HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: Follow-up to PHSO Report on Unsafe Discharge from Hospital, HC 97

Tuesday 12 July 2016

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Watch the meeting

Members present: Mr Bernard Jenkin (Chair); Ronnie Cowan; Oliver Dowden; Rt hon. Mrs Cheryl Gillan; Rt hon. Mr David Jones; Tom Tugendhat, Mr Andrew Turner.

Dame Julie Mellor, Parliamentary and Health Service Ombudsman, was in attendance.

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Witnesses

I: Ruth Hannan, Policy and Development Manager, Carers Trust, Andrew Boaden, Senior Policy Officer, Alzheimer's Society, and Janet Morrison, Chief Executive, Independent Age.

II: Dr Mark Porter, Council Chair, British Medical Association, Phil McCarvill, Deputy Director of Policy, NHS Confederation.

III: Ben Gummer MP, Parliamentary Under-Secretary of State for Care Quality, Department of Health, William Vineall, Director, Acute Care and Quality Policy, Department of Health, Jane Cummings, Chief Nursing Officer, NHS England, Dr Mike Durkin, National Director of Patient Safety, NHS Improvement, and Sarah Mitchell, Director, Social Care Improvement, Local Government Association.

Written evidence from witnesses:

- Royal College of Nursing
- Alzheimer's Society

Examination of witnesses

Ruth Hannan, Andrew Boaden and Janet Morrison.

Chair: Good morning, and welcome to this session on the PHSO's report on unsafe discharge from hospital. May I welcome our first panel? Can I ask each of you to identify yourselves for the record, please?

Ruth Hannan: I am Ruth Hannan, Policy and Development Manager at Carers Trust.

Andrew Boaden: I am Andrew Boaden, Senior Policy Officer with the Alzheimer's Society.

Janet Morrison: I am Janet Morrison. I am Chief Executive of Independent Age.

Chair: May I first apologise for keeping you waiting? This is our first meeting since the referendum and we have had a great number of matters to discuss. May I also inveigh upon you that we really do need to move through, so very, very short, to the point answers would be very helpful. Please do not be too discursive. You may, of course, submit a memorandum afterwards if you want to add to what you have said, but we just need very quick answers, if we can have them.

Q1 **Ronnie Cowan:** Good morning. The first question is, unfortunately, rather long. I will run through it. The Parliamentary and Health Service Ombudsman reports four types of unsafe discharge. Those are: patients being discharged before they are clinically ready; patients discharged when they are clinically ready but without adequate assessment or support to cope at home; relatives and carers not being consulted or informed of discharged plans; and patients being kept in hospital due to poor co-ordination across services. Beyond that, from your experience, to what extent do you agree that those are the four main issues, and are there other issues as well?

Janet Morrison: Independent Age provides a helpline, information and advice to families and their carers who are trying to deal with navigating health and social care issues, and this is one of the issues that comes up quite a lot. It is largely families and carers who are making contact with us, and it does make me quite anxious about those people who don't have an advocate to speak on their behalf and to help deal with this.

The themes that are brought out by the PSHO report are very familiar to us, and I would endorse that that is an issue that we see. I would say that most of the people who come to us are coming to us because they are in crisis and having a problem, so we don't hear the good examples. And all the cases that come to us are very complex, so it does show why there is not a one-size-fits-all solution for patients, because they are living with multiple conditions, long-term conditions, and sensory impairment. A couple of things that I would pull out—one of the things that we do see is pressure put both on carers and on patients themselves

to leave quickly, without adequate consultation with them about what care they might need. It is literally, "You don't need care. Why should the NHS pay for your transport home?"

Q2 **Ronnie Cowan:** Pressure from whom?

Janet Morrison: Pressure from the hospital staff to say, "Why do you need an assessment? You are perfectly well to go home. Why should you have transport to take you home?" We have one case of that. We have other cases where a family member who has had cancer is expected to care for their wife coming home after a major incident—and expected to take up that care without any sufficient assessment and support being put in place.

Q3 **Ronnie Cowan:** If the pressure is coming from hospital staff, who was putting the pressure on the hospital staff in the first place? Is this target-driven? Is it a question of, "We do not want to be bed blocking"?

Janet Morrison: We know that hospitals are under severe pressure to free up beds. I think there is great practice set out by the Department of Health in terms of discharge and how to manage discharge. It seems to me if that policy exists it is not embedded in the culture of hospital wards and staff are not trained to pursue it. They are the people feeling the pressure to get people home. I think the problem is there is a culture clash, because in hospitals it is based on a medical model, a curative model of, "You are well, you must go home."

A lot of the older people that we support are living with multiple conditions, sensory impairment and cognitive impairment. They are not well. They may have got through the incidents, but they need a person-centred care approach to help them get home. I think that is a culture clash between what goes on in a hospital and the social care model, and the discharge is the point where it stops working. The pressure is coming from hospitals to discharge, but there is not full thought about how to get them home.

Andrew Boaden: I very much echo what we have just heard here in terms of the Alzheimer's perspective on this. We also have a helpline where we routinely hear from people affected by dementia, so carers and families. I have heard much the same thing. This prompted us to launch a full-blown investigation into the quality of care people receive in hospital and in discharge. It is called the Fix Dementia Care campaign. To do that we did a big survey of 570 people affected by dementia. We did freedom of information requests, which looked at things like how long people stay, whether they have had falls in hospital, and then also things around discharge, people being discharged in the middle of the night between the hours of 11 pm and 6 am, people who have had their discharge delayed, and those who have come back as an emergency within 30 days.

We found that there is a real picture. There is poor quality care, and there is a real variation across the country. Overwhelmingly, what was particularly difficult, from the dementia perspective, is the lack of transparency. It took an investigation by the Alzheimer's Society to find this. It is not there in the public domain. It is currently much easier to find out about your hospital's finances than it is the quality of care your loved one would receive in hospital.

One of the key recommendations of this report that we put out recently is that there should be an annual statement of dementia care that reports on exactly the experiences that people have. On the back of the Francis inquiry into Mid Staffordshire this data should be routinely collected and monitored by the board to ensure that catastrophic breakdowns in care do not happen. It should be a case of publishing this. But what we found was that we are comparing the outcomes of those over the age of 65 with those of people with dementia, and often the dementia is not recorded. It is integral that there is much greater transparency so that hospitals are more accountable and we can see where improvement is required. I would really ask the Committee to consider that seriously.

Ruth Hannan: I would agree that the four points highlighted in the report are some of the key ones. As we speak for all carers, not just those for older people, it is about integrated working, not just between health and social care, but between health services, within their own hospital sometimes, but also across health. We have had examples of people with severe mental health problems being admitted to a general hospital and the carer having to help manage their mental health because the general hospital is not able to cope. They are discharged, and then they are immediately admitted to an acute psychiatric hospital because their mental health has deteriorated so badly.

It is about integrated working across both health and social care. One of the big problems for us, I think, is—and it underpins all of those four examples—a lack of awareness and understanding of carers—so not working holistically, not looking at the person and who their support network is, whether that support network is able to cope with somebody who, albeit is well to leave the hospital because of the condition they have been treated for, may not be well enough for that person to be able to look after them.

Q4 **Ronnie Cowan:** What I am hearing is a breakdown between what we see as clinical, NHS hospital-based help and then people in the community and the link between them. People fall through that gap and it is left to carers and family members—

Ruth Hannan: The Care Act should have addressed that to some degree. The Care Act talks about collaboration, working between the NHS and social care. Our one-year-on report that has just been published shows that that collaboration is not working well and that is still not as effective as it could be.

Q5 **Mrs Gillan:** Obviously we have situations where patients are discharged prematurely or have delayed discharge. I was very interested to read that the BMA says that premature discharge is an important contributor to unplanned readmission, with 1 million people going back within 30 days of discharge, which costs over £2.4 billion to the economy. Apart from those macro scenarios, could each of you tell me what impact you have seen on the patient's concern, either from premature discharge or delayed discharge?

Ruth Hannan: Premature discharge is a serious problem for carers, and one that they probably highlight on a regular basis to us, about people coming home who are not well enough to come home. They talk about not being listened to. They talk about telling staff the person's history, the present underlying health problems, and that information not being taken on board. They often talk about repeating that over and over again, not just about the person that they are caring for, but what is happening at home.

An example that we have was a gentleman who had an underlying condition of cancer. He was admitted with pneumonia and discharged. His wife had said, "He does not seem well enough." He was re-admitted, discharged, and on the third admission they finally spoke to his oncology team and he was kept in hospital and recovered. This person's carer was talking to them over and over again, but it did not feel like that information was being gathered and recorded. One of the pieces of work that we talk about is the triangle of care, which is about including carers from the beginning of any kind of hospital or community treatment and listening to them, including the information that they give them, and having them as a partner in that care pathway.

Andrew Boaden: To start with, Alzheimer's Society is very supportive of the triangle of care. With people with dementia it is incredibly important. There are additional barriers in terms of communication, memory, and other things that can prevent people from articulating needs beyond the medical condition for which they have been brought in. It is really important that people have a full medical assessment at the very beginning with a multidisciplinary team, and that should include the discharge co-ordinator, because that planning process should begin from the very outset.

It can have a devastating impact if someone comes home too early or too late. Hospital generally is a disorientating place for people with dementia. They often get worse rather than better in terms of their overall wellbeing. We don't want people staying in there any longer than they need to, but an assessment at the beginning and an assessment at the end to ensure that the whole person has been looked at and person-centred care has been delivered is really important. Drawing a carer in can be crucial to that.

Q6 **Mrs Gillan:** You both talked about premature discharge. Do you see impact on patients with delayed discharge?

Janet Morrison: Yes. We have seen a number of cases where people have been in hospital for five months, or three months—a very significant period—and then are told at short notice that they will need to find nursing care or residential care. They are then scrabbling to find options for it, and then being delayed while they try to find suitable options. They are offered care homes that are judged inadequate by the Care Quality Commission, but pressured to go there. Delays have been caused there.

There are some hospitals that appear to have quite draconian policies in terms of eviction policies and charging policies for people who have outstayed when they are judged to be fit to return home. I think there is a real lack of co-ordination. Other disputes have been around who pays for the care. Where there have been funding disputes about whether it is continuing care, social care or the individual themselves that will pay can also delay them. I think it is that part where people are higher dependency and need a care home that can cause severe delays.

Q7 **Oliver Dowden:** You mentioned care homes. Lots of elderly people are discharged to care homes. It has certainly come up in my constituency, cases where elderly people are discharged to care homes without even a change of clothes and no shoes, and they have to get ill-fitting shoes off deceased residents. Have you come across this problem, and how do you think that transition works?

Janet Morrison: Yes. There should be a proper package of support for people leaving hospital to go into a care home. The cases that we see are often that it is very last-minute. It is a crisis decision to get someone into a care home, so some of their support, such as the provision of mobility equipment and other support going into the care home, is not arranged as well. There is a real lack of co-ordination. Local authorities do have a duty under the Care Act to provide information and advice and enable people to make informed choices, but often that does not happen. There is a real lack of it, and it is, unfortunately, a distress purchase, often, in terms of people going into care homes. That is not right, because it is a very significant and important part of someone's wellbeing.

Q8 **Oliver Dowden:** One of the points that was raised with me is that apparently there is a budget for the provision of clothes and so on, which the care homes used to have the discretion to spend on behalf of their patients. Now that discretion is with the families, and sometimes, for whatever reason, the families are not willing to spend that. You literally find patients in care homes for a period of time without any clothes to wear. Is that something that you recognise?

Janet Morrison: I will be honest; I have not come across cases about the clothing allowance or worked those issues, but absolutely the lack of care and support to make a good transition, which is a very important transition, and often a very distressing transition to make.

Q9 **Mrs Gillan:** You have all identified the severe impact on patients, and often the carers and the wider family. I do not have an impression of the

size of this problem. Is this happening very often? Is this happening often, or is it infrequently?

