

Public Accounts Committee

Oral evidence: Care services for people with learning disabilities and challenging behaviour, HC 973

Monday 09 February 2015

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Members present: Margaret Hodge (Chair); Mr Richard Bacon; Stephen Hammond; Chris Heaton-Harris; Mr Stewart Jackson; Dame Anne McGuire; Austin Mitchell

Amyas Morse, Comptroller and Auditor General, National Audit Office; Gabrielle Cohen, Assistant Auditor General, National Audit Office; Ashley McDougall, Director, National Audit Office; and Marius Gallaher, Alternate Treasury Officer of Accounts were in attendance

Examination of Witnesses

Witnesses: Sir Stephen Bubb, Chief Executive, ACEVO; David Congdon, Advisor to Challenging Behaviour Foundation and Head of Campaigns and Policy, Mencap; Vivien Cooper, Chief Executive, Challenging Behaviour Foundation, gave evidence.

Q1 Chair: Welcome. We don't like this room because you are so far down the other end, but we are here because it is more accessible; we thought it would be a better room. We are going to keep the first half to about half an hour if that's possible. It is really an opportunity for you, collectively and individually, to comment on the findings in the NAO Report, how it links into your knowledge and the areas that you believe we should question the accounting officers on when they come in. Vivien, why don't I start with you? Could you comment on and draw our attention to what you think are the salient issues please?

Vivien Cooper: I think the National Audit Office Report has confirmed what a number of us have been saying for some time, which is that post-Winterbourne View, there was a sense that a lot needed to be done. Systemic issues needed to be addressed and a range of things needed to happen. That would require strong leadership, firm commitment and good programme and project management, because it is a complex situation. It's not that it is impossible to do, but it is complex and needs good management. There needs to be a sense of, "This is where we are, this is where we need to be and this is how we're going to get

there.” I don’t think that has happened, and the key thing for me is the human cost of that, because we are talking not just about numbers, figures and process, but about people’s lives. During the four years since Winterbourne View, children and adults have gone into services even though we are saying that people go in and do not have good outcomes. They have gone in, and it has been really hard to get them out.

Q2 Chair: When they set the June 2014 target date, were you surprised? With your knowledge of the complexity of what they had to take on, did you think it was doable?

Vivien Cooper: It is always good to set a target, a time scale. I think it was an ambitious target, given that it is not just about moving people out; it is also about developing good local services, skills and support to stop people going in. I think it was too simplistic to say, “We just need to get people out and then everything is going to be fine.” We need to look at the whole system and say, “Where are they coming out to, and how are we going to stop the next lot of people coming in?”

Q3 Chair: Can I ask you one other thing? From the figures we have, it looks like more people are being admitted than are being resettled into the community. Do you have some understanding of why that is happening?

Vivien Cooper: I think it is because there is still a crisis management approach. The families that we support can identify, usually, when things are starting to go wrong and ask for support, and that support is not available. Then what happens is that people get into crisis and get channelled into these inappropriate services that deliver poor outcomes for them. Once you get in, it is very hard to get out or to get back into the community.

Q4 Chair: David, from your perspective, what do you think?

David Congdon: I think the NAO Report has done an excellent job of saying what the problem is and some of the things that need to be done, as indeed does Sir Stephen’s report. There is no doubt that people get trapped in the system. Everyone will say that, on a Friday afternoon, when a placement breaks down, whether it is in the family home or in residential care or supported living, it is easier to place someone in an assessment and treatment unit—section them under the Mental Health Act. Then they get left and trapped in that system. Certainly the experience on previous programmes to reduce provision, such as the long-stay hospital programme, was that that was done by initially restricting admissions, so you are then cutting off the supply.

In adding a couple of other points, I would strongly support, therefore, to drive this forward, a closure programme—a realistic closure programme. There would need to be a debate about what level of in-patient provision would be needed. I think some would be needed, although some areas seem to manage without any provision. That is an important point, but understanding better what has happened to some of the people who have moved out is equally important. There is no point in moving people out if six months later they come

back in because the placement has broken down. There has to be investment in community-based facilities.

The other comment I would like to make in passing is that one of the big concerns from a value-for-money point of view was that the places in assessment and treatment units cost a lot, as the NAO Report makes clear. Indeed, at Winterbourne View, the cost was £3,500 per week on average and there was very little evidence that the people there were getting a first-class service—let alone all the abuse that they suffered. One of the key things was that even the commissioners—those buying those places—didn't really know what value for money they were getting. When Margaret Flynn did the serious case review, she asked the owners, Castlebeck, to let her know how much psychiatrist input and other professional input there was, and they refused to provide the information, so there was no check on the value for money. The evidence from elsewhere—from organisations such as the Association for Supported Living—is that you can get a better outcome at a lower cost if you provide community alternatives.

Q5 Chair: Sir Stephen, you did a very helpful report. I suppose there are two questions, really. One is, why have they failed so far? Looking forward, what do you think they are failing to do at present that means that they are unlikely to achieve what has now been termed an ambition?

Sir Stephen Bubb: Like the NAO, when I was asked to do this report I was doing it against a background of failure. The Winterbourne View scandal had demonstrated what are, frankly, the evils of institutional care. The Government were completely right to set an ambitious target and to say that people need to be moved from institutions into the community. There has clearly been a failure, but I think that that failure will act as a spur to action now. That was certainly what I concluded from this report.

You asked me why it has failed. The conclusion that I came to, which is also in your NAO Report, is that in the system it is far too easy to do the wrong thing, which is to put someone in an institution and not in the community, and it is too difficult to do the right thing. That is right across the system. There are a number of things that therefore now need to happen to stop that process.

First of all, we need a radical change in the commissioning structures, and I will say a bit more about that later if you like. We need to really strengthen people's rights in the system. You challenge the people from below by giving people rights and you change the system at the top by radically reforming commissioning. Finally, we need to tackle the revolving door. NHS England has been doing some very good work on care and treatment assessments and moving people, but while there are beds available they will be filled. So far, if you read the response of NHS England, it is couched in euphemisms. It will not use the word "closure", but these institutions have to close. Unless there is a principled decision—and, effectively, a decision has to be made by the Government to close these institutions, as in the '80s when we closed the mental asylums—we won't make progress.

I absolutely understand that that needs to be planned and to be careful, so you build up community provision, as you did when you closed the mental health asylums. But I proposed that there be a timetable for closure, and one hasn't been proposed. As the NAO

Report itself said, there is not only a lack of a timetable, there is a lack of ambition. Really, this is a fairly fundamental point. I used a quotation in my report, which I think is very instructive. It was from an American, back in 1851—the chap who was behind establishing boarding schools for the blind. He was very successful in that, but he soon realised that those institutions were a problem. Afterwards, he said that “all such institutions are unnatural, undesirable and very liable to abuse. We should have as few of them as possible, and those few should be kept as small as possible. The human family is the unit of society.” You have seen in the NAO Report just how many people with learning disabilities are in such institutions and liable to abuse. That system has to end. Therefore, we need to be absolutely clear what is happening on closures.

Q6 Chair: Thank you for being so clear. Can you say a little about commissioning structures?

Sir Stephen Bubb: I talked about two levers. On the commissioning structure, NHS England are now putting in place a national framework for commissioning, which is the right approach. They also need to mandate pooled budgets under the Care Act. The Health Secretary can mandate pooled budgets between the health service and local authorities, which will tackle what the NAO Report has shown is one of the problems of commissioning—that if the health service pays for it, local authorities do not need to provide community services.

Q7 Chair: To be clear, you are talking about pooling the NHS budget that pays for somebody in a hospital and the local authority budget—not just pooling budgets in the local authority.

Sir Stephen Bubb: Yes, and this is in fact proposed in the response from NHS England, but it needs to be done under the Care Act so that it will actually happen. It is suggested that this is a way forward and the Local Government Association have said they support it, but I am not sure it will happen unless it is mandated under legislation.

