

Public Accounts Committee

Oral evidence: Funding NHS Continuing Healthcare, HC 455

Wednesday 1 November 2017

Ordered by the House of Commons to be published on 1 November 2017.

Watch the meeting

Members present: Meg Hillier (Chair); Bim Afolami; Geoffrey Clifton-Brown; Chris Evans; Andrew Jones; Gillian Keegan; Shabana Mahmood; Nigel Mills; Layla Moran; Bridget Phillipson; Gareth Snell.

Robert White, Director, National Audit Office, Jenny George, Director, NAO, Adrian Jenner, Director of Parliamentary Relations, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-113

Witnesses

I: Matina Loizou, Chair, Continuing Healthcare Alliance, Brian O'Shea, Continuing Healthcare Adviser, Spinal Injuries Association, Dan Harbour, Managing Director, Beacon, and Elise Hoadley, Hospice Director, Sue Ryder.

II: Sir Chris Wormald, Permanent Secretary, Department of Health, Simon Stevens, Chief Executive, NHS England, Jane Cummings, Chief Nursing Officer, NHS England, and Jonathan Marron, Director General Community Care, Department of Health.

Report by the Comptroller and Auditor General
Investigation into NHS Continuing Healthcare Funding (HC 239)

Examination of witnesses

Witnesses: Matina Loizou, Brian O'Shea, Dan Harbour and Elise Hoadley.

Q1 **Chair:** Good afternoon everyone, and welcome to the Public Accounts Committee on Wednesday 1 November 2017. We are here today to look at the Department of Health continuing healthcare funding and how that is implemented, after the investigation by the National Audit Office. Before I introduce the witnesses for the first panel—we have two panels today—I am delighted to welcome Andrew Jones, the Exchequer Secretary, to the Committee. Mr Jones is a member of the Committee and would like to say a few words.

Andrew Jones: Thank you very much indeed. I am an ex officio member of the PAC. I know the Committee has a long tradition of proactively challenging Government Departments and projects effectively and efficiently, and of looking at how they spend taxpayers' money.

As a Treasury Minister, that seems to me an extremely worthwhile and shared objective. We share that critical scrutiny role of the Government and their performance, not just the inputs in terms of budget but the outputs secured for the money.

I fully endorse the good work of the Comptroller and Auditor General and the National Audit Office in assisting the Committee in its work. Both the Treasury and the Committee share a common goal: to ensure that the taxpayer's money is spent well and that quality outcomes are achieved that benefit our country.

There is a general public mood for greater transparency in our political decision making and in how public money is spent. I think the role of this Committee is therefore one of the most important in all of Parliament. It has a crucial role in holding the Executive to account.

I have read the Chair's Second Annual Report of the Session 2016-17, which was published in July, where the Chair raised concerns and cross-cutting issues of how Government works—for example, the lack of key data on measurement performance and concerns about capacity, skills and project management skills particularly within the civil service.

I fully agree with the underlying thought that proper and full accountability to Parliament must be maintained and should be, wherever possible, enhanced.

Looking at the Treasury minutes, which I see within the Department, I am impressed that on average over 90% of the Committee's recommendations are agreed and implemented by the Government. That seems to me proof that the Committee is effective and is making its mark on how our public services are delivered.

I assure the Committee that the Government will always endeavour to deliver fully on the Committee's recommendations. I agree with the Committee that important issues should not just be treated with lip service. This is an important Government commitment that has been a part of performance in the past and will be a part of performance in the future.

Treasury officials will continue to challenge progress in spending discussions, as they liaise with other Government Departments, again with a view to implementing the Committee's recommendations.

I think the way the Committee holds Departments to account on delivering its recommendations, and the reporting twice a year through the Treasury minutes progress reports, is an important way to deliver some of the transparency and accountability that we are talking about. The serious nature of the recommendations will be followed through and reported back in a timely manner.

I have just a couple more points. I recognise the important work of the Committee Clerks and staff in ensuring that the Committee's business is taken forward effectively. I know the Treasury Officer of Accounts team, as a central point of contact in Government, will continue to maintain closely this good working relationship and will work with all accounting officers across other Government Departments to ensure that they are prepared to assist the Committee helpfully and meaningfully in its hearings and recommendations. The team also works with Departments to ensure that the Treasury minutes and responses are concise, fit for purpose and meet parliamentary timetables.

As an ex officio member, I will continue to follow the work and the recommendations of the Committee. I will obviously be reading your reports and, as well as that, I will endeavour to maintain that essential and long-standing relationship between the Treasury and the Committee. My point is that there have been good, positive working relationships, recognising the value added and following through on the recommendations to improve our public services. That seems to me to be a very positive thing as a shared endeavour and it will continue while I have any means of influencing it to continue. I wish the Committee all success with its good work today and in the future.

Q2 Chair: Thank you very much, Minister. We very much appreciate your visit and the affirmation that the Treasury supports the work of the Committee in ensuring the efficiency and effectiveness of the spending of the taxpayer's money.

That brings me to introduce the first panel for today's hearing. We have



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Brian O'Shea, continuing healthcare adviser at the Spinal Injuries Association—welcome, Mr O'Shea—Matina Loizou, chair of the Continuing Healthcare Alliance, an alliance of various organisations with an interest in this area; Dan Harbour, managing director of Beacon; and Elise Hoadley, hospice director at the Sue Ryder Leckhampton Court hospice. A very warm welcome to you. We expect this part of the session to last about half an hour, so could I urge you to keep your answers to the point? We have seen your evidence, so thanks to those of you who sent it in. I am going to ask Chris Evans to start the questioning. Thank you very much, Minister.

Q3 Chris Evans: Good afternoon. This question is to all members of the panel. I want to begin by asking what your experience is of the continuing healthcare process in England, starting with Mr O'Shea.

Brian O'Shea: I took the advantage of circulating some slides ahead of the meeting that hopefully you have had a chance to look at. My reason for doing that was that I wanted to give you some sort of visual representation of the complexity that is built into the continuing healthcare system. I am talking about the fact that responsibility for continuing healthcare is spread over, effectively, three areas of the NHS and there are a number of workstreams—anything up to half a dozen or so workstreams—across the three areas. My experience of continuing healthcare is of an extremely complicated system where the individual who is going through the assessment process finds it incredibly difficult to navigate their way through the process and to understand where they are in the process, where they are going in the process, what the purpose of the assessment process is and how the assessment process works. Certainly a lot of the work that we do at the Spinal Injuries Association is simply about explaining to people how the process works. There seems to be a real lack of ability to communicate in very simple terms to the individual what the purpose of the continuing healthcare assessment is and what the consequences of the outcome of the continuing healthcare assessment are.

What is really important to understand from my perspective is that there are essentially two elements to continuing healthcare. There is a guidance element, which is incorporated and encapsulated in the "National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care" of 2012. That document effectively is the statutory guidance that underpins the delivery of continuing healthcare, and in and of itself I don't think that that document is fundamentally flawed. It is flawed mostly by the fact that it omits to give guidance in a number of really important areas, particularly around the resolution of disputes between individuals and CCGs when it comes to eligibility decisions and, very importantly—hopefully we will have a chance to cover this a little bit later—around the area of commissioning and what commissioning responsibilities the CCG has once the individual is found to be eligible for continuing healthcare.

By and large, that framework and the statutory guidance are not fundamentally flawed. However, the process of deciding eligibility is done by using the assessment tools, which are essentially the checklist



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screening tool, the decision support tool and the fast-track pathway tool, and those three documents—in particular, in our experience, the decision support tool—are open to such a wide range of variations and interpretations that I believe that that is where the vast majority of the variability across CCGs, in terms of both the rates of eligibility for continuing healthcare and the levels of support that are offered to individuals across CCGs, arises. I believe that the vast majority of that variation arises from the structure, the make-up, and therefore the interpretation and the application of the assessment tools. I think that they are unclear and, if I can go so far as to say this, I actually think that they are not fit for purpose.

- Q4 **Chris Evans:** Could I put the same question to Ms Loizou? How has the experience been for your members in particular?

Matina Loizou: I should start by saying that this system is supposed to be in place for some of the most vulnerable—

Chair: Sorry, I don't want to cut you short, but we have seen your extensive evidence, which was really helpful. We do not need to describe what we are looking at today, because we all know that. If you could answer the question, because we have a lot of people to get through—

- Q5 **Chris Evans:** Chair, perhaps it would help if I targeted the question a bit more. I recently met the Motor Neurone Disease Association, and they had an Improving MND Care survey in which 30% of the people who answered were receiving continuing healthcare funding and 33% said that they did not know what it was. Have you found the same thing with your members as the MND Association have found?

Matina Loizou: Absolutely. The MNDA are part of our alliance, and our report shows that a lot of people come across NHS CHC when they are towards the end of their journey through the health and social care system. Our report shows that around 66% of people found out about it really close to the end, and even then it is by chance. They are not hearing about it through their GP; around 3% of people find out about it through their GP, so you can see that people are not being signposted to this service when it is the most appropriate thing for them.

It raises eyebrows at Parkinson's UK, for example, when we see 50 or 60 calls a quarter to the Parkinson's UK helpline. There is the severity of some of those calls as well. When people come through to us, they really are exhausted and distressed. They have been through such a complex and baffling process that by the time they get to us, they are at their wits' end. This is a big priority for us, certainly, and across the alliance as well. It is the same story for other members of the alliance.

(Correction from witness – see footnote).

- Q6 **Chris Evans:** I notice you cover some awful conditions, including Alzheimer's, dementia, MS, MND, as I have said, and spinal injuries. One of the anecdotal things that has come back to me when I have met various associations is that clinicians are not aware of the complexities of



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the several conditions that I have mentioned. Is that something you have noticed in your work—that clinicians are not aware and there needs to be more understanding of what people are going through, especially before they go through the Fast Track process?

Matina Loizou: Absolutely. Again, that is something that our report picked out. And again I think it's a similar figure: around 60% of healthcare professionals are assessing people without a very good knowledge of the conditions that they are looking at. For example, if you are looking at motor neurone disease or Parkinson's, you need to understand all the symptoms associated with that in order to make the right decision, and we are not seeing that. We are seeing healthcare professionals who need more training and more knowledge of the conditions that they are looking at and making important decisions about.

(Correction from witness – see footnote).

Q7 **Chair:** Mr O'Shea was saying that the framework is just about in the right place, but what you have said, Ms Loizou, and what he has said so far—perhaps we will ask the other witnesses as well—is that the assessment tools still have problems.

