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Improving access to mental health services

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to the report*

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

Contacts

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

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Summary

One in four adults is diagnosed with a mental illness at some point in their lives, but only around a quarter of people estimated to need mental health services have access to them. The Department of Health and NHS England have a laudable ambition to improve mental health services but, given the current pressures on the NHS budget, we are sceptical about whether this is affordable, or achievable without compromising other services. Achieving 'parity of esteem' between mental and physical health is a task for the whole of government. The challenge is to build joined-up, well-configured services within the health system and across other parts of government that provide people in all areas of the country with access to the services they need, near to where they live. Achieving parity of esteem will also depend on the health system having the right staff, with the right skills in the right places. Staff costs represent the largest part of the cost of services. But the workforce needed to achieve parity of esteem, and the consequential cost, is poorly understood. Better information is also needed to assess the gap between current mental health services and need so that this can be used to inform planning and decision making.

Introduction

The Department of Health (the Department) is ultimately accountable for securing value for money from spending on healthcare and, through its annual mandate, holds NHS England to account for the outcomes the NHS achieves. In 2014–15, the NHS spent an estimated £11.7 billion on mental health services, some 12% of total spending. Mental health problems cover a broad range of disorders, including depression and anxiety, psychosis and eating disorders. In 2014–15, 3.3 million people were known to be suffering from depression. Psychosis is less common but more severe and may affect up to 3 in 100 people during their lives. Mental health conditions can have a significant impact on the health of the people affected and their quality of life. They also affect the health system, the economy and society more widely. What makes good access to mental health services so important is that many people can make a full recovery if they receive appropriate treatment when they need it and at an early stage.

Conclusions

1. **Achieving parity of esteem between mental and physical health is a laudable ambition but pressure on the NHS budget will make it very difficult to achieve.** The Department and NHS England have taken an important first step towards parity of esteem by putting in place, for the first time, standards for the time people should wait for mental health treatment and the care they should be able to access. So far, they have introduced standards for three specific areas of mental health provision. How the improvements in services will be paid for is less clear. The Department has announced an additional £1 billion for mental health services over the next five years, but this money is not ring-fenced. There is a risk that commissioners and providers, already under financial pressure, will have no choice other than to deprioritise other mental or physical health services if they are to meet the new standards. Witnesses gave evidence that spending on mental health services leads to a net financial gain, once better outcomes for patients, lower costs to the health system and wider economic benefits are taken into account. However, information available to commissioners about the full costs and benefits of spending on mental health services is not good enough to support well-informed decisions about how best to use the limited available funding. NHS England also confirmed that it aimed to extend waiting time standards, firstly to eating disorder services and then to a broader range of mental health services. Given the pressures in achieving standards in the first three areas, however, it is not at all clear how easily or quickly standards can be introduced more widely.
2. **Structures are not in place to enable joined-up working across government to ensure the most appropriate action is taken to support people's mental well-being.** Responsibilities falling within other parts of government, such as prisons, housing, employment, armed forces support and schools, can all influence outcomes for people with mental health conditions. The 'crisis care concordat', established in February 2014, has gone some way to ensuring that people with mental health conditions receive appropriate treatment, and the Department and NHS England have started a dialogue with other departments with the aim of providing better integrated services for people who have mental health conditions. However, more generally, systems for working across government are weak. People leaving prison, for example, have no consistent way to access mental health services on their release. Around half of people with lifetime mental health problems experience symptoms by the age of 14 and schools play an important part in identifying mental health issues among young people, but counselling services are not available in all schools. We also heard that services helping people with mental health problems get back into work are not joined-up between the NHS and the Department for Work and Pensions.
3. **It is difficult for people to access the support they need because the way mental health services are designed and configured is complex, variable and difficult to navigate.** There are many different ways in which people can come into contact with mental health services. Referrals often start as a result of contact between a patient and their GP, but people can then face a complex process of diagnosis, referral and treatment involving multiple clinical staff in different health settings. This can make it more difficult for people to get the treatment they need. Mental health services

have grown up over years and are commissioned in different, inconsistent, ways in different areas, with the result that there can be multiple alternative routes to access services. There is significant variation in people's experience of access to services and the time they wait depending on where they live and other demographic factors. The National Audit Office found, for example, that in 2014–15, the proportion of people able to access psychological therapy within six weeks of referral varied from 7% in one clinical commissioning group to 99% in another.

4. **There is insufficient information about the numbers of mental health staff and their skills, and there is not yet a clear plan to develop the workforce needed to achieve parity of esteem.** The Mental Health Taskforce highlighted, in February 2016, high vacancy rates in consultancy psychiatry posts and psychiatry training. Health Education England estimates that implementing the access and waiting time standards will require the number of mental health nurses to rise by 7%, from 39,000 in 2014 to 42,000 by 2020. In contrast, trusts expect their demand for mental health nurses to fall. There is a further problem that, because of the number of nurses leaving the NHS, the number of people completing their training is not translating into an equivalent increase in the number of people the NHS is employing. Health Education England is now starting to develop a workforce strategy for mental health, the first since 1999. In the meantime, the Department has put new waiting time targets in place without a clear understanding of the workforce needed to achieve them.
5. **Current structures, practices and payment mechanisms do not incentivise commissioners and providers to deliver high-quality mental health services for all who need them.** Governance and accountability structures are complex and lack transparency, undermining confidence that services are being commissioned and provided in the best ways. There is a risk that, because there are only a small set of targets for a few mental health services, commissioners and providers will have an incentive to prioritise these at the expense of other services. Commissioners currently pay for most mental health services using 'block contracts' that pay providers a fixed sum each year irrespective of the quality and timeliness of the services being provided and the number of people accessing services. These contracts lack transparency, and provide few incentives for providers to improve the quality or efficiency of services. NHS England reported that it is now undertaking an 'open-book' exercise with clinical commissioning groups to understand better how much local commissioners are spending on different mental health services. In addition, NHS Improvement is developing new mechanisms for how mental health services are priced and paid for.

Recommendations

As the Department and NHS England recognise, much remains to be done to secure the improvements that are urgently needed in mental health services. Our recommendations are as follows, and we will be returning to this topic to review progress later in this Parliament:

- i. The Department and NHS England should collect the cost and performance data needed to understand, by the start of 2017–18:
 - what the baseline position is in terms of the mental health services currently being delivered and the money being spent;
 - how much money it will take to achieve their ambitions; and
 - how best to prioritise the money available to get the best results and be clear about the outcomes that services achieve.
- ii. The Government should build on the dialogue taking place in the Department of Health and NHS England, as well as with other government departments, to develop an effective strategy to integrate health services and to join up services between different parts of government to ensure continuity of care for those with mental health problems, whatever their circumstances and wherever they live.
- iii. The Department, NHS England and Health Education England should work together to collect the information needed to estimate the workforce required to achieve parity of esteem between mental and physical health. By the start of 2017–18 it should put in place a plan for supplying that workforce.
- iv. NHS England and NHS Improvement should accelerate work being done to incentivise clinical commissioning groups and providers to improve mental health services and outcomes, including by developing better payment mechanisms for implementation by April 2017.
- v. NHS England should report back to us by December 2016 on implementing open-book reporting by clinical commissioning groups, particularly to explain what this shows about how much money clinical commissioning groups are spending on different mental health services.

1 Costs and funding

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England on preparations for improving access to mental health services.¹ We also took evidence from Andy Bell, Deputy Chief Executive of the Centre for Mental Health, Joe Rafferty, Chief Executive of Mersey Care NHS Foundation Trust, and Dr Gary Wannan, Senior Consultant Psychiatrist at Central and North West London NHS Foundation Trust.

2. Around one in four adults in England is diagnosed with a mental illness at some point in their lives, and may need to use mental health services. Mental health conditions cover a broad range of disorders of varying severity. The most common problems are conditions such as depression, anxiety and panic disorders. In 2014–15, 3.3 million people were known to be suffering from depression. Psychosis is less common but more severe and may affect up to three in every 100 people during their lives. Other forms of mental illness include eating disorders and personality disorders.²

3. The Department is ultimately responsible for securing value for money from spending on healthcare, including mental health services. It sets objectives for NHS England through an annual mandate and holds it to account for the outcomes the NHS achieves. In the 2015–16 mandate, the Department set out its expectation that NHS England would introduce access and waiting time standards in key areas of mental health services by March 2016, as part of its wider objective to work towards ‘parity of esteem’ between mental and physical health. Parity of esteem means that mental health is valued as much as physical health, for example in terms of access to care and allocation of resources on the basis of need.³

4. The Department completed an impact assessment in September 2014 that envisaged a staged implementation of access and waiting time standards across all mental health services between 2015–16 and 2019–20. However, because of the funding available and uncertainty about future policy priorities, the Department and NHS England developed firm proposals for only three specific areas of mental health provision: improved access to psychological therapies, early intervention in psychosis and liaison psychiatry. From a long-list of options, they considered that these three areas had the strongest evidence base supporting the likelihood of positive outcomes for users.⁴

5. In 2014–15, the Department gave a total of £97.4 billion to NHS England for all NHS services. NHS England directly commissioned around £3.7 billion of mental health services, and clinical commissioning groups an estimated £7.9 billion, together representing some 12% of total NHS spending. Mental health services include a range of interventions offered in community, inpatient and primary care settings, which may need to be integrated and multidisciplinary. Most of the spending is on the cost of staff. Treatment may include medication, such as anti-psychotic drugs, anti-depressants or mood stabilisers, and appropriate psychological therapies.⁵

1 C&AG’s Report, [Mental health: preparations for improving access](#), Session 2015–16, HC 492, 21 April 2016

2 [C&AG’s Report](#), para 1

3 [C&AG’s Report](#), para 3

4 [C&AG’s Report](#), para 2.3

5 [Q 122](#); [C&AG’s Report](#), paras 2, 1.9

The cost of mental health services

6. The National Audit Office reported that limited data are available to attribute spending on mental health services to treatment for different mental health disorders.⁶ We also heard from the Centre for Mental Health that we need to have real-time data on what is being spent on what.⁷ The Department agreed that transparency in data is incredibly important, and pointed to work that NHS England has done to track spending better in the future than it had in the past.⁸ NHS England told us that it has attempted to carry out a reconciliation for every clinical commissioning group comparing last year's out-turn spending to the goal for increased spending on mental health they had set. NHS England confirmed that, during 2016–17, they were moving to open-book reporting, which would mean clinical commissioning groups would have to be able to show what money they were receiving and how they had spent it.⁹

7. We asked what was happening to the drug budget for mental health. NHS England explained that clinical commissioning groups are spending about £400 million on mental health drugs prescribed by GPs, a total that NHS England expected to increase about 4% in 2016–17. This spending would not be visible to a mental health trust, because it would appear in GPs' prescribing budgets rather than in the trust's own income and expenditure.¹⁰ NHS England confirmed that total NHS spending on mental health medication would not be very much greater, because long-term prescribing is done by GPs. In the context of the total £11.7 billion spent on mental health, the cost of drugs represents a small proportion because almost all drugs are off patent.¹¹

8. An estimated 90% of prisoners have a diagnosable mental health problem or substance misuse problem, with 70% having two or more recognised conditions.¹² We asked how much of the total budget for mental health is spent on prisons and secure units. NHS England, which is responsible for providing mental health and other health services in prisons, told us that the total health budget for the criminal justice system, including mental health treatment, is £493 million a year. Secure mental health services operated by NHS providers or third parties outside the criminal justice system cost around £1.7 billion a year.¹³

Funding and health outcomes

9. The Centre for Mental Health questioned whether there is sufficient accountability for how much funding is given to mental health services in each local area.¹⁴ NHS England told us that it has commissioned an independent panel to assess the extent to which every clinical commissioning group is using money appropriately to improve mental health services.¹⁵ NHS England emphasised that focusing on funding is a proxy for the availability of high quality services and the outcomes they achieve, and that more

6 [C&AG's Report](#), para 1.10

7 [Q 38](#)

8 [Qq 68, 103–104](#)

9 [Qq 61, 70–71](#)

10 [Qq 105–107](#)

11 [Qq 119–121](#)

12 [C&AG's Report](#), para 1.15

13 [Qq 133–136](#)

14 [Qq 18, 38](#)

15 [Q 71](#)

of the funding needs to be linked to the outcomes that services achieve. The health service has not in recent years been very precise about what the improvement goals for mental health services should be. NHS England told us that it is now being precise, based on the recommendations of the mental health taskforce, and would become more prescriptive so as to hold the NHS to account for delivering those improvements.¹⁶

10. We heard that current payment systems do not act as incentives to promote higher quality or more efficient services. The Centre for Mental Health pointed to the fact that many mental health services are paid for on ‘block contracts’, under which a provider will get paid a certain amount every year rather than being paid for the number of procedures it carries out.¹⁷ The Department agreed that it was hamstrung by the fact that so much of the money spent on mental health is hidden within block contracts, making it difficult to make judgements about whether that money is being well spent. The Department emphasised the importance of being able to relate the money being spent to the outcomes being achieved in order to start properly measuring value for money. NHS England and NHS Improvement are working to replace block contracts with one of two alternative models. This would either be a proper capitated budget, under which a provider would be responsible for the local population, or funding would be attached to the episodes of care themselves.¹⁸ NHS England confirmed that it is seeking to realign financial incentives.¹⁹