Ruth Hannan: I think because we work across all areas of health and social care it seems to be something that is talked about to us a lot, about people being told, "You are going home," especially in mental health. That is a really significant problem in mental health. We have had people being told, "You can go on weekend leave, but there will not be a bed for you when you come back". Obviously the anxiety that that puts on a family who, when somebody is still recovering—there is a real pressure in terms of bed availability and carers feeling that they have to take somebody home. It seems to be something that we are told about regularly, that people feel they need to have somebody home sooner than they can.

Q10 **Mrs Gillan:** Is it a big problem or a little problem?

Andrew Boaden: To hark back to my original point, there is a real lack of data around this, particularly in terms of dementia. What is in the ombudsman's report very much resonates what we have heard over our phone lines and what we have collected through surveys. There needs to be national information and data available to make more of a judgment on this.

Q11 **Mrs Gillan:** In the absence of the data, what is your feeling?

Andrew Boaden: Absolutely, yes.

Q12 **Mrs Gillan:** It is a big problem?

Andrew Boaden: It is a big problem, yes.

Janet Morrison: My feeling is it is a very big problem. We all only see the problems. We only see people when they have managed to find us, to get helpline support to try to tackle or challenge the lack of care assessment and the lack of a package being put in place. The ombudsman has seen an increasing number in this area of complaints. Those are going to be the tip of the iceberg, those who finally get to the ombudsman. There is a lack of culture of communication and co-ordination between hospitals and social care. I think that is pretty universal, because the pressure is on both funding-wise.

Q13 **Mrs Gillan:** You see the impacts increasing on patients and the cost going up, and it is moving in that direction rather than showing any amelioration in the pattern of behaviour?

Janet Morrison: Yes.

Q14 **Mr Jones:** We have touched on this, but could you describe the sort of consequences you see for patients when they are discharged without their relatives or carers being sufficiently informed, or carers not being involved in those discharge arrangements?

Ruth Hannan: Some of the examples in the ombudsman report show that in quite devastating ways. We have had examples of elderly patients being discharged to an empty home in the evening and their family only knowing this has happened because they have gone around to check that the house is safe when it is empty and find their mother sat in the darkness. Even though that person does have a care package in place, the care package was not re-started, so they were just sent home.

Obviously this puts a huge pressure on families, because then that is something they have to pick up. They have to look after that person until the correct support can be put in place. A lot of this is just down to poor communication. Families, and carers especially, should be recorded on a patient's notes and be included in that discharge plan. When we have carers who live with the person they care for and have their own significant health problems, the impact of having someone who is acutely unwell being discharged home for them to look after can be terrible for both.

Q15 **Mr Jones:** If care plans are already in place, why is it that they are overlooked?

Ruth Hannan: I don't work in a hospital, so I am not sure. I think one of the big problems is that the systems don't speak to each other. This is where carers end up being the carriers of the stories. They are the ones who can carry someone's entire medical and social care history with them. I know carers who have ring binders filled with this information that they take around with them, because the hospital has its own IT system, social care has its own IT system and the GP has its own IT system. I have spoken to GPs who have said, "I quite often see my patient before I get the letter of discharge," because the letter is a physical letter written, put in an envelope, and sent in the post in this modern day where we are all Tweeting. The systems contribute to the problems. Carers have that added pressure then of almost acting as a care co-ordinator between all of those points. It would make it easier if they were able to communicate more freely.

Q16 **Mr Jones:** One might have thought that the existence of a care plan would be routinely recorded on hospital systems.

Ruth Hannan: That will be the hospital's care plan, not the social carer's care plan. There is one of the big problems.

Andrew Boaden: To add to that, in terms of someone who has gone through hospital, their care needs might be slightly different, having gone through the hospital process. Also, hospital is a disorientating place. You come out and you may not have been eating and sleeping well. You are going to be additionally frail. There needs to be a small period of adjustment where someone, if they are going back to their own home, can re-adjust and then come in, say, 48 hours later, to re-look at it.

Janet Morrison: As my colleagues have said, some people need a new care assessment, and many people do not get one at all. Some people get an inadequate care assessment, and some people are just sent home with no one to consider what their needs are and to think about it. We see lots of cases of people where there is no consultation with carers, or even communication to let them know that they have come home and their circumstances have hugely changed. As you said, there is no triggering between the systems to let them know. That has to be planned in the hospital before they are discharged. Even if a care assessment happens, there may be no follow-through to ensure that it has been put in place. If someone is on their own and does not have a carer in the home with them, there is no one to advocate for them and to hassle to get that support put in place.

Q17 **Mr Jones:** What sort of impact can these unannounced discharges have on the carers?

Ruth Hannan: Lots of research shows that carers of all ages have worse physical and mental health than their peers as a result of the caring role. This increases as carers get older. The vast majority of carers are older themselves. The impact on them is significant. So many carers that I have spoken to have their own significant mental health problems and their own significant physical health problems, but they then feel that they cannot do anything about it because of the caring role. We will also see crisis admissions to hospitals of carers who have neglected their own health because the person they are caring for is not being properly supported. It is such a vicious cycle for carers, and they really draw the short straw at every turn.

Q18 **Mr Jones:** How could the involvement of carers and relatives in the discharge process be improved? Is it simply a question of IT systems? Or is it a question of professionalism?

Ruth Hannan: I think it is about practice. I think it is about having carer awareness as part of all training for health staff. We have talked about the medical model versus the social care model, but really the medical model needs to be looking at a much more holistic approach, not just curing a physical health condition. It is about being aware of carers, who they are, and the impact of caring on somebody with significant health problems. The value of including them in a process, so the value of talking to them, recording that information, finding out from them what is happening in that person's life, but also ensuring that they are getting help and support in their own right. We have lots of services that work with hospitals to plan discharge and in that planning they provide services to the person with care needs and they provide support to the carer, so that that reduces readmission and maintains the health of both people.

Andrew Boaden: To add to that, it does not start at discharge. It starts when someone comes into the hospital, that a carer should be engaged and there needs to be that cultural shift where carers are engaged from

the outset of someone arriving in hospital to their medical needs, their personal needs and preferences, so they can be addressed while they are in that space, all the way through to discharge and what happens to someone afterwards.

I wonder if it would be possible to draw the Committee's attention to something that the Alzheimer's Society would really like to see put a stop to, which is discharge at night—between the hours of 11 pm and 6 am. As part of our freedom of information request for the report I mentioned, "Fix Dementia Care", the hospitals report, we FOI'd all of the acute trusts. There are 164. We received around 68 responses, so one-third, but within that we found that over 5,000 people with dementia had been discharged between the hours of 11 pm and 6 am. The potential for someone to leave without the right information and support, and for the right information and support not to be there when they get home is much higher. It is an incredibly dangerous practice, which needs to stop.

Q19 **Mr Jones:** Did you establish in that FOI request the reasons for discharges at night?

Andrew Boaden: Unfortunately, we did not mine that level of detail. As a follow-up piece of work it would be very valuable to ask why that happens, but if someone wants to leave and their carer wants them to leave then they can, and no one can hold them there, but there are certainly stories we have heard of people being taken back to their care home at 1 am and the doors being locked and their being stuck outside in the cold. Not only is it very disorientating for someone with dementia, but it is just inhuman.

Janet Morrison: There is very good Department of Health guidance on managing discharges and those policies are very available to hospitals. I think it is a question of that not having been integrated into the culture of hospitals, because the guidance is great and if it worked you would be planning discharge with carers from the day someone came into hospital.

The other thing is that the principles in the Care Act are very good principles, but unfortunately they apply to local authorities and not to hospitals in the same way, and those principles of person-centred care focus on the wellbeing of the older person as the expert on their own wellbeing and their own needs, and assessing carer's needs are all there. The problem is they apply at a later stage and we need it to be brought into the culture of care for older people and people who are vulnerable.

Q20 **Mr Turner:** What do you consider to be the main causes of the discharge failures we have discussed?

Chair: Each in one sentence.

Ruth Hannan: For us it is often lack of carer involvement from day one. If we don't listen then we don't have the full picture.

Q21 **Mr Turner:** What is the underlying problem?

Ruth Hannan: The ombudsman report highlights those four, and I would support that those four are key to correcting the issue.

Andrew Boaden: I would say a lack of integration between health and social care, but very much that is underpinned by the fact that there is a lack of social care support available across the country and the funding cuts for that over the last five to six years have been pretty devastating, I think.

Janet Morrison: Funding pressures, lack of integration and lack of culture of communication and consultation.

Q22 **Mr Turner:** It seems to me that these things are not uniform. Perhaps they are, but are they uniform or are there pockets of good behaviour and quite a large area of thoroughly bad behaviour?

Ruth Hannan: There are examples of good practice, and that can sometimes be the real frustration for people, because they are aware where things work well, but then another time they will have a really bad experience. It is about ensuring consistency. We tend to find that those good practices are very dependent on staff who may be very aware of including carers, or very good commissioners who look at integrated work between health and social care, but it isn't a consistent practice across the country.

Q23 **Mr Turner:** What percentage are we talking about? Is it that 60% is poor and 10% is lousy? I am trying to get some kind of picture that is more than just general.

Ruth Hannan: I don't have that kind of data of what would be good, poor or lousy. I would think that the ombudsman statistics probably give a good guide to that.

Andrew Boaden: Much the same. We found with the freedom of information requests it was very hard to judge exactly what would be good practice, for instance. What you can see very plainly is this variation, so some hospitals are delivering and then other hospitals are three to five times worse at what they do. Some of that might be issues with the data, but you get this sense as you would across the country that there is real variation.

I think initiatives such as the new models of care, the NHS initiative, the Better Care Fund, can facilitate good, integrated working and develop good practice. I think there are opportunities between the sustainability and transformation plans. The latest Government initiative to improve integration could focus on hospital discharge and one of the key things that it does look at is the clinical commissioning group improvement and assessment framework. Again, there could be metrics within that, which could be focused around hospital discharge and seeing how things are and working to improve that and supporting areas to improve.

What I can say is there is certainly poor care and care is very variable, but there is some excellent care as well. I think it is facilitating that learning.

Janet Morrison: I think where adult social services are based within hospitals and are well integrated into practice there you will see good practice. I think also where hospitals themselves have taken responsibility for some of the reablement services or social care services you will see good practice, but it is a hugely variable scene across the country. It is very different from area to area, which makes it very hard to advise families and their carers how to navigate the system because it is different in every single hospital.

Q24 **Ronnie Cowan:** In Scotland they are rolling out a new health and social care partnership with 30 councils, and it has been described by the OECD as, "Bolder and wider in scope than most seen elsewhere". Are you familiar with it? Are we doing the right thing in Scotland? We had exactly the same issues with the same problems and we seem to have taken that on board and tried to do something about it.

Andrew Boaden: We do not work in Scotland but I have heard that Scotland is leading the line with this initiative or this approach.

Ruth Hannan: We have colleagues in Scotland and with integrated models of care our experience seems to be that they work much more positively. It is where health and social care aren't connected in any way that tends to be a significant problem. Where they are working closely or fully integrated we tend to see a shift in the culture of each organisation as well.

Janet Morrison: I do not think I have anything to comment except to say that there are models of pilots in England and Wales that work well. It is just not system-wide. I am not sure if Scotland is going for full integration but there is better integration.

Q25 **Chair:** How does this operate in countries other than the United Kingdom? Why are we so incapable of learning how they do things in other countries?

Ruth Hannan: I think they have more integrated health and social care systems. Therefore they plan together and there may be different structural models in terms of funding. I think the funding creates a real cultural barrier between health and social care.

Q26 **Oliver Dowden:** On the related point, what do you think the impact will be of the Better Care Fund? That is the Government's solution at the moment. Will it work?