Matina Loizou: Exactly. We want a radical overhaul of the assessment tools, because that is leading to some really strange, different decisions and a lot of variation across the country.

Q8 **Chair:** On just that point, Mr Harbour, is that your experience at Beacon as well?

Dan Harbour: Yes, entirely. Absolutely—

Chair: Yes is fine for now. Ms Hoadley?

Elise Hoadley: My experience is slightly different, because I speak on behalf of Fast Track continuing healthcare funding.

Chair: Perhaps we will come to that in a moment. We will now go back to Mr Evans and then Ms Phillipson wants to come in.

Q9 **Chris Evans:** Mr Harbour, you are based in Oxfordshire. As I was doing some research into this, I was looking at an example of good practice, and actually Oxfordshire's delegated healthcare task referral policy is an example of good practice in terms of meeting specific health-related care needs. Do you find that, in your experience?

Dan Harbour: Sorry, I missed the middle part of that.

Chris Evans: I just said that it is a different way of delivering continuing healthcare, which is far better than in other CCGs. I was wondering if that is something that you have seen in your day-to-day work; and what does Oxfordshire do specifically better than anybody else?

Dan Harbour: We worked with Oxfordshire primary care trust when we started out and, latterly, the clinical commissioning group, for about 14 years now. We took 8,500 calls from families across England in the last 12



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months. One of the things that I think makes Oxfordshire stand out among a lot of other CCGs for whom we have experience of attending assessments and of advocating for these families, is the approach to multidisciplinary assessment. To a degree, that comes back to what Brian was talking about a few minutes ago.

The national framework is clear that the multidisciplinary team in the context of continuing healthcare should be one health professional and one social care professional, or two health professionals from different backgrounds. I shall not go into detail but just give you the illustration. However, it goes into a great deal of guidance about the importance of the MDT being comprised of health and social care professionals who are actively involved in the delivery of care and knowledgeable about that particular individual's care needs, with one assessment process: discussing the care needs, completing the assessment, filling out the toolkits, then coming together to make a genuine and meaningful recommendation about whether that person is eligible for continuing healthcare or not—whether they have a primary health need, and the criteria.

What we tend to experience in most areas of the country, in a lot of the assessments we attend, is the minimally constituted multidisciplinary team—a nurse assessor and a social worker who have never met the individual before. Not only are they not specialists in their field but they do not even have familiarity with the individual's care needs before starting the assessment process. We often see that those informed health and social care professionals who are familiar with the individual's needs are cut out of the process. That is entirely against the best practice guidance in the national framework and related guidance.

What Oxfordshire on the whole does is to make sure that they identify the correct multidisciplinary team—it is not just minimum constitution. They are involving doctors, nurses, carers, OTs, physios and so on who have direct recent experience of looking after the individual, and they are fully involved in the entire assessment. It is not dominated by one person, by one individual, so it is a much more detailed and much more informed and personalised assessment. We tend to find that more often than not the correct outcome will be reached for that reason.

- Q10 Chris Evans:** Some of the things said about Oxfordshire is that they are quicker and flexible, as you said, and they also use a shared care team. My question is quite simple: if this is working so well in Oxfordshire, why isn't it being rolled out across the country?

Dan Harbour: That is one of my questions, and it is a question we have been asking for some time through the stakeholder group. There are pockets of very good practice. Oxfordshire certainly has its challenges as well, but they do MDT assessment well. Their assessments—their decision support tools—are very detailed; that is good. Why are we not identifying and picking up those areas of good practice? The approach to local resolution—the first part of the appeal process—is another area of good practice for Oxfordshire, and certain other CCGs I could mention. Why is that not being identified, picked up and replicated across the country?



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Q11 Bridget Phillipson: Ms Hoadley, you mentioned your organisation's experiences are different because you focus on end of life care. Could you tell us the challenges that you see there, and how that might differ from those living with other conditions?

Elise Hoadley: First, I have got information from my other six colleagues—directors of hospices in Sue Ryder; the picture across the country is varied. In some areas of the country, continuing Fast Track funding is remarkably good—patients are getting really good, timely care, and are dying in their place of choice—whereas in other areas of the country it may not be so well co-ordinated, maybe not so timely, and the patient and family experience is not as good. So, varied: when it works, it works really well.

Q12 Bridget Phillipson: And what do you seek to change, to improve that process? Are there any steps that could be taken?

Elise Hoadley: I think it would be good if the teams could look at getting a lead—if each continuing healthcare team had a lead, and a team co-ordinated in good relationships. Where it is working well, the continuing healthcare team is linked in with the palliative care team in the county they are serving. It is a multidisciplinary approach. There is good communication and a good use of electronic record keeping, so a lot of good communication going between the teams to provide the care.

Q13 Chair: I am surprised to hear you say that, as though that is a great thing and not the norm. From what you say, good electronic record keeping is not the norm.

Elise Hoadley: I do not honestly know a lot of the other areas, but I know that in the areas where electronic record keeping is being shared, the patient experience is better because the patients and families do not need to keep repeating their story. Those filling in the forms with families have got the information at hand. They do not have to keep going over and over the stories.

Q14 Chair: I will quickly ask the other witnesses: is that a problem you have come across as well? A yes or no will suffice.

Brian O'Shea: I am not aware that it is used very much in the decision to support full assessments.

Q15 Chair: Is electronic record keeping something that has come up in your experience?

Matina Loizou: It has not come up.

Q16 Chair: Mr Harbour, has it come up for you?

Dan Harbour: Yes.

Q17 Chair: So good electronic record keeping makes it a lot better.

Dan Harbour: Good record keeping makes it a lot better.

Q18 Chair: Of any sort.



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Dan Harbour: Of any sort. But also attitudes towards how that information is used without arbitrary additional rules being placed on the use of evidence, which does come up.

- Q19 **Bridget Phillipson:** Moving on to a different area, I am keen to understand the impact that delays in assessments might have on patients and also on those supporting them through that process. Perhaps Mr O'Shea could begin.

Brian O'Shea: Delays in the assessment process are the difference between essential care and support being in place and not being put in place. One of the things that always confuses me, or I am always amazed at, is that continuing healthcare somehow sits apart from so many other NHS services. The example that I give is dialysis. If somebody needs dialysis to stay alive, would it be acceptable for the NHS to take 18 months or two years to come to a decision about the nature of the form of that dialysis? It wouldn't, but people who need NHS continuing healthcare need that care to stay alive. It is taking 18 months or two years sometimes to simply get a decision about whether you are going to get that care and then what that care will look like.

My carers keep me alive in exactly the same way that dialysis keeps somebody with renal problems alive. I ask you the question: would it be acceptable for family members to provide dialysis in the interim while the NHS decided whether it was appropriate to provide that and how it was going to provide that? That is essentially the position we are putting people in. We are forcing them to rely on informal care for the delivery of complex care that is the responsibility of the NHS.

The one thing I keep coming back to is that eligibility for NHS continuing healthcare is a matter of law. It is not a matter of policy and not a matter of CCG policy. It is laid down in statute. It was in the 1948 statute and it is in the Care Act 2014. It has been interpreted in the Coughlan judgment, and the wording from the Coughlan judgment has been incorporated. We hear quite a lot of talk from the NHS about benchmarking and all the rest. I find that incredibly frustrating because the primary benchmark is the case law. The primary benchmark is the law. So this is not an optional extra for the NHS, yet we are making people wait, and in the meantime they often develop health complications.

In the case of spinal cord injury, people develop pressure ulcers, they develop contractures, they lose function—any number of complications that could be easily avoided—and that ends up costing the NHS more in the long run. The health economic argument around the efficacy of timely and appropriate complex care packages is something that has simply not been looked into and simply not been factored into the arguments.

- Q20 **Bridget Phillipson:** Do any other witnesses wish to comment on the issue of delays?

Elise Hoadley: Certainly at the end of life, there is an issue. Very often there is not a delay in the release of funding; it is a delay in the provision of care bought by that funding, so the consequence ultimately is that



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patients are dying in a place that is not their choice, and the impact of that is some distressed relatives who are the survivors and who go on to maybe suffer in their bereavement because they felt they could not give their loved one the best.

Matina Loizou: Quickly to echo the points made by colleagues, people that we speak to have loved ones who have died waiting for a decision. Whereas it should be a 28-day timeframe, we are seeing people waiting up to 18 months, and up to three years in some cases. I spoke to one lady the other day whose husband had Parkinson's, and the assessor knocked on the door the day after he had passed away. She then went on to have all sorts of problems with the reassessment process, which is another kettle of fish. As you can see, the distress that this causes to people—essentially this is precious time for a lot of people towards the end of life.

(Correction from witness – see footnote).

Chair: Your evidence had some interesting examples of that.

Dan Harbour: Briefly, I agree entirely with what my colleagues have said about the distress caused by deadlines not being met. We have similar experiences of delays of up to 18 months. I just wanted to sound a note of caution about the remedy. I do not think the remedy is a hard and fast stick to say, "Assessments must always be completed within 28 days." The 28-day guidance is primarily there for the individual and the families supporting them.

What we have seen, conversely, is that CCGs are in such a hurry to complete by that deadline that the assessment ends up being quite poor quality. They cannot assemble a proper multidisciplinary team, and the evidence is not there. The framework talks about the importance of stopping the clock and going out and seeking crucial pieces of information, evidence and reports that will feed into providing a better understanding of the individual's care needs. It is crucial that we allow that to happen and do not just rush them through. At the same time, we cannot allow them to continue to go on for months on end.

Chair: One size does not quite fit all.

Q21 **Geoffrey Clifton-Brown:** Mr Harbour, I would like to ask you something as the advocate helping people to get CHC. Mr O'Shea referred to the Coughlan case, which effectively provides the legal base as to what should be provided. The Courts and Tribunals Service told us that Pamela Coughlan would likely be eligible today for CHC. Does that mean that this blurring of 100% of what should be provided under CHC is allowing the CCGs to not provide the service in some cases, because there is no clear legal base?

Dan Harbour: The answer is yes. We continue to see a great deal of variation in the application of the eligibility criteria. What we tend to experience is that there are pockets of very good practice, but where we experience very poor practice, we tend to see lots of variations in the criteria. Even in writing, assessors will tell us, "If you do not have



physically challenging behaviour, you cannot be eligible.” Conversely, others will tell us that behaviour is not a care need, so it is not a nursing need and cannot be taken into account. We hear, “If you do not have a certain score”—we understand Pamela Coughlan would never achieve the score using the current tools—“you cannot be eligible.”

