call; it is now our MIG. We have also got a couple of schemes going within the vanguard process for, if you like, man-marking the top 4% of our most seriously ill and frail older people, who we know have a disproportionate demand on acute services, and almost taking them out of the traditional "wait until you get in and then somebody will see you" system and putting them into some sort of regular check and follow-up system.

Q31 Caroline Flint: That role within the whole package seems to be a vital part of what is happening in Northumbria, but my perception is that it is not happening to that extent elsewhere. I have a sense that in my own area that central role has declined. Is that the case, or am I wrong about that? Is it something that has lost its input and value in other parts of England?

Harold Bodmer: I think the extent to which community matrons are used and that sharing of information exists varies greatly from trust to trust. There are some really good examples, but I think it is variable.

Q32 Caroline Flint: So you can't say it is something that is being taken up across the board. Is that a negative or a plus?

Harold Bodmer: There is no doubt that anything that improves the sharing of patient information at that point of planning is crucial, and ignoring that, as the Report says, is one of the things that get in the way of integration.

Janet Morrison: In our experience of the cases we deal with, often it is the family members who are relied upon to keep the history of what has been going on prior to entry into hospital. Often, if they are not there at the moment when there are key staff on the ward, they are not there to keep up that history. What they tell us is that having to repeatedly tell the story and the background of the medication and all of the history to whoever they come into contact with is a big burden. It is of concern for those who do not have people to advocate on their behalf.

Q33 David Mowat: I have a final observation question for all three of you. We have established that there is a systemic issue in England's NHS—everywhere except perhaps Northumberland—in this regard. In your view, are we better or worse than peer health systems in other countries, such as France, Germany or Italy? Would they all have a similar set of metrics, or do they do this differently?

Harold Bodmer: That's not a question I could answer.

Chair: So ADASS does not have international comparisons.

Q34 David Mowat: Because you are immersed in this as your life's work, is that not something that you are interested to know the answer to? Is it a feature of our NHS or is it happening everywhere in Europe?

Harold Bodmer: Where we have looked at other systems—I am sure David and Janet will be able to comment—part of the problem sometimes is that the whole background and context in which the system operates is so different that it is difficult to make comparison. Sweden is often looked at in terms of delayed transfers of care and issues around that, but the context is very different, with different local authorities of very different sizes, so it is difficult to make that comparison. It is difficult for me to give a meaningful answer.

Q35 David Mowat: So you don't know the answer to that. That would be the same. We have got almost a £1 billion problem here, on the face of these numbers. It would be interesting to know whether any other country similarly had a £1 billion problem, or whether they had found other ways to deal with this. Or is it a feature of how our NHS works?

David Evans: I agree that it is very difficult to find a comparator. Sweden for many years has had total integration across the system and still they have a problem, but their geography challenges are far greater than ours. The Dutch system has some fantastic examples but, again, that is an insurance-based system and their geography is very different.

Q36 David Mowat: Our system has some fantastic examples—i.e. you—but it also has a £1 billion problem. We don't know. We haven't got comparability of metrics or anything like that. I would have thought that it was an area that might have merited some study and thought.

David Evans: It is very difficult to make any comparison across Europe.

Q37 Mrs Trevelyan: In the NAO Report there is quite a lot of talk about the system resilience groups that are seemingly established across the country. Although the social care side of organisations seems to have a level of competence, the hospital side does not. I am interested to know your views, both locally and with colleagues across your own sectors, about how they are working, if at all, and what we should do better.

David Evans: We have a resilience group, but we were a bit of a step ahead when those were set up, so our way of working has in many ways superseded the tasks that the resilience groups were designed to tackle. So although we have a group and we support it, it has not had a major impact because we were ahead of the curve, as it were.

Q38 Mrs Trevelyan: Across other parts of the north-east, where I know you are very interlinked, are we seeing that as a constructive part of the process to help that interrelationship?

David Evans: Certainly, and some of the vanguards elsewhere in the north-east of England are working in that way—the Sunderland scheme, in particular.

Harold Bodmer: We see variability in this. The system resilience groups provide a very good forum, particularly in complex health and social care communities, for communication between the various players, and for a common target in this. Of course, for the acute trusts it is up to us outside of the hospital to have a way of reducing the dependence and the flow of people coming into hospital on unplanned admissions. Understandably, since they see these numbers continue to go up, they don't necessarily have confidence that we have got this right at the moment. I am optimistic that the work that we are all doing around sustainability and transformation plans will really help to galvanise that.

Q39 Mrs Trevelyan: Obviously in the case of Northumbria the hospital trust has actively engaged. Would that be a constructive thing to do elsewhere? Or can it come from the social care side and can these groups build a relationship that doesn't presently exist?

Harold Bodmer: I can only speak locally, but in our system resilience group the acute trusts are very involved in that. It is seen as a whole-system approach. Of course, they need to see the reduction in unplanned admissions.

Q40 Mrs Trevelyan: So in itself it is not a solution.

Harold Bodmer: It is part of the solution, I think. It is a very good mechanism but in itself it is not achieving quite what we want to yet.

Q41 Chair: Thank you very much. I will ask my final questions. We have got Simon Stevens and Department of Health representatives in our next panel. Unfortunately, Simon Stevens is not here to listen to your excellent evidence, but we will relay it to him. What are the one or two questions that you think we should be asking them, to make sure that we get more Northumbria and less of some of the problems that are going on around the country? David Evans, do you want to kick off?

David Evans: This could be a career-limiting pursuit.

Chair: You are in quite a good spot at the moment.

David Evans: A phrase I use a lot is "grasp the nettle". This is a difficult one. It is the recognition that the individual patient is not the problem; it is the system that is the problem. Working more closely together and doing away with organisational boundaries in everything that we have done seems to have paid a dividend.

Chair: Put the individual first—the user first. That is what we like to think on this Committee as well. Harold Bodmer?

Harold Bodmer: Adding to that, I would want to see a stronger link. I would want to explore the stronger link between social care markets, particularly for home care, community nursing and community health. How are we going to integrate those services, to make them more sustainable? I am anxious about that.

Janet Morrison: I was going to say a similar thing: whole-person care, thinking about the journeys that people go through and how to get the best choice and control and the best outcomes for them, and how they can have a say in what those outcomes look like.

Q42 Chair: Do you think that individual budgets will help? In particular, we have talked a lot about people with dementia. You all nod—you all agree.

Harold Bodmer: A personalised approach is absolutely crucial to this.

Chair: Still, as I pointed out at the beginning, Richard Bacon reminded us before we started that 13 years ago this Committee was looking at the same issue.

We are going to say thank you to you all and call in the architects of the current system—well, the people running it—and see what they have to say. You are very welcome to stay. Our transcript of this hearing will be available on the website in the next couple of days—it goes straight up, uncorrected. I am not sure exactly when our Report will come out, but it will probably be some time in July, because of our recess dates and because of the referendum. We will send you a copy, of course. Thank you very much.

Examination of Witnesses

Witnesses: **Simon Stevens**, Chief Executive, NHS England, **Dr Kathy McLean**, Executive Medical Director, NHS Improvement, **Sarah Mitchell**, Director, Social Care Improvement, Local Government

Association, and **Jon Rouse**, Director General, Social Care, Local Government and Care Partnerships, Department of Health, gave evidence.

Chair: Welcome. I am sorry that we are starting later than usual. We had a very useful previous session. It is a shame that you weren't here to listen to it, Mr Stevens, because it was really instructive; I think others who were in the room were able to hear that. For those who may be tuning in or who were not in the room earlier, I repeat that we are here today to take evidence on the basis of the National Audit Office's Report, "Discharging older patients from hospital". In the last couple of years we have seen delays for older patients in hospitals rise to record levels. In our pre-panel, we heard from what we might describe—I think I speak for the Committee—as the exemplar model: David Evans, chief executive of Northumbria Healthcare NHS Foundation Trust, where they have 0% of overstaying older people, which is the model.

On our second panel is Dr Kathy McLean, executive medical director of NHS Improvement. Welcome, Dr McLean. I think this is your first outing in front of our Committee.

Dr Kathy McLean: Yes.

Chair: Simon Stevens, a regular visitor to us, is chief executive of NHS England—I am sure you look forward to every time, Mr Stevens. Jon Rouse is director general of social care, local government and care partnerships—I think your title gets longer every time you come. Sarah Mitchell is the director of social care improvement at the Local Government Association. We felt that it was important to get the balance, as we have heard from our first panel about the interaction between social care and health. Our hashtag today, for anyone who is just tuning in, is #olderpeople. I am going to transfer straight to Anne-Marie Trevelyan, to kick off.

Q43 Mrs Trevelyan: We have had a very interesting pre-panel meeting. Mr Stevens, you will know that I have been very closely involved with the Northumbria developments over the past 10 or 15 years. It is therefore really depressing to read in the Report that while we have cracked it in Northumbria, in terms of joining up all the various parts of the medical frameworks that are needed to look after a patient from the moment they come into A&E to the moment they go out again into either their home or some sort of residential support, across the country that really is not happening at all. I was not here at the time, but this was looked at some 13 years ago and it was deemed a Government priority to sort this out, according to the recommendations. It has not gone in that direction. We are looking at nearly £1 billion, which could be spent a whole lot better in any part of this framework, being poured down the drain.

The first question is this: why has there not been the planning that must have been needed? We knew that the growth in the over-65s was coming—that was not news to anyone—and that there would be this predictable rise in A&E admissions. Where has the failure been in planning for and preventing that increase over the past 13 years?

Simon Stevens: An open question. Perhaps I can begin by slightly taking issue with the premise of the question, and indeed with something that you said, Chair. Actually, the late discharge of older patients from hospital is not at a record high; it is almost certainly better than it was in 2003, when the NAO last reported. Indeed, the NAO's 2003 Report recorded that there were 4,100 older people awaiting discharge in hospital at that time. I think the definition used then was people over 75 rather than over 65, which has been used in this Report. The situation is in fact substantially

better than it was then, both in absolute numbers and in terms of your chance of being delayed in hospital, because obviously we have many more older people using the national health service now than we did then.

That said, the fact is that we clearly can do better. I do not think that the figure of nearly £1 billion that you talked about is right, but that does not detract from the fact that there are parts of the country where these arrangements are working well and there are parts where they are not. Although only 3.5% of bed days overall are affected by the definition of delayed discharges, that is 3.5% too many, so it is not good for older people. Although, I do think that it is worth noting that the NAO Report itself says: "we heard from a broad range of stakeholders that the main driver of day-to-day decisions on when to discharge patients from hospital remains patient care and safety, rather than financial considerations." I am sure that we would all agree that that is right.

Q44 Chair: I need to bring in the NAO on this issue of the record levels. Could you explain the figures so that we are all clear what we are talking about?

Ashley McDougall: We would have been very happy to give the 2003/2016 comparisons, but the numbers were not available to us, so we could not compare. We were not actually able to say whether it was better then or now from the numbers that were available.