11. The Department explained, however, that it had not ring-fenced funding for mental health because that would have distorted local spending, and emphasised that it is trying to strengthen incentives to focus spending around the patient rather than around the service. Around 30% of people who have long-term physical conditions also have mental health issues. The Department told us it wants GPs, clinicians and others to think about what the right package of care is for each patient in the round, taking into account both their mental and physical health issues.²⁰ NHS England’s National Clinical Director for Mental Health added that all trusts would be required to join quality improvement networks that would, over time, show the impact of funding and targets for waiting times.²¹

Meeting future funding needs

12. Mental health problems cost the economy an estimated £105 billion each year.²² We heard from both Dr Wannan and from the Centre for Mental Health that spending on mental health would free up other resources.²³ The Department told us that there is quite a lot of evidence about how much specific interventions save, although the amount varies depending on the particular treatments and on whether they are done well. NHS England pointed to the Centre for Mental Health’s report, *Priorities for mental health: Economic report for the NHS England Mental Health Taskforce* for evidence of the savings that can be made by investing in mental health services. The Department noted that the way it had prioritised funding for specific conditions and interventions has been partly driven by that cost-benefit analysis.²⁴

16 [Qq 78, 151](#)

17 [Q 1](#)

18 [Q 95](#)

19 [Q 145](#)

20 [Q 67](#)

21 [Q 101](#)

22 [C&AG’s Report](#), para 4

23 [Q 20](#)

24 [Qq 92–94](#)

13. The Department and NHS England allocated some additional funding to support the access and waiting times programme, totalling £120 million over the two years 2014–15 and 2015–16. However, the amounts are relatively small and commissioners are mainly expected to use their existing budgets to fund improvements in services.²⁵ Furthermore, according to evidence from NHS Providers, only 52% of mental health trusts said that they had received a real terms increase in funding in 2015–16.²⁶ NHS England accepted that in some parts of the country the money is not getting through. In other areas some of the money is going to other parts of the mental health system such as independent providers, GPs and liaison psychiatry services in accident and emergency departments, rather than to mental health trusts.²⁷

14. In written evidence, the British Psychological Society raised a concern that mental health services tended to suffer disproportionate pressure on finances when NHS services more generally were under pressure.²⁸ NHS England asserted that large cost overruns in acute hospitals have crowded out what would have been investment in mental health services and primary care, but that this year it would adjust some spending in acute hospitals to free up resources for mental health.²⁹ Of the funding increases available to the NHS over the next five years, £1 billion has been earmarked to implement the mental health taskforce recommendations.³⁰ We asked whether that money is going to be provided evenly over the next four years. NHS England confirmed that it is not, but that most of the improvement will be seen in 2018–19, 2019–20 and 2020–21.³¹ NHS England also cautioned that mental health services will need to make the same 2% efficiency savings expected of other parts of the NHS. Furthermore, were there to be a continuing unbudgeted overspend in the acute sector, or any substantial economic shock to the financial prospects of the National Health Service, that would call for a rethink.³²

15. We challenged the Department and NHS England over how confident they were that estimates of the cost of meeting access and waiting time targets were accurate, and raised a concern that any underestimate would mean additional funding would not be enough to meet actual need.³³ NHS England confirmed that the projected figures should not be treated other than as estimates, but assured us that the waiting time standards are being implemented as part of what the NHS is doing this year.³⁴ NHS England made clear, however, that the need on the ground already outstrips the budget and, while increased funding meant that more people would be able to access services in future, demand will still outstrip even the expanded budget in 2020.³⁵

25 [C&AG's Report](#), 2.12

26 [Q 60](#); NHS Providers ([MHR0020](#))

27 [Qq 60–63](#)

28 British Psychological Society ([MHR0023](#)), para 5

29 [Q 80](#)

30 [Qq 42, 87](#); [C&AG's Report](#), para 2.22

31 [Qq 43–44](#)

32 [Q 87](#)

33 [Q 56](#)

34 [Q 59](#)

35 [Qq 82–83](#)

2 Staff

16. We heard that most of the cost of mental health services is the cost of staff.³⁶ We also heard, however, that in terms of achieving access and waiting times standards, the biggest barrier appears to be workforce availability. It is important to have the right people with the right skills and, if staff are unqualified or not properly supervised, sometimes mental health interventions can do more harm than good.³⁷

17. Providers must ensure they have enough suitably qualified, competent and experienced staff to provide high quality and safe care. Providers are responsible for employing staff and providing on-the-job training, while Health Education England, an arm's-length body of the Department is responsible for providing leadership and oversight of workforce planning, education and training. Its role is to ensure that the NHS has the staff and skills it needs to meet current and future needs of patients. NHS England and Health Education England have some information on the current and future workforce requirements for improved access to psychological therapies but, until recently, very limited information was available nationally about the capacity and capability of the current workforce to support early intervention in psychosis and liaison psychiatry services.³⁸ Written evidence from the Royal College of Nursing pointed out that there is currently no way of monitoring the number of nurses and skill mix in services delivered by independent providers outside the NHS.³⁹

Workforce planning

18. In our May 2016 report on managing the supply of clinical staff we concluded that, to align with financial plans, trusts' workforce plans had consistently understated how many staff they would need.⁴⁰ The National Audit Office again highlighted that there is a considerable discrepancy between numbers of staff that local providers estimate they will need and Health Education England's forecasts. Trusts forecast, for example, that their demand for mental health nurses will fall while Health Education England estimates that implementing access and waiting time standards will require the number of mental health nurses to rise by 7%, from 39,000 in 2014 to 42,000 by 2020.⁴¹ In written evidence submitted to us, the Royal College of Nursing said there was a disconnect between workforce planning and service design. The Royal College of Nursing called for more transparency in workforce planning, saying that it was unclear how national forecasts would meet the increase in demand by 2020.⁴²

19. Mersey Care NHS Foundation Trust agreed that trusts frequently underestimated staffing needs. He explained that this was because trusts have worked out what service they could deliver with the existing staff they have, rather than develop a staffing model to support the care model they are trying to achieve.⁴³ The Department also confirmed that providers do tend to take a more pessimistic view, partly based on their experience

36 [Q 122](#)

37 [Q 6](#)

38 [C&AG's Report](#), paras 3.23–3.25

39 Royal College of Nursing ([MHR0024](#)), para 4.1

40 Committee of Public Accounts, [Managing the supply of NHS clinical staff in England](#), 40th Report of Session 2015–16, HC 731, Summary and para 1

41 [C&AG's Report](#), para 3.27

42 Royal College of Nursing ([MHR0024](#)), para 2.2

43 [Qq 13–14](#)

over the last few years of the money they have had available to spend on staffing. The Department argued that Health Education England was justified in making a more optimistic projection in recognition of the five year ambition that has now been set out by the mental health task force and the extra money being made available to help achieve that ambition.⁴⁴

20. The Department assured us that, through Health Education England, it is preparing a comprehensive new workforce strategy for mental health. The strategy is needed to understand the implications for staffing of the mental health taskforce report and to make sure that the right numbers of staff become available. The Department told us that the strategy should be ready by the end of this year.⁴⁵

Training and retention

21. NHS England explained that the pace at which new staff can be trained means that an expanded workforce will only start becoming available between 2018–19 and 2020–21.⁴⁶ The Centre for Mental Health called for a longer term view of the workforce needed that would look even further ahead, beyond the current five year horizon. Mersey Care NHS Foundation Trust also told us that there is about a three year time lag needed to train new staff, which is why decisions have to be made now about way into the future.⁴⁷

22. The Department cautioned that, although it is confident that Health Education England can train adequate numbers of mental health nurses, there remains a concern because the health system has struggled with the rate at which nurses have been leaving the NHS over the last few years. This has meant that the numbers of staff being trained has not translated into equivalent numbers being employed by NHS providers.⁴⁸ Mersey Care NHS Foundation Trust noted that it offered six-month or twelve-month contracts to liaison nurses and that recurrent funding to support long-term contracts would help attract the best people and make the liaison service feel like a positive career move.⁴⁹ In that context, the Department told us that the way the Department and NHS England were setting out ambitions for the next five years, plus the fact that clinical commissioning groups' know broadly what resources they will have over the next four years, should give them more confidence about making longer-term employment commitments.⁵⁰

Working across organisational boundaries

23. The Centre for Mental Health pointed out that the mental health workforce is much bigger than the people employed by mental health trusts. Because 90% of people who receive any treatment for a mental health difficulty only ever see someone in primary care, GPs and their staff are incredibly important. Looking more widely, people working

44 [Q 126](#)

45 [Q 126](#)

46 [Qq 44–45](#)

47 [Q 12](#)

48 [Qq 127–128](#)

49 [Qq 8–9](#)

50 [Q 136](#)

with children in schools and in youth services, for example, are also part of the mental health workforce.⁵¹ Dr Wannan commented that young people most value quality and continuity in the relationships with mental health services they have.⁵²

24. The Centre for Mental Health particularly emphasised the importance of partnership working, both internally within the health system and between the NHS and other services such as the police, housing or employment services.⁵³ The Department told us that there are some pilots going on between schools and NHS England that are exploring how schools and mental health services can work together.⁵⁴ It also told us about its work to strengthen relationships with other parts of government, for example with the Department for Work and Pensions to better integrate mental health and employment support, and with the Department for Communities and Local Government to tackle issues arising from homelessness and housing problems.⁵⁵

51 [Q 15](#)
52 [Q 12](#)
53 [Q 8](#)
54 [Q 141](#)
55 [Q 154](#)

3 People's experience of mental health services

25. Good access to mental health services matters. Many people can make a full recovery if they receive appropriate, timely treatment. However, a high proportion of people with mental health conditions do not have access to the care they need. Only around 25% of those estimated to need mental health service have access to them.⁵⁶ People's experience of access to services and the time they wait also varies depending on where they live. The National Audit Office found, for example, that in 2014–15, the proportion of people able to access psychological therapy within six weeks of referral varied from 7% in one clinical commissioning group to 99% in another.⁵⁷ Successfully implementing the programme to introduce access and waiting time standards should help to improve services and outcomes for the large number of people who are affected by mental ill health at some point in their lives.⁵⁸ Mersey Care NHS Foundation Trust told us, however, that there has generally been a low expectation of mental health services, first of all by those people using the services.⁵⁹

Accountability

26. The system for delivering mental health services is fragmented, involving a variety of national and local bodies.⁶⁰ We asked who is ultimately responsible for making sure people with mental health problems get the help they need. The Centre for Mental Health told us that parents and young people particularly find it difficult to navigate the system by themselves, meaning that GPs have a really important role as the advocate for somebody to make sure they get access to a service. Mersey Care NHS Foundation Trust agreed that accessing mental health care can be very difficult to negotiate. It explained, for example, that there were about 19 different routes by which people could be referred to the trust for treatment and therefore a multitude of different connections to make. Dr Wannan also agreed that it is very confusing for patients, and said that it is a clinician's responsibility to explain the system to them.⁶¹ The Department assured us that everyone in primary care services should have a named accountable GP who is responsible for the oversight of their care. When a person is referred, for example to secondary care, there should be a lead individual who is responsible for making sure that person's care is co-ordinated.⁶²

27. The Department emphasised that parity of esteem needs to not just be about the health service but involve other bodies such as schools, prisons, local authorities and employers. The vision for mental health services the mental health task force had set out would only be achieved if all those services had the same sort of positive attitude towards mental health.⁶³ The Department assured us it was working, for example, with the police in relation to crisis care, the Department for Work and Pensions on employment support, and the Department for Communities and Local Government on housing and mental health.⁶⁴

56 [C&AG's Report](#), para 5

57 [C&AG's Report](#), para 2.5

58 [C&AG's Report](#), para 12

59 [Q 1](#)

60 [C&AG's Report](#), para 1.7

61 [Qq 16–18](#)

62 [Q 113](#)

63 [Q 138](#)

64 [Qq 153–154](#)

Improving services

28. Written evidence from the Mental Health Policy Group welcomed the new focus on access and waiting times, but cautioned that it is important that prioritising some services does not lead to disinvestment in other effective, evidence-based services.⁶⁵ Mersey Care NHS Foundation Trust expressed the same concern that, because targets cover only a limited proportion of mental health services, there could be incentives to focus attention, and funding, on some services at the expense of others.⁶⁶ Dr Wannan also pointed to the risk of creating perverse incentives. For example, the target that, by 2020, all children and young people should be seen within four weeks of referral was a good thing, but there was a risk of simply extending the time people had to wait for treatment in order to achieve the target time for assessment.⁶⁷ The Department stated that it thought targets in this case, when it is trying to change behaviour, can be important but tracking against actual outcomes is extremely important. It emphasised that targets were part of a wider package of incentives to change behaviour that included oversight by NHS England and regulatory activity by the Care Quality Commission.⁶⁸

29. NHS England agreed that there would be a benefit in introducing waiting time standards for other mental health services. Having done that for improved access to psychological therapies and for the early intervention in psychosis service, NHS England confirmed that it aimed to do the same for eating disorder services, and then extend targets to a broader range of services. This would help to highlight the gap between need and treatment availability, focus management and funding efforts, and improve patient outcomes.⁶⁹