We often hear that we are looking for things that the carers cannot manage. That is an illogical statement. Does that mean that for the thousands of people in care homes eligible for continuing healthcare, those care homes cannot look after them? Of course it does not mean that. We are seeing lots of different flavours as assessment teams try to grapple with what the criteria are and what the primary health test is. That ends up distorting the original intentions of the primary health needs approach, which, as Brian says, gets its authority from law and the Coughlan judgments. That results in this huge amount of variation across the country.

- Q22 **Geoffrey Clifton-Brown:** I have one other quick question that you or other witnesses may want to answer. Reading the evidence and the reports, it struck me as an insensitive part of the system, where families cannot be involved in the process—they are not involved when the assessment takes place and they are not given copies of the assessment. Do you or any of the other witnesses wish to comment on that?

Brian O'Shea: It is not only families; carers and, as Dan said, the people directly involved in an individual's care are often excluded from the process, leaving the individual effectively doing battle against the NHS, which is a behemoth. That particularly comes into play when you are appealing against a decision of ineligibility, because the resources that are thrown at the individual by the NHS and the CCG are, to me, just fundamentally unfair. You have a well-resourced CCG on the one hand, and on the other hand you have one information-poor and resource-poor individual who is attempting to answer very complex questions that, in my view, are often framed in too complex a way and almost designed to distort the issues.

- Q23 **Chair:** Mr Harbour, would you like to add anything to that?

Dan Harbour: Briefly, we have seen varying approaches to the involvement of individuals and their representatives in the process. The framework is clear that, with the exception of the discussion about the final eligibility recommendation, they should be fully involved in every other stage of the assessment process. On the whole, they are invited to and involved in assessments, but we still hear of plenty of people who are not involved in that way, and it's distressing.

Elise Hoadley: Certainly in end of life care there is mixed practice, but the six ambitions for end of life care really promote the involvement of families and putting patients at the centre.

- Q24 **Chair:** Do you think that helps in this set of circumstances?



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Elise Hoadley: To be honest, I feel I can only speak about Fast Track funding—earlier on is not within my experience, so I respect my colleagues on that.

Q25 **Chair:** But the principles of end of life care are set, as well as the framework for continuing healthcare funding, so are the palliative care rules the ones that help reform support for the Fast Track?

Elise Hoadley: Yes, I would say that they are.

Q26 **Chair:** So it is actually that extra set of rules that helps?

Elise Hoadley: It truly complements it, yes.

Q27 **Chair:** The NAO Report investigation picked up some quite concerning things about people who are not getting care in the place that they would prefer to get it. The implication is that it is a rationing process. I wonder if you have examples of people who are in an inappropriate setting because somewhere along the line, although, as Mr O'Shea highlighted, it is statutory to offer this, it is not being given in the same way. Ms Hoadley, I am sure you must have examples, if there are any, from palliative care.

Elise Hoadley: Yes, certainly. In a hospice setting, a lot of people think that people might want to die in the hospice. Some people do, but the majority don't. The majority of people would actually like to die at home, and although continuing health funding is granted, it is very often about getting the appropriate care package to get somebody home. Very often that is what hinders people.

Q28 **Chair:** Is it the practicalities or the money attached to that package?

Elise Hoadley: The practicalities of getting teams together to actually care for the person at home.

Q29 **Chair:** Mr Harbour?

Dan Harbour: Do you mind if I initially defer to Mr O'Shea?

Chair: No, that is absolutely fine.

Brian O'Shea: The short answer is yes, but it is actually a multi-layered answer, because we are seeing an increasing number of CCGs that are placing arbitrary financial caps. That is something that the Equality and Human Rights Commission is looking into in the provision of care for individuals in their preferred settings of care. There is a bit of an irony, in that these are often benchmarked against residential care settings, and yet every time you turn on the news or listen to anyone talking about residential care, all we hear about is residential care beds being shut down and a shortage of residential care beds.

I was involved in some research that the NHS did a couple of years ago that found that the primary drivers of delayed discharges from neurological specialist care centres across London was the lack of specialist residential care beds to discharge people with complex



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neurological conditions to—yet CCGs are effectively saying, “If the cost of your care goes above the cost of a residential setting bed, we will expect you to live in a residential setting.”

Typically, the profile with spinal cord injuries tends to be younger. Spinal cord injuries are a non-improving condition. When managed, you can avoid complications—people work and have families and do things like that. This is not uncommon with spinal cord injuries. There is a case in Manchester that was on “You and Yours”—I am sure you are familiar with it—of a 53-year-old running his own business. He has four children between the age of four and 14 and he runs his own business, which he has been running from his hospital bed for the last six months. He has been told that he is expected to move into a nursing home and not be allowed to go home and live with his family.

What we believe is happening is that CCGs are not actually serious about incarcerating people in nursing homes, because we don’t believe that there are enough nursing home beds available. What they are doing is using it as a tool to blackmail people into accepting unsafe levels of care and of funding to live in their own home or their preferred setting of care and relying on informal support to pick up the rest of the care.

Matina Loizou: I echo what my colleague is saying. Cost capping is a really worrying trend and is something that we are concerned about. For example, in Leicestershire we have been campaigning over the summer. We have seen a shift in policies. They are trying to bring in a settings of care policy, and we see those across England. They are moving their 25% cap over and above the cheapest possible care option down to 10%. As Brian was just saying, what that means for people is that they will have to choose between accepting an unsafe level of care and staying at home—say, for 100 hours of care a week, rather than the 168 that they have been assessed to need—or move out to a care home, regardless of whether or not that is where they want to be or if it is assessed to be the most appropriate place for them. We are seeing policies like that being bulldozed through in places like Leicestershire, without much due regard to public consultation processes. It is really worrying. These policies are already in place—for example, Brian mentioned Simcha, who is stuck in hospital while his kids are asking after him. We are going to see that across the piece.

Q30 **Chair:** We have up next the people who set the framework and are responsible for it nationally, although it is commissioned locally. Could I ask all four of you, finally, what are the two or three things that you think would make the biggest difference to the people that you are here representing today who have lived through or are living through the process of getting continuing healthcare?

Elise Hoadley: I would like to see an overall measuring of the assessment, with people being held accountable, so more targets—it sounds horrible, saying targets, doesn’t it?—or something to work for to uniform the outcomes and bring together a more robust process that is more equitable across the country. I would like to see training for the

people who are actually doing the assessments so that they do understand the diseases that they are assessing, and for the multidisciplinary team to be truly working together—social care and health care coming together to work for the patient's best interest.

Dan Harbour: The main point that I would like to get across is that we don't think that this is a matter of policy. The policy is pretty good, and the framework is quite good. I know there are a number of improvements and changes being proposed at the moment for next year's update, which on the whole we support, but this is almost exclusively about implementation and training in our opinion. We have been talking about some technical misguided assessment techniques, such as double scoring. That should not be happening—the framework clearly says it shouldn't be happening—yet the issue of double scoring tends to come up in almost every assessment we attend across the country. It is a technical issue. It should be an easy win. It should be something that is easy to disseminate from NHS England to the CCG leads through assurance—

Q31 **Chair:** This is the quality control system.

Dan Harbour: It is quality control. Our concern is that it is very well talking about training, and training is clearly required, but there are such deeply ingrained misguided ways in which the framework is applied and criteria are applied nationally, and I think it is going to be very difficult to change those things. We need to get into the mindset of changing the culture and unpicking some of that bad practice, and then introducing some really robust national training, with good-quality assurance and accountability.

Matina Loizou: My top three? First, we need to get serious about how we fund this. The demand for this service is going nowhere; we have an ageing population and we need to talk about how we are going to put a support system in place. Secondly, we need to radically overhaul the assessment tools, so I ask you to call for that. Thirdly, there is a lot to be done to make the system more user-friendly and transparent, because by the time people come to us they are exhausted by it. I think that that is the low-hanging fruit.

Q32 **Chair:** The point about exhaustion came through loud and clear in the evidence you sent. Mr O'Shea?

Brian O'Shea: I echo absolutely everything that my colleagues have said. First, there is not only the involvement of, but the due regard being given to, people with condition-specific knowledge. Assessors are, by their nature, generalists, and they need to involve those with condition-specific knowledge in the assessment process.

Secondly, simplification. When I think of continuing healthcare, I always think about how the last thing that my lecturer said to me after I studied business at university for four years was, "Business is easy; you buy cheap and sell dear." I almost think that continuing healthcare is working in the opposite direction. Continuing healthcare is simple. There is a lawful limit to the amount of healthcare that a local authority can provide. If the



health element of your care needs go beyond that, you are the responsibility of the NHS. That is a simple concept, yet there are so many layers of complication built into the system for what is effectively a simple decision—does the health element of the individual's overall care needs place them beyond the lawful authority of the local authority?

The final thing I will say is on continued reassessment. People with non-improving and deteriorating conditions are subject to regular three-monthly and then yearly reviews, which often turn into full-blown reassessments of eligibility. Nobody has ever justified the amount of resource that is put into testing somebody with a spinal cord injury once a year to see whether they have improved. The whole question of reassessment and review is often a waste of money.

- Q33 **Chair:** Interesting. There are some different overlaps with some of the PIP assessments that we have looked at as a Committee before. I thank you all very much for giving up your time. We will be moving on to the next witnesses. The uncorrected transcript will be up on the website in the next couple of days. Our report will be out in due course; I cannot give you an exact date—it will possibly be before Christmas, but we already have a few other reports to publish—but we will obviously send you a copy. We will talk to our sister Committee, the Select Committee on Health, once we have had this hearing to see how we can work together to make sure we can take forward what we have heard today. Thank you very much indeed.

Examination of witnesses

Witnesses: Sir Chris Wormald, Simon Stevens, Jane Cummings and Jonathan Marron.

- Q34 **Chair:** Welcome to the Public Accounts Committee on Wednesday 1 November 2017. We are looking at continuing healthcare funding and focusing particularly on some of the issues raised by the National Audit Office's investigation. I shall introduce the witnesses, but then I have some preliminary questions before we get into the main session. We have Jonathan Marron, director general for community care at the Department of Health—welcome, Mr Marron—Sir Chris Wormald, permanent secretary at the Department of Health; Simon Stevens, chief executive of NHS England; and Professor Jane Cummings, chief nursing officer at NHS England. Welcome to you.