Q45 Stephen Phillips: And what about the 3.5% of total beds that Mr Stevens talks about that are essentially blocked by those who are awaiting discharge?

Ashley McDougall: I think that refers to the delayed transfers. The 2.7 million bed days—we are probably heading for about 8% or 9% of total bed days. That would be my understanding.[1]

Q46 Chair: Mr Rouse, it looks like you can cast light on this.

Jon Rouse: I just question where the higher figure comes from—the 8% to 9%.

Ashley McDougall: When multiplying the delayed transfers figure, which is the 3% I think Mr Stevens is referring to—

Chair: We don't want to spend forever on this, but we do need to be clear about what we're talking about.

Simon Stevens: The point is, there is not a basis for saying it is the worst it has ever been. If anything, it probably isn't, but the fact is there is still a lot more we can do. That is where the concrete conversation needs to focus, and that is what patients want.

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[1] Clarification from the National Audit Office: "The C&AG's report (paragraph 5) notes that delayed discharges account for around 3% of total bed days. Using the NAO multiplier of 2.7 against the figure of 3% to get to the full number of bed days occupied by patients who are no longer benefitting from acute care would yield a figure of approximately 8.1% of total bed days (3% x 2.7), or 6.9% of those occupied by older patients."

Q47 David Mowat: Just for clarity, you said that the £1 billion figure was wrong, or was not right. What in your view is the figure?

Simon Stevens: Well, it is £820 million in the NAO Report, as you know, and that has various assumptions behind it. First, there is an offset of £180 million, which the NAO says would be the cost of providing care in alternative settings, producing a net number of £640 million. That number is based on a grossing up by 2.7 of the actual day's delay that hospitals themselves report, which is 1.16 million. Multiply that by 2.7 and that gives you a bigger number, and then multiply that by £303 a day, which I am not sure is indeed the right marginal cost for an in-patient day—

Chair: Sorry, that is an NHS England figure.

Simon Stevens: No—

Chair: What is the right figure, then?

Q48 David Mowat: I asked you what the number should be. We will just take that number.

Simon Stevens: I think the bookends would be net zero to net £640 million. Net zero would be if you assumed that you didn't gross up by 2.7%, you just took the recorded delayed discharges; you used £200 a day as the marginal cost, rather than the reference cost trim point; and you took some allowance for the extra costs of primary care. Those are the bookends.

Chair: Sorry, can I—

Q49 David Mowat: Sorry, Chair, if I could just finish this. If you are managing the issue, what number would you take as the target that you have got in your organisation to go after in this regard?

Chair: You must be planning it financially.

Simon Stevens: If you think that somewhere between nought and £640 million is quite a range, then let's call it £300 million to £400 million as a central estimate. It could be north of that. It is worth going at, there is absolutely no doubt about that, but the context for all this is that the NHS has been incredibly efficient over two decades in the use of emergency in-patient bed days. What has actually happened is that we have accommodated a 17% increase in the number of—

Q50 Chair: You have answered Mr Mowat's question about the figure. I want to bring in the NAO here. We know that there was a discussion about how to guesstimate or estimate the cost to the taxpayer—how the NAO do their figures. I am not taking into account the personal costs to individuals of this. The NAO had trouble getting the data. I am going to ask Ashley McDougall to explain very briefly the process that the NAO went through so that everyone is clear where those figures in the Report came from. It is very unhelpful to have an argument about those figures—even if they are acknowledged not be perfect by the NAO—in the opening five minutes of the hearing.

Ashley McDougall: We went to NHS trusts. We had two starting points. The first one was the delayed transfer figure, which are returns collected by NHS England. That takes you to about 1.1

million bed days. The second figure was an extrapolation. We had 27 trusts in our sample. Trusts collect lists of patients they say are medically fit for discharge and/or no longer benefiting—I think that is the phrase in the Report—from acute care. The 2.7 multiple that Mr Stevens talks about came from the figures of the people who were not counted in the delayed transfer figure but were there and not benefiting from acute care.

We then multiplied that by the £303. We certainly discussed with the Department and NHS England whether there was a better figure for using for that. These figures are all national estimates. I think with the figure of £303, what tipped it for us in the end, to an imperfect estimate, was that £303 is the NHS's standard number that it uses to count these figures. You may be familiar with the Carter review. The Carter review came up with a figure of about £900 million for the delayed transfer gross costs, and we are at £820 million—I think they are broadly in that field.

Q51 Chair: Mr Stevens, we have heard from both sides, but there shouldn't be sides on this. This is an agreed Report.

Simon Stevens: This wasn't agreed.

Chair: The NAO is supposed to be here in silent support while we deal with their excellent work, not having an argument about this.

Simon Stevens: Their work is excellent.

Chair: Can we agree that we agree the Report? We know those figures have come with caveats. We know that as a Committee. We don't need to hear every detail about those caveats.

Simon Stevens: Well, the detail matters if we are trying to get a true estimate. The NAO have entirely legitimately laid out an appendix to how they have come up with—in your word—a guesstimate.

Q52 Chair: We've got the Carter figure. We have got the NAO figure, with its caveats. We have got your bookends, as you put it. We have now got you down to £300 million to £400 million.

Simon Stevens: That would be the central estimate between those two.

Chair: So you are taking not quite a median, but near enough. We will leave that there and go back to Anne-Marie Trevelyan to carry on with the questions.

Q53 Mrs Trevelyan: Whatever the quantitative number, the qualitative issue is real: we have very serious bed blocking issues because of the breakdown. So I would turn it on its head and say that, with the resilience groups now set up and spread across the country, it would be interesting to know the views of all the panel on whether that is helping in real terms. There is a difference in views, certainly in the NAO Report, between those on the social care side and those on the acute hospital side of whether that relationship is actually helping to reduce the blocking and helping the comfortable and effective throughput of patients.

Simon Stevens: As you say—I agree with you—it is a pretty mixed experience across the country, and I think that is what comes out of the NAO's survey. These so-called SRGs were essentially a workaround to get people sitting around a table clocking the fact that the impact of one organisation's behaviour spills over into how patients in other parts of the care system experience their continuity of care. In some places, they have worked reasonably well, in other cases clearly not. There is a limit to what one can and cannot mandate, sitting within a mile or two of this building, in terms of the relationships and the quality of these conversations, but there are some other changes in terms of processes inside hospitals, the relationships between hospitals and community health services and the relationship between the NHS and social care.

I think we have got an increasingly clear picture what the gold standard looks like, and we will be using that as a criterion to judge whether people are able to graduate from what they currently experience as quite an onerous set of oversights around the Better Care Fund. We intend to lay out, "If you are doing these kinds of thing, you potentially get to graduate from the Better Care Fund and all its reporting requirements." That is quite a strong incentive, I think, in various parts of the system, but there are other things we are doing as well, and we can certainly talk about those.

Q54 Mrs Trevelyan: So what does that gold standard look like?

Simon Stevens: To start with the discharge planning process inside the hospital, we know that beginning that process early on in a patient's stay is very important. We know that it makes sense to try to discharge—this is the goal that we have set—at least 35% of patients by midday. That is not happening uniformly across the country. Seven-day discharge arrangements inside hospitals are important too. We know that hospitals' ability to discharge patients safely and appropriately to home on a weekend is diminished.

In terms of the hand-offs between hospitals and community health services, there is a disconnect in some places on the incentives and availability of those community services. In terms of the interaction with social care, as the NAO Report rightly points out, many care homes do not at the moment have response time standards as part of the contracts that have been set with local authorities. That is an important part of making this a slick system as well.

Then there are a set of other things around so-called discharge to assess, so that when a patient is ready to leave hospital, they can have an assessment of what sort of follow-on care they need when they are back at home or in a nursing home or intermediate care bed. There is a whole series of things that we have published with the LGA, ADASS and a number of other bodies about what those standards should look like.

Q55 Stephen Phillips: What you have just described, Mr Stevens, as the solution, if I can put it in those terms, is a series of process changes that need to be made, as I understand it. If you had been here for the last session, you would have heard my questions to Mr Evans from Northumbria about how they have got it right, with 0% delayed transfer cases. I asked him whether it was about structures or processes. His answer, as I understood it, was that if you put the right structures in place, the processes will follow. My question to you and to the rest of the panel who are responsible for it is this: are the right structures currently in place to deal with this problem, which on any view is costing the NHS in England several hundred million pounds a year?

Simon Stevens: I am a huge respecter of the work that has been done in Northumberland. That is, obviously, a series of relationships built over many years. It is not something that you can just conjure up overnight. However, I doubt that the Northumbrian model is replicable in every part of the country, and I certainly don't think that the de facto nationalisation of social care by the NHS is a model that would work in every town, city and county across the country. So I think we are deliberately going to have different approaches. Jon Rouse is here—

Q56 John Pugh: Why wouldn't it? Why wouldn't the Northumbria model work in other places?

Simon Stevens: Versions of the Northumbria model are in place. One of the differences is that the structure of provision of care and public financing versus self-pay, and so on, is quite different in the north-east of England from how it is in many other parts of the rest of the country. So there is a mixed funding model in social care and there is a mixed provision model in social care.

Q57 John Pugh: So for absolute clarity, are you saying it wouldn't work in other places because the inherent structures upon which you are building in other places are actually too different from Northumbria? Is that what you are saying?

Simon Stevens: The starting conditions are clearly different, yes. I don't know if John—

Chair: I don't know if Sarah Mitchell might have something to say about that from the social services perspective.

Sarah Mitchell: I think there are very different sets of circumstances that influence whether the model would work in different places. The difference in terms of the number of self-funders in one local authority will influence that—there are some places where there are 85% of the older persons funding themselves, and in some parts of the country that's very different.

In response to the structure versus process point—I think someone did mention this—the important bit about leadership is also linked to the system resilience groups. We have been round a lot of systems resilience groups, and where the leadership is strong and all the partners are brought together and they have a shared vision, a shared ambition, and a plan—it sounds a little bit managementy, but it does work. We have seen it work where places are really not working well together; it has been about facing that up, putting a mirror to them, and saying to some places, "If an older person who is a patient in the hospital walked into this meeting now, would they feel very confident about your ability to solve the problems?" That can shift places, and we have seen places shift.

Q58 Chair: Can you give an example?

Sarah Mitchell: Oxfordshire would be a good example of that, and Cambridgeshire, actually, where really complex and difficult relationships shifted. Now, they are not at the lowest end of the delayed transfers, but they are certainly on the way, and, most importantly, the relationships have changed.

We have really seen that it does take time to change this; and the model that we have been working with, with NHSI and NHSE and DH, is around looking at what really are the best things out of Northumbria, and turning them into a set of things that you ought to be doing, like early discharge, multidisciplinary working, all of those things. It is about listening to people, as Independent Age pointed out, and you can start to apply those things in different places.

Just very quickly, on the SRG issue, I think there needs to be a relationship with the health and wellbeing board, so that this is really put together for a local area; and the voluntary sector and the care providers need to be round the table as well. There is no point in us saying, "Oh, you know, the care providers don't respond", or "We haven't got the workforce," if they are not part of finding the solution together.