30. We took evidence on the experience of particular demographic groups such as ethnic groups, and children and young people. The Centre for Mental Health pointed out that, if we want parity between mental health and physical health, we also have to work towards parity within it, but that there are serious inequalities in the system. For example, there is a discrepancy in African and Caribbean men and women's experience of mental health services, in terms of what people are diagnosed with, and what care and support they receive. The Centre for Mental Health also told us that people from lesbian, gay, bisexual and transgender backgrounds have much poorer experiences and much higher rates of poor mental health, and Stonewall raised similar concerns that there was limited understanding of the specific mental health needs of this group of people. Mersey Care NHS Foundation Trust and Dr Wannan both added that part of the task of achieving parity of esteem was destigmatising mental illness. Different cultures have different ways of thinking about mental illness, and cultural sensitivity of how services are offered is a major part of this.⁷⁰

31. NHS England acknowledged that people from Pakistani or Bangladeshi heritage have about a 10 to 12 percentage point lower recovery rate from psychological therapy than the white British population. NHS England told us that there needed to be more of link between funding to the outcomes providers achieve, but that this would not address the whole problem. For example, fewer adolescents from black and minority ethnic

65 Mental Health Policy Group ([MHR0019](#))

66 [Q 4](#)

67 [Q 20](#)

68 [Qq 68, 100](#)

69 [Q 96](#)

70 [Qq 35-36](#); Stonewall ([MHR0016](#)), para 5

backgrounds were presenting into child and adolescent mental health services, but for adults more black and minority ethnic men are represented, particularly in the in-patient and secure parts of the mental health service. The Department pointed to the taskforce report recommendation that some form of ‘equalities champion’ should be appointed to make sure that the issue continued to be given prominence.⁷¹ We asked whether the data being collected to monitor who accesses services show what the outcomes are for people broken down by ethnic group, age, gender and other factors. The Department assured us that changes it had made to the mental health data set give it this information, and also include data about children and young people for the first time.⁷²

Children and young people

32. The Centre for Mental Health told us that it had recently completed a review of children and young people’s mental health. This work had found that it typically takes 10 years between the first symptoms of a mental health condition appearing and a young person having access to effective, evidence-based support. Delays were partly explained by low mental health literacy among parents, who found it difficult to know the difference between a mental health difficulty and ordinary childhood experiences, but also because of difficulty accessing services. Even when people made contact with services this could be a remote, formal and frightening experience.⁷³ Written evidence from Bringing Us Together reinforced concerns about children and young people’s experiences of poor mental health care.⁷⁴

33. The Department pointed to the “Future in Mind” report by the taskforce on children and young people’s mental health in 2014–15, which had involved over 700 young people in developing its proposals. The Department expressed concern, however, about whether the local transformation plans for children and young people’s mental health across the country were now doing as much as they should to include children and young people’s voices, and suggested that the picture is quite variable across the country, concerns echoed in written evidence from Barnado’s.⁷⁵ In response to a specific concern we raised that vulnerable children may have to travel a considerable distance to get treatment for eating disorders, NHS England acknowledged that there had been huge geographical inequalities across the country. For example, compared to a national average of about 11 in-patient beds per 1,000 children, there had been five in the south-west, seven in Yorkshire and Humber, 14 in the north-east and 12 in the east midlands. NHS England told us that it had increased the total number of beds, and gave a commitment that it would be specifically increasing capacity in places where there was still under-provision. It also said that it is connecting local children and adolescent mental health services with in-patient units in the same area to try and help flows of patients and ensure there are as few out-of-area placements as possible.⁷⁶

71 [Q 151](#)

72 [Q 150](#)

73 [Q 6](#)

74 [Bringing Us Together \(MHR0022\)](#)

75 [Q 142](#); [Barnado’s \(MHR0011\)](#)

76 [Q 152](#)

Criminal justice

34. According to the Prison Reform Trust, 26% of women prisoners and 16% of men have said that they had mental health treatment before they went into prison. However, once they enter prison, 57% of women and 62% of men are diagnosed with a personality disorder. We asked why people with mental health problems are not being identified before entering the criminal justice system. NHS England told us it was rolling out liaison and diversion services. These services provide closer interaction between mental health professionals, the courts and police. NHS England told us that these services currently covered around half the country, but that it aimed to increase coverage to 75% next year, and to achieve coverage across the whole country by 2020. This would mean that a lot more mental health problems would be identified before people reached prison. NHS England added, however, that around half of people who go to prison have an antisocial personality disorder for which it is not easy to access treatment.⁷⁷

35. We questioned why people leaving prison are not referred into the NHS. NHS England agreed that it would make sense to have a direct referral system for people leaving prison with mental health conditions, but told us that many people coming out of prison with a significant mental health problem are not always willing to engage and are often distrustful of professionals. Mental health professionals have to be very assertive to get to the people who need help.⁷⁸ The Department acknowledged that this was a very important point, and noted the proposal that the Secretary of State for Justice has made about focusing prison on rehabilitation. The Department highlighted the example of the ‘Through the Gate’ programme, which was piloted in the north-west of England; which emphasised continuity in professional relationships, so the people that prisoners had been working with while in custody were the same people they carried on working with when they were released back into the community.⁷⁹

77 [Q 137](#)

78 [Q 138](#)

79 [Qq 138–139](#)

Formal Minutes

Monday 12 September 2016

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon	Nigel Mills
Caroline Flint	Stephen Phillips
Kevin Foster	Karin Smyth

Draft Report (*Improving access to mental health services*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 35 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

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

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

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

[Adjourned till Wednesday 14 September 2016 at 2.00pm]

Witnesses

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

Wednesday 15 June 2016

Question number

Andy Bell, Deputy Chief Executive, Centre for Mental Health, **Joe Rafferty**, Chief Executive, Mersey Care NHS Foundation Trust, and **Dr Gary Wannan**, Senior Consultant Psychiatrist, Central & North West London NHS Foundation Trust [Q1–40](#)

Professor Tim Kendall, National Clinical Director for Mental Health, NHS England, **Jon Rouse**, Director General, Social Care, Local Government & Care Partnerships, Department of Health, **Simon Stevens**, Chief Executive, NHS England, and **Chris Wormald**, Permanent Secretary, Department of Health [Q41–154](#)

Published written evidence

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

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

- 1 38 Degrees ([MHR0021](#))
- 2 Army Families Federation ([MHR0006](#))
- 3 Association of School and College Leaders ([MHR0018](#))
- 4 Barnardo's ([MHR0011](#))
- 5 Bringing Us Together ([MHR0022](#))
- 6 British Psychological Society ([MHR0023](#))
- 7 Carers Trust ([MHR0001](#))
- 8 Centre for Mental Health ([MHR0013](#))
- 9 Department of Health ([MHR0026](#))
- 10 Mental Health Policy Group ([MHR0019](#))
- 11 NHS Clinical Commissioners ([MHR0027](#))
- 12 NHS England ([MHR0028](#))
- 13 NHS Providers ([MHR0020](#))
- 14 Royal College of Nursing ([MHR0024](#))
- 15 Stonewall ([MHR0016](#))
- 16 The Otsuka and Lundbeck Alliance ([MHR0015](#))
- 17 UK Council for Psychotherapy (UKCP) and British Psychoanalytic Council (BPC) ([MHR0012](#))
- 18 UK Council for Psychotherapy (UKCP) and British Psychoanalytic Council (BPC) ([MHR0025](#))

List of Reports from the Committee during the current session

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2016–17

First Report	Efficiency in the criminal justice system	HC 72
Second Report	Personal budgets in social care	HC 74
Third Report	Training new teachers	HC 73
Fourth Report	Entitlement to free early education and childcare	HC 224
Fifth Report	Capital investment in science projects	HC 126
Sixth Report	Cities and local growth	HC 296
Seventh Report	Confiscations orders: progress review	HC 124
Eighth Report	BBC critical projects	HC 75
Ninth Report	Service Family Accommodation	HC 77
Tenth Report	NHS Specialised Services	HC 387
Eleventh Report	Household Energy Efficiency Schemes	HC 125
Twelfth Report	Discharging Older People from Acute Hospitals	HC 76
Thirteenth Report	Quality of service to personal taxpayers and replacing the Aspire contract	HC 78
Fourteenth Report	Progress with preparations for High Speed 2	HC 486
Fifteenth Report	BBC World Service	HC 298

Public Accounts Committee

Oral evidence: [Improving Access to Mental Health Services](#), HC 80

Wednesday 15 Jun 2016

Ordered by the House of Commons to be published on 15 Jun 2016.

[Watch the meeting](#)

Members present: Meg Hillier (Chair); Mr Richard Bacon; Chris Evans; Mr Stewart Jackson; Nigel Mills; David Mowat; Stephen Phillips; John Pugh; Karin Smyth.

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

Questions 1-154

Witnesses

[I](#): Andy Bell, Deputy Chief Executive, Centre for Mental Health, Joe Rafferty, Chief Executive, Mersey Care NHS Foundation Trust, and Dr Gary Wannan, Senior Consultant Psychiatrist, Central & North West London NHS Foundation Trust.

[II](#): Professor Tim Kendall, National Clinical Director for Mental Health, NHS England, Jon Rouse, Director General, Social Care, Local Government & Care Partnerships, Department of Health, Simon Stevens, Chief Executive, NHS England, and Chris Wormald, Permanent Secretary, Department of Health.



Report by the Comptroller and Auditor General
Mental health services: preparations for improving access
(HC 492)

Examination of witnesses

Witnesses: Andy Bell, Joe Rafferty, and Dr Gary Wannan.

Q1 Chair: Good afternoon and welcome to the Public Accounts Committee. We are here today to get evidence and look at mental health services on the back of a National Audit Office Report, "Mental health services: preparations for improving access". This is an area to which both this Committee and the National Audit Office will return a number of time during this Parliament, because it is obviously a hugely important issue and one on which there is a major Government policy shift, although it hasn't quite happened yet, which is one of the things we are here to discuss today.

We are delighted to have a pre-panel today of experts in the field actually at the sharp end trying to make sure that Government policy gets delivered. We have on my left Andy Bell, deputy chief executive at the Centre for Mental Health; in the centre is Dr Gary Wannan, who is senior consultant psychiatrist at Central and North West London Central NHS Foundation Trust; and then Joe Rafferty, who is chief executive of Mersey Care NHS Foundation Trust. Welcome to you all. We hope you will be candid in your comments—we take what you say very seriously—and after you we have the Department and NHS England to put your points to, as well as what is in the Report.

Why does parity of esteem between mental and physical health seem to be so difficult to achieve in practice? That is quite an open question. Perhaps I will start with you, Mr Bell, and then work across.

Andy Bell: The first thing to say is that we are starting from a low base. Mental health support at the moment receives around 12% of NHS funding—I think that is what the NAO Report said—and accounts for about 23% of need. That is quite a big discrepancy. We know from freedom of information requests that that varies from one area to another, so different CCGs are starting from different places in terms of their support for mental health.

We also know that there is a range of other disincentives to create a fair situation for mental health. That includes the different funding systems—the fact you have a tariff for most acute hospital-based care and mental health care is paid for, with some tweaks, in what is still a block contract, so the provider gets paid a certain amount a year rather than being paid for the number of procedures it carries out. Also, we still have a system where accountability is skewed towards other areas, so it is only this year

that for the first time, we have had access and waiting standards. The NAO has focused on those, but they are only two of myriad areas of mental health support, and the rest is very opaque in terms of what is going on, what standards of care are provided and how quickly it is done.

Then there are a couple of things. One of them is that mental health is very often overshadowed, so we hear endlessly that there are limited resources in the system, and when it comes to decisions being made locally, there is always something that feels a bit more pressing and where there is a more shrill case, if you like, for support. There is always a higher burden of proof to do something different. It is easier to stay the same, and to carry on as we were, just making little tweaks to it. There are a number of disincentives that stop us making as much progress as we might.

Dr Wannan: I concur with Andy's very full answer. Starting from a low base as we do, there is a lot of progress that needs to be made. One thing that has struck me over the years is that the very good intentions that Government often has simply do not translate to what happens on the front line. I can remember even 13 years ago, when I began my consulting post, being somewhat excited by the new funding that would be coming to child and adolescent mental health, seeing the framework behind that and then, with the smoke and mirrors that went on, actually being left with much less resource than had been anticipated. As Andy said, there may often be more pressing needs or other things going on within the wider system that simply militate against the good intentions of central Government.

Joe Rafferty: Again, I concur with what has been said. I might add that there has generally been a low expectation of mental health services, first of all by those using the services. They are often very disfranchised people; many have had to struggle very hard to get into services. That, I think, combines with the public view—there is probably not enough education about the reality of mental illness and mental disorders. We still encounter lots of people who have a "Pull yourself together" attitude, or "This is a lifestyle choice"—we see that particularly around addiction services. We would argue very strongly that there is a strong line of mental illness in people with severe addictions, yet it is sort of seen as a lifestyle choice.

Q2 **Stephen Phillips:** Is that public view changing, or is mental health still the Cinderella of the NHS?

Joe Rafferty: I would say it is still a Cinderella, but I think because of better public appreciation in the past couple years, much more political focus on the question of mental health and the economic benefit of addressing it, NHS England's comprehensive review and the taskforce report, as well as the intention to invest more, put us in a position that is better than we have been in for probably the past 15 years or so. The question is how to capitalise on the opportunity now.

Q3 **Chris Evans:** Mr Rafferty, you made an interesting point about addiction.