Andrew Boaden: It certainly has potential to. What has been challenging is the impact reporting of that. What would be useful is to get more reports on the change that has happened as a consequence of that in terms of the quality of care that people receive. Yes, it has been in the

policy sphere and pointed to as the solution for quite some time. It takes a little while to embed these new models and to see the change and collect the data and so on. I would have thought we are now at a point where they should be able to collect that and publish it in a way that we can pore over and people can learn from it.

Q27 **Oliver Dowden:** Do you have any sense at this stage as to whether it is working or not, anecdotally or through the people you are in contact with?

Janet Morrison: I think they are piloting good practice and I think there will be good lessons to be learned. I do not think it is going to change the whole system. We know that local authority cuts in terms of their social care budgets are huge, 400,000 fewer people are getting local authority funded care now than they were in 2009-10. The pressures on social care are so huge. I think pilots of good practice are great but I think a more fundamental shift is needed in terms of integration and funding and we are going to need to engage the public in understanding around that.

Q28 **Tom Tugendhat:** Very briefly, the PAC report mentioned dementia as a particular element. How frequent is it? Why are hospitals failing to assess it? Finally, what can we do about it?

Andrew Boaden: Official statistics state that around one-quarter of the hospital population has dementia, but from anecdotal reports or conversations we have had with hospitals it is nearer 40% to 50% in certain places, so it is a significant amount of the hospital population.

The reason why it is not always picked up is because people are rarely admitted for the dementia; it is for other health conditions. Some of the most common include having had a stroke, a UTI, a chest infection, having had a fall, so people are coming into the hospital to have that specific medical need addressed.

People are supposed to have an assessment on arrival and the quality of that assessment, there was a thing called a CQUIN to drive a hospital's assessment of people when they arrived, but that has since been retired because apparently everyone is doing that routinely now. I think in terms of how that can be improved, there are issues around the implementation of the Mental Capacity Act. We as the Alzheimer's Society regard that as a really positive piece of legislation, but would very much attest to the findings of the House of Lords review of it a couple of years ago, which found that while it is a good piece of legislation it is not necessarily playing out in practice and is not embedded in culture. The recommendations of that report I think are still very pertinent now and should be something that the Committee relook at, because they very much cover and would address some of the issues that people have experienced around this in particular.

Chair: I think we are done with you. Thank you very much for coming. The points that we take from you are that there are rather isolated places

of good practice. There is an inability to seem to translate that good practice across the health service as a whole and the problems are fundamentally structural, as well as being confined to limited resources. The ombudsman has described to us the almost political maladministration involved in having separate budgets for interdependent services, and that would seem to be one of the messages you are conveying to us. Thank you very much indeed.

Examination of witnesses

Dr Mark Porter, Phil McCarvill and Janet Davies.

Chair: Welcome to our next panel. Apologies for the delay. Could I ask each of you to identify yourselves for the record, please?

Dr Porter: My name is Mark Porter. I am an NHS consultant and I am BMA Chair of Council.

Janet Davies: I am Janet Davies. I am Chief Executive and General Secretary of the Royal College of Nursing.

Phil McCarvill: I am Phil McCarvill and I am Deputy Director of Policy at the NHS Confederation.

Q29 **Ronnie Cowan:** The PHSO report highlights incidents of premature discharge where patients are sent home before they are clinically ready. Are we seeing these as isolated incidents or is this a wide-scale problem within the system?

Dr Porter: The key thing to remember about the PHSO report is that, like a lot of other audits within hospitals that we learn from enormously, we learn by having the very worst practice demonstrated in vignettes. Most of what was in the report was very bad practice. It was thankfully a very small number of episodes of very bad practice. I do not think there is a specific increase in the number of patients being discharged who are not medically fit for discharge. The bigger problem and the structural problems that were brought out of the PHSO report and the things that we experience all the time are to do with the poor integration that has already been discussed with the last group of witnesses and that I have no doubt we will carry on to discuss. Individual failings where somebody is discharged when they would still benefit from hospital care or should stay in are thankfully very small and I think probably have a different cause.

Janet Davies: One of the things that we find is that the important thing is it is within a culture, particularly of hospitals, that when the focus of the whole organisation is on the people within that organisation, the patients and the carers, then we do not see that and we see really good discharge. When the focus is on beds rather than the person, that is when we sometimes find those difficulties. So when we have discharge

teams, for instance, that might sweep around the wards looking for beds because of the pressure at the front of the hospital, you can understand why people do that. That is the incorrect way of assessing people who are ready for discharge.

Q30 **Ronnie Cowan:** So a discharge team?

Janet Davies: We find in some hospitals, because of the pressure on hospitals with people coming into hospital as emergencies and the lack of space within the hospital, in some areas they have developed a team of people who will go around trying to identify where beds might be. In some places that goes a stage further, where they take on some of the role of discharge. We believe the better practice we see is where the focus is on the people and the multiprofessional team who know the patient are the people who are pushing for that discharge. If that works well there is no need for that push because that is happening automatically.

There is plenty of guidance both from the College of Nursing but also the Department of Health guidance on discharge planning and this quite clearly says that that triangle of care with the carer, the patient and that multiprofessional team is absolutely key. If that culture is followed then discharges work very well. It is when we have this culture of almost panic, "We have people coming in, we are going to get penalised for the wait, we need to get people out," that the pressure comes on the team, which can create difficulties for the individuals and their carers.

Phil McCarvill: I think often we focus on one bit of the system, which is the hospitals, but it is really important that we see this as a system-wide issue. We did some work recently with colleagues across the whole of the sector looking at the experience of urgent care for older people, and what we found was the interventions need to happen at home to keep people at home for as long as possible. Support in the community, it is important what happens in terms of ambulance services, what happens at the front door of hospitals, so having the assessment teams in there to determine who needs particular support around mental capacity or a mental health issue or dementia, so that people are being assessed properly; that there is co-ordination between different bits of the system, whether it is the hospital and social care and community services to make sure that people get the right package of care. It really is important to underline the point about integration of services. We essentially have different systems, and what we are trying to do at the moment is work together with colleagues from the NHS, from local government, from social care and with the voluntary sector and other partners to make sure that we are developing system-wide responses.

We have recently done some work with the Association of Directors of Adult Social Services, with the Local Government Association and with NHS Clinical Commissioners for a goal of 2020 having integrated care and making sure that by that point integration is business as usual.

It is really important also to underline the pressure on the NHS but also to underline the pressure that is within the social care system. The funding issue is really important to NHS organisations and that is why we have stood shoulder to shoulder with ADASS and colleagues in social care to say that we agree with Simon Stevens that this is unfinished business. We have not yet sorted the issue of sustainable settlement for social care funding.

Q31 **Mr Jones:** A report last year from Healthwatch England indicated that some hospitals were struggling to implement very well-established procedures on discharge planning, while others were more successful. Why are some hospitals more successful than others?

Janet Davies: It is a combination of factors. I think the big thing, integration is really key—what are the relationships with community services, what are the community services like, are the staff experienced? It is really important that the clinical staff understand the work within the community and the work with hospitals. For nursing that is particularly important, that during their education they understand that whole system that works around the patient, that there is that integration there, there are good relationships, but also that there are really good communication channels.

Q32 **Mr Jones:** This is a question of management, effectively?

Janet Davies: It is vitally important that they can work across the whole teams, of health and social care both in the acute sector and within community settings, but also that the resource is there. That is, social care packages that are available and affordable, but also that you have the people there who can do those assessments with the talent and the skills and the knowledge to do it. Having enough community nurses, for instance, investing in community services, can only help the hospitals and at the moment it seems very separate. There are some very good examples in the vanguard—some of the things that we are hearing and seeing. Those areas do well, but all areas need to work in that way.

Chair: Do the other two panellists need to add anything to that?

Phil McCarvill: Just to say that the whole reason why we started the work on the commission was to plug the issue of why it was happening in some places and not in others, and how we get people to replicate and copy the really good practice and adapt it, so that we are giving people access to the right type of services and having the assessments taking place in the right places. For example, in Sheffield they have done some really interesting things where, rather than assessing people in hospital beds and bathrooms, they are going out into their own home to assess them in their own environment, which gives you better quality assessments and a clearer sense of what care package that individual needs. It also gives you a sense of what support networks they have in terms of people around them.

Q33 **Chair:** Dr Porter, why do you think so many hospitals tolerate so many

instances of unsafe discharge?

Dr Porter: There is quite a bit of me that wants to challenge "so many" and "so many instances" but nevertheless it happens and nobody can deny that, since we see the reports.

To add to what my two colleagues have said, there is a fundamentally important thing to bear in mind about today's national health service. The number of acute beds has been halved over the last few decades. The bed occupancy rates, which the National Audit Office says should be at 85% for an optimum balance between efficiency and a good personal experience, are now running at an average of 91.2% and 20% of hospitals in the UK today are at greater than 95%. What this means is, according to the National Audit Office, that every hospital is going to be experiencing continual bed pressure. Most will experience periodic bed crises, and individual patients will experience poor care and particularly an increase in healthcare-associated infections.

The background to the question is really important, and that background is a health service that has deliberately had its resources reduced below the level that it requires to continue giving the excellent individual care that most members of staff want to wake up every day and go in to work to do.

Q34 **Chair:** Part of the reason why there is over-occupancy of beds is because it is so difficult to discharge certain kinds of patients.

Dr Porter: That is right. My apologies. We have focused, I think, on relationships between hospital agencies, between the acute end of the NHS and social care. That is really important, but within a hospital the concept of exit block is key to understanding the experience of a patient coming through the front door. If you cannot discharge a patient or continue a patient's care through to social care when their care needs have changed or diminished and they can go out of hospital, what you get is backing up through the admissions wards and the emergency departments, such that there is a poor experience at the front end, and we are seeing the majority of hospitals in the UK now failing on their four-hour emergency department targets, the principal reason for which is the failure of co-ordination we are talking about that causes exit block.

Q35 **Mr Jones:** Recent guidelines from NICE identified the importance of having a person-centred approach to transfers of care. What does that mean in practice?

Dr Porter: I think what it means is that we all know that the best standard of care, whether it is medical care or looking at the overall care package, whether it is simply giving people food, water, conversation and company, is best delivered when you are able to focus on one patient at one time, able to focus on their needs, how to deliver them and to make it feel to them as if you are focused entirely on them.

The reason it needs to be emphasised is because there are so many pressures in any health service, but I would say particularly growing in our health service at the moment, that detract from the ability to do that, that continue to call attention to a number of other contemporary problems at the same time that prevent somebody from devoting their whole attention. We see this coming up everywhere. For example, the recent work on nurse staffing levels on wards is focused on having enough people to be able to devote that person-centred care to every individual patient when they need it, instead of going below a certain threshold that means people are trying to juggle several problems at once. You get the same problems with doctors, so for example the Royal College of Physicians in their evidence to you pointed out the 40% vacancy rate in consultant physicians. We see similar things happening, of course, with the reduction in resources for adult social care recently, with an average experience of about one-quarter of resources disappearing. So the inability to provide the person-centred care that everybody would aspire to, and indeed if you are on the receiving end you would want.

Janet Davies: I think it is also about centring on that person regardless of the setting. So it is about having the whole team focusing on that person. At the moment there is a divide between hospital services, social services, community services, voluntary services and other things that may be around that one individual person. Increasingly we have people living much longer with much more complex needs. It is not as simple as having a community nurse or a social care package. It can be really quite complex.

The point of person-centred care is that the people move around the person, not the person moves around the people. That is where it becomes disjointed and difficult and that is where discharges don't work well, when not everybody in that whole team is focusing on that person.

Q36 **Mr Jones:** How do you ensure that discharge is person-centred? Is it simply a question of resources or is it a question of professionalism?