Jon Rouse: On this particular question of models, I think we have a growing bias or interest in what are called local care organisations, which is providers coming together; and Northumberland is not the only example. We have examples now in Salford and Torbay, and there are a number of others around the country. I think we will see those grow in number. I think what we have got to avoid is believing that there is one top-down, prescribed approach for every geography. That is partly to do with the differences in starting position in terms of the markets, but it is also to do with institutional strength. Frankly, there are some health providers that are not in good enough shape to take on those social care responsibilities at this time. So we have to have a multi-speed approach if we are going to make those sorts of structural changes.

Q59 Nigel Mills: Are you thinking about it, though, Mr Rouse? When you say "not at this time", what I hear is "We'd quite like to do it, but we don't think we can." Is that—

Jon Rouse: I think I also said that we don't want a single, top-down, prescribed approach.

Q60 Chair: So could it be part of a devolution model?

Jon Rouse: It certainly can, and in Greater Manchester, which is obviously where I am heading personally next, there is an ambition in each of those local areas to move towards some form of local care organisation to integrate those services.

Q61 John Pugh: And would you say the optimum condition would be one where there was a fully integrated body delivering them? You talked about collaboration in Oxfordshire and Cambridgeshire, and these things are to some extent fortuitous. People may get round the health and wellbeing board and all agree things, but they may equally fall apart. Would you go on record and say that the optimum scenario is one where you have a Torbay, Salford or Northumbria-type model?

Simon Stevens: It depends a bit, doesn't it, on what we mean by fully integrated? There are, what, 400,000 care home beds? We are presumably not talking about nationalising those to go alongside the number of hospital beds.

Chair: Social services—social workers.

Simon Stevens: They and the domiciliary care providers, which are for the most part in the private sector, are the people delivering this care.

Q62 Stephen Phillips: Let me explain the problem that I have with all of this. You are the chief executive of NHS England, Mr Stevens. Mr Rouse, the Department is responsible for the NHS in England. Yet we have these very wide regional variations in the percentage of patients who are not discharged on time and who essentially end up blocking beds, which costs acute trusts money. Don't you regard this as a problem that you actually need to grapple with, because it's something of a national disgrace that there is this discrepancy across the country? It does not just cost the NHS money. Remember—I think this is in the NAO Report—there is 5% muscle wastage for an old person who is stuck in a bed that they should not be in. So it's important for patients as well; it is not just about the several hundred million pounds that the taxpayer is losing. So why aren't you sighted on this—

Simon Stevens: We are.

Stephen Phillips: —and bearing down on it much harder than appears to be the position from the answers you are giving?

Q63 Chair: Mr Stevens, you say you are, but just to add to that, as Mr Bacon, who has an elephantine memory of his many years on the Committee—thankfully—has said, 13 years ago this Committee, probably in this very room, discussed this very issue on the back of another NAO Report and the system was not working well then. So, Mr Rouse first of all and then Mr Stevens, what have you got to say to what Mr Phillips has raised?

Jon Rouse: First of all, you are right that there is unacceptable variation in performance.

Q64 Stephen Phillips: Unacceptable variation—your words.

Jon Rouse: Yes. I am very happy to make that point very clearly. But first of all, can we recognise that, certainly on the social care side, there are quite a lot of local authorities that are actually doing pretty well in terms of numbers of delays? In fact, there are 58 authorities—that's 38%[2]; all upper-tier authorities—whose current levels of delays are below the historic average low position from two years ago today. It's not that Northumberland is the sole celestial star out there. There are actually a lot of local authorities that are doing pretty well on this. The problem is at the other end of the spectrum: we have 22 authorities that are doing at least three times as badly as that group of 65 authorities in terms of their delay rate.

Up to this point, over the last two years, working with those authorities, and others like Oxfordshire and Cambridgeshire that have improved, we have taken the approach, working with the LGA and ADASS, of putting in place peer support mechanisms. We have gone into those places. We have worked with those systems, using the ECIP mechanism, which is the NHS-based mechanism; using our Helping People Home Team, which we set up jointly with the LGA; and using the LGA's own peer support programmes. In some of those areas, that has made a difference and those rates

[2] Figure clarified by witness in writing after session

have come down, but in other areas, they are still very much stuck, so the question that we are now grappling with—this very much includes Ministers as well—is what we do next with those localities, because you're right: we can't have those levels of delays continuing to go up in those outlier authorities.

Q65 Stephen Phillips: Of which Lincolnshire is one. I will come to Mr Stevens in a minute on this question, but answer me this, because we'll have you back at some point and hold you to account on it: when is everybody going to be down to Northumbria's 0% delayed transfers of care?

Jon Rouse: I can't give you that answer.

Stephen Phillips: Well, do your best.

Jon Rouse: I can't. I can't give you that answer.

Q66 Stephen Phillips: Well, are you going to be back here in two and a half years' time telling me that it is as bad in those acute trusts that are doing very badly as it is today, or is some difference going to have been made?

Jon Rouse: On a personal level, I will be in Greater Manchester accounting for what we have done for the Greater Manchester authorities, and three of those are among the 22 authorities that I have named. But on the substantial point, what we have to do first is turn around the upward trend. From 2010 to 2013, we brought social care delays down to the lowest level they have ever been at; it is since then, and particularly since the summer of 2014, that they have started to go up significantly. So the first thing we have to do is turn around that trend line and start making that journey back down to where we had reached in the summer of 2013.

Q67 Chair: On that point, do you think the NHS is able—at some point we'll bring Dr McLean in on this—to improve fast enough? We are bandying these figures around, but the total number of people, because of the number of people going through the system, is going up. The NHS is just not keeping pace with that change. Do you not agree, Jon Rouse, with that analysis? It is not keeping pace with the numbers going through the system.

Simon Stevens: I actually do not agree with that analysis, and I will tell you why. Over the last 17 years, we have had a 52% increase in the number of emergency hospital admissions, and we have had no increase in the number of emergency beds we have used to support those admissions. That is proof that the NHS is actually getting slicker at its discharge processes, reducing length of stay and using our acute beds more efficiently. In fact, we have a lower number of acute in-patient beds than any of our industrialised country comparators, with the exception of Sweden, which again illustrates that overall the NHS does a very good job on this point. Had we not had that efficiency over the last 17 years, we would have had to build another 39 hospitals just to accommodate that 52% increase in emergency admissions. We did not do that.

Q68 Chair: I want to bring Anne-Marie Trevelyan back in, and Kathy McLean is next, but I also want to ask you this question very directly, Simon Stevens, as you have the floor now: when you

hired Mr David Evans's predecessor, Jim Mackey, as the chief executive of NHS Improvement, did you not give him some sort of mandate to replicate across the UK some of the excellent work done in this and other areas in Northumbria? It does not sound like it, from what you are saying.

Simon Stevens: Jim was actually hired by the board of NHS Improvement, but yes, one of the—

Chair: I am sure they asked you if you liked the idea.

Simon Stevens: One of the clear attractions of examples like Northumbria and some of the other vanguards we have in place is that they are demonstrating what can be done and the impact it is having. I wonder if I can introduce a slightly—you might think this is strange—pessimistic note of conversation, which is that I think we are going to be battling some very substantial headwinds over the next two, three and four years. So the honest answer to Mr Phillips, which I know you will not like, is that I don't think we can guarantee that the number will be anything like zero over the next three, four or five years, because there are real pressures building in social care, as you know, and those pressures spill over into the NHS.

Q69 Chair: Sorry, but there are also pressures in the NHS; let's be clear.

Simon Stevens: Indeed there are.

Q70 Chair: A shortage of junior doctors and other mid-ranking professionals.

Simon Stevens: That's right. I will make the LGA's case for them, and they can make my case for me.

Q71 Chair: I am going to go back to Anne-Marie Trevelyan and then to Nigel Mills, but Dr McLean, on NHS Improvement, it is in your bag to make sure that the best practice is replicated. Can you do it? Do you think you can set a time for when you can do it by?

Dr Kathy McLean: First of all, can I say that this is a very important issue? I was a geriatrician before I became a medical director, so I have personal experience of this kind of issue. Indeed, it is not new, as you point out. We welcome the Report. The SRGs are very much about the whole system working together, and we know that. The figures from the Report show that it is not a single part of the system that is primarily at fault. This is a system thing that has to be solved. There is going to be, under the A&E improvement plan for 2016-17 jointly led by NHS England and NHS Improvement, a review of and a refocus of SRGs. That plays to the point about chief execs thinking SRGs were not as effective as other people thought, so we think they will welcome that.

On the business of why we do not roll out Northumbria's examples to everywhere, there are a number of vanguard pilots going on that will probably give us some information about different areas. If I can turn to what we have been doing as NHS Improvement and your point about it being our job to spread the good practice, we recognised that this was a problem a while ago. We set up, as a starting point, a quality improvement programme based at Leeds teaching hospital. Through that, using quality improvement techniques, they managed to reduce by 700 bed days the occupancy and by 30% the delays to discharge.

That is being rolled out as a pilot across the north of England, and a range of organisations are doing that. Our plan is to take the good practice from there and use it across the whole of the acute sector and beyond. That is our model—peer-to-peer organisations helping each other, with good leadership to bring about that improvement, and the sustainability hopefully will be around using quality improvement techniques and methodologies.

Q72 Karin Smyth: So are the system resilience groups accountable to you, Dr McLean?

Dr Kathy McLean: No, I think they are technically accountable to—each party that comes to the table is jointly and severally.

Q73 Karin Smyth: So who is accountable in each geographical patch?

Dr Kathy McLean: Each geographical patch will have a chair and a leader for each of those.

Q74 Karin Smyth: So the chair is accountable to NHS England?

Simon Stevens: Yes, but the director of social services who is a member of that committee is not accountable to NHS England. These are different statutory organisations. They have got to get together and figure it out locally with our support and with a nudge—sometimes more than a nudge. That is working in some places—it is not working everywhere—but let us not kid ourselves: even with the best relationships, restructures and good processes at the margin, a set of impending pressures is still headed our way that will make the impact on patients and the national health service a concern over the next three or four years.

Q75 Karin Smyth: Agreed. But in terms of Mr Phillips's earlier question about whether Mr Rouse is busy in Manchester or coming back here, who would come back here to be accountable for whether those resilience groups are successful or not?

Simon Stevens: They are a means to an end. They are a meeting. They are a committee. They are not a structure. They are not a statutory entity. Kathy has responsibility for ensuring the spread of best practice on hospital discharges. NHS England has responsibility for ensuring that the different parts of the health service are working well together with local authorities.

Chair: Okay, but in a locality—

Simon Stevens: That is just the reality isn't it? Local authorities run social care—

Q76 Chair: Mr Stevens, we are about to see devolution. We are already seeing public health in local authorities and we are seeing other joint models; it is not new. Ms Smyth has asked a simple question: who is going to be accountable? You have given us all the structures, but in those local areas, if I had a relative in hospital who was not being discharged, whom would I go to to raise concerns about that?