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I have been very interested in addiction and the link between addiction and mental health. In the last Parliament I was a member of the Justice Committee, and I felt that when a prisoner was incarcerated, they treated the addiction but not the underlying mental health problem. I felt that was a huge issue out there. Do you think that a lot of money directed towards addiction treats the symptom rather than the underlying cause? How can we overcome that and get value for money?

Joe Rafferty: My view is that that is an absolutely correct observation. We are trying to tackle that internally as an organisation, and I know lots of others are. For me, the issue is that our experience of addiction services is that they are incredibly underfunded. They tend to be put out to tender on a regular basis, and there are lots of small organisations focusing on addressing the addiction. The result of that is that it is really hard to find anywhere an addiction service with the sort of critical mass required to put psychology and psychiatry in and make it much broader and fuller in both assessment of and response to the underlying nature of the issue.

Chair: For anyone who is following us or wants to comment on Twitter, I should say that our hashtag today is #mentalhealth.

You have all highlighted that we are starting from a low base. The Government has set out a grand vision, but at the early stages a simple set of targets on waiting times—the sort of things that people with a physical problem have come to expect for some time. Andy Bell, you have talked a bit about this. What are the particular barriers to that? Is it the funding or is it the culture of how these services are organised? Perhaps we will start from the other side with Joe Rafferty and go back the other way. We will take Gary first another time.

Joe Rafferty: I think that both your suggestions are right. It's a little bit about how services are organised. Unquestionably, at least for a period of time, it is about some element of funding to pump-prime change. One of the difficulties in addressing this issue—I welcome the waiting time standards—is that it is a bit like a magnet with iron filings: if you hold it up, all of the attention goes to wherever you have put a specific target. I wonder whether we will end up improving bits of the system quite well, but if your presentation doesn't relate to early intervention in psychosis, IAPT or whatever, you will remain out in the cold. What I would like to see is a comprehensive waiting times backstop for all secondary mental health services.

Q4 **Chair:** So you think that is feasible. One could argue that the Government is putting it this way to take it step by step, but you think it is possible to do it all at once.

Joe Rafferty: I understand the step-by-step issue. I get that, but what would have happened if we had started in acute care with a two-week cancer wait and a four-hour wait in A&E, but hadn't addressed anything else? I think we would have pushed those things really rapidly, but the rest of the system would have felt like it wasn't getting attention. Why is mental health somehow out in the cold? We didn't do that for physical



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health. If the issue is parity, why, if you don't fall inside those current waiting times guarantees, do you have no guarantee at all?

I think it is perfectly feasible. It makes us all sit up and decide that everybody with a mental illness who needs access to those services is important. It will make us fundamentally change how we think about delivery. Just having to think about it will make us more efficient.

- Q5 **Chair:** Mr Rafferty, it sounds like you are recommending yourself for a national advisory position. The permanent secretary is sitting looking rapt behind you. Do Gary Wannan and Andy Bell have anything to comment on what Joe Rafferty has just been talking about?

Dr Wannan: Child mental health has been described by some as the Cinderella of Cinderella services. Between 2010 and 2015, it is estimated that about £85 million in total was taken out of child mental health, despite the intention of increasing funding. If one looks at the amount invested by the NHS and local authorities, one can see that there has actually been disinvestment. We all know that mental illness follows a life course, and that by investing at an early stage we are going to save money in the long run.

In terms of new resources, one of the things that encouraged me considerably was seeing the Government and clinicians like me and others working together over the children and young people's improving access to psychological therapies programme. We saw very clear training and goals, and we have seen progress, but more needs to be done to think strategically about how we can best use new resources to find ways to invest to save, among other things, and to make sure that there are not smoke and mirrors and that the Government's commitment does not wither.

- Q6 **John Pugh:** We have had a submission from the Association of School and College Leaders. They polled their members, who were asked what they thought works well in terms of children's mental services—that is what you are drawing attention to—and 43% said they were very happy using in-house counsellors and least happy with the referral process to CAMHS and other psychiatric treatments. One in five reported that they were very happy, but nearly two thirds reported that the experience had been poor or very poor. Is that entirely a consequence of funding, or is a consequence of the wrong service being provided in the wrong way?

Dr Wannan: I am not sure I can give a complete answer but—thinking about school counselling—schools are a great place to reach children and young people. That is where the great majority of children and young people are sure to be found. Having a school counsellor or a children's mental health worker embedded in schools is a great way to reach out. If there are any choices to be made about funding, that would be one of the first places that I would be emphasising.

I sympathise with the comments made about accessing child and adolescent mental health services. The Children's Commissioner's enlightening review of CAMHS services that was published recently shows



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a huge national variation. In some CAMHS, the waiting time might be seven months. In others, it might be two weeks. It comes back to my comments that there needs to be strategic investment. We as clinicians need to be motivated and sometimes roughed up a little bit by the Government to ensure that we are making the very best use of our resources and to ensure that we—

John Pugh: The Government might take up that invitation.

Chair: The Government are excited behind you. I wish the cameras had another angle. Sometimes we get a bird's-eye view.

Andy Bell: We would be happy to do that from the voluntary sector as well.

Chair: Rough them up?

Andy Bell: In terms of the access and waiting standards we have at the moment, the biggest barrier appears to be workforce availability. You need to have trained people to carry out the interventions according to the evidence. In lots of areas of mental health support, unsurprisingly, if you have unqualified staff or staff who are not properly supervised, sometimes the interventions can do more harm than good. It is very important that you have the right people with the right skill to give people the support they deserve. There is something about building up a workforce that is capable of meeting the standards in all the areas.

To pick up on the issue of schools, we have recently finished a major review of children and young people's mental health. The stark finding that came out of that was that it typically takes 10 years between the first symptoms of a mental health condition appearing and a young person having access to effective, evidence-based support. That is a range of delays based on low mental health literacy, on parents finding it hard to know the difference between a mental health difficulty and just ordinary stuff happening in childhood, and on what parents and young people described as a maze-like way of getting into services.

If a parent asks for help, schools very often do not know what to do. Unfortunately, when people end up in services and make contact, they often find a remote, formal, frightening, clinical feeling, so even when people get access they very often walk away and do not maintain contact. We have to look thoroughly at children's mental health.

I hope very much that the access and waiting standards that we have are just the first few of a number that address this by actually using the evidence of what an appropriate amount of time to wait is. We should ensure that people are getting access to support in a way that is timely and takes advantage of them asking for help.

Q7 **Karin Smyth:** I want to pick up on the system, which you have all talked a little bit about. If we were looking at mental health as a whole, we would have about 20 different people in front of us, particularly people from housing and other providers. Would you all say a little bit about the



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financial incentives in the system? How might they be better to get you all working a bit better together?

Dr Wannan: As a clinician, my incentive comes from the needs of children and young people. I know that it is nearly always the best thing for families for me to help to bring professionals together to ensure that the package of care and treatment received is well designed and well planned, so that we do not overuse resources or swamp a family with professionals, but that we target children.

Q8 **Karin Smyth:** Are you purely hospital-based?

Dr Wannan: I am based in a clinic in the community. I will do a small amount of work in hospital, but a lot of time I may be out in families' homes or going to the housing department or social services, so for me, it is instinctive almost to bring professionals together, to work together efficiently and in the best way for children and families. I am not sure the financial incentive would necessarily change the work I do in that respect.

Andy Bell: In almost every area of mental health we look at, partnership working and coming together are really important. Sometimes, we see integration in two-dimensional ways when it actually works in three. Sometimes it is about primary care working with specialist services; sometimes it is health and social care working together; sometimes it is mental health and physical health; it is also relationships with the police, housing and employment services. In almost every case, the incentives—the hard wiring of the system, as the taskforce usefully called it, seems to militate against that happening. It is much easier to commission and provide services on your own, rather than in partnership. When times are tight financially, we see drawbridges going up rather than people making arrangements to work together.

We have long-standing arrangements in adult mental health where social care tends to be part of a community mental health team. I certainly heard anecdotal reports of those arrangements coming to an end, which is clearly a very backward move when we know how important it is that people get joined-up support. Likewise, joining up with housing is incredibly, fundamentally important.

With something like employment, there is a real disjunction at the moment between the kind of support people are getting in the NHS—some of which is very good, and where there are evidence-based employment services—and the experience they are having of the DWP's programmes, which, for people with mental health problems, is extremely difficult.

Joe Rafferty: That is a really great question. As Andy says, in difficult times, partnership can be really hard to do because it is often down to will rather than financial incentives. Sometimes, the financial incentives could be made easier, though. I will give you a simple example around the A&E liaison services that we provide, which we have to do in partnership with the acute trust, police, social care and so on. For us, a great incentive would be a very simple thing like having our staff funded on recurrent money¹, so that we can give them real, long-term contracts, attract the



best people in and make the liaison service feel like it's a real career move.

Q9 **Chair:** When you say "your people", are we talking about particular clinical groups?

Joe Rafferty: Our liaison nurses, some of our social workers—we are offering six-month and twelve-month contracts.

Q10 **Karin Smyth:** Is that because those liaison services are pilots or perhaps perceived as short-term interventions at that particular time, so they are not part of the general make-up?

Joe Rafferty: That's right. There is always this view of, "We've got to see how this works." The truth is that getting over the hump and trying to get people in so that they can invest real time and energy—the partnerships work then, because you build long-term relationships. Sometimes the incentives could be as simple as that.

Q11 **Stephen Phillips:** I want to go back to Mr Bell, and probably to you, Dr Wannan and Mr Rafferty, on the question of staffing, at the risk of telegraphing some of my question to Mr Wormald in due course. Let us look at the Report prepared by the NAO, of which you have a copy. In figure 13 on page 46, there is quite a discrepancy between the numbers of staff working in mental health that the trusts think they want between now and 2020, and the demand as predicted, for example, by the King's Fund. I wonder what your views are on that, first as to who is right, and secondly as to how those discrepancies are going to reflect themselves in improved access to mental health care over the course of this Parliament. Do you want to start, Mr Bell?

Andy Bell: If I could find the correct page—

Q12 **Stephen Phillips:** Page 46, figure 13. If you look at the figure first, you can see the divergence—the fork in the graph. If you go to the preceding page and look at paragraph 3.27, just look at the second sentence: "There is a considerable discrepancy between numbers that local providers estimate are required, and Health Education England's forecasts. Trusts forecast, for example, that their demand for mental health nurses will fall over the coming years. Health Education England, however, estimated that implementing access and waiting time standards would require the number of mental health nurses to rise from 39,000 in 2014 to 42,000 by 2020".

So we have one picture from the trusts and another from Health Education England. Not having the staff, if they are needed, is obviously going to reflect itself, I would have thought, in poorer mental health services, poorer access to mental health services and defeating the objectives the Government appear to have. That is the area on which I wanted the views of all three of you.

¹ Witness wrote to Committee to clarify answer on 28 June 2016



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Andy Bell: In this area, it is certainly fair to say that, in the time I have been working in the sector, workforce planning has not been a strength in terms of the way in which services and national strategies have been developed. It has not been a major factor in any of the recent strategies—probably not since the national service framework in 1999, which had a very clear sense of the workforce that would be required and how it was going to be brought together.

This needs to be thought through, because obviously we need enough people on the ground to do the work and we also need to look very carefully at what workforce we need, particularly if we are focusing on earlier intervention. We need to think about what people with what skills we need—it is not just, “Do we need X number of nurses and X number of psychiatrists or psychologists or anything else?” There is certainly a growing role for peer support workers, who can very often be a very valuable part of any clinical team, or employment specialists, who can provide support with work.

This probably calls for a proper look at what workforce we need, taking a long-term view that looks considerably beyond the five-year horizon we have now. It is about identifying what skills and what people we need, and how we can get them. I suspect that will take quite a bit of work.

Dr Wannan: Staff are the core of the service we provide.

Stephen Phillips: You can’t do it without them.

Dr Wannan: Exactly. The great majority of our work is done through talking treatment, so workforce planning is vital. It is helpful of the National Audit Office to have made this point as clearly as they have. When we look at young people and what they say about the services, what they most value is quality and continuity in the relationships they have.

Joe Rafferty: One of the reasons I welcome the current review by NHS England of mental health—by the taskforce—is that it starts to give us a longer-term view. The interesting thing is that there is, I guess, about a three-year lag in all this, so you have to be making decisions now about way into the future. That is why this is such a critical point.

I do not know entirely about Health Education England—I can only talk about my own organisation in that sense. We have quite a clear five-year view of where we want to be, how our staffing numbers reduce through attrition and retirement, the types of services we intend to deliver in the future and what type of workforce we might need and want. For example, nurse associates is another alternative to training nurses in a traditional way. There are physician associates. We are now recruiting our 17th or 18th peer support worker in the organisation—people with lived experience who deliver a really different view.

I guess the issue is, because of the lag in this, that we absolutely have to get it right. I argue, from my perspective, that we have a clear view.



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Whether that aggregates to the right view at the Health Education England level, I couldn't comment.

- Q13 **Stephen Phillips:** It is being suggested to me in real time by a very senior mental health nurse that trusts frequently underestimate staffing needs at the outset. Jobs are calculated on tasks, rather than the actual time you need to spend with patients.

Joe Rafferty: Correct.

Stephen Phillips: Is that a fair criticism of what takes place across trusts at the moment?