Janet Davies: It is a combination. Resources are very important because it is really important that there is enough of a package of care within that person's home that will support them safely but will also support the carers. There is also that cultural shift I talked about where everybody works together. That means systems work together as well, so do our computers even talk to each other? Can we pass information through very quickly? Do we know the person? It is very good that you have that relationship as professionals to professionals, so hospital nurses, community nurses. Do we have enough community nurses? We know there is a huge problem. We hear about problems with nurses in hospitals, but the number of qualified district nurses—those are the specialist nurses working in the community—has dropped significantly over recent years. These are the people with the skills to do the

assessment, to co-ordinate the care. It is cultural, it is education and it is money. It is the whole thing. It is really quite systemic.

Phil McCarvill: I think there are a number of principles that come into play and in our commission our first principle was building care around the individual. I think the most important thing is the engagement of the individual, their family, their carers, in the decision-making processes and working across different organisations, so the system is working around the individual, as you have said, rather than the individual or their carer having to navigate a really difficult system. It is where we bring members of staff from different teams together to exchange information and to discuss individuals that you get better joined-up care. We have seen it in Sheffield, in Oldham, in Norfolk. It is about completing the right assessments at the right time, so that people get the right package of care in place.

Q37 **Mr Jones:** So some parts of the country are doing better than others?

Phil McCarvill: There are lots of examples of where we are getting it right. The trick now is how we replicate that and make sure that it is happening across all parts of the country and that we have a way, over a very diffuse system, of sharing that practice and making sure that people can learn from it and also copy and adapt so that it fits their local population. You cannot just simply take initiatives wholesale. You have to adapt them to meet the needs of your particular community, whether that is a rural community or an urban community, whether it is a community in which you have a largely older population or a much younger population.

Janet Davies: I think there is also something about the different specialties, so we know it works really well in specialist units where we have rehabilitation units, transitional care, some of the cottage hospital-type models, where people have the time and people can focus on them. What we need to do is to make sure that model works across all acute settings, because it does seem to work better where there is less pressure, where people do have that time and that link with the community, more than perhaps some of the very busy acute wards. We need to make sure everybody has that ability to do that.

Chair: You are all doing very well and being very quick. Thank you very much indeed.

Q38 **Mrs Gillan:** I want to turn to a couple of points that the PHSO report identified and also Healthwatch England, and just to continue on this theme of the failures to communicate with relatives and carers particularly.

I have heard that there is a lack of resources, lack of co-ordination, there are so many services involved in each individual's care. What really explains those failures? It should not be rocket science to provide person-centred care. You have the patient in front of you, and everything should revolve around that patient, and surely the professionals should be on

top of the systems and know them well enough to know who they need to talk to about that individual before they are discharged.

Dr Porter: It is too easy to fall back on, "Oh, life is always complex and people's needs particularly so," but it is worth bearing in mind that all the good practice that is explained in some of the evidence you have had and some of the things that we are talking about here today, that good practice is all designed to get round a fundamental design problem with our health and social care systems, which is that they are separate. They are funded separately and they work separately. They have worked on the assumption that well people have an acute illness, come into hospital, get cured and go out well again. That was never true; there are people for whom it was never true. But it is not so much that it was never true; it is that it is becoming more and more untrue as time passes.

For example, at the moment over the course of this present Parliament, the number of people with three or more co-morbidities is scheduled to increase from 1.5 million to 2.5 million—in other words, people who may not be ill with those things at any one time but who require care and support to help them remain well. It also increases their individual chance of coming into hospital with an acute problem and complicates any acute problems they have. So it is not just that demand is going up in some unspecified way and we need more operations or more beds or something like that. The nature of the care we need to provide is changing, and yet the systems and the structures that we have in place to deal with it are rooted in the problems of a few decades ago. Being able to move ahead and change our systems is really important.

Q39 **Mrs Gillan:** The PHSO and Healthwatch England highlighted the failure to communicate with what I consider to be the basic essential—the relatives or the carers. I am not even talking about the complex services that support that individual.

Why is it that healthcare professionals fail to inform relatives and carers? Surely that is the most obvious pathway of all.

Dr Porter: Yes, the report describes some egregious failures that I could not possibly support or explain away.

Janet Davies: I do not know why that happens. Obviously it is totally unacceptable, but why somebody would not contact a relative I don't know. We would have to look at the individual case. It would certainly not be in any guidance or care plan or in anything that was there that fundamentally you would not officially speak to the relative. Not only would you inform them, you would consult them beforehand. That is in all the guidance. Why that is not followed or what those individual cases are, I don't know. Whether it is somebody who knows the patient or someone who does not who happens to be there at the time, whether it is a member of agency staff, I don't know. It would have to be something that we would look at case by case.

Q40 **Mrs Gillan:** As I say, it was referred to by Healthwatch and the PHSO,

and I just do not understand why that basic is not fulfilled and that there are cases that have had to be drawn to our attention. Perhaps you could give that some thought and maybe all of you could come back to the Committee and have a look at that. I would have thought your discharge planning process was the obvious primary path.

Janet Davies: It is within that, so we would have to look at those individual reasons for why that is, because that is something we would never condone. It is not in any of the guidance. It is certainly nothing that we would produce that would be there. How that has happened I don't know. Whether it is that the person has not been discharged from their ward; they may have been discharged from a different area. They may have staff who are not familiar with it. I don't know. We would have to look at it on an individual basis. We will certainly look at that.

Q41 **Mrs Gillan:** I think we need to find an explanation for these failures, because it is significant enough to be brought to the attention of this Committee by both of those organisations.

Moving on to another topic—

Chair: Mr McCarvill?

Phil McCarvill: Nottingham University Hospital has an interesting approach, which is that they have people within, so patient-centred advisers, who operate within the A&E department and other departments who are specifically there when people are readmitted within a given time period to identify what went wrong. Was there anything that could be improved in the way that the discharge process happened in the previous admission? Then they have responsibility to go back to the home ward, the ward where the person was cared for, but also out into the community services to identify if there are improvements in the way they co-ordinate care for individuals.

Dr Porter: The narratives within the report are general learning for all of us; I have already mentioned that, but another key thing you ask is about where the individual egregious failures are. Each hospital unit, area, whatever, where any of those failures occurred should have, and I would trust has, mounted an individual investigation into that particular incident and determined any addressable causes that can be taken forward. Failure to do that would be another failure again, of course, but the point about an ombudsman, having an ombudsman's office and being able to report back to the areas where this occurred, is for the individual learning to take place with an exhaustive investigation into that exact incident. That absolutely should take place with every one of them.

Q42 **Mrs Gillan:** I appreciate that. Can we turn to something else that the PHSO reported? They identified several cases where people with dementia were discharged without any assessments being made or a proper assessment being made of their mental capacity.

Could you talk the Committee through what the processes are of discharging a patient with dementia, so that we can understand what the

differences are and what special provisions are made?

Dr Porter: The differences really relate around for the healthcare professionals who are doing the discharge or doing the transition of care to be able to understand the problem and the needs that follow. So, for example, the BMA, along with a lot of other organisations, has put together information for our members, but also more specifically for the wider health economy, about tools to use in order to diagnose and detect dementia. The key thing here is not that people walk around with a label that does not change. I think one of the previous witnesses mentioned this as well; it is that people's diagnosis and needs change as they become acutely ill, as they go through the illness process, and when they come out again they may not be the same as when they went in.

Looking into, diagnosing and assessing people's needs is a difficult thing to do, which people need to work at, practise and have the time to be able to do. Sometimes you are not able to put all those three things together, but then of course to put in place a care package that can be handed over to someone else. For the sake of argument, it is not an answer to someone's needs to do the in-hospital bit perfectly and hand over a care package that simply will not be implemented, because of failures outside or failures to communicate. Indeed, whatever the service is outside, you have to be able to assess needs inside the hospital, depending on how they have changed with the acute illness process.

Getting all of those things together is just difficult. It works most of the time. We do need to be better at it as an NHS and social care system, but it does require continual work at understanding the system needs on this and being able to move ahead with applying it to individual patients.

Janet Davies: We have done lots and lots of work on dementia care. I think in general there is far more awareness of dementia and the needs of people with dementia, but particularly with the carers of people with dementia. One of the key aspects of people we care for with dementia is that the carer is even more important. They are always important, because they are the people who have the story and they are the people who understand the care needs of their loved one. The individual themselves may not have the ability to articulate what the real situation is for them at home. That triangle of care that we heard about before from the other three witnesses is so essential for this, particularly in that assessment for discharge. All the guidelines and the assessment criteria that we produce and the work that we have done for dementia would make sure that is the case.

Q43 **Mrs Gillan:** I understand all that, but the PHSO identified that there were failures in carrying out the mental capacity assessments. That is a basic function, surely. Why are mental capacity assessments not successfully carried out on each patient?

Janet Davies: I don't know, and again in those areas where this occurred they would have to look at why that had failed. Everything that

we put in place from our point of view, our advice to our nurses, is that those assessments take place. It is multiprofessional. It is the whole multidisciplinary team and the carer is absolutely key to it. Why they have failed could be for a number of reasons but those areas have to be reviewed, see what went wrong and learn from those individual cases.

Q44 **Mrs Gillan:** Is it just missing it out because you are so keen to get the patient out the door? Is it cutting corners and saving time? Are you trying to push people out of beds?

Janet Davies: It is all sorts of things. There is a problem if people who do not know the person are coming in and being involved in the discharge process—coming in and pushing for a discharge. That is one of the reasons it might happen. Another question is, do the people have the education—wherever they are working, are they trained in the use of this? Are they using it? We can issue things, and we know the Department of Health guidelines are excellent, NHS England's guidance is excellent on discharging, but why are people not using it? It is the organisations themselves that need to ensure that all the tools that have been provided are being used. Also, are there staff there who can do it?

Q45 **Mrs Gillan:** Who checks that in a hospital environment? Who does that double-check that your multidisciplinary team that is looking after a patient is going through the correct procedures?

Janet Davies: It would be whoever was in charge of that particular person in that multidisciplinary team.

Q46 **Mrs Gillan:** Who would be in charge?

Janet Davies: It would be a combination of the medical staff in charge and the nurse in charge. They would be looking at that as part of that team review. Has this person been assessed? Is this person ready to go home?

Q47 **Mrs Gillan:** So the failure would be at the top of that particular care—?

Janet Davies: On that it is being checked, yes.

Q48 **Chair:** Who should ultimately be responsible? Who is ultimately responsible for the unsafe discharges in a hospital?

Janet Davies: It is where the decision has been made, so it is the decision maker. So the decision maker will either be—

Q49 **Chair:** Is it not indicative that there is not a simple answer to that question?

Janet Davies: It depends on the type of ward. It would generally be the hospital consultant who makes that decision. In some areas it would be a senior nurse who has the responsibility for the discharge of patients. It depends on the type of ward, the type of patient and where that responsibility lies. Some wards may not have a consultant. There may be

a nurse-led unit, in which case it would be the consultant nurse. It may be the consultant physician or surgeon.

Q50 **Chair:** It seems to me that what you are saying is that in the case of every patient, working out who is ultimately responsible for the safe discharge of that patient is very opaque.

Janet Davies: Well, it wouldn't be opaque to the patient and it wouldn't be opaque to that particular area. It is just difficult to describe to you because patients in different hospitals or different environments are different.

Q51 **Chair:** No wonder hospital chief executives or regulators can't get their heads around it.

Dr Porter: Well, the better and more general arbiters would be the chief executive and the board from the point of view of provision of resources and making sure that people are performing according to how they should.

Q52 **Chair:** How do they decide who is responsible for the overall policy of safe discharge? How should they decide that?

Dr Porter: The key thing is that there are no uniform arrangements that the same professional in every unit and every department of every hospital is going to be the responsible professional. Sometimes it is going to be a multidisciplinary team meeting, for example, particularly mental health, between nurses, community practitioners and doctors. Sometimes it is going to be nurses following safe discharge protocols, because we know that somebody's needs assessment has not changed very much. Sometimes it is going to be a difficult medical decision based on a patient's complex needs. There is no simple answer other than to say the responsible healthcare practitioner.