Simon Stevens: Well, quite frankly, it is a category mistake to say that there is a single person or organisation that is responsible—

Chair: Isn't that the whole problem?

Q77 Mr Bacon: It is a very good answer; it is a very illuminating answer. Do you think we have got a systemic problem, Mr Stevens?

Simon Stevens: Yes I think we have. We have got fragmentation in our care system. I do—

Q78 Mr Bacon: Thank you—yes is good enough. If we have got a systemic problem, we plainly need a systemic solution. Yes?

Simon Stevens: Well, if by that you mean a new piece of legislation or a statutory reorganisation, no I don't agree with that.

Q79 Mr Bacon: I mean a systemic solution to a systemic problem.

Simon Stevens: The proposition in the five-year forward view—

Q80 Mr Bacon: I did not define what the systemic solution was. I am just asking whether you think that since we have agreed we have got a systemic problem, we need a systemic solution.

Simon Stevens: Yes, I think that what we need is what we have described as triple integration between primary and specialist care, between physical and mental health services and between health and social care. The form that the triple integration takes will vary in different parts of the country. That is what the whole of the five year forward view agenda is about: getting those different models going.

Q81 Mr Bacon: I accept that there has been efficiency improvement; you have made some good points about that. To be honest, I do not get a sense listening to all of you—you are all highly intelligent people who have been grappling with this problem for a long time—that you have done what Mr Evans identified as the problem, which is to grasp the nettle.

Sometimes it is useful to measure things in second world wars. This Report that we took evidence on—it actually came out in 2003—is more than two second world wars ago in terms of time. If you were going to solve the problem doing what you have been doing, you would have solved it by now. The reason you have not solved the problem yet, doing what you have been doing, is that what you have been doing is the wrong thing. That is what is wrong.

Mr Stevens you mentioned, and it is in paragraph 1 of the Report, that there are "4,100 older patients on any given day". That was 13 years ago. The National Audit Office mentioned that there two different figures: there is the 1.15 million—

Mr McDougall**:** 8,500 is the figure we are using for our—

Q82 Mr Bacon: Right. Let me finish my question. You mentioned a whole series of people that are not being counted. Am I right that that is the difference between the 1.15 million bed days figure and the 2.7 million figure?

Mr McDougall**:** Yes.

Q83 Mr Bacon: If you take the difference between those two figures, that alone is 1.55 million, and if you divide that by 365, curiously enough it is 4,200. By itself, the bit that you are not counting is more than the number from 13 years ago. I'm not saying that you're not trying but it certainly seems to me—I do not want to speak for others—that you must be missing something, otherwise you would have made more progress, notwithstanding all the different pressures.

We have all had stories in our constituencies. My late father-in-law was in the Norfolk and Norwich University hospital for four days longer than he should have been. After bellowing at everyone at four days, because he was reasonably bloody-minded and articulate, he phoned a taxi and discharged himself. But not all patients will do that, and it is costing a great deal of money at a time when you do not have money spare. You need a qualitative step change, don't you?

Simon Stevens: In many parts of the country, yes. But that step change is not exclusively in the gift of the national health service locally.

Mr Bacon: Fair enough.

Sarah Mitchell: I think that one of the reasons that there has been difficulty in recent years has been the issue about the absorption of the savings that local government had to make. We are estimating it as £5 billion since 2010, which is exactly the time from which delayed discharges have increased and where the pressures have been for domiciliary care providers.[3] There are places that are being really quite innovative about how they address that. They are starting to pay travel time. Calderdale, for example, pays for the careworker to be retained while the person goes into hospital, but it is on a shared risk element. Everybody knows that that person will go into hospital and come out as quickly as possible, and they are really working together on the ground to make that happen.

Q84 Mr Bacon: Mrs Mitchell, plainly the Northumbria model will not be equally applicable in all respects and all places. Anyone can understand that. How many other places in the country are there where the NHS trusts run adult social services in the way that Mr Evans described?

Sarah Mitchell: I don't know the actual figure but there are lots of examples. They are different according to the local circumstances.

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[3] Clarification from LGA: the £5bn gap is the gap that adult social care had to deal with, rather than local government. The £5bn gap was dealt with by £2.5bn worth of savings and service reductions in adult social care and a further £2.5bn cross-subsidy from other council services.

Q85 Mr Bacon: I'm sorry, you say that there are lots of examples but you do not know the actual figure. Do you mean where, essentially, the NHS trust runs the adult social services under a contract in the way that Mr Evans described?

Sarah Mitchell: There are some examples.

Mr Bacon: How many?

Q86 Chair: Single figures or—

Jon Rouse: Single figures. It is probably going to grow up to the 20 mark through ones that are already in preparation.

Q87 Mr Bacon: How many—Mr Bodmer would have known this—directors of adult social services are there? How many social services departments are there?

Sarah Mitchell: 152.

Q88 Mr Bacon: And you reckon that, probably, five to 10 of those, or a small number—perhaps you could write to us with the exact figures—are as Mr Evans described.

Sarah Mitchell: In variations of that. There are some places where mental health trusts have been combined for quite some time. Some of those have been really successful and some of those—and they are where the social care staff have seconded into the mental health trust—have not worked so well and they are coming out of those arrangements.

Q89 Mr Bacon: Could you send the Committee a note listing all the adult social services departments in the country and, in the second column, who runs them?

Sarah Mitchell: Yes.

Mr Bacon: Thank you. Perhaps you might combine for that.

Q90 Mrs Trevelyan: There is a clearly a balance of responsibility here, and you can defend each other or not, and that is fine. But, within the hospital framework, a variety of issues such as unnecessary admission and failure to have enough geriatricians—we have snaffled one away from the front line—are set out well in the Report. How is the NHS tackling those front-line things so as to reduce admissions? In a lot of cases, there is not necessarily the need. We have 5% to 8% of admissions on medication problems, which could have been dealt with at the door and maybe did not actually need to come into the hospital at all. How are you addressing and dealing with that front-line part of the problem?

Dr Kathy McLean: So, this is obviously a big focus for us. There is something called ECIP—the emergency care improvement programme—which started in the back end of 2015. It initially worked

with 27 trusts and foundation trusts. ECIP has clinical leadership and works right across the whole pathway from the front door of the hospitals. It tends not to work as much outside the hospitals but it has done a lot to look at the standardisation of the processes, the clinical leadership within emergency departments and so on. That continues as work, and will roll out further and be part of the overall plan for A&Es.

Q91 Mrs Trevelyan: So, specifically regarding the older people who turn up at the A&E door, what work is going on? Where are you seeing it working and where do you need to do more to actually stop those admissions in the first place that do not need to be coming through the system?

Dr Kathy McLean: Where they have good systems of supported discharge in place right from the front door, where they are able to identify good support in terms of seven-day services, physios, OTs and so on, that tends to work better, but I cannot particularly say where is doing that, from the ECIP point of view. A report was published by Monitor, pre-NHS Improvement, on moving care closer to home, and there were quite a lot of good examples. For example, Airedale has telemedicine in nursing homes and so on, which is preventing discharge to the Countess of Chester hospital. A range of organisations have good practice that is preventing admissions but, clearly, to get upstream of that is really important.

Q92 Mrs Trevelyan: Is there a particular investment in which we might more effectively pre-emptively spend this £800 million—it is a disputed figure—at the front door so that we do not have the failure at the other end?

Dr Kathy McLean: Yes. I quoted the Leeds example, and they were able to use the money and reinvest it in other ways of providing care. They used it for some elective care over the winter. Clearly, when you release the money from the bed days, you are able to use it more proactively. The other thing that the ECIP team are doing is focusing on the more simple discharges—the ones that are less complex—which makes a great deal of difference, because actually that is 90% of the patients who need discharging. By putting in place the good practice, they provide the good leadership. A lot of the practice for the simple discharges flows over into the more complex ones and creates space so that, for example, you do not have to move elderly frail people around the hospital from bed to bed, which is a key point in deteriorating their abilities.

Q93 Mrs Trevelyan: Do we have enough geriatricians in the acute parts of our hospital system?

Chair: You may be a bit biased, Dr McLean.

Dr Kathy McLean: Perhaps I am slightly biased. It is certainly an area where we need a lot of expertise, and I think it has at times been quite difficult to recruit. It varies across the country, but it is certainly an area where we need to ensure that we have the right sort of expertise. It is not just people working alone as consultants; the multidisciplinary team is clearly really important. It is really important to have the processes right from the front door all the way through the organisation, and what we found through our pilot work is that it is not just about the money. It is about the processes for assessment, and if those are done well and slickly early on, we can demonstrate that patients can move through the system a lot more quickly.

Q94 Karin Smyth: Just to pick up on Mrs Trevelyan's point about having more geriatricians in hospitals, do you think that trusts are the place to have them?

Dr Kathy McLean: I think you need both. The model of community geriatricians is very helpful as well, because that can support the discharge.

Q95 Karin Smyth: It can help them by not going in in the first place.

Dr Kathy McLean: And prevent them from going in in the first place. The Report shows that the number of organisations with frailty units has gone up, which is a really important part of managing this because it is less about age and more about the comorbidities and the frailty of patients over 65 or 75.

Jon Rouse: This is a very good example of one of Simon's forms of integration. As well as having significant numbers of geriatricians working in the hospital close to A&E and in the frailty units, it is about crossing those organisational boundaries so that you have geriatricians who are working in the community and in the hospital so that they are part of the care pathway, enabling people to go home and making sure that they are being cared for properly when they get home. Again, we have some best practice examples that take that approach, such as Newcastle and Yeovil, but that has to become the norm.

Q96 Mrs Trevelyan: Mr Stevens, are we doing enough? Is the NHS actually focusing on that? In education we have a lack of physics teachers, so we are paying people £30,000 a year to become physics teachers. Are we looking at that? The ageing population is going up, not down.

Simon Stevens: Just to build on the conversation that you have just had, the physics teachers in this sense are probably GPs and community nurses. We have published within the last month or six weeks the General Practice Forward View, which essentially makes the case or fesses up to the fact that the NHS has underinvested, relative to other parts of the system, in primary care over a decade and we must do something about that because ultimately how will we support people at home and keep them fit and healthy? It will be the primary care system and the extended primary care system, which might also include embedded consultants from some of the medical disciplines, community nurses, therapists and others.

We are going to publish—next month in fact—the new voluntary GP contract, which will substantially expand the scope of what is included within primary care to include community health services, some of the therapy services, and possibly some of the medical services that previously went on in outpatient departments. As we do that, it will be on a per person, population, capitation basis. One of the measures that they will be held to account for is whether they are avoiding people who end up as emergency hospital admissions but do not need to be. There will be a set of metrics alongside that publicly and transparently.

Q97 Mrs Trevelyan: Which is great, but in the short to medium term the increasing age and the continuing rise in A&E admissions is of over-65s. Surely the best people to meet them at the door are geriatric consultants, and if we have not got enough of them in frailty units or treated

under any other framework, we will continue having them at £300 a bed in our hospitals when they do not need that.