I want to pick up on a couple of current issues, starting with Simon Stevens. We were talking to Sir Chris Wormald last week about the 1% pay increase that has been announced for NHS staff. In fact, permanent secretary, I wrote to you yesterday—you may not have seen the letter yet—on behalf of the Committee, to ask for a bit more detail about the answer you gave us then, which was that you wanted to see this linked to some productivity improvement in the NHS and it was not as straightforward as passing the money on. Of course, there is no extra money for it, which is no doubt one reason why you said that. I have



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asked for some more detail on it, which you will write to us about in due course, but I note, Simon Stevens, that you were quite vocal about it in the media this week, perhaps sharing some of our scepticism about how deliverable the 1% pay increase is. Would you like to elaborate?

Simon Stevens: All I did yesterday was repeat what I had previously said to the Health Select Committee, sitting alongside Jim Mackey from NHS Improvement. We made the point that the NHS is already embarked on a very substantial efficiency programme and will need substantial additional efficiencies in the course of the next several years to be able to sustain the sorts of services that are already in train. Therefore, were there to be a substantial extra pay cost associated with undoing the pay cap, which inevitably is going to happen, that would need to be funded, because it would be counterproductive to increase the pay rates for staff while at the same time having to cut the number of staff who are available to provide services to patients. I think that is a statement of the obvious.

Q35 **Chair:** Do you read productivity as cuts in staff, rather than more procedures carried out by people, for example?

Simon Stevens: Well, there are lots of ways in which the NHS is becoming and can become more efficient. My point is that they are already included in our outlook for what the next several years need to be. I think there is no inconsistency between holding three truths at once in our mind. The first is that the NHS is arguably already the most efficient of any western industrialised country's health services. We spend £23 billion a year less than the French or Germans, for example. Secondly, it is still the case that there is waste and inefficiency in the NHS, and we have to get at that. But thirdly, even when we have done that, it will also be the case that if we want to continue to sustain the kind of growing and improving health service that we have had, and that I suspect the people of this country want to continue to enjoy, over time we are going to have to continue to increase its funding. Those three things can all be true at the same time.

Q36 **Chair:** Permanent secretary, have you reflected on your comments to us last week about productivity as a result of this exchange?

Sir Chris Wormald: I don't think I have very much to add to what I said. What I set out to the Committee last week was the Government's overall position on pay, and I think I said that we have not yet taken decisions on future health pay, which go to pay review bodies and other things. The criteria Simon sets out are, of course, right. Of course we have to consider affordability in what we do in all aspects of pay decisions, because they clearly have a consequence for other things, so I don't think that what I and Simon are saying are in any way different. You would expect Simon to set out the case for the health service and, as I say—

Q37 **Chair:** Well, we look forward to a response to our letter asking for exact examples of what you see as increased productivity. As I said, you may not have seen the letter—it only went yesterday—but we look forward to getting a full, detailed response.



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Sir Chris Wormald: I saw it last night.

Chair: I am impressed that you are so on to our correspondence.

Sir Chris Wormald: Yes. We have not constructed an answer as yet.

Q38 **Chair:** We look forward to that, because examples of what you mean by increased productivity in the NHS will be interesting to us and, no doubt, to Simon Stevens and his team.

Sir Chris Wormald: Sorry, but I do want to re-emphasise that almost any set of pay discussions in any sector anywhere has a "What is fair to the workforce?" question, a "What is affordable?" question and a productivity question.

Q39 **Chair:** You are speaking to the Public Accounts Committee, permanent secretary; we all worry about affordability, of course, but it is worth teasing that out. We look forward to the response to our letter. The other issue I want to raise is fraud costs in the NHS, and the comments made by Sue Frith, the chief executive of the NHS Counter Fraud Authority. Her team did analysis that estimated that £1.25 billion of fraud is being committed each year by patients, staff and contractors. That is the first time the health service has put a figure on the total fraud committed, and it is 1% of the NHS budget. Mr Stevens, is that high up on your agenda to tackle?

Simon Stevens: It certainly is, which is why it is so important that the new counter-fraud service has been launched today. I do not think, actually, that this is the first time a figure has been placed on it; I think predecessor bodies have also identified the opportunity.

Allow me to caveat what you said. The £1.25 billion is at the far end of their estimate, as against the almost certain or highly likely quantification. The highly likely quantification is more in the £300 million zone. Nevertheless, the biggest single item is their assessment that there may be patient fraud going on with the help with healthcare costs scheme, which they size at almost £400 million, but there are other big items that they estimate around dental contractor fraud and other procurement-related items. From our point of view, this is great, because we want to go after this, and every pound we save in this area is a pound we can put back into patient care.

Q40 **Chair:** You have a new organisation, but do you have more resource going into this? Do you have a target for the pounds you will get back to put into other parts of the NHS from every pound spent on fraud detection?

Simon Stevens: The new service reports directly to the Department of Health.

Q41 **Chair:** Permanent Secretary, when we talk to HMRC, we ask them how much they will get for every pound they spend on enforcement. Do you have a similar target?



Sir Chris Wormald: Yes. I do not have any numbers with me on that. I will come back to you.

- Q42 **Chair:** If you could write to us, that would be very helpful, because we will no doubt want to look at that again. We are always a bit wary of overly bureaucratic procedures for patients, which end up costing more in time, in order to protect fraud. Fraud is obviously very important, but I am sure you are looking at that. We may well want to raise that with you in more detail in a future hearing.

Sir Chris Wormald: Those are important points. To echo what Simon said, shining a light on this issue is one of the most important parts of tackling it. Putting the numbers that Simon was describing out into the public domain is a very important way of upping the general level of interest in this.

Chair: I only observe that 1% of the budget is still 1% of the budget, even if, as Simon Stevens rightly pointed out, it is at the higher end of a range. When the NHS budget is tight and demand is rising, it is vital that this is tackled. We will no doubt pick this up with you or with our sister Committee at some point. I will now ask Bridget Phillipson to kick off with questions on the main topic today.

- Q43 **Bridget Phillipson:** We heard from the pre-panel their views on the process for continuing healthcare. They talked about a complicated process that was difficult to navigate, unclear, exhausting and baffling. Mr Wormald, what is your view on how continuing healthcare functions? What do you think the experience is?

Sir Chris Wormald: If I take what the pre-panel said and what the National Audit Office put in its Report together, I think we recognise the picture that those two things paint. The National Audit Office has basically identified the right set of issues, which were reiterated by the pre-panel, around complication and particularly variation, which is clearly one of the biggest issues we face here. Between us and NHS England—I suspect Simon will want to add something—we see the refresh that was mentioned of the national framework and the associated tools, and the strategic improvement programme that NHS England has launched. Between those two things, we want to see progress made on pretty much all the issues that the National Audit Office and others have raised. I shall go into detail on what those are.

Two other things came out very clearly. The complexity of the issue and the danger of unintended consequences of what look like simple solutions are the things that we wrestle with in doing those two things. As for the exchange about the 28 days, whether a target is a good thing or a bad thing, and whether that would lead to better or worse, those are the things we wrestle with. I do not think we are coming to say we think there are any simple solutions here, but in terms of what we need to improve and the processes we have—

- Q44 **Chair:** So you acknowledge there is a problem with the process now.



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Sir Chris Wormald: If you look at the variation in numbers that the National Audit Office has put forward, I do not think any of us think that that is where the system should be.

Chair: Right, so we can bank up front that you recognise there is a problem, which means we can get into some of the more detailed issues.

Q45 **Bridget Phillipson:** Mr Stevens, do you have anything to add on that?

Simon Stevens: No, I agree with Chris completely.

Q46 **Bridget Phillipson:** In terms of the existing national framework, how confident are you that CCGs are complying with it?

Simon Stevens: To start where Chris left off, if we remember the history of this, it began back in the mid-1990s with 100 local health authorities and no national guidance. Then national guidance was, on the back of some court cases in 1999, 2004 and 2006—

Q47 **Chair:** We know all this, so will you answer the question?

Simon Stevens: The point is that this has accreted over time. The first national guidance I think was in 2007, and we have ended up with a very complicated set of guidance for frontline nurses, therapists and other clinicians to operationalise. Just to illustrate it, here it is. This is what you have to take account of when you are trying to get this right. Under those circumstances, it is not completely unpredictable that there will be variation, and that is the reason why, on a variety of fronts, we are trying to take action to improve the experience for families and improve the consistency of the judgments. One of the things we are doing is reviewing the way in which the checklist and the assessment process itself is structured, but we are also taking direct action with CCGs to ensure that we standardise more of the way they go about their job.

Q48 **Bridget Phillipson:** We do not have as complete a picture as we would like in order to make some of these changes because, as is clear from the National Audit Office Report, some of the data just is not there. What work is being done to make sure that we have a better informed picture, so that we can make some of those changes?

Simon Stevens: In fairness, the NAO do set this out. They correctly describe the data gaps that have been in place. They also describe the new data that has been collected from April this year. Looking at the range of information we have, we more or less now are collecting the information that we need. There are probably one or two items that it would be good to add into the mix, and we are looking at that, but we have a much more complete picture than we had 18 months ago.

Q49 **Bridget Phillipson:** Why is it that such a small proportion of screenings would lead to eligibility being determined for continuing healthcare?

Simon Stevens: It is because we are erring on the side of caution. We are doing many more assessments than are likely to lead to eligibility for continuing healthcare. On the one hand, that is a good thing to do, because it means fewer people are going to fall through the net. On the



other hand, it has some serious downsides. One of them is that many more families go through the uncertainty—sometimes the false expectation—of what will emerge from this process, and the other is that we are tying up a lot of nurses doing these kinds of assessments for no clinical benefit. That is the reason why we think this process has to be looked at again.

- Q50 **Bridget Phillipson:** On that point, Professor Cummings, what can be done to improve that initial screening, or even in terms of deciding whether to take people through the process, to avoid the distress that can be caused, as Mr Stevens has just outlined?

Jane Cummings: That is a really important question. We are supporting the Department of Health in its review of the framework and what the policy should look like. It is a careful balance between not wanting to have a checklist that potentially excludes people and having one that does not, as Simon said, set unreal expectations. The current policy and the current framework are incredibly complicated. I will not bore you with all the details, but we are talking about 12 different domains. There are five different levels of need. There are another four areas in which you have to contextualise that need before you determine whether somebody is eligible. That is incredibly difficult to do, and it is also quite difficult to make sure that it is standardised across the system, because you are asking individual clinicians to make judgments.