Joe Rafferty: My view is that traditionally, we have looked at the staff we have and we try to work out what service we can deliver with the staff we have, which I think is the wrong way to do this.

- Q14 **Stephen Phillips:** Yes, isn't that completely the wrong way around?

Joe Rafferty: Correct. The way to do it is to have a clear view of the care model—what you are trying to achieve—and then work backwards to look at the opportunities to think differently about the types of staff. To use the model that you suggest, we should ask, "How much time does someone need to do this?", rather than simply, "What's the task?", because the task tells you nothing. The task tells you nothing about the acuity of the patients in front of you, the treatment pathways, the handovers—all those things. I think we need to get a lot slicker at workforce planning generally.

- Q15 **Stephen Phillips:** I do not want to prolong this unnecessarily, but Dr Wannan, do you want to comment on that?

Dr Wannan: Yes. I think that with the new money coming into child mental health that the Government have promised, workforce planning is vital. That money needs to be spent well. I was speaking earlier about investing to save. There are huge opportunities to save money, such as being able to give intensive community provision for young people, rather than admit them to an in-patient bed. We need to make sure that we have the right workforce in place and to look creatively and strategically at how best to use resources.

Stephen Phillips: Very briefly, Mr Bell.

Andy Bell: I do not want to comment on how trusts do their workforce planning, because I don't know, so it would be unfair. The other thing to say is that the mental health workforce is a lot bigger than the people employed by mental health trusts. When you think that 90% of people who receive any treatment for a mental health difficulty only ever see someone in primary care, so GPs and their staff are an incredibly important part of the workforce. People working with children in schools and in youth services are all part of the workforce. I think we need to see that broader set of people outside the system.

I have seen from data from the NHS Benchmarking Network that staffing, particularly nurse staffing in in-patient services, has increased over the



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last few years, because of safe staffing, following Mid Staffs. I think that creates a very particular pressure on wards to make sure that they have enough people. The average in-patient ward has a bed occupancy rate of 93%. The safe occupancy rate is 85%, and that is excluding people on leave, so there is enormous pressure in some of these services. I think there is a culture of making do with the resources available, which you don't get in other parts of the NHS so much.

Chair: I just want to advise Members on who is coming in when: John Pugh, David Mowat and then Chris Evans. I am aiming to finish this segment of our hearing by about twenty past, so could the witnesses bear that in mind? If you agree with someone, we are happy for you to say you agree—you don't have to repeat, though we welcome your evidence.

- Q16 **John Pugh:** I just have one big question and one quite small question, to Mr Rafferty, while he is there. One of you mentioned the system a few minutes ago and we have some submissions that show that people are occasionally baffled by the system and the lines of accountability. I would like you, just briefly, to comment on that, because if we look at how a patient with an often extremely troubled psychology is treated, and with a very fretful family, they normally find the entrance point to the system via the GP, who refers them to some provider, who is commissioned by a third body. The provider—I think I am right in saying this, Mr Rafferty—can sometimes just diagnose and then refer on to another provider, who provides the treatment. That is fine when everything goes seamlessly, but when things go wrong and the treatment isn't working—there are certainly some touching accounts in the submissions we have had about when it hasn't—it doesn't seem an ideal set-up. I was mindful when preparing for this that there are some areas where commissioning is done slightly differently or better or more wisely. I would just like all of you to comment on the accountability factor. Who is responsible ultimately for the troubled patient?

Chair: Who shall we start with? Well, you asked Joe Rafferty.

Joe Rafferty: I think that we have probably talked about this before in other times. You are absolutely right. It can be an incredibly difficult set of pathways to negotiate. For example, as a secondary provider, we have about 19 different ways into the trust—19 different routes of referral in—and therefore a multitude of different connections to make. It would be much easier, I think, if we had a system where we could rely more heavily on a referring practitioner—a general practitioner as the core, until somebody absolutely moves into another part of the service. I guess the difficulty is that many of these services have grown up over years, been commissioned in very inconsistent sorts of ways, and there are lots of legacy systems in there. That doesn't excuse it, but it is probably a description of why the history of things is as it is. I think we are seeing now quite a big move, certainly with the CCGs that we work with, to bring the various agencies round the table and have much more of a multidisciplinary-team-type approach. I am absolutely certain that that is going to resolve quite a lot of the issues, with a very strong sense of



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making sure that we navigate people—not just diagnose or treat, but assist with navigating to the next right place.

Dr Wannan: I agree it's confusing for patients, and it is my job to explain the system to them and make it very clear—

Q17 **David Mowat:** You're able to?

Dr Wannan: Yes. I think that if I meet a family and I am clinically responsible for the child, it is my responsibility to let them know that that is the case and confirm that in writing, as it would be for anybody else who works in my team. There may be times when we have overlapping responsibilities, but as well as asking the question about who is responsible clinically—coming back to the issue of resourcing and so on—I sometimes ask myself the question: who is responsible for the resource allocation? My experience is that these clinical lines of accountability are sometimes clearer when we have some of the financial, managerial—

Q18 **John Pugh:** But neither is particularly clear, to the patient at any rate.

Dr Wannan: Yes.

Andy Bell: Again, it's the way parents and young people particularly describe the difficulty in navigating services—having to do it themselves. The NHS is a gatekept service, so general practitioners are really important in terms of being the advocate for somebody to make sure they get access to a service. If we put as much effort into providing support as we do into assessing people and excluding, we could probably have a much more productive set of services. But accountability is troublesome throughout the system, throughout the NHS. In what way is there accountability for how much we fund mental health services in each local area? At the moment, it is very unclear where that line of accountability is and who is responsible.

Q19 **David Mowat:** We started the session with the question of why parity of esteem is or seems to be so hard to achieve. What strikes me is whether or not the Government or the system has been honest in its intentions in all of this, we have put this objective out there, into a system that is under such pressure in so many other areas. We have a situation where 80% of acute trusts have a deficit. We have a massive shortage of GPs. So whereas the objective is clearly a good one, it does not necessarily say what we are not going to do as a result of having that objective, and because of that, it is not totally honest. And it just struck me, reading the Report, that one of the issues that arises is that when money is given to clinical commissioning groups and is not ring-fenced, it tends not to get spent on mental health stuff but on other stuff, presumably because those people have decided they have other and—in their opinion—more pressing needs. I just wonder whether we are trying to do something here that is honest.

Chair: No one wants to go first on that one. Andy Bell.

Andy Bell: Parity as an idea has really resonated in lots of places and been used very creatively by people in local CCGs and councils to make a



difference, so it has had a resonance in local areas, which has been incredibly helpful. I think it's entirely achievable. It certainly would be a shame if we got further from parity and I think we can get closer to it. The way we can get closer to it is to recognise the waste at the moment in spending, in the NHS and other public services, on failing to support people's mental health. The NHS spends as much again if not more on the consequences of untreated mental health problems among people with long-term conditions like diabetes and people with medically unexplained symptoms who are having endless out-patient tests. A whole range of people are getting very poor care at very high cost.

Q20 David Mowat: That answer implies that parity of esteem over the life cycle, if I can put it like that, pays for itself.

Andy Bell: There is no question about that. An analysis we have carried out shows that if you refocus and reinvest in effective early mental health help and integrating care across that great divide with physical health, it will pay a dividend.

Dr Wannan: I very much agree with what Mr Mowat said and I come back to the idea of investing to save. We should be looking to spend money to free up other resources. It is cheaper but also much better for young people to receive intensive treatment in the community rather than being admitted, but it requires strategic and long-term committed planning to be able to do that. I am concerned as well that with targets—for example, we have a target by 2020 to see all children and young people within four weeks of referral. I very much agree with that goal. That is a good thing. A six-month wait is a long time in a child's life. My concern is that we will simply remove something else, so the time for treatment may simply be increased to shorten the time for assessment.

Q21 David Mowat: In his very first answer, though, I think Mr Bell made the point that 12% of resources go into this area and 23% of need—however that is measured—is in this area. That implies that you think that there should be more resources put into this area, although the two of you who have answered so far have said that actually, over the life cycle, it is not a question of more resources, because you save more by doing it earlier. I have heard that before. Which of those two positions do you take?

Andy Bell: From my point of view and from the research we have developed, I think we should spend more as a proportion on mental health. I do not know what the right proportion would be—I think it would be different in different areas—but at the moment there is an underspend on mental health. It is about identifying where there are opportunities to make change. It is incredibly difficult at the moment.

Q22 David Mowat: I agree. That looks to me to be the case, but if we think we should be spending more on mental health, as your first answer implies—

Andy Bell: Absolutely.

David Mowat: A strategy that says parity of esteem, which is clearly a



good one, works extremely well until we find out what we are not going to do as a consequence of that, perhaps in some other area, such as—I don't know—cancer drugs, fewer GPs or something. That is where the difficulty arises, presumably, for those people who are making those resource decisions in the clinical commissioning groups and in other places. That is the issue that we may not be addressing properly.

Chair: Quick-fire answers, please.

Andy Bell: There is a risk in making that change, but there is also a risk in staying where we are, which is that we continue to treat people badly and pay the costs. As a perfect example of where you can shift resources, we know that if you invest in liaison psychiatry services in general hospitals, you can reduce the number of admissions and the length of stay of very vulnerable patients. In some hospitals where they have invested in liaison psychiatry, they have actually been able to close wards—in-patient wards, which are very high cost.

Q23 **David Mowat:** Right. But that answer is internal to the mental health area; it is not saying that there is an area that is going to lose out.

Andy Bell: No, that is within physical health. That is in an ordinary hospital—a district general hospital—shifting a bit of resource across to mental health, which is a relatively small service in the context of a huge NHS. As an example, to provide psychological support to people with cancer, who have very high rates of poor mental health, would cost 0.2% of the cancer budget. It is a tiny bit of the resource that would be needed to provide people with a little bit of extra help, which might help to improve their quality of life markedly.

Q24 **Chris Evans:** I am deeply concerned. Obviously, there is an understanding across the panel that secondary school-based counselling is extremely important in terms of child mental health. There are 70,000 to 90,000 cases in secondary schools each year. What worries me is that according to the British Association for Counselling and Psychotherapy, provision is very inconsistent and patchy across England. However, Wales and Northern Ireland have national school-based counselling programmes. What is the problem in England? Why have Wales and Northern Ireland in particular recognised this problem while England is so far behind the curve?

Chair: I don't know which of you is qualified to answer this one. Who can answer it? Andy Bell is offering himself again.

Andy Bell: I can have a go at a bit of the question. I know the reason Wales invested in school-based counselling. Unfortunately, it was as a result of the spate of suicides in Bridgend. That was the motivating force; they felt that they had to make a response. You have to build the evidence base first of all about—

Q25 **Chris Evans:** Sorry to interrupt. That was a direct response to what was happening in Bridgend in 2008-09—yes?



Andy Bell: That is my understanding, yes. It was a response by the Welsh Assembly Government to concerns about that. Why are we not doing it in England? That is a good question. We know that schools have a really important role. School counselling is part of what we describe as a whole-school approach. You might have only one thing in a school. If you have only counselling and you do not have anti-bullying support, you do not have it on the curriculum and you do not quickly identify children who are having difficulties—actually, the way you get the right results is by having a school that embeds mental health across all the ways in which it works. It should train up teachers in mental health awareness.

If you are a primary school—primary schools have as big a role, if not a bigger, in supporting children’s mental health as secondary schools—it is about working with parents and families and identifying families who are struggling to manage their children’s behaviour. Children with behavioural problems go on to have the poorest life chances and the most diminished future opportunities in life. It is about embedding a whole-school approach. That is what we have to get closer to and where there is a big prize, and it will be incredibly good value for money.

Chair: We have the permanent secretary before us in a moment.

Q26 **Mr Bacon:** Dr Wannan, you have repeatedly mentioned invest in order to save. How much investment would produce how much saving?

Dr Wannan: As much as you want to give me; that is the easy answer.

Q27 **Mr Bacon:** Well, it is an easy answer to the first part. You have invited the Government to rough you up. If I were Mr Wormald, I would want an answer to the second part. In fact, I also want an answer to the second part. How much money would you save?

Stephen Phillips: For every pound invested.

Dr Wannan: I do not have the answer to that readily available but, with £1.25 billion promised over the next five years, I hope that will make a substantial difference to the services that can be provided.

Q28 **Mr Bacon:** It is the saving that I am after—the number. Would £1.25 billion save £600 million or £3 billion?

Dr Wannan: I can’t give you the answer to that. Look, for example, at the research that has been done on intervening in parenting when children have a conduct disorder—behavioural problems. I do not have the figures in my head but there is clear evidence to show that the return on every pound is quite colossal in terms of the amount of money saved through these children and young people being diverted away from the criminal justice system and the like.

Q29 **Stephen Phillips:** If there is some research on that, would you mind sending it to us? Just signpost us to the research.

Dr Wannan: I am very happy to do that.

Q30 **Mr Bacon:** I am not saying that you are wrong. You may very well be



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right. I was interested in Mr Bell's example. I am just saying that if you are going to persuade people, you will need evidence.

Dr Wannan: I am very pleased to furnish that.

Q31 **Chair:** There is a figure in the NAO Report that I am just going to ask them to highlight.

David Raraty: There is the widely quoted number that mental health problems cost the whole UK economy an estimated £105 billion a year.

Q32 **Mr Bacon:** £105 billion?