Simon Stevens: Geriatricians are very important, but they cannot be seen as distinct from what is happening to acute medicine in hospitals. The Royal College of Physicians has an important programme, with which I am sure you are familiar. The Future Hospital Programme is looking at the fact that acute medicine has tended to fragment too much now so we have lots of ologists who are not themselves looking after the holistic needs of the bulk of the patient group who are admitted to hospital as emergencies. This has particular ramifications for the viability of small and medium-sized hospitals because if you have to have a whole pyramid of ologists for every ology, all of a sudden a hospital is deemed not viable. That is the tail wagging the dog. There is great recognition now at the head of the Royal College of Physicians about the importance of generalism in acute medicine and the intersection with primary care. We are therefore, now at least, pushing against an open door between what GPs and physicians can see is needed.

Q98 Mrs Trevelyan: So you will not be investing heavily in the geriatric consultant part of medicine.

Simon Stevens: I think that is part of the multidisciplinary team, but if we just did that we would be missing a trick.

Q99 Nigel Mills: Just a quick one on frailty units, Mr Stevens. Are you saying every A&E should have a frailty unit somewhere next to it or behind it? I think only 55% have one according to the NAO Report.

Simon Stevens: Do you want to answer this one, Kathy?

Dr Kathy McLean: In many organisations they are found to be extremely helpful. They concentrate expertise around older people and they are not just the doctors, as we keep pointing out, but the broader multidisciplinary team, which is really important. They allow that expertise to come to people immediately. A lot of organisations have found them very helpful, but whether they are appropriate for every single hospital is a debate.

Q100 Nigel Mills: Do you think only half is right? Figure 7 suggests 55% have one.

Dr Kathy McLean: Which has risen from, I think, about 29% previously.

Q101 Nigel Mills: Are you saying to hospitals that this is a really good thing and they ought be doing it, or are you just waiting and hoping?

Dr Kathy McLean: The model we tend to adopt is to ask organisations to go and look at those that are doing it well and if they find that useful to them and they can translate that, that is what they do. I think it is about checking to see whether it is applicable in their area. The model may be different in some places and it may not be appropriate.

Q102 Caroline Flint: We have something called the Mallard ward in the Doncaster hospital in my area, which has been cited as really good practice for dementia. It is a dementia-friendly ward. I find it a bit difficult to understand, given all the evidence we have around a growing older population and all the associated issues that arise with that, why your body, NHS England and the Department of Health seem so nervous of championing what should be expected in more places within our health service. You seem so reticence about that. Do you feel reticent about saying, “This is good; this is a bench mark that should be happening everywhere”?

Dr Kathy McLean: Not at all. It is not about reticence; it is actually about pointing out good practice and encouraging organisations. As Mr Evans said earlier, 51 other trusts have been to have a look at Northumbria. To point out where the best possible practice is so people can adopt it is really helpful, but sometimes, in different places, it is not quite the model that is best suited to their own. They may have a slightly different way of doing it.

Q103 Caroline Flint: Don’t you think politics—with a small p—and fiefdoms sometimes get in the way, with people saying, for example, “You know what, I know I am director of this, you are the director of that.” The best solution is for us to get rid of some of those titles and probably integrate, and some of the reticence against doing that is possibly because people are worried about their own positions and the politics involved in that. Therefore, who is the champion of the best models?

Simon Stevens: I do not know whether Kathy would agree with this: I think that is often a fair point across the health service, and that is true in health systems across the world. There are examples, where the evidence base is very strong, where we have been pretty directive, as you know, across the NHS. We have said you have got to have a stroke unit and that major emergency trauma is going to be concentrated in a smaller number of centres. As a result, hundreds of people are alive now who, if they were knocked over by a bus, wouldn’t have been even three years ago. So yes, we absolutely do that where the evidence is clear. Perhaps, in the case of the frailty units, we are talking about two or three or four alternative models, but you have got to have one of those two, three or four models. The point is that you cannot just muddle through.

Q104 Nigel Mills: What I have not got totally clear in my mind—this may be one for you to start with, Mr Stevens—is exactly whose fault is this problem? Is this an NHS fault? Is it a local government fault? Is it a care provider problem that is causing this? Where do you think the main causes are?

Simon Stevens: We have looked at this pretty hard over at least the last 18 months, and it has received an enormous amount of time from people in the NHS, from social care and from Ministers as well. Every time you think you have come up with a single answer—“If we could just sort this out, all would be well”—it turns out that it ain’t like that. So, the disappointing response is that it is a combination of stuff, and that combination seems to differ in different parts of the country. I think we have got an increasingly clear view as to what the good recipe would look like; it is not necessarily to Mr Bacon’s satisfaction in terms of a mandated structural solution, but certainly in terms of the care processes which, whatever your structures are, you have got to have in place. That is what we have now got to drive.

Q105 Nigel Mills: What proportion of the causes of delay do you think are down to issues within the NHS's control, rather than issues outside of the NHS's control?

Simon Stevens: As measured on the returns that are provided by hospitals and others themselves, it is about two thirds to one third.

Q106 Chair: So, to be clear, that is two thirds NHS, one third social care?

Simon Stevens: Two thirds NHS, one third social care. The social care proportion has been increasing; that has been the main driver of the increases, as the NAO Report says. I think the NHS number itself probably may not be completely straightforward, because it is measured from the discharge from a hospital. If you discharge to a community hospital or a community bed, and then that community service cannot themselves discharge the patients they are looking after into social care, that will not show up on the radar of the acute hospital itself. It might look like it's some other part of the NHS, but it is because it is getting sort of blocked up further down the system.

Jon Rouse: Therefore a key part of your answer is that some of those systems that are doing best are ones where all the system owns all of the problem, and they do not distinguish between whether this is a social care discharge or an NHS discharge.

Q107 Mr Bacon: Thank you. That was a good answer to my earlier question.

Simon Stevens: We finally got there; stumbled across it.

Mr Bacon: It took a while but it came there. I would have thought there is a blindingly obvious corollary, which is that it is all very well talking about leadership, but there needs to be an "it" that is led, doesn't there?

Q108 Nigel Mills: We think it is roughly two thirds to one third an NHS problem. Ms Mitchell, I guess you are happier with that than perhaps where we thought we were going to be at with the Report?

Sarah Mitchell: We totally understand that and we're not happy about it at all. There is absolutely nothing right in someone not having a safe and timely discharge. I think what we have seen is increasingly elderly people coming into hospital. They need time to recover and convalesce from what might have been a really traumatic experience for them, and their families need to work with them to make the right decision for their future care. We do not believe that should be done in an acute hospital at all. It is not the right place. Finding the right place is what the discharge to assess and the step-down arrangements have been about. Actually we have seen some quite innovative stuff coming out of this winter particularly, where I think trusts and local government have come together to see how they might fund, together, step-down and discharge-to-assess beds, and get people home so that they can make their decision from a place where they feel comfortable.

The funding shortfall is real, and local government want to be part of the most innovative things that we were talking about, for example, the new arrangements in primary care. In A and E where we have had multidisciplinary teams, home care workers and domiciliary care workers are there from 9 o'clock in the morning till 10 o'clock at night, and we have seen people go home and

not be admitted. Kirklees is an example where they really invested in some home care workers, and they have achieved that. Similarly there are places where social workers are based in GP practices and in primary care, and, working as a social worker myself, my key people that I worked really closely with and depended on were the district nurse and the health visitor. That was your integrated team, and you worked really closely with them.

Q109 Nigel Mills: We appear to have a problem that we all recognise we have. It is bigger than it should be and bigger than we would all like it to be.

Sarah Mitchell: Sure.

Nigel Mills: Yet it seems on the ground that people are really working quite hard, doing the daily review of every patient who is in hospital for too long. What is your message to them? I guess this question is for all of you. Everyone appears to be working quite hard doing a lot of things, yet the problem is going the wrong way. Presumably at some point you are going to give them something different to try and do; otherwise they are going to start focusing on something else, aren't they?

Sarah Mitchell: I think that actually the cultural change is the important stuff. We have seen the discussion—and Northumbria is absolutely a place to go and see, and to translate the messages; but if you look at Leicester, their cultural change has been across all of the organisations, and it has been about, for every single person, talking about "Why not home, and why not today?" Once you get those conversations being very different throughout the hospital and throughout the whole system, people change the way that they behave with each other as professionals, and their relationship with the patient, and the older person.

When you have worked in the NHS and you have been part of that multidisciplinary team, making sure that what the patient wants is absolutely central to what happens is the success story. All the politics with a small "p", and the worrying about people's jobs and the pressure that people are under—if you can get people really focused on "This is right for this person," the rest will follow.

Q110 Nigel Mills: Okay, so Mr Stevens, on that same point, how do you make people, who are already working really quite hard on this, work probably even harder to tackle the problem you said earlier was going to keep growing—we were going to see this drift the wrong way? What is your message to those people who have been really trying quite hard on this? What they should be doing differently?

Simon Stevens: Well, as the NAO Report rightly says, it is not the case yet that every hospital is applying all of the good practice that Kathy wants them to do; but I think people can now see that there are pretty big operational consequences, for their organisations as well as for patients, from not doing so. So I think this is now much more visible to people than it was 18 or 24 months ago, and I think that NHS Improvement will be working hard with those who are not yet doing 35% of their discharges by lunch time because the pharmacy is not organised, or the prescriptions were not written up the night before by the junior doctors, or whatever the particular cases may be—just to take two examples I have recently heard from hospitals I have been visiting.

It is tackling that kind of blocking that will actually make a difference in terms of the internal processes; but there are these real pressures. I am not going to name individual authorities now, but

you go to visit some primary care, some hospitals, and the reality is that the relationship is rather tense with the local authority in respect of social care; and the local authority, when I sit down with them and talk to them, describe the funding pressures they have got, and they do not see a way through this right now. They do not see a way through it in terms of the availability of the domiciliary care, or the access to care homes, that they would need in order to keep the system moving.

Q111 Nigel Mills: So, aside from Mr Bacon's wholesale "chuck the system upside down and see what else we could do", what tangible changes could be made to contracts or models that you think could make a quick win?

Jon Rouse: One of the things we are trying for 2016-17 is, through the Better Care Fund mechanism, requiring every locality to consider the use of local risk-sharing arrangements in respect of delayed discharges, so that there is a joint and agreed responsibility with respect to the extra unnecessary days that an individual spends in hospital. One of the things we struggle with is a lack of alignment of incentives between the different parties.

Q112 Nigel Mills: So are you saying that acute trusts should be exercising their powers to fine social care providers?

Jon Rouse: In 2003, you recommended that we should be very careful about going down that route, although of course that mechanism does exist on the statute book on a discretionary basis.

Q113 Nigel Mills: What is the current usage level of that mechanism? How many trusts are using that mechanism at the moment?