Janet Davies: It is very important because it is about focusing on the patient, not the system. Where we had problems previously was where we fitted everybody into that person responsible for that discharge and that person isn't necessarily the person with the right skills for that particular person. It may even be a social worker who has that final say, because that is the bit that will make the difference. So they would be responsible for that final jigsaw. What we cannot do is have one system where it is one particular person, because it has to fit the person's individual needs and care plans, and it will be different in different settings.

Q53 **Mrs Gillan:** I am just absorbing what you are saying to me, because you are describing to me something that means that every hospital is different.

Janet Davies: No, I am not. It might be different in different wards of a hospital, because it is important that the person who is responsible for that discharge is the person who is co-ordinating the care with the carers

and with the patient for that person. It is not necessarily going to be uniform, because it is about what that person's needs are. It is different in mental health as it might be in a surgical ward or a rehabilitation area or in oncology. People do not fit into neat boxes, so it is important that it is right, but the person in that area will know, and the hospital themselves will know. That is the important thing—that it does not fall between.

Q54 **Mrs Gillan:** It is quite obvious from the reports that we are being presented with that that is not the case. So what is the solution? Obviously the guidelines that you keep saying are good—or people are giving us the impression are good—are not working.

Janet Davies: It is about having the right guidelines, the right staff with the right education, the right culture, the right resource. It is also the really key issue that has come out all the way through today about integration. So people do not sit within hospital or within community. Everything has to work around the patient with more integration.

Q55 **Mrs Gillan:** So how do you improve it?

Phil McCarvill: I was going to say, I think the real value of the PHSO report is it highlights examples of where things have gone wrong, which we in the NHS can learn from. That is the really important point.

In terms of what went wrong in individual cases, I do not think any of us can comment. I think it is really important that we learn the lessons and we identify how we replicate what is working in some areas, so that it happens in all areas and we have consistency so people know that they are going to be engaged in a particular way, and that the care is going to be co-ordinated around them and what works for them.

Q56 **Mrs Gillan:** You are saying it is really a question of disseminating best practice?

Phil McCarvill: I think it is learning and copying and finding a way that we can communicate across the whole of the system and learning what is working, not just in terms of hospitals but out in the community. Some of the really interesting stuff is where you have people focusing on the social wellbeing of the individual to keep them well for as long as possible. There is some great work in Cornwall with Age UK where they are co-ordinating care and their starting point is what matters to the individual.

Q57 **Oliver Dowden:** I think we have discussed quite a bit of this already, but on specific policy solutions two things have been suggested to us. First of all, we heard evidence earlier saying that there should be a ban on night-time discharge. Do you think that would be something that would be useful? What is your reflection on that? Secondly, what is your reflection on the Better Care Fund and how that is helping with co-ordination between hospital care and social care?

Janet Davies: I would absolutely say that people should not be discharged at that time of night unless it is at their request. Nobody would be expecting to be travelling at that time of night, and certainly to go into a house or a home that will be cold and nobody there—I think that is an absolute for me, unless it is at that person's request.

Q58 **Oliver Dowden:** Do you think that is happening currently and why is it happening currently?

Janet Davies: We do not have those statistics. We heard about those before. We do not have those. One of the things we are looking at at the moment with Healthwatch is how many cases there are. They have done the freedom of information request, but we do not know how many cases it is. Anecdotally, we hear it is not as many and we think that some of it has been the recording of the time by whoever is recording it, but we do not know that, so we just have to check on that data.

Dr Porter: There is another key confounder in there as well. Many hospitals use a variance on the discharge lounge process now. In other words, a patient is prepared for discharge. Their transport may not have arrived, so they are formally signed out of the hospital, accommodated in some discharge lounge arrangement or other, while they are waiting for their transport to arrive. Now, it may be that some of those—I do not know, you would need to look into it more deeply—are simply the time at which a patient is formally discharged but not necessarily the time at which they are physically removed from the hospital. All of that does not get around your basic point, and the one that I would like to reinforce, that Janet made. Leaving the hospital itself should not be happening unless it is both wanted by the patient and appropriate for their care needs.

Q59 **Oliver Dowden:** Do you think it would be a useful policy solution to introduce a ban on it or do you think it is just something that would be more cumbersome?

Dr Porter: You have to be really careful with saying a ban because when anybody bans things like that as a response to egregious things like this that happen, it always has unforeseen consequences in stopping other practices that are meant to happen.

Q60 **Oliver Dowden:** On the Better Care Fund, what are your reflections on that so far?

Phil McCarvill: The Better Care Fund is part of a bigger package. What we have at the moment is a real drive at a national level with the Five-year Forward View, the new models of care work and the vanguards and the like to drive integration across different populations across the country. You have the Better Care Fund, but you also have a lot of activity at a local level through the sustainability and transformation planning process and individual relationships within local areas, which are driving integration and removing some of the barriers between individual

services. I would say the Better Care Fund has been part of a package that is moving towards greater integration of services.

Q61 **Oliver Dowden:** Do you think in the end we need to have, as is being suggested I think by the Labour Party, a completely integrated health and social care system? I think it was said once you would have a national care service that is essentially the same as the NHS. Is that the ultimate policy destination you think we should be aiming for?

Dr Porter: I think if we were to go back some decades and look at how we should set up the system, that would have been a good aspiration. It probably still is. I think the big problem at the moment is illustrated by where the Better Care Fund comes from. It is not new money into the NHS; it is top-sliced money that was previously paid to the National Health Service that has now been taken away in order for the Better Care Fund to provide these innovative solutions. All very good, but at the end of the day that means that we are under 8.5% cost improvement programmes at the acute end of the NHS; in other words, having to do more every year for less money. I am not in any sense saying that we should not look at structural reorganisation and that might be an answer, but it is unlikely to be a short-term answer and it is likely to cause many more short-term problems.

If I was looking into a radical change along that level, I would look much more at integrating the existing services by funding them—forgive me—properly, better than they are today, not reducing resources year by year, not cutting out all social services because it is considered to be outside the NHS guarantee, but funding them properly and allowing them to work better together rather than by setting out to integrate organisations that have decades of separate activities.

Q62 **Oliver Dowden:** Would that mean a single funding for all of them rather than two separate sorts of funding?

Dr Porter: It is probably worth at this point mentioning what is happening in Manchester—one or two other places, but Manchester is the best example. Several statutory organisations, both health and local authority, have come together to share and pool their funding for shared objectives. Each of the organisations retains its statutory accountability and in the event of a major problem one can see that some might be under great strain by continuing that arrangement. Nevertheless, roughly 14 or 15 organisations across Greater Manchester have come together to pool their budgets to achieve exactly those objectives while retaining their individual statutory existence. I think that sort of experiment is something that we should watch with great interest, particularly because the relationships between local authority and health bodies in that area give a degree of confidence about moving forward there than in other areas.

Q63 **Oliver Dowden:** Is there evidence that is working so far or is it just too early to say?

Dr Porter: It is too new. It needs studying and follow-up. It is too new.

Janet Davies: We are working in Scotland where that is happening from April and we also work in Northern Ireland where the systems are together. We still have problems occasionally with unsafe discharge in Northern Ireland despite that. The big thing is that, again, it is focusing on the person and the person does not know the difference between health and social care. They require that support. Therefore, the investment—and there does need to be investment—needs to be in that health and social care that supports that individual, and that division gets in the way. The person does not understand it. It causes problems, as we heard earlier—arguments about who is paying for what. That can delay a discharge and get things in the way. The funding should be based around that person and not around our systems, I think.

Q64 **Chair:** That is very helpful evidence—helpful because it demonstrates why the system is so chaotic. May I turn back to the question of who decides who is responsible for the safe discharge of a patient, because we have not had a clear explanation from you yet on that question?

Dr Porter: I will give you a "for example". My personal principal practice is in maternity services. Patients who have had caesarean sections are discharged according to a discharge pathway that we usually write at the time of the caesarean section itself. It is usually administered by midwives. It has input from hearing specialists, paediatricians and so forth who might need to check over mother and baby before they leave but, generally speaking, the midwife will be responsible for most discharges because everything follows the normal pathway. It is when things go off the normal pathway that you need to involve other people.

Even in that very constrained area with relatively healthy people who literally come in and then go home again with a baby, you cannot give a single answer to that because an individual's experience and pathway might diverge from what we would hope and expect. Anywhere else it is even more complicated than that. The point is that a healthcare professional will know what they are doing at the centre of it, but you cannot give a single answer as to who that healthcare professional is or should be.

Q65 **Chair:** No; I understand the point you are making. It is instructive that you have given us an answer there where somebody comes in with one condition and they are sent home after that condition is resolved. Most of the cases are not like that and that seems to be where we have multi-problem cases; these are the ones where the responsibility becomes dissipated.

Dr Porter: There is guidance around at the moment that I think will bring a greater coherence along the line you are looking at. For example, NICE published, at the end of last year, guidance on the care of adults who have social care needs when they leave hospital. That is in the process of being embedded. The quality standards are being drawn up

and we expect NICE to publish in a few months guidance for the care of patients with multiple co-morbidities who, of course, do not fit traditional treatment pathways that currently exist.

Q66 **Chair:** When you are involving a lot of people in a multidisciplinary environment, it is quite obvious that the responsibility also dissipates. How do you avoid that?

Janet Davies: You have a very clear care plan, which gets ticked off. It is a physical plan. It is not just that everybody has been informed that—

Q67 **Chair:** Okay. That leads me to the next question. The obvious solution to this would seem to be to have checklists.

Janet Davies: Yes.

Q68 **Chair:** How widely used are checklists for discharge?

Janet Davies: There are checklists and every person with multiple needs would have an assessment and a checklist and everything should be signed off before that person leaves hospital. Those exist.

Q69 **Chair:** How widely used are checklists, in your experience?

Janet Davies: They are very widely used but obviously things—

Q70 **Chair:** But then they cannot stick to the checklists; otherwise, they would not discharge patients in the way they do.

Janet Davies: There are clearly cases where they have either missed something off the checklist or they have not used them in these particular cases, but that is what we would recommend.

Phil McCarvill: That is where the real value of the PHSO report is that people can then identify where there are things missing from the checklist.

Q71 **Chair:** Well, a checklist is probably a question for our next panel. Do you want to add anything more?

Dr Porter: I was smiling because before you said that I had written down "WHO safety checklist and log for discharge". In operating theatres, where I principally work, the care has been revolutionised over the last five years by the introduction of the World Health Organisation checklist. I was going to go away and look into whether that would assist in this area. It is not so much the existence of a checklist; checklists are everywhere. It is a question of the accord and the respect paid to them and the ability to proceed despite them not being—

Q72 **Chair:** Absolutely. It is a brilliant book, Atul Gawande's "Checklist Manifesto", and it would seem we need him to write a book about unsafe discharge. Anything further to add?

Phil McCarvill: Other than we are happy to share the examples from our members in terms of the work that is happening with local government,

with community services, acute services, to give you a flavour of where things are working well and a sense of how we can replicate that across the country.

Janet Davies: Again, the same for us.

Chair: Thank you very much indeed.

Examination of Witnesses

Ben Gummer MP, William Vineall, Jane Cummings, Dr Mike Durkin and Sarah Mitchell.

Chair: We have a very big panel. We will need to have very crisp answers. May I ask each of you to identify yourselves, please?

Ben Gummer: Ben Gummer MP, the Minister for Care Quality.

William Vineall: William Vineall, Director of Acute Care and Quality, Department of Health.

Sarah Mitchell: Sarah Mitchell, Director of Adult Social Care Improvement at the Local Government Association.

Jane Cummings: Jane Cummings, Chief Nursing Officer for England based in NHS England.

Dr Durkin: Mike Durkin, NHS National Director for Patient Safety.

Q73 **Chair:** Can I start by asking PHSO to answer the first question, which is what the scale of the problem is from her report?