The other point I would make is on the right to challenge. A strong aspect of the response from the Government and NHS England is a proposed Green Paper to enshrine such rights in law. In a sense, that has gone further than what I proposed in terms of a right to challenge in the system. Legal rights for people with learning disabilities and their families is the right approach. The Green Paper is a strong part of how we move this forward.

David Congdon: On that last point, one of the things that screams at you when you read the individual family accounts is that parents know best the needs of their sons and daughters, and they are usually horrified when they find their son or daughter sent hundreds of miles away to an assessment and treatment unit. Not only are they hundreds of miles away, but they are usually sectioned under the Mental Health Act, and it is very difficult to get them out. There are lots of stories of people being in them three, four, five years and beyond. A right to challenge at the point at which you are admitted, as well as going forward, is important.

Clearly, that has to encompass a review of how the Mental Health Act is working in practice for these people. The irony is that there are people in the system who stay in an

assessment and treatment unit for a long time, sometimes for a minor misdemeanour. They have been diverted from the criminal justice system, but if they had gone through it, they would probably have had a conditional discharge or whatever, instead of being sectioned for five, six or seven years. Strengthening the rights of people with a learning disability and their families really goes to the heart of this.

Q8 Mr Bacon: As a quick follow-up to that point, it is extraordinary that the costs are so high, as you said earlier, but that people stay in these places for many years, when some of them plainly shouldn't. There are vested interests at work in most spheres of human life, and there must be holders of these budgets—£3,500 a week, times however many people—who, if people were not in these institutions for six or seven years, would be unable to continue justifying their budgets and who would perhaps not have employment in the way they do now. Do you think that one reason why people end up staying as long as they do—in many cases wrongly, from what you are saying—is institutional inertia? Are there people who, however unthinkingly, see it as in their interest that the status quo should continue?

David Congdon: I think there is an institutional inertia, and it does vary a bit between the independent sector and the state sector. In the independent sector, quite rightly, they are running a business, so they clearly have an incentive to keep people in for longer, as indeed Castlebeck did, but it is not that different, necessarily, in the state sector, because often the people are placed under what are called block contracts—they have got the beds, so they will keep them.

You can also put a more positive spin on it. Often the psychiatrist or the responsible clinical officer will take the view they do not want to discharge the individual because there are not the facilities in the community. That is a perfectly reasonable response, so the challenge is actually getting the facilities in the community to break the inertia, but that does also link back to the point that was made just now about pooled budgets—money following the patient—because the money is often in the wrong place. A lot of this money is tied up in institutional provision. We need to invest in community provision, which, in the medium term, will be more beneficial to the individuals and more cost-effective.

Vivien Cooper: I just wanted to add something about rights, which I think is hugely important. People have the right to challenge, but it is not just about having the right. It is about having the support to exercise that right, because often families are in very difficult situations. It is a crisis situation and you need to know where to turn to enable you to mount that challenge. So it is about implementing. There is a lot of process, but it is about implementing things that deliver good outcomes for people. So I think we need to think about that.

Q9 Dame Anne McGuire: Could I ask Sir Stephen to elaborate on a comment that he made? You said that you hoped the NAO Report would be a spur to action. What makes you think this will be the spur to action, given that everybody thought that the Winterbourne review would be the spur to action? Historically, I am sure most of us could elaborate on other issues where we thought, “That was the thing that was going to make the step change.” Are we all going to be here in another two or three years saying, “Yes, we thought that was

the spur to action. It was pretty damning. It built on the Winterbourne review. It built on a whole legacy of experience, and we are still in the same situation”—where learning disabled people are, frankly, almost the Cinderellas, in terms of how we look at people, in terms of exercising their rights to independence and to proper equality?

Sir Stephen Bubb: Thanks, Anne. It was interesting, when my report came out, I was very pleased. There was really strong, and a very broad, consensus around the recommendations.

Dame Anne McGuire: Because it was based on outrage at the time, and I think that is the issue that I want you to elaborate on.

Sir Stephen Bubb: But what people said, in the same way that you have just said it, Anne, was, “Well, we have seen reports before, and nothing has happened.” There is therefore natural scepticism—cynicism—in the community for people with learning disabilities, on whether things will happen. I am more optimistic, frankly. I think we have a leadership in NHS England that gets this, and understands the need for change and is driving that change. I think, although I have been critical of the NHS England response on closures, the actions that they are taking are in the right direction. Importantly, I have been asked to review progress at six months and in a year, and I will be fairly outspoken if I do not think that progress is being made against the recommendations that I have made, both at six months and a year. It simply is not tenable, given my report and the NAO Report, not to now take decisive action, including closures.

Q10 Dame Anne McGuire: Can I ask a follow-up question to your comment about the pooling of budgets? Do you see this as part of the transition to an individual budget approach, not just for institutions pooling budgets—because then you just have another institution managing the life of an individual person with learning disability—but looking at how that is individualised in a far more positive and proactive way, not necessarily for the individual themselves to manage their budget but those who can support and offer advocacy and so on? You know the script as well as I do.

Sir Stephen Bubb: Absolutely. Personal budgets are important and, again, there is a commitment to roll them out for people with learning disabilities. One of the other rights that I proposed was a right for community providers to propose alternatives so that, together with a right to challenge a decision, a family, working with a local or national charity, could say, “Not only do we not accept that our loved one is going to be shipped halfway across the country but we have an alternative.” That family could then challenge the system on why that alternative provision in the community is not acceptable. It is really about driving change from the people for whom we should be providing proper health and social care.

Q11 Dame Anne McGuire: I have one more question, and it is to either David or Vivien. A comment has been made about the promotion of individual rights. Do you still think there is a medicalisation approach, particularly to those with learning disabilities, and that there should be a more rights-based approach? In other words, it is easy to get into the medical system and into long-stay so that you never get out again—I don’t mean to be brutal about it—once they get their hands on you. That links a wee bit to what Richard was saying

about this system grabbing you and not letting you go. Is part of that to do with the culture of medicalisation?

Vivien Cooper: I think it is partly that. We should be starting with a rights-based approach. We know a great deal about supporting individuals with learning disabilities who have challenging behaviour. We know about getting the environment right in what they call a “capable environment”. We know about the importance of skilled staff. We know about all of those things, yet we persist in putting people in terrible environments that are damaging them, causing them further distress and even death, and at a massive cost. We just have to shift our approach. These are individuals with the same rights as the rest of us. They have the same needs as the rest of us; they just need additional support for the particular issues that they have at the time. We know what to do, and we know how to do it; we are just not doing it at the moment.

Q12 Austin Mitchell: I am running a bit behind this discussion. To me, learning disabilities and challenging behaviour are two different things. I can see that one is more appropriate for treatment in the community than the other. I see from the Report that 83% of the people with whom we are concerned are there because they have been sectioned. How can those people be cared for in the community in the way you are arguing? Sir Stephen wants to close the institutions, but there will surely be some need for continuing in-patient facilities and continuing constraints.

David Congdon: Very often, the sectioning occurs because that is the only way to get them into these institutions on the anecdotal Friday afternoon to which I referred. In any event, it may or may not have been appropriate at that point to section them, but they are supposed to be sectioned for assessment and treatment. Most people would say that assessment and treatment should take months, not years. The problem we have is that, these days, sending them to an assessment and treatment centre means that they stay for a very long time when they probably do not need still to be sectioned. There may be a stage when they have very challenging behaviour and when they may need to be sectioned but, as Viv was saying, if you create the right environment in the community with the right staff supporting these individuals, you can reduce the incidences of challenging behaviour and enable them to live very successfully in the local community with proper professional support.

What you don’t want to do is have a situation where they live in the community, often without proper support, and for it then to break down with their being sectioned and put into an assessment and treatment unit. So the key is having good quality support for these individuals—people who understand their needs—and then you reduce the need for them to go into an assessment and treatment unit. I hope that helps to clarify matters.

Q13 Austin Mitchell: What does Sir Stephen see as the continuing need for in-patient facilities, if we close all the institutions?