Simon Stevens: It is completely minimal. Basically, trusts recorded somewhere between £2 million and £3 million-worth of reimbursement through that mechanism last year. If you set that against somewhere between nought and £820 million, it is clearly just a drop.

Q114 Nigel Mills: In two years' time, what do you think they should be charging per year? Are you saying there should be more use of that, or are you saying it might be a bit disastrous for relationships?

Dr Kathy McLean: There are some vanguards looking at the whole-population budget, which is probably a better way of approaching that. There is also CQUIN, to encourage early discharge and so on. There are other incentives, rather than a carrot-and-stick approach. That seems to work better, and that is the approach we have been largely talking about.

Q115 Nigel Mills: If you were advising a trust that had a real problem because its social care provider was not acting how they ought to be, would you be saying, "You should be using this mechanism to move them in the right direction"?

Dr Kathy McLean: The best way of using any fines is to come to an agreement on how that money should be invested in mechanisms to help reduce discharge delays. Rather than using fines in a punitive way, it is better to invest the money in the actual care. On your earlier point about what will be different, we have shown that this can be improved by doing some of the work that has already gone on. Rolling that out using the support mechanisms that NHS Improvement will use, for example, with hospitals, is a way forward, and we have already shown it in a number of organisations. We should retain a certain amount of optimism that we can do something about that.

Q116 Nigel Mills: I sensed from Mr Rouse's answer that he thought this was something that looked to be a tool.

Simon Stevens: I think the reality is that looking out over the next two or three years, there is likely to be a widening gap between the availability of adult social care and the need for social care. That, inevitably, will show up as delayed discharges and extra pressure on hospitals. Although the data should be used to try to work out the exchange rate for a pound of cut in social care and a pound of some subset in the national health service, those data are hard to come by. Some estimates suggests that a pound out of social care equals another 35p to 50p of pressure on the NHS. That is not costed into the NHS's funding envelope for the next five years.

Q117 Nigel Mills: Okay. I think the Better Care Fund had a target of reducing delayed departures by 85,000, but since that started the figure has gone up by something like three times that. When hospitals are doing Better Health Care plans, what are you saying to them? Are you saying, "You should be planning for a rise in bed-blocking days, but your plan should be to lower the trend"? I am not quite sure what the strategy is.

Jon Rouse: They have two-year targets. You are quite right; in the first six months, only 40% of the areas achieved the ambition that they set themselves, which is why we have taken a tougher approach in terms of the 2016-17 framework and required them to put in place risk-share mechanisms whereby they face up to the fact that they need to align incentives between the different organisations, to recognise that those extra unnecessary days in hospital are costing the NHS a certain amount per day. We might argue about what the figure is, but it is an amount of money that is being spent that does not need to be spent.

Q118 Nigel Mills: So how do you align incentives other than by charging, then?

Sarah Mitchell: May I say that the incentive for local government is that the longer people stay in hospital the more expensive they will be, whether they then go home or whether they go into a care provider, because they will have deteriorated in their mobility and their ability? So there is no incentive to leave people in hospital longer.

There is no correlation between places where there is a fining system in place and good performance on delayed discharges, and there is a lot of evidence that local authorities have to put money aside to pay fines rather than actually doing something to improve their contract with a domiciliary care provider and spending that money in domiciliary care, which is where they need to be. And if we were to introduce a system of fines, we would just increase the gap that social services has to fill—

Q119 Nigel Mills: Okay, so I get that Mr Rouse is saying that we need to find some way of aligning incentives, and the only idea that we've had so far is one that everyone thinks is a bad one—

Q120 Chair: And also didn't work before.

Q121 Nigel Mills: So, Mr Rouse, I'm trying to work out what you are suggesting.

Jon Rouse: So it could be a local agreement as to how you are going to invest in some additional stepdown care, with different parts of the system making a contribution to that in terms, therefore, of aiming to reduce the cost of delays through an invest-to-save mechanism. That is one approach that you might take.

Q122 Nigel Mills: So that is what you would expect to see in a lot of Better Health plans going forward, when they come round. But what measure are you going to be assessing? When the Royal Derby hospital sends up its Better Care plan, what are you expecting to see? Are you expecting to see a fall in these bed-block days in return for the money? Are you expecting to see a reducing increase—? I am just a bit unclear now as to what measurements you will want them to come up with.

Simon Stevens: So, there is Better Care Fund maths and there is the real world. Okay?

Q123 Chair: How honest and refreshing, Mr Stevens. Carry on. Please give us this maths lesson we are keen to hear.

Simon Stevens: The Better Care Fund maths was driven by the fact that it was money taken off NHS spending and rightly allocated to local government, but it was money that the year before was actually funding emergency hospital admissions. So, if those hospital admissions didn't come down, then the patients would still show up in the hospital and the hospital would need funding for that. So that's why BCF maths required that there be, in order for money to be released, a reduction in emergency admissions.

In the real world, outside of BCF maths, what we're actually trying to do is moderate the rate of growth in emergency admissions, and if we do that over the next three, four, five years that will count as success, given the growing ageing population that we are—

Q124 Nigel Mills: Okay. So, when you have got teams of people spending time producing plans, you're almost saying, "Send us any old rubbish and we'll give you the money, because we know it's a different world." Is that the message you're sending out today?

Simon Stevens: No, I think we're saying for the BCF bit, which was the £5.3 billion—

Q125 Nigel Mills: But this is an ongoing process; it wasn't like it was a one-off bid that you don't do again.

Simon Stevens: Well, it was, because there was a one-off—the new incremental transfer occurred in 2015-16. So there was an issue about that level of funding in that year in the baseline, but for subsequent increases this can be done in a genuine fashion and that's what's happening this year and in subsequent years.

Q126 John Pugh: But in the real world, there appear to be disputes—don't there?—about the allocation of Better Care Fund money. I know my own local authority has differences of opinion with the local NHS. Are they an outlier in that respect or is that quite common?

Jon Rouse: Right now, for 2016-17 only five out of the 152 plans are in dispute—are not agreed—which is actually not bad given the pressures on both systems at the present time, and we are working through those five through an escalation route.

John Pugh: Okay.

Q127 Nigel Mills: There are a couple of other suggestions in the Report. One is the impact that delays to the continuing healthcare assessment have. Do you have any ideas for how best practice could be improved, to avoid people sitting around waiting for an assessment?

Jon Rouse: Sorry, could you repeat the question?

Q128 Nigel Mills: I think one of the issues cited in the Report is delays caused by people waiting for the continuing healthcare assessment. Is that an area where there is scope for best practice or contractual changes to speed up that process or not duplicate other assessments?

Jon Rouse: Yes, definitely—let me just start, and then I will hand over to Dr McLean. We own the overall policy framework for CHC, but obviously it is then implemented by the NHS. One of the keys here is that most CHC assessments should not need to take place in an acute hospital. Provided that you have followed your original checklist correctly and that you have a trusted approach within the care setting that the individual is going to be moving into, it is actually far better in most cases for the assessment to take place in that other setting, whether it is an intermediate care setting or somebody's own home. One of the reasons for that is that the evidence shows that you end up with a care package that is 25% less intensive, on average, than if you had carried out that assessment in hospital. Why? Because when people get into those other settings, with the right physio and OT support and everything around them, in many cases they begin to improve and the assessment therefore becomes more proportionate to their real needs. That is one very practical, tangible thing that we need to make sure is rolled out across the country.

Dr Kathy McLean: We know from work we have done that we can streamline that process. The checklist can lead to a lot of people being screened who don't need to be. The staff who are looking after them will often know what to do and the trusted assessors are very important, so that people are not repeating work. What we mean by "trusted assessor" is that, whichever setting the person is assessed in, all the other partners take that assessment as the correct one.

Q129 Nigel Mills: What is the prevalence of that? I have a sense from my own casework that everyone likes to do their own assessment and come up with the answer that they might like.

Dr Kathy McLean: Yes. We have been piloting some work on that. I think that, as it comes through, we will find that it would be good to roll that out further. If we can get the documentation changed in order to support that, that will be very helpful.

Q130 Nigel Mills: Figure 10 of the NAO Report suggested that trusted or joint assessor arrangements were in place in about 49% of cases. I am not sure how many actual individual patient cases are done on that basis, but are you saying that that number should be in the 90s pretty quickly—that this is a real thing that should be there?

Dr Kathy McLean: Yes. There seems to be a blockage to doing this speedily, so it is a sensible thing to maximise, and that is what we would like to see.

Q131 Nigel Mills: You are suggesting to all parts of the NHS that they should have joint assessor arrangements in place pretty quickly?

Dr Kathy McLean: I do not think it is just the NHS. I think this is across all the partners.

Q132 Nigel Mills: I agree, but that is your organisation's power, isn't it—to suggest it to the NHS?

Dr Kathy McLean: Yes.

Jon Rouse: I visited an excellent care home in Lancashire a couple of weeks ago: a nursing home, which had increased its number of intermediate care beds, partly because it had established a trusted assessor system, which had given confidence that those CHC assessments could be carried out in that care home to a higher level of acuity.

Q133Nigel Mills: I am just trying to work out what the measurable situation is here. Are we saying that all acute trusts or all CCGs should ensure that these trusted joint assessor arrangements are in place by the end of 2017, or something like that? I am trying to have something here that we can measure and see real progress on.

Chair: When would be a good date to aim for, for the trusted assessors to be in place? From your end, Dr McLean, and then perhaps we will ask Sarah Mitchell.

Dr Kathy McLean: Can we come back to you on that—on the good date to aim for?

Chair: Yes. We like to make our recommendations realistic—if we are minded to recommend in this area, which I cannot be sure about.

Q134 David Mowat: It strikes me that it is not the toughest of questions. Maybe I can just come in here, to Mr Stevens—

Simon Stevens: I would have thought Mr Mowat was on to something, quite frankly. I think that is a reasonable point. What's more, I think we should go further than that, because I don't think it is just the trusted assessor.

David Mowat: No, I don't think it is either.

Simon Stevens: I think it is also the proportion of CHC assessments that are done outside hospital—

Q135 David Mowat: My overriding impression from today is the disparity between the way we have dealt with this subject and, for example, when you have previously given us evidence on the Carter review. The Carter review says that we have areas of excellence in the NHS and that if only we could do procurement that way everywhere else, we would save millions or billions of pounds. This is an area with massive differences in performance, in which we just get the impression that it is all pretty difficult, because everywhere is a little bit different: we have different nuances here, different nuances there. You have used words like "encouraging" people to do things, "pointing out best solutions"—I have heard the phrase "in some places that is not appropriate". I am sure that all of that is true, but, for a start, it does not bode very well in terms of the Carter review principles. At the start of this, Mr Stevens, you gave a number: £400 million. You are the Chief Executive of the organisation that has this £400 million issue. Which of your direct reports owns the problem and is going to come to you on Monday, or the following Monday, not with a suggestion to write to the PAC about when we might ask people to do something, like Mr Mills just said. Not with that, but to say, "How far are we going to get with making progress on that £400 million, because you are the Chief Executive and it is one of the things that should be on your agenda?" Who is that person?