David Raraty: £105 billion.

Q33 **Mr Bacon:** So, that is one seventeenth of GDP.

David Raraty: Which is substantially more, of course, than we spend on treating mental health conditions.

Q34 **Mr Bacon:** That is almost the entire NHS budget—not quite, but nearly.

David Raraty: How much of that you would save depends on the effectiveness of the mental health interventions, perhaps.

Joe Rafferty: There is a good economic analysis of the benefits of intervening with mental health at the back of the Mental Health Taskforce document. I cannot remember the aggregate invest to save figure, but it is often two and threefold. For every pound spent, you would liberate or release £2 or £3.

Mr Bacon: If you could send us a memo with some details, we would welcome that.

Q35 **Chair:** A couple of quick questions from me before we finish. The first is about the well-known fact that, nationally, black men have a higher estimated rate of psychosis than white men. I know that is an issue in my constituency. More are also admitted into hospital. There seems to me, as a constituency Member of Parliament, to be a real issue about equality in mental health treatment. Would those of you who feel qualified each give a comment about why you think that is and what could be done to make it better?

Andy Bell: There are numerous inequalities. The experience of African and Caribbean men and women in the mental health system is—

Q36 **Chair:** Women in general or Afro-Caribbean women?

Andy Bell: African and Caribbean women. There is a very serious discrepancy in what people are diagnosed with, and what care and support they receive. There have been numerous efforts to try to address that—some with funding—and it does not appear to have made a huge amount of difference. We are quite keen to see what interventions can be offered to people younger in the age spectrum to prevent people from coming into contact with the mental health system through the police, which is often the route that leads people into that very negative cycle.



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Lambeth Council has done some terrific work with the African and Caribbean community in the borough to identify what support they would like in terms of earlier intervention and the support people get. There are other inequalities that are hidden and serious. People from lesbian, gay, bisexual and transgender backgrounds have much poorer experiences and much higher rates of poor mental health. In terms of people with learning disabilities, there is very little in the way of evidence around what help and support people want, but we know that there are very high rates of poor mental health. There are lots of inequalities, and if we want parity between mental and physical health, we also have to work towards parity within it.

Chair: Absolutely.

Dr Wannan: Building on that, with the Government's emphasis on parity of esteem, part of that is destigmatising mental illness. Different cultures have different ways of thinking about mental illness. Any progress that can be made in that area is very welcome. With the increased emphasis on early intervention in psychosis, I can talk about my own experience of being in an early intervention psychosis team, where efforts were made within the community to increase public education.

Joe Rafferty: The only thing I would add is that cultural sensitivity of how services are offered, not just how early, is probably a major route into this. We have some evidence from working with the Somali community in Liverpool that cultural sensitivity is a really big issue.

Q37 **Chair:** Do you have anything you can send us on that?

Joe Rafferty: I can do.

Q38 **Chair:** A quick-fire final round. We have the permanent secretary and the head of NHS England in front of us next. What two or three things do you think would move this agenda forward appropriately and quickly? Obviously, we are in the early stages.

Joe Rafferty: Commissioning, funding and information to make better decisions.

Chair: Very succinct, thank you.

Dr Wannan: Auditing the promises made by Government—

Chair: The auditors are smiling. You are currying favour.

Dr Wannan: —in terms of what is exactly spent on child and adolescent mental health.

Chair: So actually knowing the data, which, as the Report highlights, is an issue.

Andy Bell: I can't be that quick. Accountability, transparency about funding in mental health in every local area—we need to have real-time data on what is being spent on what, and there needs to be some kind of



accountability for doing that. Sustainability of transformation plans have not been talked about. They are the big thing in the NHS at the moment, and we need to ensure that mental health has a fair crack of the whip in those. It would be absolutely disastrous and a backwards step if we had 44 of these plans come out and all of them increased the disparity. We have to make sure that they are treating mental health fairly and appropriately and working towards parity. We need infrastructure, to help people locally to implement that big taskforce report and do the things they need to do. They are not going to do that without support. We need to have a proper infrastructure to make that happen.

Q39 **John Pugh:** Are you saying that there is a lack of predictability in infrastructure plans?

Andy Bell: I suppose I mean infrastructure in terms of support through—

Q40 **John Pugh:** Human infrastructure. There is a capital programme as well.

Andy Bell: No, that's not what I mean at all. What I mean is people available on the ground to go and help local organisations to do this very complex work, to make these big changes. We need people with a capability to go out there and support them on that journey, as we had under the national service framework for mental health. An incredibly important part of the success of that was that there was a proper support system to help people locally to do it, and then there was proper accountability for whether they achieved it or not.

Chair: Thank you very much indeed for your time. You are very busy people. We will publish the transcript online in the next couple of days, and it goes up uncorrected. We will send you a copy. I am not sure when our report will be coming out. We have quite a lot to get through. We hope it will be by late July, with the possibility of September, but hopefully not that long. You are very welcome to stay for the next panel, if you wish, but we quite understand that you may have to go off to other things. We will send you a copy of the report once we have published it.

Examination of witnesses

Witnesses: Professor Tim Kendall, Jon Rouse, Simon Stevens, and Chris Wormald.

Q41 **Chair:** Good afternoon. Welcome to our second panel on the issue of mental health services, on the back of the National Audit Office Report. I am delighted to welcome our witnesses. From my left to right we have Professor Tim Kendall, who is the national clinical director for mental health for NHS England. Welcome, Professor Kendall. We have Simon Stevens from NHS England. We have Chris Wormald in his first appearance as permanent secretary at the Department of Health. Jon Rouse, who comes regularly, is the director general for social care, local government and care partnerships at the Department of Health.

It is fair to say that when we were preparing for this, we recognised that the Government, the Department and, indeed, NHS England are on quite



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a journey, in terms of trying to get parity for mental health and physical health. We know there are challenges, and we are hoping today to get out some of the baselines—where things are now, and where all of you think we are going to get to by 2020, to pick a figure at random.

I will start with Simon Stevens. We will obviously come to you, Chris Wormald, on some of this. Simon Stevens, in the foreword to the NHS plan in 2014—the mental health strategy—you say, “Mental health problems are the largest single cause of disability, representing a quarter of the national burden of ill-health, and are the leading cause of sickness absence in the UK”, so you highlight some of the issues. This is in your foreword. Then you go on to say, “This makes it all the more indefensible that there is such a large ‘treatment gap’ with most people with mental health problems receiving no treatment and with severe funding restrictions compared with physical health services.” You rightly go on to highlight one of the consequences: “people with mental illness die on average 15-20 years earlier than other people—one of the greatest health inequalities in England.”

You talk there, accurately and understandably, about the severe funding restrictions in mental health services. No one can disagree with that. I have done a quick add-up of the number of times you have been in front of us in the last six months. This is chapter 6 in how the NHS budget pans out. It is our sixth hearing since January, and our 10th since October, excluding social care hearings, which you have attended as well. Each time, we have had a series of budget issues. Let me give you a quick run through of some of those.

Just last week, you talked about better care fund maths and real world maths. You acknowledged that there was an issue about funding there. NHS specialised services—this was about a month ago, in May this year—account for 13% of the total NHS budget. I am sure Chris Wormald is learning these figures in his new role. It costs about £43 billion a year to employ clinical staff across the NHS. I haven’t got the percentage figure to hand, but I’m sure you can do the maths. And then, of course, there was £1.8 billion of additional funding to bail out trusts for the last financial year. GP practices are 8% of NHS England’s budget. I think you agree with these figures. They are all from NAO and PAC Reports. Neurological services are 3.5% of spending.

I could go on. That is just for the spending, not the waste, which we often look at as well. My question for you is this. Each time we see you, we are looking at a hugely pressurised bit of the budget. For mental health services, it is 12% of the budget. How on earth are we going to get to the point where it is affordable to have parity of mental healthcare with the current budget situation?

Simon Stevens: Well, I don’t think we can accept the current budget situation. We want to put more money into mental health services.

Q42 **Chair:** So where does it come from?

Simon Stevens: Well, the best buys that the independent Mental Health Taskforce, which I set up, and which reported in February, has laid out for

us add up to an incremental spend of about £1 billion a year. If we are putting that money in, by 2020 that will buy us a series of improvements. Frankly, I regard that as the minimum necessary. If more funding were available, we would see a faster rate of progress on mental health services.

Q43 **Chair:** Is that money going to go in evenly over the next four years?

Simon Stevens: No, unfortunately it is not.

Q44 **Chair:** So it is like a hockey stick?

Simon Stevens: Yes, or a U shape. That is the profile of our spending review settlement. That means that a lot of the improvement, both by virtue of when the funding becomes available and because of the workforce—the need to expand and train up people to deliver these expanded services—is going to be coming online more like 2018-19, 2019-20 and 2020-21.

Q45 **Mr Jackson:** Why will it take that long?

Simon Stevens: Because that is the pace at which we are getting the extra funding. It is the pace at which the extra staff are getting trained.

Q46 **Mr Jackson:** The trouble is we always get jam tomorrow with you. You come along with a lot of emollient flannel—

Simon Stevens: I didn't set the NHS budget; Parliament did.

Q47 **Mr Jackson:** Let me finish. And you set unrealistic targets. Incidentally, thank you for joining us, because I know you have been involved in pontificating on geopolitical issues like Brexit.

Simon Stevens: I am here once a week, as you know. In fact, I was here last week.

Chair: We are here to discuss mental health.

Q48 **Mr Jackson:** May I ask one particular question? You set a specific target on parity of esteem, and you have missed it.

Simon Stevens: What is the specific target you are referring to?

Mr Jackson: The target you set on the timeframe for achieving key objectives in terms of parity of esteem—I'm asking the questions, incidentally—and you have missed it. This Report shows—

Simon Stevens: It doesn't show that at all.

Q49 **Mr Jackson:** Yes, it does. Don't be argumentative, Mr Stevens.

Simon Stevens: I am replying to your assertion.

Chair: Mr Jackson, you can ask questions in a polite manner.

Mr Jackson: When I am asking a question, don't argue.



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Simon Stevens: Well, you are making assertions that I disagree with.

Q50 **Mr Jackson:** I'm inviting you to say why you missed the target. If you want to explain during the course of your answer—

Simon Stevens: I'm asking you which target you are referring to. If you can point to which target in the NAO Report you are talking about, I will of course respond.

Chair: Mr Jackson, we need to bear in mind that Mr Wormald from the Department of Health is here, and the Department, on behalf of the Government, has a responsibility for setting the targets.

Q51 **Mr Jackson:** Mr Stevens, you have presided over a record number of deficits in trusts, and today it was reported that you have presided over a significant increase in the remuneration of senior managers running those trusts. That is the issue we are looking at, in terms of management and what you're delivering.

Chair: Very briefly. You have a right of reply, Mr Stevens.

Simon Stevens: Thank you. If you could specify which of the targets you believe has been missed per the NAO Report, of course I will describe what is going on, but I think you are making a more philosophical point, which is that we all have a shared ambition to get equal respect and equal treatment for people with mental health needs, compared with physical health needs. That goes under the rather jargonistic description of parity of esteem, which, frankly, I don't really like, because I think most normal human beings wouldn't know what on earth that means, whereas when you set it out in words of one syllable, they can see that there is a real problem that we have to address. We are seeking to get going on that.

We have a clear set of service improvements that the independent Mental Health Taskforce has told us to get on with. That is what we are doing. But in terms of the funding profile for the NHS and the speed at which we can put extra money into the national health service, that is a function of the funding available to the NHS overall, and if the NHS had its way, of course we would do more faster, but we do not actually set the NHS's budget.

Q52 **Chair:** I want to get back to the money. *[Interruption.]* Mr Jackson, I was in the middle of getting to the point about the budget. Let me get through the budget point and, as we discussed, I'll bring you in at a later point.

Going back to the budget, there is £10 billion, Mr Stevens, that you trumpet to us very often that you have secured from the Government to help shore up the NHS between now and 2020. This extra £1 billion that will be coming into the mental health services looks, on reading the figures, to be the mental health services' share of that £10 billion, or is it additional funding? It does not look like additional funding from where we are sitting.

Simon Stevens: I don't believe that that £1 billion is, or should be, the total increase in mental health services over the period.



Q53 **Chair:** Is it part of that £10 billion?

Simon Stevens: Of course it is. It is part of the extra available to the NHS, which in cash terms is from £101 billion up to £119 billion by 2020. As part of that general growth, there will be routine pressures in mental health services that will have to be funded and met by the mental health system. Over and above that, the independent taskforce has set out a series of very clear improvements that we want to see on people with severe mental health problems who are getting that onset in their teenage years—early intervention in psychosis, an expansion of psychological therapies more widely, perinatal, and a whole range of things.

Q54 **Chair:** We will come on to that, but I am concerned. We have laid out at some of the hearings when you have been here in front of us that we have 12% of the NHS budget going on mental health services. We know there is more need. One of the pre-witnesses suggested 23% of need. I wasn't quite sure how that figure was worked out. Even if you just doubled it, that would be unsustainable, on the NHS's current funding. You talked about real world maths last time you were in front of us. What is the real world maths that means we can achieve this?

Simon Stevens: I don't think parity necessarily means that 23% of the NHS budget should be spent on mental health services.

Chair: I said I'm not sure about that.