Dame Julie Mellor: Actually, this is from the NAO Report because ours were illustrations of poor practice that had people going through horrendous ordeals. This is actually the baseline. It is the growth. It was just to rehearse the growth of the problem with the official data showing the 31% increase in bed days taken up by patients with a delayed transfer in acute hospitals, one of the main drivers being the increase in days spent waiting either for a home care package—the number of days had doubled from 89,000 to 182,000—or waiting for a nursing home placement or availability, which increased by 63%. We were conceptualising unsafe discharge and delayed discharge, two sides of the same coin. On the unsafe discharge side, 26% of people felt they were discharged early. As I am sure you know, the NHS has seen a 6% increase in complaints about unsafe discharge.

Q74 **Chair:** What more information do you need to convince yourself that this is a chronic problem across the NHS, Minister?

Ben Gummer: Mr Jenkin, just before we start off, I do not know, this might be the last opportunity that we are here with Dame Julie. May I put on the record my thanks to her for her public service in this role, which has helped me a great deal?

Chair: We expect her to be around for a bit yet, but it is very generous of you to say that.

Ben Gummer: I hope so.

Dame Julie Mellor: Thank you.

Q75 **Chair:** I am grateful for the report, which highlights some appalling instances in delayed transfers of care, but it is the tip of an iceberg, is it not?

Ben Gummer: They are not typical but they are certainly representative of a significant but minority proportion of DTOCs, which should not be happening. This has been a feature of the system for many years. That is no excuse. It should be getting better and I hope you will hear in the next hour or so how we intend to do that.

Q76 **Mrs Gillan:** What assessment, Minister, have you made of the root causes of the three areas we are talking about—delayed discharge, premature discharge and unsafe discharge where relatives and carers have not been adequately consulted and involved? What assessment have you made of what causes this in those three instances?

Ben Gummer: The figures that Dame Julie has given accord closely with what the system in various ways believes to be true, which is that there is a proportion, although it is a minority proportion, which is due to the problems that is due to problems in the integration between social care and the NHS, the unavailability of social care packages or domiciliary care.

What is striking in the figures—this is something that makes the problem more inexcusable than it would otherwise be—is the simple failure to join up systems to make timely assessment and for the NHS to get its administration in order. From my point of view, the easiest way to attack this problem—certainly the quickest one—is to make that co-ordination better. That will provide us with a quicker reduction in delayed transfers of care.

Q77 **Mrs Gillan:** That is well and good, but what about not talking to relatives and carers? That does not seem to be a system failure; that seems to be a failure in the education or capabilities of the staff caring for the patient or who are involved in the transfer. You have not covered that.

Ben Gummer: The vast majority of people, as far as we can see from the Inpatient Survey, have a good experience in their discharge, but there is still a significant minority who do not. We are seeing marginal improvements in the quality of discharge from the Inpatient Survey but there is still more to do. It goes to the heart of care within the NHS,

which we have talked about in this Committee before. It is going to be a cultural change over several years. It is not something I can change by edict from the Department.

Q78 **Mrs Gillan:** It is just that you are saying it is improving, from the Inpatient Survey, but we have had evidence in this session, from the first session, that it is a growing problem. I go back to what data you are relying on and whether you are satisfied that you are getting the right data on this. If the people dealing with the patients on the ground, the organisations that we heard from in the first session, are to be believed, this is a growing problem, not a diminishing problem.

Ben Gummer: Sorry, there are two separate statistical sets that we are using here. The Inpatient Survey, which measures the experience the patients have, shows very marginal improvements in the quality of people's reported patient experience but it is true that there is also a growing number of people who are experiencing delayed transfers of care, most prevalently because of the unavailability of care packages.

Q79 **Mrs Gillan:** You are saying that the primary reason is the disconnect between the social care system and the health system?

Ben Gummer: Yes, that is the overall reason. The larger proportion of the cause for delayed transfer of care is the disconnect, administrative failure and the inability of hospitals and their partners to co-ordinate care. The minority is the unavailability of care packages but that element is growing.

Q80 **Mrs Gillan:** Would the rest of the panel like to reflect on that question about the root causes for delayed and premature discharges?

William Vineall: The figures we have, to break it down a bit and put it into context, are that as of April this year there were about 168,000 delayed discharges. That is in the context of about 40,000 who are discharged every day from the NHS. That is about four days' worth of discharge, roughly, so about half a week's worth.

Q81 **Mrs Gillan:** It is still 168,000 people.

William Vineall: I know. I completely agree.

Q82 **Mrs Gillan:** That is a large number of people.

William Vineall: In the breakdown, as the Minister says, the predominant one is care packages in own home, domiciliary care, but in similar proportions are further NHS care and completion of assessment, and then nursing/residential home places, patient and family choice, and then a mix of things that are others. When you break that down on the figures, it is about 60% NHS, 30% social care and 7% to 10% both.

We have trend data since 2010, when we started collecting on delayed transfers of care, and for non-acute on the NHS side it has been pretty well consistent at about 55,000. It went down a bit and has come back to

that. The change has been on the acute side, where it went up from about 55,000 to 80,000 between 2010 and 2014, and then from 80,000 to 110,000 in the last two years. In a sense, that it is why we are here today. That is just the context.

Q83 **Mrs Gillan:** Ms Mitchell, obviously the Minister and Mr Vineall have made comments about this disconnect. Would you like to comment on that?

Sarah Mitchell: I would like to comment firstly on the availability of care packages. That is a very real problem. It is particularly in some parts of the country rather than others and it is where, in a low-wage economy, there is full employment. People choosing between different types of job in retail or tourism, or whether they want to go into domiciliary care or residential and nursing home care, are choosing not to go into the care industries. That is a real issue.

We can see some patterns. In the south, west from Hampshire down to Cornwall, in the Midlands around the Nottinghamshire/Lincolnshire area and in the north in Cumbria and Yorkshire, there is this direct correlation between a high number of delayed discharges and the care packages.

For local government, colleagues and previous speakers from the voluntary sector as well have identified the pressure in social care. It is absolutely real. We appreciate the 2% precept that was allowed but in many places, that has not even allowed people to pay the living wage. There is still a £1 million gap in a number of authorities who have invested all of it in social care.

That affects the support when people are discharged but it also affects the support to keep people at home. I would echo the comment about the investment in community health services. Nine per cent of the NHS budget goes into community health. If you are going to keep somebody at home, as a social worker many years ago you were absolutely with your GP, your district nurse and your social worker. That is what the integrated local working was that kept older people in the community. We have seen a reduction in the availability of district nurses to support social workers in doing that. That was highlighted in a number of reports. It is about investment in social care but it is also about investment in community healthcare.

The last point, in terms of why there is such a problem in the funding of social care and why we need the change to happen now, is that local government and social care have made the equivalent of £5 billion of saving over the last five years. It is not that we are being profligate with the money that is available. We are working hard to be as efficient as possible. We welcome the Better Care Fund. What would really help now to change this situation is the £700 million that is further down the road in the Better Care Fund coming upfront now to get some of those integrated care systems off the ground.

Q84 **Mrs Gillan:** Ms Cummings, particularly when looking at the assessment

of the causes of premature or delayed discharge or unsafe discharge, you have heard a lot of criticism that is falling on the fact that people do not consult relatives and carers often enough. Would you like to comment on that? Do you think that that is a failure among professional staff?

Jane Cummings: It is completely unacceptable. One of the fundamental things you have to do as a clinical professional, whether you are a doctor, nurse or allied health professional, is not only communicate with your patients but also families and carers. Certainly the stories that were in the PHSO report make for incredibly distressing reading.

I spend a considerable amount of my time out in the system working with staff in hospitals and with student nurses at universities. Communication is one of the significant priorities that people talk about all of the time, but there are clearly individual cases where that is not happening. If you ask any clinical professional—you had both Janet and Mark Porter at the last session—they will agree that this is not right.

The key issue for us is to highlight when that happens and for organisations, hospitals and communities to pick up any complaint or any issue where somebody flags a lack of communication, to talk about it, learn from it and highlight what has gone wrong so people can start to put changes in place. Fundamentally, we cannot accept poor communication as being a contributing factor to poor discharge.

Q85 **Mrs Gillan:** That leads me neatly into my next question, which hopefully, Dr Durkin, you might be able to pick up as well. How do you expect hospitals to learn from each case of unsafe discharge and the patterns of unsafe discharge?

Dr Durkin: We expect it fundamentally as an issue of creating a very different culture across the NHS in terms of learning, in terms of understanding causality and in terms of spending time listening to each other. As you know from your other experiences, variation is the biggest issue for us—variation in process and variation therefore in outcome. We have variable approaches to care and packages in hospitals between beds, we have them between wards and we have them between hospitals, and that ultimately drives a difference in outcomes for us.

Donabedian, who is an educator and a clear individual who did the early work on checklists before Atul Gawande, talked about structure and process improving outcomes. That is absolutely key. He also talked about the ethical behaviours of the individuals within the system, which was a key driver for success of that system. At a very low level, in terms of the root cause of some of the issues that we see in Dame Julie's report, it is because there is a breakdown in the ethical responsibilities of the individuals.

Everything we try to do as a system is to let that local conversation thrive, the treasured opportunity that a clinician, whatever their tribe and hue, has with a patient, so that conversation takes place. Listening is part

of that conversation as well as communication. A key element for us is how we as a national system, a countrywide system, create that opportunity for local systems for thrive.

We have examples of that starting to happen. In the evidence pack we gave you, we had done a National Patient Safety Alert on communication at the discharge process. That was on the basis of a review that we did in 2013 of the 14,000 references to discharge that we had picked up in the National Reporting and Learning System. This is a confidential reporting system by the staff of the NHS. It is the staff concerned about issues and they report confidentially to that.

Of those reports, 14,000 mentioned discharge. We reviewed those and 10,000 of them were specifically about discharge. Of those, 96% were on the basis that there was a concern about a delay in medication or a delay in the process but signalled that there was low or no harm to the patient in that process. However, 4% signalled moderate to severe harm or even death. Of that 4%, 300 or so have been extensively reviewed. This chimes with the proportionality the PHSO has identified.

Out of that, we issued an alert and on that alert we asked the system to come up with a number of key elements—this was in August 2014—first of all to nominate an individual who is responsible for discharging and the process within the hospital, and also to identify good practice in that local hospital and how that good practice could be shared.

Since then, we have had 260 responses from hospitals and we have had over 300 from GPs in community settings. Through that, we have created a set of case histories and case studies that are now being shared on the NHS Improvement website and also through academic health science networks. I may come on to the collaborative process about learning and sharing that learning later on.

Q86 **Mrs Gillan:** Are you able to assess how many people have accessed that information on your websites?

Dr Durkin: We should be able to but I do not have the answer with me.

Q87 **Mrs Gillan:** I would be interested because in conversations this Committee has with you and others it always seems to come back to sharing best practice. That seems to be a common theme.

Just coming back to the Minister, are there some policy implications there? Are there some areas that you are looking at? It still seems to be, whether it is sepsis or the other areas, we always come back to the fact that there are pockets of good practice but it does not get spread through the whole system.

Ben Gummer: The primary focus of the Department at the moment is how to create a learning organisation, "The world's largest learning organisation", as the Secretary of State rightly calls it. That requires deep culture change. Part of that has been learning from the recommendations

of this Committee, creating safe spaces, giving people the ability to speak up when they see things have gone wrong and own up to their own failures and mistakes, and creating a culture of learning and not of blame. It is going to take a while. The good news in a sense is that despite the enormous pressures on the service, which are more significant with every week, patient satisfaction continues to remain high and in some cases improve. That is not to say that we do not have a huge distance to travel. We do.

Q88 **Mr Jones:** We have heard from this and the previous panel about the shortage of community nurses. The Royal College of Physicians identified a shortage of consultants as impacting upon the ability of doctors to effect satisfactory discharges of patients. To what extent would you say that poor discharge is due to problems with staff shortages?