Simon Stevens: Our Commissioning Operations Directorate had the responsibility for driving these changes through local health system—

Q136David Mowat: So who is it?

Simon Stevens: The guy who has just taken up that role is in just his second week, replacing Barbara Hakin—he is called Matthew Swindells. So Matthew, from NHS England's point of view, is the lucky winner of that accolade.

Q137 Mr Bacon: Is that the Matthew Swindells who was the senior responsible owner of the national programme for IT in the health service for a while, Mr Stevens?

Simon Stevens: Picking up the pieces of the mistaken national programme for IT that you so rightly dissected down the years, Mr Bacon.

Chair: I hope he has read Mr Bacon's book.

Mr Bacon: He is mentioned in it.

Q138David Mowat: On Mr Mills's question about when you would get this piece of standardisation imposed, which seems to be a perfectly rational thing, it has not been done yet—

Simon Stevens: Processes inside—

David Mowat: Do you understand the problem that we have here?

Simon Stevens: I do.

Q139David Mowat: There is a complete difference between what you are saying here and what you are saying about the Carter review.

Simon Stevens: Sure. I do accept that they are different and the reason for that is that here we are dealing with a system of many different agencies, some of which are outside the National Health Service and some of which are inside it, with different statutory accountabilities. It is NHS Improvement that can actually drive change inside individual hospitals. That is the accountability structure established by the Health and Social Care Act 2012. We are doing our best to work around that—

David Mowat: You say that, but—

Simon Stevens: That is actually the accountability structure in place.

Q140David Mowat: Two-thirds of it is an NHS problem though. Two-thirds of it is your problem. I think we have accepted that, roughly speaking.

Simon Stevens: On the NHS side, yes.

Q141David Mowat: Yes, so there is a lot to go after there, and all four of you, to an extent, seem to be much stronger on analysis than on solutions. I do not know if that is just the nature of the NHS or whether it is the nature of the centre. Would you accept that?

Simon Stevens: No. You would not expect me to, I know. I think it is out of recognition of the different starting points and the different conditions in different parts of the country. Mr Phillips is not here right now, but having recently been in Lincolnshire, there is a different set of issues in Lincolnshire than in Gosport, where I was down looking at what is happening in primary care. So, unfortunately, there is an element of horses for courses here.

Q142David Mowat: Can I just explore that? I do not totally understand why it is so different in these different places. In the end we have acute hospitals, we have older people, we have a number of variables that have to be managed, yet we seem to be saying that the landscape is so different that a Northumberland solution is completely inappropriate because it just wouldn't work because everything is so different.

Simon Stevens: Sure.

Q143David Mowat: Are you sure you are right about that?

Simon Stevens: There is always a substantial possibility that I am wrong on many things and that is probably one of them.

Q144 David Mowat: The reason I asked that is in management terms there can be too much understanding of why things are different, and not enough insistence on bringing things up to the standards of the best.

Simon Stevens: If you are Guy's and St Thomas' hospital. you are admitting patients from dozens of different local authorities. The differences in approach between Lambeth, Southwark and Lewisham do not go unnoticed, let alone Wandsworth out to Greenwich and so forth. If you are dealing with a single hospital with a single unitary—if you in are Northumberland, for example—it is pretty clear who you are dealing with, and although it did not probably come out in the conversation, if you look at the less harmonious relationship that exists in North Tyneside, compared with Northumberland or Newcastle, you can see that even in that part of the north-east it is a slightly messier picture than perhaps a single county solution might suggest.

Q145David Mowat: All right. Just to finish off on this accountability point, you now have a direct report who will own this issue, who will be coming to you and saying, "Well, it's £400 million last year. This time next year it's £200 million." That conversation will be going on—

Simon Stevens: We will own the things that NHS England can do, and Jim and Kathy will own the—

Chair: Jim Mackey and Kathy McLean.

Simon Stevens: Jim Mackey and Kathy McLean will own the things that they can do.

Q146 David Mowat: I am not sure if that is a yes or a no.

Simon Stevens: Well, it is a shared endeavour.

Chair: We have got a name.

Q147 Mr Bacon: Mr Rouse, you are a Department of Health senior civil servant, and there must be somebody in the mix who comes along and says, "Aha! The problem is that Dr McLean owns her bit and these people in such and such a place own their bit and Sarah Mitchell's local government people own their bit, but there is a systemic problem in the way that you described." Without having a "throw it all in the air and see where it lands" approach, which is how Mr Mills caricatured what I was suggesting, surely there is scope for experimenting rather faster, and

mimicking best practice at speed to get some of the changes that are needed, because if you have the right structure, as we heard, the processes will naturally follow.

When you were talking earlier, Mr Stevens, about these people fining each other, I was reminded of the train operating companies and Railtrack. Instead of fining each other, the resources should be going elsewhere. If it were being run as one system, it would be more likely that the resources would be going into solving the problems, wouldn't it? So where is the policy piece? I know we are not a policy Committee, but where is the piece that is coming along and saying, "Here are the tweaks that are needed"?

Jon Rouse: The Treasury, through the spending review, made a very clear statement about producing an integration framework for the period from 2017 to 2020, and that policy has not yet been fully articulated in terms of how exactly that will work, but what we do know is that a significant part of it will be channelled through the sustainability and transformation plans under the five year forward view in the 44 areas, and Ministers are going to have to make some judgments within that, in terms of how permissive or prescriptive they are going to be around different models of care.

There are many advantages to a bottom-up approach, because you get real ownership. If it is gestated locally and people really own it, there are many benefits to that, and I am sure we will see that through the vanguards programme that the five year forward view bodies have set up. On the other hand, there is also a need for pace, because as we are talking today, we have problems that are pressing. Ministers over the next few months are going to have to find that point of balance between prescription and permissiveness.

Chair: I am going to bring back Nigel Mills, then Karin Smyth and John Pugh. It is already half-past 6, so if we can have short answers and short questions, that will speed things along.

Q148 Nigel Mills: We were close to a meeting of minds on setting target dates for some of these, so it would be a shame not to do that. Joint assessor arrangements—is that this year? Unrealistic, I guess, because we are in June.

Dr Kathy McLean: The trusted assessor?

Nigel Mills: Yes.

Dr Kathy McLean: I think we mentioned 2017.

Q149 Nigel Mills: Do you think that is realistic?

Chair: Spring, summer or autumn? By end of?

Dr Kathy McLean: April is often a good time, isn't it? The beginning of the financial year.

Q150 Nigel Mills: Discharge to assess schemes were being used in only 52%. Do you think they should be much more widespread and on the same timetable?

Dr Kathy McLean: Those should be more widespread, but I think that is a joint thing that we would need to commit to. Perhaps not 100% in the first instance. What do you think would be reasonable? This is very much a joint thing.

Sarah Mitchell: It is about putting a plan in place to achieve it and do it properly, and I think we are already trying to do that. It would be very confusing to the system if we had lots of different dates for different things, and I do not know how it would fit with other plans that are coming on board, but we could align them for the moment and say April 2017, and then if, taking consultation from the field, we thought that was impossible, we could come back to the Committee.

Chair: Okay. Thank you for your candour. It is amazing that you are not making it up in front of us—hopefully not. But thank you for that.

Mr Bacon: If it works, you should try it more often.

Chair: Yes, maybe we should bring you in front of us on every local issue we deal with.

Q151 Karin Smyth: Perhaps unhelpfully, I may be slightly disagreeing with some of my colleagues. I found the Report slightly frustrating because it almost gets us somewhere and then I think we lost it. In the conversation in the last hour, we made some progress, but then we seem to be going back. I did not recognise parts of this picture. Mr Stevens, you said that different things are working in different parts of the country, but at each turn, we seem to be going for a national prescription. We have had 20 pieces of guidance on this subject in 15 years. We clearly do not need any more guidance. I am not sure we need any more plans, actually. I think you know between you what is working, where it is working and where it is not working. This Report does not help us with that, and this hearing is not really telling us where things are working and where they are not. That is also where part of this accountability issue is not working. It would be a shame if we went away from this wanting a total national prescription without somehow getting beneath some of that detail about where things are working and where they are not, and why that is. Is that fair?

Jon Rouse: I think you are right in saying that we have a pretty darn good idea of what works now, in terms of the different teams that we have sent into places over the last two or three years and the guidance that we have produced. As has been said, there are some essential ingredients that every place should have, and that we should pretty systematically over the next year or so be making sure are in place, because we know they work and they ought to be core to each system.

Beyond that, it gets more difficult, because in those areas that are really struggling with this, when you get down and really spend time with them, you find that the barriers are different in each place. In one place, it may be that they are grappling with a real labour supply problem on the care side, because they have full employment or near-full employment and it is very difficult to attract people to become domiciliary care workers. They are attempting different approaches and solutions, but—

Q152 Karin Smyth: We heard that in the pre-evidence session.

Jon Rouse: Yes, and it is really hard. There is no point in beating them up with a stick, because you have to own the problem commonly with them and try to find innovative approaches.

I will not name names today, because it is not fair or appropriate, but there are some authorities that have been stuck at the top of the DTOC list for social care literally for years. They have been the top three or five worst-performing authorities—multiples away from even the average position, let alone the highest position—and there is clearly a leadership and relationship problem in play there. There is still a question about what you do in those circumstances with those authorities, because they are contributing substantially to the national numbers. I have said there is variation here. Those bottom 24 authorities—that is 14% of all authorities—are a third of all delays, to give you some idea of the proportionality here.

Q153 Karin Smyth: So why have we not used that work and the work of the ECIST team and so on and just focused on that, rather than continuing to shroud what seems to be a massive problem across the whole country?

Jon Rouse: We have done a lot of work with most of those authorities on a voluntary basis. Some have responded very well and their numbers have come down and stayed down, and they are to be commended. There are some authorities that were in the top 10 for a long time in terms of their rate and are now down in the pack. But there are others that either have not been properly receptive to that offer or that work or, for whatever set of reasons, have been unable to take the practice that we know works and embed it within their system. There remains, therefore, a question about what we do with those authorities in those areas that we are still grappling with.

Q154 John Pugh: I have two quick questions. One is in relation to figure 9, which talks about the rather dismal figures for the number of older patients fully involved in the decision about their discharge from hospital. Obviously, involving people takes a certain amount of time. Is getting that figure up compatible with delivering a better service, or is it to some extent just dragging out the process?

Simon Stevens: Sorry, could you say that again? Compatible with what?

John Pugh: In figure 9, there is a rather depressing figure. It mentions that "54%"—barely half—"of older patients felt fully involved in decisions about their discharge." Obviously, you could try to correct that. The simple question I am asking is: if you tried to correct that, would that prolong the process, or could the process be done just as expeditiously?

Sarah Mitchell: I think involving people usually makes—

John Pugh: The process longer.

Sarah Mitchell: No, shorter, actually. I think part of the problem, as I was saying earlier, with not being patient-centred or person-centred, is that actually people—

Q155 John Pugh: Okay, so it's compatible. My second question is massively parochial.