Sir Stephen Bubb: Can I just go back to the closure of mental health asylums? There was a principled decision made—politically—that those institutions were inappropriate and had to close, and they did close, but exactly the same arguments were made. Now we

wouldn't dream of reopening those asylums, so we tackle people with mental health problems in a very different way.

Of course, there will be the need for treatment and assessment, and part of the task is now to work out how many beds that actually requires; I think it is a very small proportion, as David has outlined. But these institutions are not an appropriate form of care in the 21st century for people with learning disabilities, and we need to approach it from that principled stand, and then work out what facilities you need for assessment and treatment, and not keep institutions because some of them might be doing assessment and treatment.

Q14 Chris Heaton-Harris: On Austin's point, is it not the case that lots of families of individuals who end up being sectioned phone the emergency services or someone because there is the lack of the community support that you talk of, or it is very patchy around the country? So we are in a particularly bad place, because we have people who want to look after these individuals but they feel at certain points that they are not getting the support, and therefore can't do so. And as you say, that seems to happen more regularly on a weekend than it does at any other time.

Vivien Cooper: Typically, as I said, what may happen is that a situation happens, or something happens, and a person's behaviour starts to deteriorate, and then the family or whoever is supporting them will ask for additional support or additional help. For example, with Simon, who was in the Winterbourne review, that was exactly his situation. He was being supported well, his needs changed slightly and he needed some additional support.

What happened with Simon was that instead of someone assessing those needs and meeting them, he was taken into an assessment and treatment unit. Now, taking someone out of their ordinary environment, and putting them in a strange and different environment with a lot of different people who they don't know, and with routines that they are not used to, supported by staff who they don't know and with other people who are in crisis, is not a good place to assess someone. People's behaviours deteriorate and then you are on this sort of never-ending downward spiral.

Actually, what you need to do is look at the individual and see what their needs are, because often challenging behaviour is an indication of an unmet need. It may be that someone has terrible toothache and starts self-injuring, or there may be some other issues. It is about trying to understand what the cause of the behaviour is and then addressing that cause, rather than picking people up and putting them into places that can make their situation worse.

The other thing around the sectioning is that the Mental Health Act, as it stands at the moment, means that if you have a mental impairment and behaviour that is a danger to yourself or others, you can be sectioned. My son has severe learning disabilities and a range of difficult behaviours. He is supported perfectly well in the community, because he has a good support team and a good environment that he lives in, but he could be sectioned—he could be sectioned now, this minute—under the requirements of the Act.

Q15 Chair: I would like to ask Vivien a final question, as you have been working in this area for?

Vivien Cooper: Eighteen years.

Chair: Okay. What has changed in those 18 years?

Vivien Cooper: I think there is a greater understanding of individuals who display behaviour described as challenging. There is a greater amount of information available but it still doesn't get to the right people in the right time. And for some people we get it right and they have good lives, but not for enough people. There are too many who we don't get it right for. What we need to do is to invest much earlier in people's lives—in children—and when people start to develop difficult behaviour.

Q16 Austin Mitchell: Why do you think that progress in delivering the commitments has been so slow? Are the authorities losing faith in the commitments and thinking that it is a step too far?

Vivien Cooper: I do not think it is a step too far; I think that in order to deliver the change that is needed, a range of things need to happen concurrently. That range of things that need to happen are the responsibility of a range of different organisations. All that needs to be organised and managed, and that has not happened.

Chair: Anything else, any of you? That was really clear and very helpful, and it has given us some good pointers as to where to take the next session.

Examination of Witnesses

Witnesses: Una O'Brien, Permanent Secretary, Department of Health; Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, Department of Health; Simon Stevens, Chief Executive, NHS England; and Jane Cummings, Chief Nursing Officer, NHS England, gave evidence.

Chair: Some of the members of the Committee have to go to a delegated legislation Committee, so we are going to change the order. Chris Heaton-Harris is going to start.

Q17 Chris Heaton-Harris: It is a bit weird being Margaret. I will not rant or close you down quite so quickly, but I really would like to know why this failed so badly—why you raised aspirations for people and then failed so terribly in actually delivering anything in this field. I guess this is for you, Una.

Una O'Brien: First of all, I would like to say that I am very much welcoming of the NAO's Report. We accept the Report. I listened with great care to the evidence given by the witnesses who sat here before us.

It was a really difficult call for us, after the horrific revelations in Winterbourne View, how to manage addressing this problem. The judgment that we made around the particular deadline was one that I can see now we underestimated just how much—not just the work that was involved, but just what an embedded culture we were dealing with. I think that that is one of the reasons why it has taken longer than we would have wanted. At the same time, I believe that it was right that we got going on that programme when we did in 2012, coming into 2013, because if we had waited until we had perfect data and understood all of the factors that were pointed out in the Report, I think we would have lost another year. Actually, in the time that we got going during 2013 we learned a lot, and that is going to be extremely useful as we go into the next phase.

Although I accept the Report and what the previous witnesses have said, it is also true to say that we have made progress on a number of points, and there were four in particular that I would just like to mention. I will not go into detail, but you may wish to come back to them. First of all, the CQC inspection regime, which has been tightened. Secondly, we have now introduced both a duty of candour and the fit and proper person test to run organisations. These two in particular were driven by an analysis of what had happened at Winterbourne View. Of course, we have also introduced criminal liability, which is a brand new thing that was never there before. We have done a raft of things which are acknowledged in the Report around guidance, although I accept that guidance is not enough.

On where I am right now, quite apart from what Simon may wish to say, I believe that the next step is to enshrine rights in law, because there is an inequity in power between institutions and families of people with a learning disability. I think that we will only really make progress when we combine our managerial actions with giving people more rights to challenge.

Q18 Chris Heaton-Harris: I do not underestimate the difficulty of trying to get these people out of these institutions; not in the slightest. In fact, the first thing I ever did in voluntary work was to volunteer in a former mental asylum, St Ebba's, so I have first-hand experience of how horrible those places were. Equally, I saw some fantastic care of individuals within them at the same time.

In Stephen Bubb's report and the NAO Report, there is a fantastic passage saying that "previous commitments to discharge large numbers of inpatients had associated funding to build and maintain community services. However, there was neither funding for patient transfers, nor pump-priming money, available for this programme". Was it really just set up to fail from the very beginning?

Una O'Brien: A lot of money is being used in the system, and again, we underestimated how difficult it would be for commissioners to adjust their decision making. I think we have learned a lot of lessons through that. It is also true to say that we have put some capital money behind the programme. I accept that we could always do more, but we have an absolute determination now—in fact, it has been doubly reinforced since Sir

Stephen's report last year—to take the action needed to build the capacity to support people. I think giving people individual budgets will strengthen our actions in that area.

I do think we have a problem with some of the points that came up in the previous session about vested interests. Once you have a set of institutions in place, it is easy to do the wrong thing. I think tackling that is going to take determined action and time.

Q19 Chris Heaton-Harris: In figure 6 on page 28 of the Report—there are lots of points, actually, including paragraph 2.19 on page 27—there are questions about the quality of data that you keep centrally. It looks to me—I know the NAO put in figure 6 to draw a slightly different conclusion from the one that I drew—like you do not actually know exactly how many people there are like this. I was a bit concerned about that. There is not one point—well, I suppose the graph crosses—at which your numbers and the NAO numbers are equal. These are quite high-need individuals; I would have thought you would be able to track at least 2,600 people fairly carefully.

Una O'Brien: I understand that, and I think Jon can comment on the discrepancy between the two data sources. To be honest with you, when we began this work in 2011-12, our data was absolutely nonexistent. In creating the census—we just had the second report in January—we have made really significant progress on that front, but it is still not good enough. I think we are closer to a point of knowing exactly who everybody is and where they are, and who is responsible for them, but there is still a gap, and we need to close it. Perhaps Jon can comment on the technical discrepancy between the two—

Q20 Chris Heaton-Harris: Could you also tell us how many people with learning disabilities are in hospital today?