The way we want to work, both through the strategic improvement programme and in supporting the Department in its policy objective to improve that checklist, is to be clear about what will make a difference. We are currently looking at going out and discussing that with people, holding roundtables to discuss what “good” might look like, and reflecting on some of the best practice that we can see in some parts of the country. I know a couple of people talked about that in the pre-panel earlier.

Sir Chris Wormald: Can I come in on this question? This came out very clearly in your pre-panel. The first stage is exactly as described: it is a checklist. It is the second stage that is the very nuanced clinical judgment. When we looked at whether you could just up the threshold of the checklist so that fewer people went through, we found that people who would eventually end up with a CHC package would have been excluded by the process of having a higher threshold. It is not simply a case of saying, “Let’s have a tougher checklist so fewer people go through,” because so much is rightly put on those very nuanced clinical judgments. We have a policy intention of, “Can we get to fewer people going through?”, but as Simon said at the beginning, it has to be the right people going through. As a matter of policy, we have erred on the side of caution on that, in order not to exclude deserving cases.

- Q51 **Bridget Phillipson:** Returning to Professor Cummings, we heard from the pre-panel about the make-up of multidisciplinary teams. Sometimes those teams are not composed of people who would have greater knowledge or dealings with the patient to understand their health and care needs. What is being done in that area to try to make it a better



process at that point?

Jane Cummings: We have been doing some work for a while now looking at what the needs are in terms of training and education. It is really important that the clinicians who are responsible for making those assessments have appropriate training. NHS England has decided to just go ahead and do that. We are doing some deep dives at the moment into what a multidisciplinary team should look like, in terms of competencies and skills. We have some e-learning packages available, so that people can do some e-learning online. Through the strategic improvement programme, we are looking at standardising the assessments and ensuring that we learn from the best and are able to spread that good practice.

- Q52 **Bridget Phillipson:** But it seemed to be a question of also just getting the people involved. The pre-panel described a social worker who had limited dealings with a patient perhaps being involved, but said that those directly involved in managing their care were not part of that process. It is not just about the training; it is about ensuring that those people are part of the decision. That seemed to be what the pre-panel were getting at.

Jane Cummings: You need to do both, I think. You need to have people who are skilled and able to make decisions based on doing it a lot. They are therefore used to assessing patients, looking at their care needs and making objective judgments about what those needs are. To do that you need to talk not only to the individual people, but to their families, their carers and those other clinical professionals who are looking after them, whether that is social care or NHS care.

- Q53 **Bridget Phillipson:** Moving on to a different point, the NAO Report identifies that the estimated proportion of people referred for a full assessment had fallen in the period from 2011-12 to 2015-16. Mr Stevens, is that indicative of CCGs restricting access, do you think?

Simon Stevens: No. I think you have got two things going on here. One of them—we have not talked about this, but it is hugely important—is that over the past several years, CCGs have been having to do a lot of dealing with the backlog that they were asked to sort out when they came into being. CCGs have been working their way through 63,000 historical cases going back to 2004. At the time the CCGs came into being, there was still an outstanding question about those cases, and they have resolved all of them. They have done all of the eligibility assessments for those 63,000 cases, and that work only finished in March. That has obviously had an impact on the speed of cases, but in response to your question, probably what is happening is that people are getting a bit more familiar with making more accurate early judgments about whether cases need to go through to full assessment. As the precision of that improves, we expect to see the ratios continue to change.

- Q54 **Nigel Mills:** On the kind of flow that you would expect, Mr Stevens, I might naively think that NHS policies were moving people into falling within this assessment, rather than staying in hospital. If you want to die



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at home, I assume you need a care package from this, or if you are going to have complicated care in the community, you will be in this package, rather than staying at home. Would you not expect the volume to be rising, with effectively a saving elsewhere matched by an increase in cost here?

Simon Stevens: What you would expect if that hypothesis were right—which it probably is—is for the proportion of the cases that are represented by Fast Track to be going up, because Fast Track cases are the end-of-life cases and those cases with that urgent need you described, and of course that is exactly what is happening. In the course of this last year—these are the 2016-17 figures, which were obviously not available at the time the NAO did its Report—what we have seen is that the number of standard CHC assessments and eligibilities has gone down by 6%, and the number of Fast Tracks has gone up by 5%. We are seeing more people getting that Fast Track-type NHS-funded continuing healthcare, which would be consistent with what you are saying.

Q55 **Nigel Mills:** I might expect a proportionate switch: to have more Fast Track proportionately, but—

Simon Stevens: The absolute number has also gone up. The absolute number of Fast Track has gone up from 92,000 to 96,500.

Q56 **Nigel Mills:** And the absolute numbers of non-Fast Track?

Simon Stevens: The absolute numbers of non-Fast Track have gone from 68,000 in '15-16 to 63,000 in '16-17. Overall, numbers are about flat in total.

Q57 **Bridget Phillipson:** But would it also appear that patients are receiving continuing healthcare funding for shorter periods? Is that your understanding? The data is a bit patchy and could be better, but—

Simon Stevens: We have got more people as individuals getting Fast Track and, at any one time period, we have got more people on standard CHC than Fast Track, which you would expect, because obviously their duration of support is going to be longer.

Q58 **Bridget Phillipson:** In terms of the review process, when patients or their families are not happy with what has happened, why is it that the appeal process is so variable across CCGs?

Simon Stevens: Well, there is a safety net there, isn't there? When people are not happy with the appeal process that their individual CCG arranges, they can go to an independent NHS England-arranged appeal, so that introduces consistency across the country. Actually, what the figures suggest—though I don't want to over-interpret the numbers here—is that it is a very small proportion of people who feel the need to go to the independent review. In fact, it is less than 1% of the cases deemed eligible. Last year, in 2016-17, of the 160,000 people who went through the process with eligibility, less than 1% or 609 people went to the NHS England appeal and, of those cases, four fifths were found not to be right



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through the process. So it was only 122 who had an appeal upheld. In some ways, that is a pretty striking success rate for the original process.

- Q59 **Bridget Phillipson:** That could be interpreted as a measure of success, but also we have heard—

Simon Stevens: Or accuracy, I should say.

Bridget Phillipson: Patient groups and others have said that the process can often be so long, time-consuming and exhausting that perhaps by the point that they get to that stage, they have just given up all hope of taking it anywhere. It is hard to know what does not—

Simon Stevens: It is, and I have a lot of sympathy with that. In some situations I am sure that is right, which is why I say we should not over-interpret the figures. All I am saying is that if there were an enormous differential, then that would show up in the overturn rate, as it were, that CCGs got through the independent process. I might add, there is not just the independent process run by NHS England; people also have the right to go to the parliamentary commissioner, the Parliamentary and Health Service Ombudsman, and, again relative to ourselves, of the 160,000 people, only 1,245 did so last year. Of those, only 43 cases were upheld. None of those 43 were successful appeals against the judgment of the independent NHS England appeals panel.

Look, I am really not saying that everything is perfect in this world—that is not the case—but equally, if it were dramatically problematic, I think we might expect to see some of that showing up in both of those independent appeal processes.

Chair: There is a difference between a problem in the decision and a problem with the process.

- Q60 **Bridget Phillipson:** A final point: on many of the different aspects of this process, improved data would give us a much better understanding of what is going on and what needs to be done differently or better to improve the experience for patients and the swiftness of the process, and ensure that money was spent properly, and that the people who need it are getting it. Will we see anything happen to make sure we have better data, to understand what is going on in the system?

Simon Stevens: As I said, from April this year, we have quite substantially improved data quality and range of data capture. There are one or two items over and above those that we have started collecting and that we are going to add on top of, one of which will be fast-track information. We want more information on what is happening there, in terms of speed of fast-track assessment and the consequent decisions made off the back of it, and average waits, which was one of the NAO's implied recommendations as well. We also agree with the NAO that it would be useful nationally to collect data on the duration for which individuals are getting CHC, which at the moment is just collected locally by CCGs. I think we are aligned on a lot of that.

Bridget Phillipson: Thank you.



Chair: Ms Moran?

- Q61 **Layla Moran:** To bring it back to the individual families, who, as we heard in the pre-panel, are so often badly affected, we were given the example of Sue from Gloucestershire, who cared for her husband, Bob. They found out about the CHC funding from their nurse, went to the CCG and were passed from pillar to post. Sadly, he ended up going into a care home and died. The day after he died, the CHC assessor knocked on the door and ended up doing a retrospective assessment. Seven months later, Sue received a 64-page document, and she said: "The whole process was dreadful. It was as if they forgot that they were dealing with real people." I should say that, in this case, their application was rejected. Mr Stevens, you spoke about the families. What would you say to Sue?

Simon Stevens: I am very sorry to hear of those circumstances. You said her experience was in Gloucestershire? Obviously, the local Gloucester NHS are the folks who interacted with her and others, and I do not think any of us are sitting here saying that we think this process is working perfectly right throughout the country. That is precisely why we have this big national improvement drive, to try to speed up assessments and improve the way in which local teams are working with families.

I say to the people in Gloucester: come and spend time with places like the NHS in Great Yarmouth or Leeds, where they are now actually getting it right. In Great Yarmouth, a team of nurses connected with each care home sits down with each family to discuss the range of options, not only through NHS CHC but other parts of the NHS and social care. It has dramatically improved the quality of the patient and family experience and, by the way, because it has produced better decisions on care packages, it has, I am told, reduced their overall NHS continuing healthcare costs as well. What there is in places like Leeds and Great Yarmouth is what we need in places like Gloucestershire.

- Q62 **Layla Moran:** A quick follow-up: how many retrospective assessments—after someone has died—are carried out a year? That is surely heartbreaking. Do you keep that data?

Simon Stevens: That would presumably come out of the fast-track data, would it?

- Q63 **Layla Moran:** This wasn't under Fast Track; this was the normal data. Do you keep the data? By all means, you might not have the number, but—

Simon Stevens: Obviously, individual CCGs will have that. Whether that is tabulated nationally, I would have to—

- Q64 **Chair:** Are you sure, because the CCGs did not seem to have a lot of information? Are you sure they have it? I am not trying to catch you out. Do you know that they have it?

Simon Stevens: As we know, the legal, statutory framework is that CCGs have to make the assessment. They cannot delegate that to somebody else, and they cannot pass it up to us.