Sarah Mitchell: It is putting pressure on staff. We have heard a lot about the issues of communication. If you are going to communicate well with families and patients, you need time to do that. When staff in wards and in the community are feeling pressured for time because of the number of people that they have to see, the deadlines and the targets that they have to make, then they are going to cut corners. Where you cut corners is in talking to people, unfortunately.

When you look at the examples of what happened in the report, there is no nurse, doctor or social worker working in the system at the moment who would think it was right to send someone home in the circumstances of some of those cases, late at night or without care. There is something about the pressure and the frustration that they are feeling in the system at the moment. That is about how we support them and that is about the culture and the leadership because it is the responsibility of us as leaders to make sure that they do not feel that. There is something about adequate workforce planning. We are doing it increasingly together to ensure that the NHS and local government have a sufficient workforce.

There is a place where there is accountability for this and for poor discharges, and that is the Safeguarding Adults Board. The Care Act made that a legal entity when it was introduced and it is the joint responsibility of the NHS, local government and the police. The accountability does sit with that board and they are working with the quality surveillance groups that CCGs co-ordinate, able to look at the examples of poor practice—Healthwatch are very good at making the board aware of that—and look at the trends and the learning that comes from that. There is a place where accountability, both for the inadequacy of the workforce and the performance, exists already.

William Vineall: Can I take a cut of the question that you asked? It is maybe not so much in numbers of people but pressure on hospitals and whether there is some better demand management that means you can keep some people from going into hospital or coming out faster to reduce the pressure.

There are a number of things, some of which you will have heard from the previous speakers. Some of the things, to give you examples of how you can perhaps reduce the pressure on the current numbers of staff, are continuing healthcare and probably not doing assessments in an acute setting. You do it when the person has stabilised. There has been some work through the GP Forward View and the GP Access Fund on extended opening times, which reduces the number of people coming into hospitals. Then there are some other smaller-scale but quite important things like fire and rescue visits and putting in grab rails for older people. NHSE has some healthy ageing guidance and the electronic frailty index.

There are lots of different things but one of the ways of reducing pressure on the hospital is to make discharge more effective and to reduce the number of people coming in. In that example I gave you from the GP Access Fund, the extended opening time, when they did an evaluation of that, they found there was a 15% reduction in A&E attendances where they had put that in place compared with 7% elsewhere. You can do a lot of smaller things that preclude some of the people coming into hospital who may not need it.

Q89 **Mr Jones:** Is it the case that notwithstanding these initiatives, staff shortages remain a problem?

Ben Gummer: It would be the wrong conclusion to come to that this could be fixed by changing staff profiles or the numbers in the workforce. The reason for that is there are some parts of the country where discharge is being managed very effectively and they are under the same pressures as other parts of the country where they are not being managed properly. To try to address this purely through staffing would be to miss the point because you would end up with more staff still poorly arranged and not efficiently organised and you would still end up with discharges not being done properly.

The key here is to make sure that staff time is being used properly, that they have full access to proper digital capabilities, that they are not having to duplicate work all the time and that they can therefore spend their time talking to patients and their families, as other speakers have correctly said.

Q90 **Mr Jones:** In your written evidence to the Committee you did acknowledge that there was, for example, a shortage of nurses, and you described what Health Education England was doing to address this. Presumable the issue of the shortage of consultants identified by the Royal College of Physicians is a matter that concerns you too. What is being done to address these shortages?

Ben Gummer: I do not think I said there was a shortage of nurses across the system. We have more nurses and more people in the NHS than ever before. There are of course localised shortages that we are not yet good enough about addressing. The reforms that I have introduced around apprenticeships, around nursing associates, around diversifying

the skill mix of the workforce and around nursing bursaries are all designed to try to increase the workforce, to increase the availability and the skill mix available to hospitals. Those are the big reforms that we are undertaking to give especially some parts of the country that traditionally had problems in trying to recruit nurses the ability to change their workforce.

Q91 **Mr Jones:** What about the shortage of consultants that was identified by the Royal College of Physicians?

Ben Gummer: Again, we have more consultants in the NHS than at any time in its history. Are they being used properly in all hospitals? No. I point to the same conclusion. I am sorry; it is a boring and rather binary one. There are some parts of the country where consultants are used very effectively and discharges are done effectively. There are some where they are not. That is what we need to change, that variation across the system, which is my work day in, day out.

Jane Cummings: May I add to what the Minister has said? Yes, there are some parts of the country where there are some shortages. We know that. However, one very important thing is that the staff we do have are used and are able to do the work that they have been trained to do. For example, reducing the number of part-time or temporary staff, agency staff, is a really good way. Having people who are permanent members of staff working in teams has a much better outcome in terms of patient care, patient experience and staff experience. Some of the work we are doing across England at the moment is trying to reduce the number of agency staff and bring those staff back into permanent roles, but flexible roles that suit their individual lifestyle. That is really important.

The second one is, as the Minister said, talking about using technology effectively. I can give you a couple of good examples. I spoke to some community nurses in Bristol. They implemented new handheld technology that saved every single community nurse an hour a day in time. Similarly, in Imperial College London they have put in systems where they use electronic recording of patient observations. That has saved over an hour and a half a day for members of staff. That time can then be spent with patients, communicating better, managing the things that registered nurses are there to do and support staff are there to do, and delivering the roles that they are trained to do, rather than wasting time. That for us has to be a key priority, rather than just saying, "We need more".

Q92 **Chair:** This is a really important point that is coming out. You are right to throw this out, Minister, and Jane Cummings. The idea is that shortage of resources therefore gives permission for people to provide unsafe discharges because they do not have enough hands or brains. All it means is that if you do not have enough resources, you just have to do things differently. It is not an excuse for abdicating your responsibilities. That is a very clear message you are sending out and I very much welcome that. Dr Durkin?

Dr Durkin: On that, I mentioned to the panel this work we did in analysing the reports from the NRLS. It is interesting. The staff of the NHS report 1.8 million times a year about the NHS on this confidential system, so they are not shy in saying when things are not quite right. A large number report issues around staffing.

In drilling down into this particular cohort, though, related to discharge, that was not raised as an issue within the discharge process. Staffing in itself was not. What they did comment on were clear issues about failure to communicate with the family and between staff teams, clearly about unexpected deterioration, not assessing someone properly before they left, and about medication errors. Staffing did not come through from that particular cohort, which is an interesting reflection.

Q93 **Chair:** While we are on the question of resources, may I jump ahead to the question of, first of all, current funding settlements for the NHS and for local authorities? What work is being done to make funding for health and social care more joined up? I know we have the Better Care Fund but it is clearly a bridge between two separate and independent budgets that are meant to provide a seamless service. It was described by PHSO in an earlier session as almost a deliberate act of political maladministration to put two separate funding lines in place, under two different command chains, that are designed to provide a seamless service. What is the solution to this?

Ben Gummer: Shall I give an overview? I know that others will then want to contribute their perspective. The whole focus of the increased amount of money that we are putting into the NHS—£10 billion over this Parliament, into adult social care £3.5 billion—is to make sure that that money is available to an increasingly integrated service, as the Prime Minister has made clear, a service that he wishes to see integrated by the end of this Parliament.

The two ways of doing that are to ensure that, first of all, the money available through the Better Care Fund is for an integrated system. That is the purpose of the fund. Secondly, it is through the STPs, the mechanism by which the local area money is being spent. In our respective constituencies, the money being spent by the NHS over the next five years is being designed by social care and NHS systems together. It will be governed by NHS and social care systems together. That is the whole purpose of what Simon Stevens is doing to enable the NHS and social care systems to integrate through that period.

Q94 **Chair:** Particularly, the LGA has highlighted that of the £1.5 billion by 2019/2020 for the Better Care Fund, £800 million is dependent on the New Homes Bonus. What will happen if the money does not come from the New Homes Bonus?

Ben Gummer: It is predicated on a fairly conservative estimate of the New Homes Bonus. The new Prime Minister has committed herself to increasing the number of homes being built in this country.

Q95 **Chair:** It is a daft way of predicating funding for such an underlying, fundamental public service.

Ben Gummer: All of the funding for all Government budgets is predicated on the economy achieving trend rates of growth, as outlined by the Office for Budget Responsibility.

Q96 **Chair:** We do not have hypothecated funding for different bits of the health service. Why for this?

Ben Gummer: You will have to direct that to the Chancellor.

Q97 **Chair:** It beggars belief.

Ben Gummer: I do not think it does.

Q98 **Chair:** If the Chancellor wants a local authority to build new homes there are ways of doing that, but this is about people's wellbeing.

Ben Gummer: It is an entirely reasonable way of encouraging local councils both to build new homes, which are needed, but also to invest in the infrastructure and part of that is social care funding, which needs to come with new homes. I think it is an entirely reasonable policy objective.

Q99 **Chair:** What about the way the money has been back-loaded in 2016-17? Only £105 million is being put in. Sorry, no additional funding for 2016-17, and only £105 million for 2017-18.

Ben Gummer: The Better Care Fund has been growing through the period of its existence and we have the adult social care precept, which is to release significant new funds into the social care system. I do not think anyone is pretending that the system is not running hot at the moment, but the money will grow over the next five years and we will hopefully be putting that money into a reformed system that will be spending it much better than it is at the moment. My problem at the moment is that a significant amount of the money is wasted precisely because of these delayed transfers of care that you are investigating.

Q100 **Chair:** We heard through the PAC that Northumbria Healthcare NHS Foundation Trust is reaching 0% delayed transfer of care days and is clearly a success story. Why can they do it so well? What do they have to teach the rest of the health service?

Dr Durkin: We are obviously very close to Northumbria. As you probably see from that PAC Report, there are a lot of good examples of integrated practice within Northumbria. That took time. It took the previous Chief Executive, Jim Mackey, a number of years to put in place the building blocks to have a consistent relationship between the organisations across that part of England, and I think that is starting to bear fruit now, but that was not overnight.

Q101 **Chair:** What are you doing in NHS Improvement to say, "Let's do a study of this. What are the key lessons to learn? Here is the template that

everybody else should be able to learn from"?

Dr Durkin: We have a number of factors here. We have an emergency care improvement programme, which is absolutely looking at the discharge processes around which systems will improve, and we are looking at 27 sites across the most challenged areas. That will be rolled out further to look at how we can improve the whole process of care in that.

We are also investing heavily into safety collaboratives within which nine of the current 15—it will soon be 15 of the 15 collaboratives across England—will be looking at safe mechanisms for discharge and the use of appropriate learning tools that have come from Northumbria.

I would also like to talk about East Lancashire, which has some fantastic tools on checklists, using a checklist at every single stage, electronic as well as on paper. Mid-Nottingham has done some really stunning work on that, and so has Leicester. We are not short of good practices and the challenges, as the Minister has said and that you have recognised on the panel, is disseminating that quickly.

Q102 **Chair:** It is about the people, isn't it?

Dr Durkin: Yes, absolutely.

Q103 **Chair:** So what are the programmes that you are rolling out that are going to get people into classrooms? Very complicated things can seem impossible if you do not know how to do them and you have not had any practice. When you finally meet somebody who knows how to do it and has had some practice everything gets much easier. So what things are you doing to get people into classrooms to have people in front of those other people explaining, "This is how you do it"?

Dr Durkin: We have a number of different initiatives on this, all looking at different elements but on the same principle that you have to learn together and you have to share together. That is on the basis of developing a whole quality improvement agenda for all aspects of healthcare, of which the most important are when people are at risk. That is both in terms of handovers and transitions of care—

Q104 **Chair:** There is a very strong sense at the moment that every hospital is trying to reinvent its own wheel on safe discharge. Where is this being turned into a central programme of proper dissemination of learning?

Dr Durkin: We currently have one programme looking at nine of the patient safety collaboratives, so that is covering a population of about 35 million and the systems within those clusters. That is probably a little bit more than just one little individual site.