Jon Rouse: Circa 2,600, but NHS England can probably give you the precise number. In terms of the data, what we need is a statutory data set, which is what we are going to move to through the health and social care information centre, so that we do not have several versions of the truth, with the census giving one figure, the Assuring Transformation programme saying something else and the NAO, because it identifies discrepancies in those data, coming up with a third number. We need one version of the truth.

Q21 Chris Heaton-Harris: Out of interest, does NHS England have the figure for the number of people with learning disabilities in hospital?

Jane Cummings: We have been doing a bottom-up count. We have been asking local organisations, CCGs and specialised commissioning to be very clear about the number of patients that they have in place. It is a continually moving feast, as people come in and go out. If you are asking me whether I can tell you exactly the number of in-patients today, the answer is no because I would inevitably be wrong. What I can tell you is that we have 2,537 people who we know were in hospital as of April 2014. Of those, we will have discharged approximately 789 by the end of March.

We have a much better handle on the figures now. We are getting fortnightly management information. That is not validated, in the sense that we are not publicly reporting it, but it gives us a much more detailed understanding of the number of patients coming in, the number of patients going out and where they are going. Until probably last October to November, we did not have that level of detail.

Q22 Chair: How many have you admitted in the same period? You said that 789 have been discharged.

Jane Cummings: Our October to January figures show that, for every seven patients we are discharging, we are admitting six. We are still very concerned about that. If it would be helpful, we can describe what we are doing to try to stop admissions because as well as discharging patients, preventing people from needing to be admitted is an absolute priority for us.

Q23 Chair: How many of those are readmissions?

Jane Cummings: Of the six to seven? I do not know that. We do not have that figure in detail at the moment.

Q24 Chair: You don't know? So you don't know how many go through a revolving door?

Jane Cummings: We are beginning to get that level of information but it is very difficult to get. That is one of the things that we are working on. It is fair to say, as the NAO has reported and as we have all said, that data is one of our biggest issues. The census was put in back in 2013. We have put in Assuring Transformation data, which is the information that the NAO use. That is quarterly information. On top of that, we have started the fortnightly detailed management information. We are better, but it is still not good enough. We are moving that to the HSCIC now.

Q25 Chair: A final question on data, and then I will go to Anne—why are your figures so different from the Health and Social Care Information Centre figures?

Jane Cummings: In terms of the census and the Assuring Transformation data?

Q26 Chair: You talk about 2,600 or thereabouts and they talk about 3,000 and something.

Jane Cummings: Yes—3,230. They are two different counts. The census asks providers to tell them the information as a snapshot of the number of patients in the hospital at any one time. What our Assuring Transformation figures show are the numbers commissioned by CCGs or specialised commissioning.

Q27 Chair: So who is doing it for the others?

Jane Cummings: The difference is people from Scotland and Wales, for example. It also includes people who are funded by local authorities and other areas. There is an inevitable discrepancy, but one of the benefits of moving both collections to the HSCIC is that they can work to bring those much more together and to be very clear about the discrepancies between the two.

Q28 Chair: Just to get this absolutely clear—the policy objective is not just the NHS figures; it is to reduce the number of people in long-stay hospitals, isn't it? Whether they come from Scotland, Wales, England, local authorities or directly through the NHS.

Jane Cummings: Yes, absolutely.

Q29 Chair: So the real figure that we have to worry about is the 3,000 and something.

Jane Cummings: The providers certainly give us that figure. The commissioners that NHS England are responsible for have given us the 2,600 figure that was reported in September, and those are the patients that we are currently working on. Obviously, links with the other three countries—particularly Wales and Scotland—are crucial as we move forward.

Q30 Dame Anne McGuire: If I were to ask you how many people went through the NHS to have their appendix taken out, would you be able to give me the figures?

Simon Stevens: Yes, but not off the top of my head.

Q31 Dame Anne McGuire: I am not asking for it off the top of your head, but if I asked you how many people had heart operations, would you be able to give me the figures?

Simon Stevens: Sure.

Q32 Dame Anne McGuire: Obviously, every week or every fortnight we get to know the figures for how many people go through A and E. Can someone therefore explain to me why it has been so difficult to have proper data in front of us about people with learning disabilities until fairly recently? Why was that such a Cinderella part of the health service? I can understand the cynicism of parents when the senior people from the NHS and the Department of Health have admitted here today that actually, they were not all that sure of the figures—but you could give me all the other ones, if I asked for them in advance. Why is that?

Jon Rouse: My personal view is that up to the time of the Concordat, there are no excuses. It should not have been that way. Since then, bit by bit, we have got our grip on the data, certainly in terms of the NHS England Assuring Transformation data. I think that they do know now who those individuals are. They have done care and treatment reviews, care plans, and planning discharge where that is appropriate. We are in a totally different place from where we were two years ago.

Q33 Dame Anne McGuire: But you do understand why parents in particular, but families too, feel really cynical about the commitment and the Concordat, and the fact that the ambitions, or the aspirations—whatever words we want to use to describe what was in the Concordat—have not yet been achieved, and in fact, have been pretty badly missed.

Jon Rouse: We are absolutely sensitive to families' feelings in that respect. We engage with representatives of families often, and they are the most important people to listen to.

Q34 Dame Anne McGuire: Sir Stephen was very optimistic, and he said that he was an optimistic person. I am usually pretty optimistic, except frankly, when it comes to this particular area of work. If I said to you that on page 31, the one piece of progress or action was that five different Committees have been established—

Chair: It is page 30.

Dame Anne McGuire: Thank you. Can you tell me what actions all these Committees have produced? The post-Winterbourne View project board was replaced by the joint improvement programme board. The senior sponsors group was then established. The group is chaired by a senior responsible officer and has various people from various stakeholder groups—I notice that not one of them is from either the parents or families. There is then the joint improvement programme board and the transforming care assurance board. The new board first met in September and will give feedback to the learning disabilities programme board. How do I as a parent, or as a family member, swim through that bureaucracy?

Jon Rouse: Essentially there have been two lots of governance during the course of the programme. To start with, we put in place governance that was directed at supporting local areas and local commissioners to make change. The oversight was therefore the joint improvement programme, which was working with those local areas. When we got through the first data, which was in March 2014, we realised that that was not sufficiently effective, because we were not making progress and at that point, we changed and strengthened the governance. That is why we had a senior sponsors group of the key officials including myself and Jane, and why we introduced an assurance board that had a person with learning disabilities as the co-chair, alongside the Minister, to hold everybody to account. So we moved from a governance structure that was about enablement, because we thought that commissioners would change their behaviours and commission a different way. When we realised that was insufficient, we tightened the whole thing up and went for a stronger accountability framework.

Q35 Dame Anne McGuire: What have you done to ensure that commissioners now change their behaviour, given the fact that the thrust behind the change in the structure of the NHS is, in fact, to give more autonomy to commissioning groups to determine for themselves, linked to local needs, how they will commission?

Jon Rouse: There are two parts to this, and I will hand over to Simon and Jane for the second part. In terms of our relationship with NHS England, we have placed a requirement within the mandate, which governs the relationship between us, expecting them to make progress in respect of the commitments that they made within the Concordat back in December 2012.

Simon Stevens: Let me just start by saying that sometimes when I come before you, I think that, as we discussed in relation to cancer services last time, the glass is more than half full. In this instance, my belief is that none of us should be sitting here defending the indefensible.

Dame Anne McGuire: Thank you for that.

Simon Stevens: I do not think that this is a satisfactory position to be in and I think people have been badly let down. Given that fact, which we must state baldly, the answer is that recently we have been making progress on three things through the commissioning system. First, we have been getting support for the people who were in Winterbourne View to start with—48 people, of whom only five are still in in-patient settings, based on their particular care needs.

Secondly, we are trying to ensure that we get better care for the people who were in in-patient settings as of April this year. In order to do that, we have put in place a pretty far-reaching programme of what are called in the jargon care and treatment reviews; that is, we are taking a fresh, independent look, outside of the particular situation and the current provider, and saying, “For this person, if we were looking at this with fresh eyes based on what families, experts by experience and other clinicians are saying, could we do it differently and better?” So far, we have done 1,167 of those care and treatment reviews, on the back of which about a third of people who have had a care and treatment review are moving to a better place with alternative forms of support. We think that that number will increase continually.