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- Q65 **Chair:** The investigation showed that CCGs do not have good data on all sorts of things, such as how many appeals have happened and so on, so they might not have that data. I don't want you to walk down a road where you are not absolutely sure.

Simon Stevens: We will go away and check that.

Jane Cummings: We will have to let you know.

Chair: Please, if you could let us know. I am going to bring in Geoffrey Clifton-Brown and then Nigel Mills.

- Q66 **Geoffrey Clifton-Brown:** Mr Wormald, if you have a local decision-making process, you will have local variation. We all accept that. However, what can you do to really highlight the worst decision making? For example, we know that Arden and Greater East Midlands commissioning support unit—the so-called CSU—covers three CCGs, so they must be dealing with a lot of people. You have issued them with one performance notice and two fines in 2016-17 for this dreadful performance they have had. What can you do to highlight those really bad performances and drive up quality control?

Sir Chris Wormald: Those were NHS England problems, I think.

- Q67 **Simon Stevens:** We have had concerns about Arden & GEM and the way that they have handled some of those cases. There have been some substantial changes—

Chair: Mr Clifton-Brown just said that, so let's not repeat it. Professor Cummings.

- Q68 **Geoffrey Clifton-Brown:** What can you do to drive up quality control, basically?

Simon Stevens: We have actually changed—

Chair: Professor Cummings, please.

Jane Cummings: You are absolutely right: there was an example where there were about 327 patients, I think, or 72 patients that actually were not reviewed. They were having care and they had had a review of that care, but it had not been quality assured. It was a complete error, there was a full investigation done, and they completely changed their processes. There was no patient harm as a result, and they looked at that.

- Q69 **Chair:** What can you do to make sure that that does not happen again?

Jane Cummings: Part of the work that we are doing through the strategic improvement programme is having a greater range of data, information and metrics around that. We are also working through the regions of NHS England in terms of oversight and assurance of both CCG and CSU delivery and performance. I think that is beginning to improve and bear fruit. As Simon has said, we are not sitting here saying that it is all perfect, because it absolutely isn't—the case that we have just heard from

Gloucestershire was a really good example of that—but we are moving, and we have been doing that now for some time.

Chair: It is wonderful that everyone is saying that they recognise that it is not all perfect and there is room for improvement; we have heard that so many times today that if it could be banked, it might pay for some of the necessary improvements.

Jane Cummings: We won't say it again, then.

Chair: We have heard that, you don't need to keep saying it.

Q70 Nigel Mills: The variation on this is quite a concern, isn't it? If you look at figure 11 in the NAO Report you have a range of CCG spending, with one CCG spending around 1% of their funding on this, and one CCG spending more than 10%. The average is somewhere around 4%. Do you monitor that spending and intervene where you see it being really out of line with the national average?

Simon Stevens: We certainly monitor it, but we have to be careful about taking up your last invitation, because obviously we are not putting some arbitrary cap on the amount that should be spent on continuing healthcare. What drives that will be the clinical decisions made about the appropriate packages for individuals and their families.

That said, there are some factors that probably explain part, but not all, of the variation. One is obviously the age composition of different parts of the country. It is worth just reflecting that we typically spend six and a half times more on NHS funding continuing healthcare for people aged over 65 than we do for people aged 18 to 65. We spend 18 times more per person for people aged over 85 than we do for working-age adults, so obviously that will have an impact, but that only explains a small part of the variation.

Another part of the variation can be explained by the differential costs of funding care packages in different parts of the country. It is no secret that the cost of buying a nursing home place differs substantially, and there are all sorts of pressures in the care home and home care market that we are familiar with. We also know that there are differences in the content of the care packages that have traditionally been made available in different parts of the country.

We are expecting that variation to narrow. Perhaps we will come on to talk about the £855 million efficiency that we are driving into this programme—

Chair: We can get into other areas.

Simon Stevens: Some of that will of course be by tackling variation.

Q71 Nigel Mills: So you are expecting it to narrow. What sort of narrower variation do you think would be acceptable?



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Simon Stevens: Over the course of the last several years, the variation between CCGs in their standard continuing healthcare has fallen by 6%, and the variation in their Fast Track continuing healthcare eligibility and spending has fallen by 19%, so we are on track for reducing that variation. Even over the course of the last year, we have seen the variation fall by about a quarter.

We believe that the combined effect of the refresh on the assessment processes that we talked about right at the start, the training and the data held up so that people can see how they perform relative to others, plus other approaches which we will get to when we talk about the £855 million will significantly narrow the variation. I am not going to pluck a figure from the air, but in aggregate that will contribute towards £855 million of savings, against the counter-factual.

- Q72 **Nigel Mills:** I quite like figures plucked from the air. I look at my own CCG, which I think spends about 2.2% of its total spend on this area, which is about half the national average. There is quite a big ageing population in our area so we are probably average on care home costs—cheaper than the south east but dearer than some parts of the country. Should I be worried that my CCG is being a little tight and setting the bar too high? Should you be worried that CCGs spending a long way below the national average are perhaps getting the balance wrong?

Simon Stevens: We are talking about—

Nigel Mills: Southern Derbyshire CCG.

Simon Stevens: Actually, your CCG does rather well on a number of the performance metrics. So one of the things you might be doing is congratulating them on that performance.

Chair: We will bank that popularity bid, Mr Stevens.

Nigel Mills: They are relatively quick on assessment time, I grant you.

Simon Stevens: Here are two specifics. One of the things we know is that if somebody gets their assessment about the sort of care they need when they are living back at home or in a circumstance that is closer to what it would be if they were living more independently, they are less likely to end up with a recommendation that they should go into a care home and be funded in perpetuity by the NHS. That has come out of the British Geriatrics Society and others for a while now. We have set a goal that fewer than 15% of NHS continuing healthcare assessments should take place in an acute hospital bed.

Your CCG has exceeded that target. I have the figure that for quarter 1 this year, it has managed 10.9%—only 10.9% of CHC assessments were done while in one of your local hospital beds. That means that the nurses and professionals doing that assessment are more likely to make smart judgments, together with individuals and families, about what CHC packages should look like and, by the way, that will probably save money for the NHS in your area as well.



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Q73 Nigel Mills: You don't think there is any particular level of low spending that would trigger you to take some action or investigation to ensure that there is a competent and fair process taking place?

Simon Stevens: We will do random selections of case reviews for the very high spending and the very low spending CCGs.

Q74 Nigel Mills: How do you define those two bands?

Simon Stevens: The NAO has excluded the lowest spending 5% and the highest spending 5% and, as in so many ways, it sets us a good steer for how we might approach this task.

Sir Chris Wormald: But to be clear on the approach, the data tell you where to go and look, not what the answer is, for all the reasons that Simon has set out. It could be an example of good or bad practice. We want data triggers to go and look, which I think is the heart of your question, but we do not want a sort of mechanistic, "You are spending too low" or, "You are spending too high".

Q75 Chair: Can I be clear, because earlier we were talking about the data, is the information that you want to see now a required marker for collection by CCGs?

Simon Stevens: Sorry, what was the first part of the question?

Chair: The NAO investigation has thrown up the problem that a lot of the information is not collected at CCG level so you cannot monitor it.

Simon Stevens: This is mandated data.

Q76 Chair: It will be mandated?

Simon Stevens: We have an extended data set that is now mandated and financially incentivised. One of the ways in which CCGs have access to something called the CCG quality premium is by improving their performance in the kind of measures that Mr Mills and I were just describing.

Sir Chris Wormald: It is basically the data set out in appendix 3 of the Report.

Nigel Mills: So we drift naturally into the £855 million efficiency savings.

Simon Stevens: I thought we might.

Q77 Nigel Mills: I suppose the first question on that is, do you really think they are going to achieve those savings by doing this better—by standardising assessments and delivering a better quality process—or is this in danger of becoming salami slicing and just giving it to fewer people to save money?

Simon Stevens: Let's make sure we all understand what the £855 million is. The efficiencies that we are talking about driving are proportionally about the same as the efficiencies already earmarked for NHS spending over the next several years. That takes us right back to the first question



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from the Chair, which was: is the NHS going to get more efficient over the next several years? Yes, in many ways it is, and this is one of the ways that we already have pencilled in. That is against our assumption as to what would have happened to spending growth had we not acted.

The counterfactual is, if previous trends had carried on going up and up, what would we be spending and how do we want to moderate that growth? The key point is that NHS spending on continuing healthcare will still be higher in 2020-21 than it is now, even if we succeed in this programme. We just want to slow the rate of growth.

- Q78 Nigel Mills:** We had an exchange earlier where I said that it looks as if you are strategically choosing to increase this spending by moving people out of hospital care and into this. I suppose you would expect that to go up, through demographic change and more people living longer with more conditions, and through the strategic choice of wanting people to access this rather than something else. The question is, are you not just denying the inevitable increase in spending by trying to pretend it is an efficiency saving, when in reality what you will get is reduced eligibility, which is probably not what we want? Are you actually saying that people can really save that proportion of the budget just by doing this more effectively?

Chair: You have banked the saving already, in effect.

Simon Stevens: I am sorry, what was that?

- Q79 Chair:** You have already banked the efficiency saving. It is in your budget.

Simon Stevens: Indeed. None of this is premised on changing the national eligibility criteria. That is a matter for the Department of Health and would require a much bigger public consultation. It is premised on dealing with some of the variation we have talked about and on adopting some of the practices we see in the best-performing CCGs, including examples such as your own.

That includes better so-called case management, where nurses work with individuals to get the right mix of services, and better procurement of care home and home care places when the NHS rather than the local authority is the payer. It includes e-procurement systems, which are now being used in some parts, but not the totality, of England. It includes training and speeding up aspects of the way in which nurses involved in case assessment work, and it involves taking out some of the burdens of administrative cost in the process. We can take some comfort from the fact that, if we look at the trajectory that we needed to be on, CCGs have indeed made a contribution of £170 million against the counter-factual to that, during the past year.

- Q80 Nigel Mills:** When you say better procurement, do you mean we are buying the right care package at the right price, or do you mean, as we heard from the pre-panel, trying to force somebody into a care home who really ought to still be at home with their four young children?



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Simon Stevens: There is variation in the rate that is being paid for care in different parts of the country and there are issues about whether CCGs locally and collectively are engaging in smart medium-term relationships with care homes and home care agencies, rather than just using the spot market, which as you well know has all kinds of pressures and problems. I do not think we are overstating the ease with which this can be done, but equally, we do not think we should just accept as inevitable the kind of compounding forward of growth rates that we saw several years ago. We have shown that we can put a kink in the curve, and we want to get the benefit of that so that your CCG can reinvest in other health services. Nobody is taking the money away; we are just moderating the pressures present in your local CCG.