Simon Stevens: In just the same way as we have a conversation about primary care and we say that 90% of patient contact applies in primary care, that doesn't mean we should be spending 90% of the NHS budget on primary care.

Q55 **Chair:** No. Mr Stevens, you know that I don't mean that. What I am saying is that if the budget is 12% at the moment, and we are nowhere near achieving just the aims that you have outlined, let alone the golden end of absolute parity—

Simon Stevens: I agree. I have explicitly commissioned the independent taskforce to do a soup-to-nuts study, laying it out bare, so as to make very explicit the baseline, the situation and the treatment gap that exists. We then have a series of very specific service improvement goals for which we hold ourselves accountable.

Q56 **Chair:** May we turn to figure 8 in the Report? I warn Chris Wormald that I am coming to him next. Figure 8 on page 31, part two of the Report, refers to the cost of the early targets in IAPT—improving access to psychological therapies—early intervention in psychosis, which you just mentioned, and liaison psychiatry services, which is psychiatric treatment in hospital given to those who come into hospital for other reasons. There is a concern that the published figures are an underestimate as a baseline. Are you confident that those figures are accurate? If there is an underestimate, a percentage of any money going in will be eaten up by the gap between that underestimate and the actual need.

Simon Stevens: The substantive point is that we are now measuring—



Chair: That's a good start.

Simon Stevens: On the IAPT, notwithstanding Mr Jackson's pessimism, this is an area where there has been dramatic improvement since 2008, when the programme was first introduced. Over that period, 3.5 million people have had access to psychological therapies, and indeed, the speed at which people are getting treated and the success of their treatment has improved quite substantially even since the NAO had access to the 2014–15 figures. On the access to IAPT services, we are doing very well, but we want to go even further from 15% access to 25%, and that is one of the funded propositions in the independent taskforce.

On the early intervention for psychosis, there is a very strong evidence base that that is not only good for individuals but will improve the rest of their life, and potentially save money in other parts of the health service. In terms of ensuring the waiting time standards—the first two waiting time standards that the NHS has introduced in mental health—we have now got the provisional data collection on that, against the target waiting time that 50% of people should be seen within two weeks. The provisional figures for March show that that was 64%. The key to this will be to make sure that the treatment that they are actually getting within that rapid timetable is the full NICE-approved package. Rather than a series of self-assessments, we are getting the Royal College of Psychiatrists to oversee the package of care that is being delivered against that standard to make sure that it is the full whack.

Q57 **Chair:** To return to my question about the baseline, you are working to getting—

Simon Stevens: The baseline estimates that were done in September 2014 by the DH were what they said: estimates. In the real world, the question is, are patients getting treatment within the waiting time standards that we have now set, and is that treatment of the approved quality?

Q58 **Chair:** My point is, just to repeat—

Simon Stevens: The answer is yes.

Q59 **Chair:** Right. If the estimates are low, we will have a problem of attrition, in terms of the extra money going in.

Simon Stevens: The point I am trying to make is that these standards are already happening. These are new waiting time standards that have come on track from April of this year, and so their delivery is being implemented as part of what the NHS is doing this year.

Q60 **Chair:** One of my colleagues will consider that further, but may I go back to the funding issue straight? According to evidence to us from NHS providers, only 52% said that they had reported an increase in funding in 2015. We have had a lot of evidence in the debate about ring-fencing or not ring-fencing, but if only about half of providers have said that they are getting an increase in funding, where is the money going to improve mental health services? Is it actually getting to where it is supposed to



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go?

Simon Stevens: The honest answer to the question is that it is a combination; in some areas, the money is not getting through and in others the money is going to other parts of the mental health system, but not necessarily to the NHS mental health trust in the local area.

Q61 **Chair:** You don't know really, do you?

Simon Stevens: We have attempted to do a reconciliation for every CCG, as to what their out-turn spending was last year compared with the increased goal that they set. We are doing the same again this year and will move over to open-book accounting, so they will have to be able to show their local mental health trust and everybody else where the money has gone.

If I may, I will explain a little more about why some of the increases in mental health spending might not be with the local mental health trust. One example is that we want to expand what is called liaison psychiatry, which is services for mental health in A&E departments of acute hospitals. Often that will be provided by a mental health trust, but not necessarily. It might be provided direct by the acute hospital itself. That extra spending therefore will not show up in a mental health trust's account.

Secondly, we are committed to expanding the number of therapists and psychologists in general practices, helping GPs deal with the workload of patients who present in primary care. That may or may not show up as revenue to the local mental health trust. Thirdly—

Chair: No, I am going to stop you there.

Simon Stevens: It is quite a long list of ways in which investment might not show up in the local mental health trust.

Q62 **Chair:** Yes, absolutely. I don't want the long list. Mr Stevens, my point is not about the long list. I hear exactly what you are saying about bits of money going to different places, but let us be clear: according to the providers themselves, only around half have reported an increase in funding in 2015.

Simon Stevens: The secondary mental health trusts, yes, but that is not the same as the mental health provider sector in the round.

One of the other issues, by the way, is that there has been a steady shift in the proportion of mental health funding and usage in NHS trusts, compared to the independent sector. The independent sector of mental health providers has reported increases of around 4% a year for the last three years. One thing we have got to do, and are now doing, is to take a very hard look at those patient flows and that funding growth to make sure we are getting good value from that expenditure as well.

Q63 **Chair:** I will bring in Chris Wormald in a moment, but the Comptroller and Auditor General first.

Amyas Morse: Just to clarify, this information is from NHS providers as a



whole—that is how they represent themselves.

Simon Stevens: Yes, but that is not the independent sector and it is not expenditure in general practice. It is not improvements in—

Amyas Morse: I am not trying to say it is, but it is a moderately significant proportion.

Simon Stevens: It is. As I have said, the honest answer is that it is both parts of this. That is absolutely a fair reflection in some parts of the country, where mental health trusts have not seen the investment we would have wanted. In other parts of the country, some of that investment has been going into other parts of the system.

Q64 **Chair:** Notwithstanding the fact that it goes to other parts of the system, I am surprised that that many had none. That is the point. You agree that that is possible. Well, that is what they have told us.

Simon Stevens: Yes. I do think that is possible

Q65 **Chair:** That is not very good from our perspective. Mr Wormald, on the money that is available, you are responsible, and the Secretary of State has a duty to address mental health in the Act. It is in the NHS mandate, which is the bit that Simon Stevens is responsible for delivering. Is there going to be enough money to deliver this by 2021?

Chris Wormald: I think Simon described the situation exactly as it is.

Q66 **Chair:** Yes or no?

Chris Wormald: Well, we agree with NHS England that the additional investment being made, prioritised in the way that is described in the five-year plan, ought to be able to achieve the outcomes that Simon is describing. That is not to say that money is not tight—of course it is—but in terms of, “Is there a forward plan here, and are there resources that go with that forward plan?” the answer is yes.

Q67 **Chair:** We are glad that there is a forward plan, but without the money—as I outlined just now—every bit of the budget we see for the NHS is under stress. Efficiency savings are being demanded of hospitals and we have the bail-out of the acute trusts, with the promise that efficiency savings are coming down the line. There is nothing to guarantee that mental health services will be protected from that, is there?

Chris Wormald: Just as a matter of fact, we have not ring-fenced the resources for mental health. That was one of the questions I asked when I arrived in this area, and the answer that I was given was extremely convincing. You have to look at facts such as the fact that 30% of people who have long-term physical conditions also have mental health issues. You have to think about the behaviours we are trying to incentivise, such as people spending around the patient, as opposed to around the service.

All a ring fence does at local level is distort spending, and if we want—as I am sure we all do—GPs, clinicians and others to think about what the right package of care is for this patient in the round, taking in both their mental



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and physical health issues, what you don't want is their clinical priorities distorted by a ring fence.

So, although a ring fence is a simple solution and makes a good and easy story to tell, in terms of how we promote the kinds of practice that we are looking for—the kind of way that the budget works and the way that Simon has described—that does seem to make sense.

Q68 **Chair:** I will bring in Karin Smyth in a moment, but what you seem to be saying there is that not ring-fencing allows for a joined-up service for the patient. However, how can you at the Department be sure, given this is a major political priority—you are responsible for helping to do that on behalf of your Secretary of State—because you can't track the data, that it's not the first thing that gets cut when there is a pressure on budgets?

Chris Wormald: Well, all the things—I did actually think, and I should have said this at the beginning, that the NAO Report gave a very fair assessment of where we are and what we need to do next. So I don't think that anyone is denying that there are considerable amounts more to do to achieve what we need to, but I also agreed with your pre-panel evidence that we've got a better opportunity to do that than we have had for quite some time.

Now, if we're not going to use primitive methods such as ring fencing to track what we achieve, it is the set of policies that we have set out. Transparency in data is incredibly important. So that is all the work that NHS England has done to track spending and track it much better going forward than we have historically. So we will be able to tell what is spent where. That is incredibly important.

The transparency that has been brought by the local transformation plans, not just for what the NHS spends but for what local partners spend and how they do so, is extremely important.

You had a debate with your pre-panel about targets. I think targets in this case, when you are trying to change behaviour, can be important. I think there can be a debate about what those targets are, but clearly tracking against the actual outcomes is extremely important.

The other point that also came out of your pre-panel—

Q69 **Chair:** We heard it too. We don't need the whole pre-panel repeated, Mr Wormald.

Chris Wormald: Sorry, but I wanted to emphasise the point that thinking about mental health is being built firmly into everything that the NHS does: in the sustainability and transformation plans; and in everyone's thinking around health reform and efficiencies. That is the other piece of the jigsaw. When you put all that together—if you have transparency, good data, targets that you can track and everyone working on it, that does seem to me to—

Chair: Mr Wormald, I have been indulgent, because this is your first



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outing, of your giving a full read-out of all the things that you are going to be doing, but we need to stick to answering questions.

Just for interest for witnesses, I read through the last transcript. We are getting shorter in our questions, but your answers aren't getting short. Now we're not asking you to give bite-sized pieces—we do need information—but we do have a report we're discussing.

May I bring in Karin Smyth and then I will bring in David Mowat?

- Q70 **Karin Smyth:** This is a baseline report; we're very keen to get a good baseline, to be able to revisit some of this. I just want to track back to where we are tracking the money. I think, Mr Stevens, what you said was that you were looking to have open-book reporting from CCGs on what they are getting and therefore on what they are spending, and what they get for that, which would allow us to track the money better than perhaps just looking at some providers. Is that right?

Simon Stevens: Yes.

- Q71 **Karin Smyth:** When would we be able to see the results of that?

Simon Stevens: During this year—during '16-17. And related to that, we have commissioned an independent panel to assess the extent to which every CCG is using that money appropriately and delivering on the improvements that are in the independent taskforce. That panel is being chaired by Paul Farmer, the chief executive of Mind, who was the principal leader of the independent taskforce.

So we will be publishing CCG ratings. Everybody else will be able to see how their CCG is doing on mental health and on the improvements—

- Q72 **Karin Smyth:** So when we look at this in the future with the NAO—whenever this is relooked at—to form our next look at how this is progressing, we would be able to use that to start tracing the taxpayer's pound.

Simon Stevens: That plus the programme budgets, which will be more timely as a result of the changes we are making.

- Q73 **Chair:** When do you estimate—between you, or maybe Professor Kendall—that we will actually be able to see real outcomes? Obviously, there is a time lag in people getting treatment. You are going to look at the benefits and cost savings to the NHS of early intervention. What is the timeframe for assessing the cost-benefits once you have got this data?

Simon Stevens: I will bring Tim Kendall in in a moment—or rather Claire Murdoch, who is our national director for mental health and who I have appointed to lead the implementation of the taskforce. Claire is the chief executive of one of the largest mental health trusts and is one of the most respected operational leaders in mental health in the country. Next month she will be publishing the implementation plan that goes behind the taskforce recommendations. That will set out the phasing of the outcomes



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improvement and the services that we will put in place, which we will then be able to track against.

Q74 **Chair:** So is there an idea of how many years it will take?

Simon Stevens: Without making this a long answer, looking at the improvements that the taskforce is setting out for us, some of them are phased—between 15% and 25% expansion for IAPT over five years. Some of them—such as the early intervention for psychosis—we are getting going on right now, so we will see results soon.

Q75 **Stephen Phillips:** Sorry, Mr Stevens, but that is a very long answer. It is a very simple question: when will we start to see an improvement in outcomes? Give us a date.

Simon Stevens: We are seeing improvement in outcomes this year from the expansions that are in place this year. The timing for each of the individual improvement goals set in the taskforce will vary depending on the nature of the programme.

Q76 **Chair:** So we are starting some this year, and ongoing—

Simon Stevens: Yes, and Claire Murdoch's implementation programme will lay that out—what the phasing of this looks like.

Q77 **Chair:** Ms Smyth highlighted what we will be able to ask next time you are in front of us. So let us say that in a year's time you are here again—it may be before then, who knows?—we will be able to have some clear data about what the investment has actually achieved.

Simon Stevens: Yes, exactly, so for example—

Chair: I don't need examples—that is fine.