Thirdly, we have to do what Stephen’s report rightly put the spotlight on: the fundamental redesign of care for new cohorts of people going forward. That must be a permanent shift away from the residue of institutional care models that we have. Take a step back. In the mid-90s, there were around 12,600 in-patient NHS beds for learning disabilities; that number has come down to 1,500 or so, with perhaps another 1,500 or in the independent sector, so there has been a big shift over that period of time.

My personal experience is that my first job in the NHS, 25 years ago, was working for the mental health service in North Tyneside and Northumberland. We were closing the old Victorian psychiatric hospital that had been serving the people there. Just down the road there were two long-stay learning disability hospitals. It is troubling that, 25 years later, the mental

health services in North Tyneside and Northumberland have been dramatically re-provided, yet there are still 200 or so long-stay learning disability beds in that part of the country.

In general, we see a problem in the fact that the midlands and the north are much more dominated by this institutional model of care. I am afraid that the time has come to say that some of the remaining facilities are going to have to close and care will have to be re-provided in a more radical way. On the back of the report that Stephen has given us and the points made by the families, we must use the next 12 to 24 months to chart out what that substantial transition programme is going to look like for those facilities.

Q36 Chair: Are you telling us that there is going to be a closure programme?

Simon Stevens: For some of these facilities, there will have to be.

Q37 Mr Bacon: I am sure that Sir Stephen Bubb will be very glad to hear what you have just said in the light of his earlier comments, but he also said that it would have to be planned very carefully. You just talked about charting it out; can you speak to the question of how it is planned properly so that you do not inadvertently make the situation worse?

Dame Anne McGuire: Can I just piggyback on that question—or has Richard piggybacked on mine? Given your frankness, would you have advised two years ago that you should set a target of a two-year programme?

Simon Stevens: I wasn't here at the time, but the judgments were made. The benefit of setting the ambition was that, frankly, it has meant that trundling along with the status quo is obviously unsatisfactory. We would not be having this conversation in such stark relief had that ambition not been set. Equally, echoing what Una said, we have to learn why that transition has not been as rapid as was hoped. It is about not only the technical stuff, but where power lies inside the health and social care system. For a lot of the people with learning disabilities who receive institutional care, the imbalance in power explains why we allow these things to be perpetuated. That is what has got to change.

Q38 Chair: We are all delighted to hear that statement. However, in preparing for today's sitting, I looked at, for example, St Andrew's hospital in Billing Road, Northampton. It had a terrible CQC inspection at the end of 2013 and is now planning a £45 million new unit. It is one thing to come here and say that to us, but if people on the ground are building new units and waiting lists are still growing, how will you square the circle?

Simon Stevens: Yes. That is why we will need a twin-track approach. For NHS facilities we will need to have a planned transition programme, recognising that among some of the unsuitable models of care there are dedicated staff and people who need often intensive levels of care that are not necessarily provided in the legacy environments. That is a managed NHS transition.

For independent providers, we will have to take a more engaged approach to the front end, if you like. Rather than waiting for people to have been in hospital for six to 12 months

and do the care and treatment reviews that we have just been going through for the April 2014 cohort, we have got to do those right up front at the point when people are about to be admitted, or after they have been admitted for a few days, to ask the question. The right to challenge, which was talked about in Stephen Bubb's report, is the right way to go. I think what will make a difference as well is personal budgets for people with learning difficulties so that their choices and those of their families are what stick. We cannot just have the situation where we simply reduce the NHS provision and instead it just flows over into third-party providers that expand on the back of it.

Q39 Dame Anne McGuire: What conversations are you having, in particular with local authorities, to pool those individual or personal budgets? That takes a lot of co-operation and means that local authorities have to let go of the per capita funding that they put into budgets for individuals or to provide services collectively. Are there serious discussions across the board with DCLG and local authority umbrella groups?

Simon Stevens: Yes. I talked with David Pearson, the president of the Association of Directors of Adult Services last week. Within the NHS there are about 6,000 people with learning disabilities in receipt of NHS-funded continuing health care. As of now they have a right to a personal budget. We have also announced that from April we are setting up pilots across the country for what we have called integrated personal commissioning, which brings together for the first time a health and a social care budget at the level of the individual. A number of the councils and health bodies locally that have come forward and said that they want to start on that in a few weeks' time have got a learning disabilities component of that. We will use 2015-16 as the year in which we build on the learning from those pilots. Then I think we want to see a right to personal budgets for health and social care embedded in learning disabilities services thereafter.

Q40 Dame Anne McGuire: Has DWP been involved in those discussions, given that some of those with learning disabilities will be entitled to DWP benefits? It was always envisaged that you could pool the health, social care and DWP elements.

Jon Rouse: We will certainly address this issue in the intended Green Paper. Because of that, clearly we are and will be engaging with DWP and indeed a number of other Government Departments as well. I want to place this in a bit of context, because actually, more generally, local government over the last four years has made a lot of progress in rolling out self-directed support for people with learning disabilities. The number of people with learning disabilities receiving that support has gone up from about 21,000 to over 90,000. I think the key, as Simon said, is: can we now move to integrated personal budgets that combine health and care? That is what people need to organise their support within the community.

Q41 Chris Heaton-Harris: NHS England has significant clout in the commissioning area. Research from Mencap has come up with the interesting figure that CCGs are currently commissioning about 50% of in-patient placements. How will you influence CCGs to make the right choices?

Simon Stevens: First, the fact that we are now all pooling the data, whether for CCG-commissioned or NHS England-commissioned services, means that we now have a single version of the truth across the commissioning system as a whole. Secondly, through the co-commissioning of specialised services with local services, we are looking at joining up some of those budgets.

Just click back to our conversation a few minutes ago. Making significant changes in the structure of care provision for the remaining long-stay learning disability services will take joint action by CCG commissioners and NHS England in those parts of the country, particularly in part of the north-west, the north-east and in some parts of the midlands. We will convene the CCGs and our local teams to drive that together.

Q42 Chair: What is your lever if they don't?

Simon Stevens: There is no disagreement that this is the right thing to do. The spirit is willing and the flesh has been weak.

Q43 Chair: But if somebody is in a hospital, it is cash-free; it does not cost the local authority anything. So somehow you have to get the money not only being pooled, but following the patient. If the institution loses the patient, it puts at risk the viability of the institution and the jobs of those working there.

Simon Stevens: But that is why the parallel with the long-stay psychiatric hospitals is a good one. That was precisely the same situation—

Q44 Chair: But we had a closure programme.

Simon Stevens: Yes, we had a closure programme with retraction, alternative investments, retraining for staff, the development of more community-based facilities and transition plans. That is what we will need for some of the remaining institutions.

Q45 Chair: Are you confident that you have enough money up front to create the infrastructure in the community services to be able to manage that transition? It is a bit like when we were talking about the Better Care Fund. You will need double funding to be able to facilitate the transition, won't you?

Simon Stevens: Potentially, yes, and it could be costly. One point of view says that capital is probably less of a constraint, given the ability to have new ways of getting the capital funding in for some of the more locally based supports. But on the revenue piece, I am not going to sit here and pretend anything other than that work has to be done urgently within the next six months.

Jon Rouse: I say this as an ex-local authority chief exec: there is also a responsibility on local government. These are not people who are unknown to them. These are individuals with whom they have probably been engaging through childhood and into adulthood. They

have probably previously had a care package and a care plan with the local authority. Therefore, it should not be the local authority's expectation that when these individuals go into hospital, they are somehow off their books and they no longer have a responsibility for them. Local authorities should be planning for them to be discharged back. I think that one of the reasons we see the patterns of different CCGs having different levels of commissioning of these places in hospital is partly to do with the attitude and approach of the local authority and the CCG together.