- Q81 **Nigel Mills:** So there is absolutely no pressure on CCGs from you or the Department to find ways of rationing this care or reducing its quality? We want people to get the right care for their needs in the right setting; is that what we are aiming for?

Simon Stevens: We are aiming for that.

- Q82 **Gareth Snell:** Following on from Mr Mills' point, the procurement of care packages absolutely differs around the country. You will know that in Staffordshire there is an issue with delayed transfers of care. You will know that, because you are holding £19.5 million that you should be handing over to some of the—

Simon Stevens: Of NHS funds, I might add.

- Q83 **Gareth Snell:** Given that there is a clear—not break, but— disjointedness in the CCGs between the acute setting, the sub-acute setting and the community setting, how much of this is just shunting money round a system? If somebody is not given a continuing healthcare package in a timely fashion, they are more likely to present at an acute setting, which, by the statistics we have been given, is a much more expensive provision.

Chair: Shall we perhaps recite the numbers? Mr Stevens, you used the figure of £303 a day for acute beds—that is a Department of Health figure, actually, from 2015. The cost per day of an NHS community healthcare bed is £89. Local authority-provided short-term services to maximise independence—£63. Home-based packages of social care—£41. We could go through the list. To highlight what Mr Snell is saying, they are vastly different amounts of money, and I think we all agree that it is more expensive for an acute hospital bed.

- Q84 **Gareth Snell:** My question is, in terms of what you said about the efficiencies and the procurement processes, how much of this is actually just about short-term savings now, which will re-present as longer term cost pressures? We are having people discharged from hospital, who cannot get the nursing care, the social care or the continuing healthcare packages they need because of the market distortions around the country. Ultimately, they will re-present to an acute setting and will therefore cost more money overall, whether they have continuing



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healthcare or acute care provision.

Simon Stevens: I have a lot of sympathy for the underlying point you are making, but we are in danger of mixing up two separate conversations. As far as NHS continuing healthcare is concerned, there are national eligibility criteria, and they have to be applied in Staffordshire as much as anywhere else.

Chair: We are discussing delays.

Q85 **Gareth Snell:** But you still have to procure those packages, whether it is in Staffordshire, London or the north-east. Where those market distortions exist and you cannot get that procurement, and therefore delays occur, how many of those packages are in place in good time? What is the impact if people re-present at hospital with the same long-term health conditions, but needing to be treated in an acute setting because they cannot get the continuing healthcare provision in that economy?

Simon Stevens: I think I agree with your underlying point, which is that, even when a person is deemed eligible for NHS continuing healthcare, there are often delays in that person being able to leave hospital and get access to the care home or home care package they need, precisely because of wider pressures on the care home and home care sectors. That may be true in Staffordshire; it is certainly true in many other parts of the country.

I want to correct one other thought. NHS continuing healthcare per person per year is, on average, more expensive than social care. It costs us about £50,000 on average per person per year, compared with a much smaller figure for social care-procured services.

Chair: Yes, we are aware of that.

Simon Stevens: I don't think substituting one for the other would be good value for money for the taxpayer.

Sir Chris Wormald: I think that the phenomenon you are describing mainly leads to a delayed transfer of care in the first place. I think about 7% of delayed transfers of care are CHC-related, as opposed to a re-presentation later. It definitely shows up in the system, but I suspect it is there, rather than in the scenario that you describe.

Q86 **Chair:** That is assuming that people who are getting CHC are in hospital, but not all of them will be in hospital.

Sir Chris Wormald: No, sorry. I was on the specific question of whether people discharged from hospital are not getting CHC.

Q87 **Chair:** I think what Mr Snell was also driving at—he can correct me if I misunderstood—was about people who are being assessed and do not get help because there is a delay in procurement and then end up going to an acute setting, when they weren't there in the first place. They have got a continuing healthcare need, but they weren't in hospital at the beginning.



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You have your main figures on that.

Simon Stevens: I am sure we don't necessarily want to have a deep-dive into Staffordshire right now.

Chair: I'm sure Mr Snell would love that, but I am going to rule it out.

Simon Stevens: There are many other dysfunctions in the care system in Staffordshire that are not principally driven by eligibility for NHS continuing healthcare.

Chair: Maybe Mr Snell can pursue that separately.

Q88 **Bridget Phillipson:** In terms of the efficiency savings that can be made, Mr Stevens, you said that many of the improvements that we could make in reducing variability and improving the consistency of assessment could have an impact on efficiency savings. Isn't there the risk that, if we improve this process, we could end up spending more? If we get this right, the efficiency savings might not actually happen.

Simon Stevens: It is not our assessment that that is how it will net out. There may be some CCGs and some cases where that is the case, but our central assessment is that that will not be the overall impact. If it were to be, and if we were doing the right thing for the individuals involved, in that sense it would find its own level since this is not a globally budget-capped programme.

Q89 **Bridget Phillipson:** But some areas could be assessing too few people as being eligible or could be spending too little. It is not just one-way traffic.

Simon Stevens: Which is why we are going to do these case audit reviews for the low spenders as well as for the high spenders.

Q90 **Bridget Phillipson:** I do not fully understand how the figure of £855 million has been arrived at and how that is going to be achieved.

Simon Stevens: Let me help you through that.

Bridget Phillipson: Yes, please.

Simon Stevens: In 2016-17, the estimate for our all-in continuing healthcare—this includes some elements that are not in the NAO definition of continuing healthcare—was that we would spend £4.752 billion and, compounded forward, that would have been £6.055 billion by 2020-21. We think that that £4.75 billion can become in the zone of maybe £5.2 billion by 2021 rather than £6.055 billion, and that delta is £855 million.

Q91 **Bridget Phillipson:** And how would that be achieved?

Simon Stevens: It would be achieved through all the things we have been talking about: namely, a combination of better market management of procurement and better case management; better training precision of the assessment processes; overall changes to make sure that we are not tying up so much resource in assessments that are of no benefit to individuals or their families; and taking out some of the administrative



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costs to the process. As I say, the evidence from this past year is that we are broadly on track for that kind of saving against what would have just been the trend compounded forward. I want to keep coming back to that. This is not £855 million off what we are currently spending. We are still going to be spending more—more people, more spending on continuing healthcare in 2020—than now, but getting some efficiency out of the extra that's going in.

Q92 Bridget Phillipson: It does seem quite ambitious. I am still not fully understanding—

Simon Stevens: But this is a microcosm of the sort of efficiency pressures that are bearing down on the NHS in the round. It is great that we are having a clear lens into this particular topic, but you would see this kind of ambition for efficiency in many other aspects of what we do.

Q93 Bridget Phillipson: Because only £149 million is spent on assessment costs. We always talk about administrative costs and other burdens, but that is a relatively small proportion of the overall spend. You referenced administrative and other costs, but £855 million is a large sum, and I am not entirely sure from what you are saying how the processes that you have outlined will get us to that place.

Simon Stevens: We do not think that the growth rate both in the numbers and in the cost of care packages will be as high as would have been the case if you had just clicked and dragged on the Excel spreadsheet going back to 2015-16. The first year of action, 2016-17, confirms that we are on track to come good on that.

Q94 Bridget Phillipson: We are not a policy Committee, but this feels like tinkering at the edges of what is a much bigger problem in terms of health need as opposed to social care need.

Simon Stevens: Don't get us started!

Chair: We are talking to our sister Committee.

Q95 Bridget Phillipson: This is one part of a much bigger picture. How will we sort out that bigger picture?

Chair: Permanent Secretary, this is one of your tasks.

Sir Chris Wormald: This has obviously been debated quite a lot in the recent past. We have debated with this Committee before the challenges of a free-at-the-point-of-delivery system matching on to a means-tested system, which is at the heart of our issues with this. CHC sits exactly on that borderline between health and social care. One of the reasons why it is so difficult and so complicated is that it is the nexus of that borderline. As you say, that reaches into a set of much wider policy questions, which, as I expect you know, the Government are looking at. They have promised a Green Paper following the debates over the general election period, and that is where those sorts of issues will need to be played out. Our focus at the moment is how you administer the system as it is right now, which is as Simon has described it.



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Bridget Phillipson: We have been talking about this for what seems an eternity. Now we are having another Green Paper. We have endless debates; we have had reports. I think we would all just like to get a move on and try to find a long-term and sustainable solution. I appreciate that that is not easy, but I just do not know how many debates, reports and reviews we can have before we arrive at a system that is fair and transparent, and is sustainable in the long term.

Sir Chris Wormald: Yes. I am not sure I can say very much. The debate clearly is not resolved.

- Q96 **Chair:** We will continue to talk to our sister Committees, the Communities and Local Government Committee and the Health Committee, because we try as three Committees to drive this through our various routes, and we will talk to you about it again.

Before I bring Mr Evans in, I just wanted to go back to something you said earlier, Mr Stevens. You were talking in an exchange with Mr Mills about the number of people being assessed as eligible. All the figures in the report are showing that more people are going to Fast Track. You seemed to imply that the numbers are going down because of the switch between Fast Track and standard. How can you be sure, or have I misunderstood what you were trying to say?

Simon Stevens: Sorry—how can you be sure about what?

- Q97 **Chair:** The proportion of people assessed as eligible for standard CHC has been declining. You seemed to imply that that is because more people are getting fast-tracked, which the investigation clearly shows. They are getting it for a shorter period of time, but more of them are. Are you saying that fewer people are getting standard CHC because of that—the switch between Fast Track and standard? Or did I misunderstand?

Simon Stevens: No, I am just saying that since the NAO Report was concluded, we now have the 2016-17 data that were not available at the time. What those data show is that there has been a reduction in the standard CHC and an increase in the Fast Track. It is as simple as that. I am not making any—

- Q98 **Chair:** So you are commenting on the figures, but you are not saying that there is a connection between the two?

Simon Stevens: No, what I think it shows is that awareness of and use of the fast-track mechanism is going up. That may be entirely appropriate, as judged by the proportion of those who go on to receive care.

- Q99 **Chair:** I think one of the things we found frustrating, and probably the NAO did, is the lack of data. That has meant that the historical information is limited for us to assess—

Simon Stevens: But we changed that.

- Q100 **Chair:** Exactly. That is a good step forward, but it is a shame it hadn't happened before.