William Vineall: On the point you were driving at about standardisation and getting people to work to templates if things are well known, one of the reasons why we established a discharge programme board at the start of this year was to try to identify the places where there was a need

for some kind of guidance where people would then do things consistently. That is leaving aside the fact that there are always going to be slightly different service level solutions, according to the different parts of the country you are in. So we have tried to issue some pieces of guidance, work with the LGA desk, NHSI and HSE to try to standardise processes where possible.

To give you a couple of examples, patient choice on leaving hospital, people were confused about the rights of the patient and their responsibilities as well, so some joint guidance went out, quite slim, quite effective, badged up by all the organisations, which has been well received. We have given out messages using CQC assessment processes without relying on other people's assessment when somebody comes back into a care home, so you only have to do an assessment once, and we are currently doing some similar kind of work to get people to understand the point about continuing healthcare that needs to be done outside the hospital.

There are various other examples but that board was set up to try to iron out problems where a single consistent approach can work well.

Sarah Mitchell: Some very quick examples. The rapid improvement events that NHS Improvement have been running—they have done some in Leeds and the north of the country and yesterday we launched one in Bristol. That is very quickly going across the country and has seen some real improvements, not only in delayed transfers but also in safe discharge. Those are being rolled out across the country.

With the Emergency Care Improvement Partnership we have done numerous master-classes across the country and produced what we call a "High Impact Change Model" for people, which people immediately built into their winter planning and their Better Care Fund delayed transfers model. There is some very real learning from last year that is being rolled out this year. We have seen some places that were really struggling last year improve this year and are starting to turn around, and Oxfordshire and Cambridgeshire are a couple of examples of that, where it takes about a year for those sorts of really embedded culture changes to happen.

Jane Cummings: To add to those points, we have the 44 sustainability transformation plans that are being developed now across the country. They are taking the learning from the vanguards that you heard people mention earlier. Some of those vanguards and the different new models of care that are being put into place are beginning to show some quite considerable improvements and some reductions in the number of people going into hospital, but also improvements in their length of stay and the ability to move people back out into their own homes in a very safe way. There are some very good examples of that across the country, which if we have got time and you want me to give you, I can.

The message there, I think, is you are making a really important point that we have got to stop reinventing the wheel and saying, "We are different here." We have to learn from those that are doing it well, and spread, and through the sustainability and transformation plans I think we have a really good opportunity to bring health and social care together, to learn from those and to implement them into the plans that are being made at the moment.

Q105 **Chair:** Can I just point out that NHS and social services are very good at having big plans, big programmes with good-sounding names and then pushing them down the system and making people talk about them? In my county, for example, they have lots of meetings and lots and lots of people come to these meetings and they spend a very long time in these meetings. They must cost a very great deal of money, but nothing gets through to what people do. For example, we have put into legislation that there are reciprocal duties to co-operate and promote integration between NHS and local authorities. All it means is they have meetings. Why is this so paralysed in so many counties and so many areas? What is lacking to make people do stuff?

Ben Gummer: It depends on the people.

Chair: It does depend on the people.

Ben Gummer: In our area, which we share, the relationship between Suffolk County Council and the acute hospitals is better than in many other areas, which is why discharges are rather more efficient there. If you go south of the border that is not the case, I am afraid, for your hospital and for your local authorities.

The question is, how do we replicate good relationships where those meetings are productive and do create good answers to what is a rising tide of admissions? That is the key behind these STPs. Of course there is a risk that some of them will turn into meetings that produce nothing. Our job over the next four years is to make sure that they do produce something, and that is what we need to be held to account for.

Q106 **Chair:** But actually people need to have fewer meetings, or they need to send fewer people to meetings, because these meetings do not improve understanding; they become an outlet for people not doing stuff. It really is as blunt as that. I can tell you that is the experience in my own area. That is why we have a so-called success regime in Essex. What is a system resilience group?

Sarah Mitchell: A system resilience group is co-ordinated by the CCG and it is the chief executives of all the local agencies. It would be the community trust, mental health trust if they are separate, local authority, and they come together to plan the—well, it used to be winter but now it is year-round.

Q107 **Chair:** It sounds like the familiar pattern of activity not getting to the people who are making the decisions and changing their behaviour and

attitude. How are you going to do that?

Sarah Mitchell: If I may just say, I think that the importance of that group, and the NAO Report identified this, the importance of that culture of leadership, is set around those systems resilience group people.

Q108 **Chair:** Who is accountable for the effectiveness?

Sarah Mitchell: The person accountable for the effectiveness is the person who is chairing, and we have been having this discussion in the development of a new A&E plan.

Q109 **Chair:** Another discussion. Another meeting, perhaps?

Sarah Mitchell: Maybe, but the culture is changing around that, to be really clear that you have the best person chairing the group rather than just the person who happens to be from an organisation.

Q110 **Chair:** Who is accountable for the effective joint working between hospitals and social services in each case? Who is accountable?

Sarah Mitchell: It would be the chief executives of the respective organisations and their respective—

Q111 **Chair:** Is that plural?

Sarah Mitchell: It would be the chief executive of the hospital and the chief executive of the council and their respective boards and the cabinet in the council.

Q112 **Chair:** So there we are. They are accountable all over the country. Why is it so ineffective?

Sarah Mitchell: I do not want to hog the responses but I think people are. The change from last year is more. I think the people are recognising the importance of this and their commitment to the STPs from the local government as well as the NHS has demonstrated that.

The real improvement has been around multidisciplinary teams working together in the hospital. Where we see this working well is where the change has happened with very senior clinicians and nurses working together.

Q113 **Chair:** What you are saying is, where people who are absolutely at the operational level say, "Look, we are going to grip this," things happen. All the meetings going on with the chief executives and the CCGs and the social services directorates are hopeless. They are not achieving anything.

Ben Gummer: It depends what the outcomes are, Mr Chair. I will give you an example of precisely—what you are saying is correct. So if you look at the problems in Staffordshire, they have deep problems of discharge and flow through the hospital, which is causing failure in the hospital and in the social care system. It is true that while there are now people at a senior level talking it is clearly not being reflected on the

ground because there is a disconnect in that organisation, because the organisation is not run properly. It is a simple deduction.

There are other parts of the country where there is a well-gripped system where management lines of accountability are strong and firm, where when an agreement is made it is passed down the line and you can have proper delegation of powers to clinicians and then it works. What we need to do is make sure we are copying where it is working and where it is not working. In essence it is incredibly simple.

Q114 **Chair:** In an organisation, and I appreciate the desire to create a learning organisation, what is the system learning about the failed leadership in this system where people have all these meetings and all these chief executives and people in offices co-ordinate with each other and are so ineffective? What is wrong with the leadership model? What analysis in NHS Improvement is being done about the failure of this leadership model? It characterises the health service. The health service is very good at meetings, much less good at outcomes.

Dr Durkin: I talked about the role and purpose of what the organisations are, and the ALBs, particularly the arm's length bodies in the health service, and everything is geared towards improving that conversation between the patients and whoever the relevant clinician is. That is still the primary purpose of what everybody does.

Q115 **Chair:** What is the key lesson to learn about the tendency to withdraw into the procedural, the summit, the meetings with 20 or 30 or 40 people who push pens at desks, sitting round a large table for hours on end? What is the lesson that we need to learn from this?

Dr Durkin: A key lesson to learn is that the needs and responsibilities of those who are working with patients and clients are understood and translated by the chief executives of organisations, so that we have the concept of the ward to the board, an absolutely seamless relationship between them, so that the chief executives and the directors of boards understand exactly what are the needs of their staff and of their patients. That is a key premise. Any meeting that takes place between organisations needs to hold really firm to why they are there and what they are doing. Those are key elements.

Q116 **Chair:** We have something called a national discharge programme. How many people at ward level know what a national discharge programme looks like or think it has any relevance to them?

Dr Durkin: I cannot answer that question.

Q117 **Chair:** Isn't this an engagement problem—that the people sitting in the meetings are disengaged from the people who are trying to deliver the service?

Dr Durkin: I would not agree with that.

Q118 **Chair:** I will put it more positively. How do we improve the engagement

between the people on the frontline and the people holding the meetings? How do we improve the engagement?

Jane Cummings: I would say it is about responding to what people need. If people on the frontline say, "These are the issues that are affecting my ability to do my job in the best way; these are the barriers that I am facing; you are our leaders, you are the directors, you are the people who are responsible ultimately; I need you to help me unblock those barriers," then the issue is to have feedback that says that. I would not expect a frontline member of staff—a nurse, a doctor—to necessarily know there is a national discharge programme board in place, but what I would expect them to say is that the information we have put out around the quick guides to improving, the checklists that we have issued them, which I know you talked about in the last session, and the fact that we have given advice and guidance in templates on how to support hot patient choice on the frontline, that is what makes a difference to them and that is how they do their job better.

Q119 **Chair:** Who is responsible for implementing the national discharge programme? *[Pause.]* Starter for 10? This is breathtaking!

William Vineall: Effectively, the Department is taking leadership in terms of putting discharge in the mandate, making it a requirement of the Better Care Fund this year—it was not an absolute requirement of the Better Care Fund last year; so we have tightened those things up—and introducing the discharge programme board to make the changes that I have outlined. By doing that there is therefore a line into both NHS England, through commissioners, and therefore to the hospitals. So there is a line of accountability. The responsibility for local delivery of care is for a trust and its board, which is why CQC holds them to account when it goes out and inspects them.

Q120 **Chair:** How are GPs engaged in the national discharge programme?

Jane Cummings: One of the things we have put into the assessment framework for 2016-17 is a clear metric that looks at the number of delays in transfers of care per 100,000 of the population. For 2016-17 we will start to measure through CCGs, and therefore through GP services, what their delays are, which will help focus both their attention and our assessment of the CCG ability to tackle that. That is a very specific piece of work that has changed for 2016-17.

Q121 **Chair:** May I suggest, Minister, that either you or NHS England needs to appoint somebody to be accountable for the NHS discharge programme.

Ben Gummer: I am accountable for it as Secretary of State.

Q122 **Chair:** But you do not run the health service. You do not run social services and you do not run the health service.

Ben Gummer: The Secretary of State is accountable for it. I think we have given a very clear answer about who is responsible at a local level. If your suggestion is that we should merge the management of social

care at a local level with the management of hospitals, then that would be a deviation from a subtle understanding of how you manage the health system.

Q123 **Chair:** I do not think it is necessary.

Ben Gummer: In some parts of the country that is precisely what is happening. There is a series of vanguards looking at that. I do not think it is helpful for the Committee or for us to design a management system when in some parts of the country the existing arrangements work very well. In next-door counties those same arrangements work very badly. It is not the structure that is at fault there but the way that leadership is being implemented. You are right to point to that. If you were to ask a question as to the quality of leadership across the NHS, it is variable. We run one of the largest organisations in the world. We do not have the quality of leadership in strength and depth that we would like and that is something that we are endeavouring to change. It is going to take a while to fix it. We make it much easier for leaders, both at a ward level and at a national level, if we provide formulae to getting things right—delayed transfers of care, for example—and that is precisely what NHS Improvement is endeavouring to do.

Q124 **Chair:** I am really pleased we have had this session because I think it has exposed that there is a very great deal of work to be done here. If I may suggest, Minister, if you have not published them already—they should be given more prominence if you have—you need to publish some benchmarks of success for the national discharge programme. Have you done so?

Ben Gummer: I do not believe we have; no.

Chair: Then we will need to measure your success against those benchmarks in six or 12 months' time.

Ben Gummer: The only successful metric is that the delayed transfers of care are reducing.

Chair: Publish your benchmarks and we will measure you against them. It seems to me that there needs to be some urgency injected into this.

Ben Gummer: There is plenty of urgency.

Chair: Are there any further questions? PHSO? No.

Thank you very much for what I hope will prove to be a very influential report from PHSO. Thank you very much to all our witnesses today. I dare say we will produce a short report on this matter with some recommendations.