Q46 Dame Anne McGuire: We have already heard that often when those with learning disabilities go into long stay, they are almost captured by the system. Although I accept that local authorities have a responsibility, surely the missing link is the question of who advocates on behalf of the person who has been captured by the system and cannot actually get out of it. Part of that is to do with how difficult it is to appeal and how difficult it is for families who are under stress to work their way through five boards, local authorities and local commissioning groups. We all talk about them as though it is a second language; out there, if you are facing the crisis on a day-to-day basis, you might as well be facing a brick wall.

Jon Rouse: And I agree with that, and that is probably what we have learnt most over the past two years, which is why Sir Stephen is right that we need a more rights-based system. We have to rebalance where the power is within the system and we will cover some of those issues within the intended Green Paper.

Dame Anne McGuire: With the greatest respect, we are supposed to have a rights-based system. It is now 20 years since the first Disability Discrimination Act was passed in 1995, and we are still talking about establishing a rights-based system for people with learning disabilities. I find that utterly depressing.

Q47 Chair: I have to say to you, Mr Rouse, you are obviously ex-local authority because somewhere in the Report—I cannot find it—there is a figure of the number of people that the local authorities did not even know that you had done plans for. They are being placed 250 or 300 miles from home over a very long period. If you really think that the way forward is simply to say to local authorities, when they are facing much bigger cuts than the health service, “You take on responsibility for these very expensive people without the money following them”, we will be sitting here in two years’ time and you will have failed. Simply passing the buck to local government without the resources—we are fed up hearing it—is not the answer.

Jon Rouse: I agree with that, but I do think it needs to be a partnership, and that it is not just about health transferring resources. Local government have to come to the table.

Q48 Chair: But they have no money, so they need your NHS money.

Amyas Morse: Am I right in thinking that we have not yet made a decision on closures? We are talking about it, but it is not done yet. Is that right?

Simon Stevens: This is new news for today's Committee.

Amyas Morse: Okay, but this is intentional or a decision?

Simon Stevens: We will have to do a careful transition map for the particular facilities and institutions that we are talking about. There would have to be consultation. I am not naming names, individual institutions or particular locations today, but am clearly setting a direction of travel.

Amyas Morse: And then, to follow up, I was listening carefully to what you were saying earlier, Mr Stevens. You talked about power and about disappointment at finding that there were a lot of long-stay institutions still in place in parts of the country. Have you got the leverage to get this change to happen and the closure programme in place? What do you need to give you the leverage to get this change to happen?

Simon Stevens: There are several pieces that need to come together, one of which is that if the commissioners of these services are together and say that this is no longer the model of care that we want to secure for these individuals who have been placed in these facilities up till now, then that means that they are not viable in their current form. So a public consultation needs to follow. Working with Monitor or the TDA in terms of what the transition path looks like is necessary, and the Care Quality Commission have also got a role not only in respect of NHS provided services, but independently provided services, in identifying whether a licence should be awarded, given the style of care that is on offer.

Q49 Dame Anne McGuire: I wonder if I could pick up on the closure programme. There was an element of criticism that this Report—I assume it is the one that was published recently in January—was silent on the issue of closure programmes. I think this was published on 29 January. What revelation has there been in your Department between the publication of this Report on 29 January and this meeting of the Public Accounts Committee on 9 February?

Simon Stevens: There is no revelation. Implicit in that Report is what I have just said, but the time to be explicit is upon us.

Q50 Chair: So have you got the powers? We really welcome this, so it is good news, but have you got the powers, for example, to direct hospitals to prepare patients with learning disabilities for discharge? Have you got the powers to direct hospitals to review the care of the patients? Can you do it under the current framework?

Simon Stevens: Yes, we have got the powers to require the care and treatment reviews, which is what we are doing, and have done so already for 1,167 people, and we have the power to make the decisions about whether these facilities will continue to be funded.

Q51 Chair: So you can direct the private hospitals to undertake this?

Simon Stevens: We can, yes. The CTRs apply for people going into private facilities as well as NHS facilities.

Q52 Chair: But you do have the powers?

Simon Stevens: Through the commissioning group, yes. Also, the Care Quality Commission regulates and licenses providers, be they public or private.

Jane Cummings: On the basis of the role of the CQC, we already have an example where the CQC were asked to register an independent sector provider that wanted to open an additional service. They talked to us about whether we wanted to commission from it. The answer was no. They have not registered it, so the place is not opening. So we have the ability to work with the CQC in commissioning to stop exactly what was mentioned earlier.

Q53 Chair: So what have you done, for example, about the CQC? According to page 25, paragraph 2.13, 69 of the 150 inspections “failed to meet” basic standards. What have you done about that?

Jane Cummings: There is a process in place whereby we have quality surveillance groups and risk summits. In each of those areas, if there is a poor CQC report, there is a risk summit that combines NHS England, CQC, Monitor, TDA and, in many cases, the providers, which agree on what action needs to happen. That is repeated on a regular basis, and an almost forensic level of detail goes into checking that those organisations are improving.

Q54 Chair: Have you closed any institution on the back of the CQC report?

Jane Cummings: CQC has the ability to do that, and, no, it hasn’t yet.

Chair: None?

Jane Cummings: As far as I know, it hasn’t yet.

Q55 Chair: Although 69 out of 150 failed to meet the most basic standards.

Simon Stevens: I am sure that if CQC were here, it would describe the improvement notices it served. If it doesn’t get satisfaction, it can close facilities.

Q56 Chair: The logical thing from what you’ve said is that if you’ve got an institution that is not performing, you stop putting people in. That is the beginning of the closure programme.

Simon Stevens: It is a bit blurred, but there is a distinction between providing poor quality care on a care model that is wrong, and providing reasonable care on a care model

that is wrong under any circumstances regardless. CQC can deal with the care standards piece; we have to deal with the care model piece.

Q57 Stephen Hammond: Just coming back to the point about closure and what is going to make that work, you accept the NAO Report, and recommendations 26b and 27c on page 13 are pretty fundamental. Are you going to meet those recommendations by January 2016 and April 2016? They state that every in-patient must have a discharge plan in place. It is all very well to talk about closure but, getting to the nuts and bolts of it, in-patients will need to have a discharge plan, a co-locationary multidisciplinary team and a named co-ordinator. Is any of that in place at the moment, and are you likely to meet those two timetable dates?

Simon Stevens: For 26b—I will ask Jane to speak about this in a moment—the proviso is that “every inpatient, who does not pose such a risk that they need to be in a high-security hospital, has a discharge plan”, but that is not actually the relevant test. Obviously, it is not just a question of whether the individual is in a high-security setting, but the nature of the Mental Health Act or Ministry of Justice provisions that apply in their circumstances. We need to work through not only the provisions in section 3 of the Mental Health Act, but sections 37, 41, 47 and 49. There are various pieces, and the relevant test is not just whether a person is in a high-security psychiatric hospital. That is a caveat to the recommendation.

Q58 Stephen Hammond: I accept your caveat. Will there be a plan in place for people who do not fall within those criteria and can be discharged in that period?

Jane Cummings: Our assessment is that it is entirely reasonable and appropriate to aim to have a discharge plan in place by that date for each in-patient. There will be some caveats, in terms of the type of care and whether the Ministry of Justice restrictions, which approximately 25% of patients currently have, can be changed or moved to enable those patients to be discharged. There is a big difference between having a discharge plan and having a discharge date.

Like others at this table, I have spent a lot of time in the past few months with the families of people with learning disabilities, many of whom are in-patients. It is absolutely fundamental that our premise is that nobody should be in an in-patient setting unless there is absolutely no other option. A hospital is not a home and should never be thought of as such, so I absolutely support the NAO’s recommendation.

Simon Stevens: Looking at the numbers—just so we are all clear about what we are saying—the census data that were published a few days ago showed that 70 people with learning disabilities were in high-secure settings at the time and 550 were in medium-secure settings. Even for the 1,115 people in low-secure settings, about a third of them have some form of MOJ or Mental Health Act provision. I think that we would be running the risk of making the same mistake that was made in the past if we just stated that everybody not in a high-secure facility will be on track for discharge in January 2016. I’m not sure that, sitting here today, we can say that.