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Sir Chris Wormald: I don't think we have seen anything that suggests there is a switch between the two routes.

Chair: That is what I was trying to wrinkle out. Mr Marron is nodding too.

Jonathan Marron: They are quite different. The Fast Track is really for people at the end of life. Their own clinician is able to make that assessment. The standard process takes them to the multidisciplinary team assessment that we talked about earlier. It is possible that somebody in palliative care could go through the full process, but it is much more likely that they would take the Fast Track. There are different groups.

Q101 **Chris Evans:** I am still struggling to understand how a CCG can make savings. I am looking at figure 16 of the Report, and in particular "implementing an electronic procurement system...this might include using collaborative purchasing systems, which may reduce expenditure". Might and may are the operative words there. Equally, further down, under the heading "improving market management", it says, "CCGs could renegotiate care home prices with providers". Looking at that, I have to ask how that is achievable.

Simon Stevens: It is achievable because it has been achieved. CCGs have saved £170 million against their targets this past year.

Q102 **Chris Evans:** That leads on to my next question. We are not a policy Committee—we talk about finance—but we are dealing with people in the most difficult circumstances. Are you concerned that, in the drive to make savings people could be accepting lower care packages than they need?

Chair: You weren't here for it, but we heard some compelling arguments in the first panel.

Chris Evans: We heard some anecdotal evidence there.

Jane Cummings: There is a clear set of criteria, as we know. There will be different opportunities and ways of delivering that care package. CCGs have a statutory responsibility to ensure that the care packages that are procured meet those needs. There will be some differences in what one person or one family may want; they may want something that is a lot more expensive, but delivers the same outcome, depending on who provides the service. The key thing is to do this with patients. Obviously, I didn't hear the details of the case that was referred to earlier, but the real issue here, as you well know, is that this is about real people. The key for us is making sure that we use the eligibility criteria well and that we work with the Department around improving that as we move forward, but that people have an opportunity to get the care they need, and that CCGs are duty bound to provide it. Through our improvement programme, through much greater oversight and through much better data collection—many of you have rightly said that data collection was a problem in the past—we should have much more ability to assess how many times that happens.



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And there is a review process in place, so that people can ask for support if they don't feel they've got what they need.

Q103 Chair: I don't doubt what you're saying, Professor Cummings, or that you mean it, but the reality is that the patchiness of approach across the piece is evident, for all the plans that you have to make things better; everyone always comes with future plans. But it's not good now. I think we can agree on that.

Jane Cummings: We agree on that; we know that.

Q104 Chair: And the reality is that if you are a CCG, you will take it to the edge of what you are legally required to deliver, because the cost on your budget is very direct and very uncertain, as you can't predict that budget; you have some parameters, but you can't really predict it. So, how will you really ensure that the law is upheld on this? And can you also reassure people that—this may be for Mr Wormald—that the guidance will remain, so that this is available on the NHS for the people who need it? First of all, Professor Cummings, and then I will come to the permanent secretary.

Jane Cummings: The first thing to say is this: Fast Tracks are individual clinicians who can make that judgment. An average of 96% of the Fast Tracks are people who are found to be eligible; in some places, the figure is 98% to 100%. So, clinicians are making decisions day in, day out. Yes, clinicians all have a duty of care, for value for money; that is part of everybody's duty. But they are there to make sure that the individual patients get the right care.

I would expect the clinical assurance and the clinical governance within CCGs to be part of that assurance package, and our strategic improvement programme, which is actually led and directed by a nurse with extreme experience in commissioning, should provide the oversight. And, as you rightly point out, reducing that variation has got to be one of our key priorities. You can see it in the NAO Report, and I know you heard it earlier. That's what the programme's about, that's what we've started to do—

Q105 Chair: How are you really going to drive it, because earlier Mr Stevens talked about putting information out there, and encouraging people with poor performance to go and see areas of good performance? We go round in a circle on this Committee about how you really drive change. Mr Snell talked about sanctions on local health bodies. You can have CCGs that are just badly run that choose not to take it on. Where do you get in, because the individuals whom this affects are affected particularly harshly? Dare I say it? Waiting for a hip operation is bad, but you're probably not going to die of it quickly. This has a real-life effect on people and their families, so how will you ensure that you really get those worst performers up to scratch?

Jane Cummings: It is a perennial question: how do you, with an organisation the size of the NHS and with that number of staff, spread best practice? And what happens in Telford and Wrekin, or in Great



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Yarmouth as Simon referred to earlier, is something that everybody accepts. And to be honest, we have struggled with that over many years.

The key way to do this is through our regional teams and our regional assurance processes. So, for example, I am also currently working across London, as some people will know, and as part of the work in London we've done deep dives into each of those CCGs. We have looked across a huge number of key performance indicators to see what they are doing, how they are doing it and whether there is anything we can learn.

We have got a pan-London commissioning framework for commissioning care, so we've been able to drive out inefficiencies that way but still provide the right care for people. It's not perfect anywhere; your own CCG doesn't deliver as well as we want it to. But it's only by having that level of granularity at a local level, provided by the regions and the regional teams through the strategic improvement programme—I am doing this because some of them are sitting behind me—that we will actually be able to drive that out.

Some of the metrics that we're measuring, some of the case studies and some of the examples of good practice will help. The four commissioning support units that are working on CHC have got a network, whereby they are working together. They're learning from each other and they're spreading good practice across those four CSUs. So we've already started to do that. We have got some way to go—

Q106 **Chair:** I just worry where this falls in the list of priorities?

Jane Cummings: I know. This is a big priority; it's one of our key priorities around improvement.

Q107 **Chair:** That is good to hear. And Chris Wormald, can you reassure people tuning into this sitting that the national framework remains and that the legal requirement to provide this remains? Mr Marron's nodding, so I take that—

Sir Chris Wormald: Yes, I can, and I will ask Jonathan to say a bit about how we're refreshing it—

Q108 **Chair:** No, I was just asking. So you can guarantee this is going to continue. There is not a plan to water it down.

Sir Chris Wormald: Yes. This came out very clearly from your pre-panel. The policy intention here and what the framework sets out is not really in dispute. The challenge with the framework and the associated tools is exactly as Simon described it earlier, and that contributes—

Chair: We just needed the reassurance; that is fine. We do not need more than a yes, really, to be honest. We just need to be clear that it is not changing. Can I ask my final question? You said yes, and that is it, really.

Sir Chris Wormald: I was just getting into my stride!

Q109 **Chair:** That is all I ask: the question is the question and the answer is the



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answer; it had been embellished. One of the key things that pre-witnesses said—it was in a lot of evidence—was that people just did not know about this. Hopefully, this investigation by the National Audit Office and this Committee meeting today will have highlighted it. But perhaps I will give Mr Marron another shot at this. Can you tell us how you are going to ensure that people know what they are legally entitled to? They have paid their national insurance money, they have contributed into the system and they should be getting this, but many of them do not know. Could you tell us how you are going to ensure people are aware of their entitlement rights?

Jonathan Marron: One of the things that I think is really important—we heard it really strongly from the pre-panel—is being able to communicate this more simply. Simon waved the framework earlier for us all to see. It is not the simplest and easiest document to follow, either for professionals or indeed for people looking it up. One of the things we would like to do in the refresh is make that much simpler and easier to communicate so that people understand the entitlement much more clearly. There is a set of things in the framework to make the process work better, which we think will also help, without in any way trying to change the core eligibility criteria based on the legal requirements.

Q110 **Chair:** So, simplification and then communication on that.

Jonathan Marron: Yes.

Q111 **Chair:** Are you going to make sure that people on the ground know to communicate it?

Jonathan Marron: Yes. The numbers of people coming through for assessment are significant. This is not an area where health professionals are not coming forward with assessments. So while we have heard stories today, there is still increasing evidence that we have large numbers of people picking it up. It is really important—

Q112 **Chair:** One of the things we could not identify was the socioeconomic groups and backgrounds of people who are applying. I can see that some people might be able to dig out the information that they are entitled to this and therefore go through the process. But my hunch is there may well be groups out there—it is difficult to be absolutely sure, because the numbers are not there. I can think of constituents who would not even know where to start, and others who would be there, reading every document on the web, seeking out the information and going through the process. So how are you going to make sure that the people with, perhaps, poor English or lack of literacy or just a lack of knowledge of the system are as able to get hold of this money when they need it as anyone else?

Jonathan Marron: The key change here is that our health and social care professionals, who are able to start the assessment process, fully understand both the groups who are eligible and when they should be using this process. I think that is the easier way to reach out to make sure that people get the entitlements, rather than trying to explain it directly to



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the public in all circumstances. So it should be easy to understand—people should be able to pick it up and follow it—but I think reaching out to the nurses, doctors and social care professionals is the key way of addressing the need to bring forward people for assessment who should get it.

The checklists are already being offered to people. We heard earlier that large numbers of people are given the checklist and then do not get eligibility agreed. So there is a challenge there of driving more and more people through who then do not get the assessments; that does need to be balanced.

Chair: I think we are all going to go away with questions for our own CCGs and I will encourage other colleagues around the House to ensure that we are driving that desire to get information out to our constituents. We know there are pressures on the NHS budget, but it should not be cut from here.

Jane Cummings: Chair, could I add something in support of what Jonathan just said? I know you heard from Dan from Beacon earlier, and NHS England has commissioned Beacon to help provide independent advice to people. They provide telephone consultations and free literature to enable people to navigate CHC. We piloted it first and we have commissioned it separately, and that does actually help people get access—

Q113 **Chair:** And I suspect it also helps manage expectations by having a good—

Jane Cummings: Yes. It is something. It is not enough, but it is something.

Chair: Having been through a different kind of care package process, it is certainly very helpful having an intermediary who can help you through the system.

Thank you very much indeed for your time. The transcript, as ever, will be up on the website uncorrected in the next couple of days. We look forward to a response to our letter, permanent secretary, on how you are going to help NHS England to afford the 1% pay increase. I am sure Mr Stevens is also looking forward to the answer to that letter.

Simon Stevens: In fairness, I am not sure Chris is the person who can principally provide that answer.

Chair: He is the permanent secretary and the accounting officer in front of us today—he is the nearest we get to whoever that may be. Thank you very much indeed for your time.

Footnote:

Q5:66% should read 60%

Q6: 60% should read 66%



HOUSE OF COMMONS

Footnote:

Q20: Reassessment should read retrospective assessment