Simon Stevens: Can I supplement that answer with an additional flavour? I think 99 times out of 100 that is right, but it has been the case that some hospitals report that where they have patients who would be self-funded in a care home, sometimes relatives take time to realise that that is unfortunately now the situation confronting, typically, their parent. Being clearer about what

expectations the NHS has of families is also part of the deal, so we published with the LGA, ADASS, Care England and the UK Care Homes Association a sort of guide setting out in pretty straightforward language what the deal is, including a section titled "Refusal to leave hospital", which gets into this in straightforward terms.

Q156 John Pugh: It is good to have that on record, because it hasn't been touched on so far. My second question is massively parochial. I was fascinated to come to this session, because my own local hospital has had appreciable problems. The evidence for it is ambulances turning up in large numbers and waiting there because they cannot transfer patients into A and E because they need to free up beds, because a lot of the people being transferred into A and E need to be moved on to wards. I would make a plea for somebody knocking heads together, or some level of integration or dirigism there. There are a number of parties involved, including the local commissioning group, all of whom are not quite clear whose fault it ultimately is.

When I looked at the statistics for my local hospital, I found that the percentage of people aged 65-plus who were actually admitted was a bare 33%, compared with Peterborough and Stamford hospitals in Stewart Jackson's constituency, where it is 60%, and in Kevin Foster's constituency, where it is 60%. This leaves me sceptical about NHS figures in general. Can it be that people in Southport are so incredibly hardy that they hobble away after a visit to A and E, and people rocking up in Peterborough and Stamford insist on being admitted, or the doctors do? Does this show something about varieties of risk-averseness in the system? I simply can't explain that figure.

Simon Stevens: On average, I think about half of A and E attendances result in admissions, so there is a spread around that, but it will be a function partly of what the other alternatives are. If, in your area, as well as the hospital, there is an urgent care—

Q157 John Pugh: We have a very aged demography, you see, which is why it is surprising.

Simon Stevens: Yes, or a minor injuries unit, or some other route that might be taken by those patients—

Q158 John Pugh: No, there's none of that.

Simon Stevens: Well, maybe there is in Peterborough and Stamford. We need to look at this. Different channels will therefore dictate what the admission rate appears to be, relative to the total footfall in an A and E department. In some places, people go to an A and E department when in other geographies, they would instead go to an urgent care centre.

Q159 John Pugh: There is no alternative in Southport. Do you not find a variance of that kind very interesting, if not worrying?

Simon Stevens: Well, there is also a difference in the way acute medicine works. Sometimes people are admitted straight to the emergency ward without going through A and E. That also can distort the figures. I think Kathy is volunteering to look into that for you.

Dr Kathy McLean: Yes, we will look into that for you, but it is quite a complex one.

John Pugh: I would be fascinated. Thank you very much.

Q160 Chair: There has been a lot of interest from all 650 Members across the House—well, perhaps not the Prime Minister; I am sure he is interested, but he hasn't expressed it directly—in these sorts of figure, so you may get a number of other inquiries, Dr McLean, just to warn you. We won't promise a bespoke service to all.

I am aware that time is marching on; I appreciate your patience. Can I ask a couple of other quick questions? You just mentioned self-funders, Mr Stevens. I wanted to ask you and Jon Rouse this: we have a report coming out very soon—this week, in fact—on the management of the whole care market. We heard from our pre-witnesses and from a number of people in evidence, and I know that our sister Committee, the Health Committee, is very concerned about it. The issue is that people who have to fund their own care understandably have to adjust to that as a family, but also, many care homes are putting up the price of private beds, quite rightly, because of the bulk purchase discount from social services. However, those providers say that those bulk purchase discounts are now so low that they are having to put up the prices elsewhere.

First of all, Sarah Mitchell, do you recognise that description? Secondly, is it a problem that your members come across?

Sarah Mitchell: Yes, we do recognise that a differential price is being paid in areas where there are a large number of self-funders and where the local authority is paying a different rate and cannot afford to pay the higher rate. As a commissioner in local government, the important thing is to have a really good open-book accounting system with the providers, and to be up front and have those conversations about what people are getting for the money they are paying. We would encourage those who are funding their own care to have a not dissimilar conversation with the provider, because some rates are very high, and families and people should be asking what they are getting for that money and whether the rates are exceptionally high, as they are in some parts of the country. It means that it is then very difficult for local government to negotiate adequate supply. It is also difficult for CCGs to find enough continuing healthcare placements, because the discrepancy is so large, and we recognise that as an issue.

Q161 Chair: We know there is a role for the Department and for local authorities under the Care Act in helping to manage the care market, but you just painted a depressing picture. Although you have to manage the market, it is private providers. Jon Rouse and Sarah Mitchell, what are you going to try to do to resolve the problem?

Jon Rouse: As you know, because I told you last time I was here, I have recently written to every local authority reminding them of their duties under the Act in respect of promoting a sustainable market, and that means diversity and choice. You do not have a sustainable market if self-funders and those being commissioned through the local authority do not have some degree of choice over the care setting they go into.

Q162 Mr Bacon: What percentage of domiciliary care is funded by local government?

Chair: Don't you mean residential care? Domiciliary care is in the home and residential is in a separate setting.

Mr Bacon: Either. The stuff that is not self-funded—it could be care, it could be residential—what percentage is funded by local government?

Sarah Mitchell: It will depend on the local wealth of the local population.

Q163 Mr Bacon: I am talking about the totality.

Sarah Mitchell: Across the whole country? I wouldn't—

Q164 Mr Bacon: Yes. You are the LGA. Do you know the number?

Jon Rouse: I cannot remember the number off the top of my head, but what I can tell you is—

Q165 Chair: Can you find it out?

Jon Rouse: Yes, absolutely. We can give you a note; I just did not bring the figure today. I want to echo Sarah's point: it varies dramatically.

Q166 Mr Bacon: I am sure it does. I am interested in how much of the total cake is self-funded, and how much is funded by the taxpayer. I am slightly surprised that you do not know, but if you can send us the information and split it between care and residential, that would be very helpful.

Jon Rouse: We will do that.

Q167 Chair: We will not repeat the arguments in our Report, but I know that our sister Committee is interested. Speaking of sister Committees, the Public Administration and Constitutional Affairs Committee, also known as PACAC, is looking at the work of the Parliamentary and Health Service Ombudsman, and that is part of its remit. They are also looking at how information is provided. I have been in touch with Bernard Jenkin, the Chair of that Committee, who is keen to be clear about whether there is a possibility of improved strategic financial planning in Government and, in particular, better co-ordination between primary healthcare and social care spending. I suppose, Jon Rouse, that that probably falls directly with you, but you are very welcome to deflect bits of that to any of your other panel colleagues.

Jon Rouse: Can you repeat the question?

Q168 Chair: To what extent would your efforts to address discharge delays be supported by improving strategic financial planning in Government and, in particular, better co-ordination

between primary healthcare and social care spending? Do you think you have got it right, or do you think you could do it better?

Jon Rouse: This takes us back to some of the things we have already been discussing, because it is at the heart of the integration framework. If you are going to be genuine about integrating services, then—

Q169 Chair: We are hearing about integration at the local level. We have heard a lot about that today. It is really about the departmental level, given your wide remit across local government and the NHS. Do you think that there is a different way of looking at those budgets? For instance, if you put more money into GP services, that might actually save money for social services later down the line because you do not have an emergency discharge and you do not need an emergency care plan. It is that sort of tension that I think they are focusing on.

Jon Rouse: I think we did a certain amount of that through the SR process, as you would expect. That is one of the reasons, for example, why we did the big increase in disabled facilities grant. We knew we could demonstrate from the evidence that there was a payback period that was very attractive, so over the four-year period we are doubling the amount of disabled facilities grant. That is a housing solution for a health and social care benefit.

Q170 Chair: Do you think you have got it spot on, or do you think there is more room for improvement in this area? You have got the silos—there are huge issues when you have the spending cuts that you are facing.

Jon Rouse: I personally believe that it is one of the core roles of the Department of Health to look not only across its own purview, but into the spaces occupied by some other Government Departments. It needs to work out where the best bang for your buck is likely to come from regarding the investment of resources from the public purse. That would reach across into housing, welfare and possibly one or two other areas.

Q171 Chair: I have a couple of little mop-up points. We heard that one of the good things they do in Northumbria—I know it is not alone in doing this, but it was an example that we heard today—is that patient records are available on tablets. Somebody in a domiciliary setting can look up the information they need. I don’t know which of you would answer this. Sarah Mitchell is nodding. Perhaps you could tell me, Sarah, whether this is something that you are aware is happening more widely? Is there some date by which that might be universal?

Sarah Mitchell: I don’t know that I could give a date, but I will certainly work through the digital work that is happening. There are funds going into looking at exactly how you do that. That is a real solution. Domiciliary careworkers being able to text people to say when they are coming and being able to access records very easily is a real step forward. Funds have been allocated and work is going on with each of the local authorities, linking with the STPs and CCGs, to make that happen.

Q172 Chair: Do you have any analysis of literacy and language levels among domiciliary careworkers?

Sarah Mitchell: We don’t, but I think that Skills for Care will. We can certainly get that for you. It is an issue.

Q173 Chair: If handwritten notebooks are not filled in, or are filled in with the same sentence every day because that is the only sentence that that person can write, there is an issue. It is not just about the technology. Perhaps that is an issue for another day.

Sarah Mitchell: We can come back to that.

Q174 Chair: On geriatricians, in response to Anne-Marie Trevelyan’s questioning, Mr Stevens, you seemed, after some to-ing and fro-ing, to indicate that you did not think that more consultant geriatricians was the answer to anything in particular. I may be paraphrasing. Perhaps you could clarify.

Simon Stevens: I don’t think that the transcript will show that that was my answer. My answer was that, alongside additional geriatricians, we also needed to think about the broader multidisciplinary team, including GPs, community nurses, therapists and other allied professionals.

Q175 Chair: We have looked at workforce planning before and we know that there is a challenge in recruiting people to certain posts, so what will you be doing? You have talked about what you are doing to recruit more GPs. We brought up the physics teacher issue. Dr McLean, you said people don’t always want to do it, so how do we get more people to want to become geriatricians?

Dr Kathy McLean: There is work we would need to do with Health Education England, which commissions the training of doctors. There is something to do there. We need to look at what figures they are predicting going forward and whether those match with what we need. There is also something about ensuring that it is an attractive branch of medicine for people to choose to go into. That is an important part of people’s choice.

Chair: We won’t revisit all our discussions on workforce planning. Thank you for your patience. We started late, for which I apologise. Our transcript, as ever, will be up on the website in the next couple of days. It will be uncorrected, so if you have any corrections, get in there quick and they will be corrected. The report is likely to be out in July. We hope it will be out before the recess, but we have an extra recess because of the referendum, so I am afraid that slightly slows things down. Thank you very much for your patience and your time.