Q59 Stephen Hammond: I understand that, and I take your caveats, but I am more interested in the group you could discharge. Ms Cummings has just said that she absolutely supports this as an ambition, but the issue is whether you will achieve that ambition.

Simon Stevens: What we can guarantee is not only that those people currently in hospital will have had a care and treatment review, but that successive waves of people whom it is thought should be admitted will have a care and treatment review either before or shortly after they are admitted, so that these challenging questions are asked about what is being offered to them.

Jane Cummings: At the moment the care and treatment reviews are focused on patients in non-secure or low-secure settings. The key issue is, what is the treatment? Is it appropriate? Can it be provided elsewhere? For some patients, who may be in a medium-secure setting, the treatment may need to finish or to move to a certain extent before they can be discharged. But the point around doing an assessment and reviewing whether a discharge should and could be planned for those individuals is one that our clinical experts have agreed it is reasonable to look at.

Q60 Chair: The Report says that 23% of budgets were pooled in 2013. We are now almost two years on. What are you at now?

Simon Stevens: Are you talking about between health and social care?

Chair: Yes.

Simon Stevens: I don't think we have those data for now.

Q61 Chair: Somewhere—Ashley will tell me where—the Report says that 23% of budgets between health and social care were pooled. The figure is—

Ashley McDougall: Page 26, paragraph 2.17—27%.

Jon Rouse: We do not have more up-to-date data than the 27% that is in the Report. My guess is that that is about correct still.

Q62 Chair: So it hasn't moved in the last few years.

Jon Rouse: I don't think it will have moved significantly in the last year.

Q63 Austin Mitchell: I just want to pursue the financial imperative. The targets were over-ambitious for financial reasons: the fact that the money did not follow the patient created local resistance to having the patients. Paragraph 2.24 says, "Meeting the needs of people in the community, who NHS England previously funded in hospital, is a material cost to local commissioners. This can affect their ability to provide appropriate and sustainable care packages. Hospitals subsequently experience significant delays in discharging patients

while complex negotiations continue”. This must mean that you can speed up the process through a fairer, better financial arrangement with the CCGs and local providers.

Simon Stevens: What makes this complex is that you have two sets of things going on there. One is that there are a group of people who have been in institutional care for a very long time. When you talk about moving them, as we will be when we are closing some of these facilities, you need to take the old mental health model—we talk about dowries and funding endowments that move with people, and those might be partly with the local authority and partly with the local CCG. If you look at the fact that a fifth of people in in-patient settings have been there for more than five years, those are the sort of folks for whom you are talking about dowries. But for people who have been in an in-patient setting funded by specialist care for three or six months, that is not so much about their ongoing support for ever; that is a moment in time when they are getting something. Distinguishing between those two categories is what we have to do. Some of this will have to be dowry-type arrangements; some will just have to be about a recognition that, actually, this is the CCG’s or the local authority’s funding responsibility, and they will have to step up to the plate.

Q64 Austin Mitchell: So you think the funding is fair?

Simon Stevens: In the way that responsibilities are currently split between social care, CCGs and NHS England? I think it is an accident of history, to a significant extent.

Q65 Chair: Can I just take you back to that? It sounds as if you are repeating what Jon Rouse said—that they’ll have to step up and it will only work if the money goes into local government. That won’t work. That is what it says—

Simon Stevens: Mr Mitchell was talking specifically about CCGs versus NHS England’s specialised commissioning. I think that the parallel here is with other parts of the mental health services. If a patient in Barking is referred from the local mental health services to a medium secure psychiatric service, at that point the financial baton passes from the Barking and Dagenham, Havering and Redbridge CCG to the NHS England London specialised commissioning team. When that patient is discharged back into local services in Barking, the CCG picks up the tab. That is the analogy for many of the revolving door learning disability admissions. For the long-stay admissions, the analogy is with the old retraction programmes for re-housing people who have been in psychiatric asylums for long periods, and there we will need a dowry funding transfer.

Q66 Austin Mitchell: I imagine that there is a difference between long-term patients and shorter-term patients. What do we know about the attitudes of patients themselves to this transfer into the community, and the attitudes of the families? Are they consulted? What are their views and what do we know?

Jane Cummings: We have spent a lot of time with families with learning disability, and Viv Cooper explained clearly what many people think and want. What families are saying, and what many, many patients are saying, is that they want to be closer to home,

cared for in the community and supported to live as normal a life as possible. They want to have a right to work, a right to education, a right to make their own decisions and a right to have somewhere that they can call their own home.

Interestingly, as we have been doing some of the care and treatment reviews, some in-patients have found those quite scary—I would not say threatening—in that they have become so used to being in hospital that the thought of being anywhere else can be quite distressing. One of the really important things for us as we do this programme is that we work really carefully with every individual and we tailor what we do to that individual need. In some cases, we have got examples where we have moved patients from an institutional setting, which to everybody in this room would be absolutely appalling and we could not understand how they could be in that setting for so long, and it has taken months to move people into a setting that is much more like their own home so that they have time to get used to it. Overall, however, people are very keen to be closer to home and in a setting that they can call a home.

Q67 Austin Mitchell: That sounds like someone like me in this place—so institutionalised that they do not want to leave. That is just a passing thought.

One final question: I see from paragraph 3.9 that housing provision is a particular problem. We have a housing crisis at the moment—a shortage. That must be a very difficult problem for local authorities and local communities to face. How far is that holding up transfer into the community?

Jon Rouse: First of all, there is variation across the country. There are some local authorities that work with their housing associations to plan this type of provision and make sure that they have got that capacity, and there are others that do not. We are doing some facilitation, in that we are making available £7 million of capital this year specifically to enable people to discharge. We think that that will help about 180 people this year and the beginning of next to have their own dedicated housing provision. Some of these requirements are quite expensive. They are quite bespoke conversions, and they sometimes involve acquisitions or even new builds. One of the interesting things about Sir Stephen's report is that he thinks that this may be an area where you could utilise social investment to unlock additional capital, and I think that that deserves serious consideration.

Q68 Austin Mitchell: In London it must be a real problem.

Jon Rouse: As I say, it is an issue, but it varies across the country depending on the level of planning and commitment.

Q69 Austin Mitchell: Yes, but how tough is it in London?

Jon Rouse: It is particularly difficult in London, but I can think of authorities—Richmond would be a case in point—that have planned very well where that provision is going to be made and partnered with housing associations to ensure that those units are available. Nevertheless, it requires proper planning by the land use planners, the housing

team and adult social care, working with housing associations, to ensure that the provision is there.

Q70 Chair: I am going to bring in Anne in a moment, but I want to ensure that we do not have any wriggle room here—if I can put it that way. We have an agreement that you are going to go for a closure programme, with details to come out, presumably, in the coming months.

Simon Stevens: Yes, I would think six months or so.

Q71 Chair: We have an agreement that pooled budgets are a sensible way forward, and we do not think that there has been any improvement from where we were in 2013. Can I get a feeling about when we are going to see more pooled budgets?

Jon Rouse: One of the recommendations in both Sir Stephen's report and the NAO Report is that we should look at the Care Act mechanism that was used for the better care fund as a way to mandate pooling. We will look at that and I think we will refer to it in the consultation paper. There are pros and cons. One pro is obviously that it would mandate, so we would get that mechanism established in different areas. My concern is about some of the practicalities of how localities would know how much to pool, because this cohort obviously shifts over time. Those authorities that currently do pool tend to do it for all their learning disabilities services, not only this cohort.

Q72 Chair: That seems to be a bit of wiggle room. The general consensus, certainly from the experts who gave evidence before you, was that pooled budgets are essential, otherwise you get dragged back into institutional care. Things have not shifted in the past two years. I need a stronger feel from you as to when we can expect to see real progress. You said that there are pros and cons, but there are more pros than cons. I accept that there might be a little fraying around the edges, but pooling is one of the keys to getting progress in this area.

Jon Rouse: As I say, we are committed to including it within the consultation document—in the Green Paper.

Q73 Chair: In the Green Paper, which then becomes a what?

Jon Rouse: That would be a decision for the next Government.

Q74 Chair: Does this require legislation?

Jon Rouse: There is the existing legislative mechanism under the Care Act.

Q75 Chair: I don't know why we are having a Green Paper then. Why are we having one if it does not require new legislation?

Jon Rouse: It is to work through whether it would work and how.

Q76 Chair: Sorry, Anne, I will bring you in, but let me go back a bit on this. Take Salford as an example. It took them a decade to get to this page. Here we are with an exemplar of good practice—you don't need to worry about it and think about it, you just have to get on and do it. I do not mind you telling us that it might be five years down the line or something, but for you simply to say, "It's going to go into a Green Paper," fills me with horror because it suggests to me that our successors will be sitting around the table in a couple of years' time having a very similar conversation with you.

Jon Rouse: Let me tighten up my answer. It has to be a decision for the next Government, but we will bring it to them very early on.

Q77 Chair: Why is that? I cannot see that it is contentious. Why can you not just get on with it?

Jon Rouse: Because we have to work through whether that statutory mechanism will actually achieve the objectives that Sir Stephen intends in terms of mandating the pooling approach.

Q78 Dame Anne McGuire: Is it the pooling of resources that is the statutory issue, or is it the principle of moving people from long-stay and residential care into the community?

Jon Rouse: Right now, any local authority and CCG can set up a section 75 mechanism to pool their resources. The issue for us is using a national piece of legislation that would then have to be routed through the NHS England mandate. How do we know how much we are asking those local areas to pool and how would that shift and change over time? The question that we must resolve is whether it is something that should be done top down from central Government.

Q79 Dame Anne McGuire: Does that mean that the funding would be ring-fenced?

Jon Rouse: If it was a pooled section 75 mechanism, it would be ring-fenced to that purpose.

Dame Anne McGuire: It would be ring-fenced for that specific purpose.

Q80 Chair: Ashley wants to come in on that. There are two more things that I want to try to button down, and then I will come back to you, Anne.

Ashley McDougall: I just want to say that I think the qualification of the amount to be pooled is a live question, but the concordat that everyone signed up to in 2012, as quoted in paragraph 2.16 of the Report, said: “The strong presumption will be in favour of supporting this (delivery of the commitments) with pooled budget arrangements”, so the Department and other partners set the direction of commitment two years ago. It also said that local commissioners were required to offer justification where a pooled budget has not been set.

Jon Rouse: We would agree with that, and we would stand by those words. It is disappointing that so few authorities and CCGs have created pooled budgets under the section 75 mechanism, which is why it is quite right that the NAO and Sir Stephen have made the recommendation that they have. We now just need to work through and make sure that it is the right mechanism, and that it does not have unintended consequences.

Q81 Chair: Given that this is not particularly contentious, what time frame are you looking at? So you have a Green Paper—do you do a bit more work then?

Jon Rouse: To take to an incoming Government early, and certainly by the summer.

Q82 Chair: Okay. And money following the patient—when? Pooled budgets is halfway there, but money following the patient rather than being in the institution—when will that come? The two go together.

Simon Stevens: Yes. Well, obviously this is linked to the transition plan for these long-stay facilities, where a lot of the money is locked up. The answer will probably be from 2016-17, but for those places that are doing the integrated personal commissioning, that obviously begins from this April.

Q83 Chair: That is very helpful. Finally, everybody has talked about a social investment fund—including Sir Stephen Bubb, who talked about it in his report, and Jon Rouse—to build community service capacity. You talked about the need for up-front investment. I understand that this is a difficult question, given the pressure on funding, but when will you be in a position to determine how you have managed to square that circle?

Simon Stevens: I think we can’t get to the transition plan without having answered that question, and as I have just said, we need to get our transition plan substantially nailed within the next six months.

Chair: Thank you.

Q84 Dame Anne McGuire: Just a couple of final points. I fully understand Jane Cummings’s comment about being very careful about the planning of an individual’s transition from what is effectively institutional care into community care. I have had some experience of that, from working with parents of children with learning disabilities, and one or two of them came out of institutions. One, in fact, whose parent was not involved, had been institutionalised for 40 years after being sectioned under the Mental Health Act at the

age of six. The transition can be made and it has to be made carefully, so I fully accept that comment.

I suppose this question is for Jon Rouse. I get the impression that you seem to be engaged with some of the work across the different stakeholders. Austin mentioned the capacity in the community, particularly in London, but we heard earlier that the bulk of the numbers is in the north of the country. What is the capacity in those areas, and what work is being done to look at how you break down the barriers to some of those community placements? I say from bitter experience that sometimes that is not easy, and it is about how you have to work with local communities, particularly if—dare I say it?—local media get involved and all sorts of spectres are raised. So what work is being done there?

Jon Rouse: I am going to get Simon and Jane to talk about this, because this comes down to their reconfiguration plan, which they are going to start in the north of England. Because there is an over-dependency and an over-reliance on in-patient care within significant parts of those regions, or the north as a whole, it means that there are areas of the north that have under-capacity in terms of community provision.

Before I hand over to Simon, let me mention a point of complexity, which I think is worth airing. Even if you take somewhere like the north of England, there is a small number of assessment and treatment units, which are small, relatively community-based and doing some fantastic work. It is worth saying in passing that even under our new models of care, there will still be the need for some in-patient provision. Yes, some of these larger institutions have to close. They are completely inappropriate in terms of a modern-day care model, but when we have these little gems embedded in their community, we want to protect those and make sure that they can be utilised.

Simon Stevens: I actually think we know how to do this, although not to a sufficient degree, because, over 20 or 30 years, this big social transformation has been happening not just in this country, but in many others. If we go back to the mid-'90s, we had 13,000 people with learning disabilities in in-patient beds; now that is around 1,500. We've been on this journey, and we know how to do this. We've just got to finish the job.

Q85 Dame Anne McGuire: What work is being done locally to build up those links in the local community? Are you working with some of the specialist organisations involved with advocacy and those who represent people with learning disabilities to ensure that we do not have difficulties at community level for reasons I am sure I do not need to go into detail on?

Jane Cummings: Yes, absolutely. You make an extremely valid and important point. We have got experience from working with the joint improvement teams set up with the Department a couple of years ago, who have been doing local work. But, more importantly, we have an Improving Lives team, which has visited and supported 45 out of the 47 remaining Winterbourne View patients. They have also undertaken 35 further detailed reviews. We have used their model to support the care and treatment reviews.

The really important lesson that has come through all of that work is that we can't do this without commissioners, expert clinicians and, really importantly, experts by

experience—patients or other people with a learning disability who have been actively involved in scoping and doing those reviews, as well as their families and carers. We work with a wide range of organisations that work with, and represent, people with learning disabilities. NHS England is in the process of appointing somebody with a learning disability to help us with our stakeholder engagement and to make sure we never lose sight of the reason we are doing this, which is to improve the care of people with a learning disability. So we have done quite a lot, but we have more to do.

Q86 Chair: Right. Well, I think it has been a jolly positive hearing, with lots of commitments. It is probably sensible that we return to this in something like 18 months.

Una O'Brien: Chairman, before we wrap up, I did not want to miss an important point Viv Cooper made, which we have not touched on, but which is part of this: the whole issue of prevention and support for families early intervention. Without that, we will just find ourselves going round in a circle. That is a particular focus of the work we are now doing in the Department of Health. The join-up to the new requirement under the Children and Families Act for education, health and care plans for young people up to the age of 25, which is a complete innovation, and which is just coming into force now, gives us an opportunity to get more of a lifetime plan for people, rather than what we have had, which is, effectively, an episodic intervention. If we can make the join-up between these different capacities and legal entitlements that are now open to people, we have a better chance of success, albeit that we have to go forward with humility and recognise how complex and difficult it will be to deliver this plan. So, there is no shortage of drive and intention on our part, but we have to learn the lessons of the last two to three years and to be able to plan with care over a period of time to deliver the change that Simon, Jane and Jon have been talking about.

Chair: Okay. Thanks very much indeed.