Q78 **David Mowat:** I guess what bothers me about this is slightly different. There are two ways of establishing how we spend money. One is a top-down approach: Parliament passes a law—parity of esteem—and we get as much money into the system as we can afford, and then you spend it on that. The other is more bottom-up, which in a way was what the reorganisation was about—the CCGs are responsible for establishing priorities and everything else. In a sense, some of the evidence that you have given today is saying that when you have given money to the CCGs, they have actually spent it on something different. It has not been ring-fenced. One of you used the phrase "reconciliation of what they spend it on"; you are going to rate CCGs on what they are spending it on. What I am getting to is that this implies to me that the CCGs were presumably acting in good faith and are aware of the priorities—

Chris Wormald: I don't think that is quite what we are saying. I would characterise—

David Mowat: Can I finish? A question I would like you to answer is why the CCG priorities are different to yours. That is what I was getting to.



Chris Wormald: I am sure Simon will give an answer as well. As a fresh reader, the model of reform here is local decision making within a clear national framework. We set a national framework for inspection through what NHS England does and all the other things we have been describing, but then we want sensible people locally taking sensible decisions about the actual issues in that particular area. We want them taking the decisions within a framework, but we want them to be responding flexibly. So we would expect to see some difference, and that is what plays out. The question, which is what we have just been debating, is whether we have the right sources of information to know that that is all being done properly. That is what Simon has been describing.

Simon Stevens: Yes. I think the money argument is a proxy for the availability of high-quality services and the outcomes they have. The national service framework for mental health was introduced in the early 2000s, when we did have clarity about some improvements that we wanted to see—or indeed 25 years ago when I started working in mental health. My first job in the NHS was managing a large psychiatric hospital outside Newcastle and it was clear that the programme of work there was to re-provide services in community settings. We have had a period of time in recent years when we have not actually been very precise about what the improvement goals for mental health look like. Now we are being precise, based on the recommendations of the taskforce, and we want to hold people to account for delivering those improvements. The money is a means to an end; it is not an end in its own right. Are we being more prescriptive about delivery against the things in the taskforce? The answer is yes, we are going to be. That does not fetter people's discretion in a whole set of other parts of mental health services—or, indeed, other parts of the NHS—but if you are a pregnant mum or a new mum and you've got severe perinatal mental health problems, you should have access to specialised services. If only 12,000 mums out of 42,000 in the country have that access this year, we want to change that, so everywhere needs to have those specialised services.

Q79 **David Mowat:** So what you're saying is that one of the reasons why the CCGs are not spending their money more as you would have liked them to is that they do not have the availability of stuff to spend it on, because there is a supply/demand thing—I think that's what you have just said.

Simon Stevens: That's right: that is one reason. There are other legitimate reasons as well. For example, they might be in deficit or they might already be a relatively high spender, in terms of their overall portfolio. As we have been looking at these so-called parity of esteem funding increases, we have been going down to every CCG, saying, basically, "Are you in deficit? Are you already a high spender?" Where there's—

Q80 **David Mowat:** What I'm getting to is that everybody can agree that parity of esteem is a good thing. I would have thought that was very easy to agree, or very close to it.

Simon Stevens: As a broad philosophical goal.



David Mowat: Except that it's a statement of relative priorities. Where you perhaps get into more difficulty with a statement of relative priorities is when you don't say which things you are giving less priority to as a consequence, which, given that you are resource-constrained—which is fair enough—must be the case. I always think that a strategy that doesn't point out what we are not doing as a consequence of what we are doing more of is slightly dishonest. I don't know whether you want to comment on that or say which areas you think should be being replaced by this extra emphasis on mental health.

Simon Stevens: I would be happy to. I think part of the problem in mental health services is that across the NHS it has been the squeaky wheel that has got the oil. If you think about the large cost overruns that Mr Jackson was alluding to earlier in acute hospitals, there are understandable reasons for them, but they have had the effect of crowding out what would have been investment in mental health services and primary care. The reality is that this year we are going to have to have a reset on what some of the spending looks like in acute hospitals, in order to free up some of the investment we need to make in mental health.

Q81 **David Mowat:** Okay, so another way of putting that might be that—I don't know—NICE might have less flexibility in authorising a particular drug because it has been decided, by whoever decides these matters, that mental health is the thing that we are really going to focus on. The only reason I say that is that it tends to put decisions into context, because then other people might say, "Well, how do we decide those things and how do we prioritise that?" To make it an honest discussion we should do it in both directions.

Simon Stevens: Yes, that's right, and I think that's a very important point to make, including for a lot of the conversations we have when I'm before you. The Chair pointed out the range of topics earlier, and by definition every theme that is reviewed is important. Everyone could benefit from improvement, but the reality is that, if you are a local CCG or the NHS nationally, we are having to make choices all the time and a lot of those choices are very difficult.

Q82 **Chair:** Talking about that choice, one of the challenges with the data being far less than perfect—a bit of a running theme, I know, but particularly so in this area—is what you will do if the need on the ground outstrips this budget, which is not even going to be in place until the end of this Parliament.

Simon Stevens: The need on the ground already outstrips the budget and will still outstrip even the expanded budget in 2020. Let's be completely frank about this: this does not give us—

Q83 **Chair:** This is about the fourth time—or maybe even the sixth—you've said this to us this year.

Simon Stevens: I'm known for my frankness and I'm happy to continue to be so.

Chair: Or maybe it's a bid for more money from Government.

Simon Stevens: No, I'm simply making the point that, even if you look at, say, the very important area of children and young people's mental health services, even the important extra investment that is going in there may mean that, instead of being able to respond to perhaps one in four children who might be defined as having a mental health need, we can improve that, such that we are supporting one in three. That will be hugely welcome for the 70,000 extra children who are getting those services, but that most clearly is not mission accomplished.

Chris Wormald: If I can add, I actually think the Government has been very clear on what the extra investment is and what level of efficiency saving it is expecting to see across the health service. So in terms of what needs to be stopped to make space for new things, it is all in that efficiency piece, and the Government have been very specific around things like agency nurses, etc, about things that should stop.

Q84 **Chair:** Mr Wormald, I know you are new to the Department, but we get a bit weary about the agency point, because, as Mr Mowat very ably pointed out when we first discussed this, and several times since, it is not about the rate of pay; it is about the volume. That is about shortages—

Chris Wormald: I take the point that I should not use that example.

Q85 **Chair:** Also the amount of money that spends is not going to solve holes in the NHS budget. Also, on the efficiency savings we have got, we are sceptical on some of those. Can I just be clear, actually, on efficiency savings: there isn't an NHS Transformation element to mental health services? Am I right in thinking it is not part of that programme?

Simon Stevens: Some of the vanguards, the vanguard programme that has been established, do have a mental health element, because partly we are trying to—

Q86 **Chair:** But it is not a wholesale thing?

Simon Stevens: It is not a separate, free-standing thing; but, in terms of the funding allocations for the next five years—and when Claire Murdoch publishes the implementation plan you will see this laid out—some of the transformation funding available in subsequent years is being specifically earmarked to implement the mental health taskforce recommendations.

Q87 **Chair:** So there isn't a transformation fund for mental health, but it will take a bit of the little bit? How much, do you know, roughly—ball park? Do you know?

Simon Stevens: For some of the programmes—would you allow me to give an example?

Chair: Yes, I will; this an answer where we might want the information.

Simon Stevens: If you take liaison psychiatry that we discussed—i.e. psychiatrists and mental health teams in A and E departments—the full version of that model involves about 25 whole-time equivalent staff. At the



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moment, 10% or slightly under—the NAO had it at 7%, I think, but it is probably a bit more than that, 10%, now—of A and Es have that full, core 24 liaison psychiatry. We want to get that to at least half by 2020. That is going to cost, we estimate, around another £120 million a year by 2020. We are phasing the build-up of that, some of which—in fact, most of that—is going to therefore come out of the nationally held transformation fund, because it is only one in two A and Es. We cannot just put that into general allocations.

If you take the crisis home response teams which are required—the community health teams that can respond 24/7 when people have mental health crises—that, we estimate, is going to cost at least another £150 million by 2020; and all of that money will be in CCG allocations, because that has got to happen everywhere.

Chair: So it is quite a chunk of the extra budget already. I am going to bring in the Comptroller and Auditor General and I have got a couple of points before I hand over to John Pugh.

Amyas Morse: Just to make sure I have got this clear, of the efficiency savings, how much of the funding for mental health services is dependent on realising efficiency savings in the rest of the NHS? And if they were not realised, or they just went to decrease the deficits in trusts, what would happen then? Would the amount of money spent on mental health programmes be reduced?

Simon Stevens: Of the increases available to the NHS over the next five years this £1 billion is going to be earmarked to implement the taskforce recommendations, and that is £1 billion notwithstanding what is going on in the rest of the portfolio—with two caveats. First, mental health services need to make efficiencies over this time period just like all the rest of our cost base, and the assumption is a 2% efficiency. There are opportunities, even in mental health services, despite the fact that they are stretched—and Tim Kendall gives some very practical examples of how in his trust in Sheffield they have been obtained. Over and above that, were there to be a continuing unbudgeted overspend in the acute sector, or were there to be any substantial economic shock to the financial prospects of the national health service over the next several years, that would obviously call for a rethink.

Amyas Morse: So there is a dependency? You are saying there is a potential dependency between this?

Simon Stevens: No, I am saying we have an earmarked £1 billion for this and we think that is eminently deliverable. It is not £1 billion that has been recycled out of savings from other parts of the system.

Professor Kendall: There are undoubtedly savings to be made.

Amyas Morse: You did leave yourself an exit hole there, if you don't mind me saying; I'm sorry.

Chair: That's exactly what I was thinking, Mr Stevens.



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Amyas Morse: You left yourself a burrow to go down, there, by saying, "But we might have to have a rethink."

Q88 **Chair:** That's what I heard, very clearly; that you are sitting next to the Permanent Secretary saying, "We might have to have more money."

Simon Stevens: No, I just read news in this morning's papers of the possibility of budget cuts for the national health service. That is all I was referring to. I was not referring to the base case, which we are all working to.

Chris Wormald: Just as a statement of fact, of course mental health spending is a part of overall NHS spending, and if overall NHS spending changes, mental health will be affected. I don't think that is a controversial thing to say.

Q89 **Chair:** Who knows what will happen in the next week that might make a difference, or indeed in the next year or few? I want to clarify one point, and then I have a second question, before handing over to John Pugh. Paragraph 2.18 of the NAO Report, in relation to figure 8, says: "The estimate in the Department's 2014 impact assessment was that the cost"—of meeting the new access and waiting times standards—"would be £160 million a year more than the estimated £663 million that clinical commissioning groups spent in 2014-15 on these services." I'm not sure who wants to answer this, but have you updated that estimate since 2014?

Jon Rouse: This relates back to the conversation we were having earlier about figure 8 with the pre-witnesses. The starting point is that this was an estimate done in 2014, through a proper impact assessment, looking at investment requirements and potential benefits flowing back. We came to the conclusion in terms of the first three things we were trying to do—IAPT, EIP and crisis care liaison—that the initial input for the first two years, 2014-15 and 2015-16, was actually £120 million. That was what was invested in that period. Clearly, that preceded the spending review, the taskforce report, the further analysis being done, the stretching of ambitions and the taking on of some new ambitions as well. To a certain extent, this is a bit of an insight into the past, because we are now in—

Chair: That is a lovely phrase. You mean it is an underestimate for the current one?

Jon Rouse: It is, because we are now in 2016-17 and we have reset through the taskforce report.

Q90 **Chair:** You have reset it. Can you just be clear about what the figure would be today, in 2016?

Jon Rouse: We have calculated, within the £1 billion, the extra requirement for what we are going to do next, including the expansion of IAPT, with the further increase through to 2020-21 and EIP through to 60% rather than 50%; and the work that Simon has described around liaison psychiatry, home treatment teams, eating disorders and perinatal. We have calculated what we think is the affordable level of investment



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required, taking into account efficiencies that may be gained. That is essentially where that £1 billion comes from. It is built up from those component parts.

- Q91 **Chair:** We will be coming back to this. I may come back on efficiencies later, but Mr Wormald and Mr Stevens, what proportion of the NHS budget should be being spent on mental health services, given that we know not enough is being spent on it at the moment? What proportion, ultimately, is the aim?

Simon Stevens: I don't think it would be sensible to set a proportion in that way for the reasons that Mr Mowat gave, which I agree with, in relation to this question. What we should be doing is targeting investment on the areas that the taskforce has marked our card with. They have done a clear evidence review of the best buys for mental health improvement over the next five years. That is what we want to deliver. Over and above that, there will be other changes and other investments that CCGs locally will want to determine. The percentage will be the combined effect of all those things.

- Q92 **Chair:** Okay. I am going to hand over to John Pugh, who I know will pick this up, but the key thing is this: we heard from previous witnesses that money spent up front saves money down the line. Chris Wormald, how are you going to be measuring that? Over what timeframe will you measure it, and how will you factor that into the funding decisions for this really important area?

Chris Wormald: I might ask Jon to give you a more detailed answer. There is, I gather, quite a lot of evidence—in answer to Mr Bacon's original question—about how much you save for specific interventions, which is not the same as whether there is a pound rate for every £1 spent. We can send the Committee—

- Q93 **Mr Bacon:** I presume it varies depending on—

Chris Wormald: As I understand it, it varies treatment to treatment and it varies, crucially, as with all spend-to-save schemes, on whether it is done well. We have all seen a spend-to-save scheme where you get the spend but not the save. So we are quite happy to send you the research evidence—

- Q94 **Chair:** John Rouse can answer that, and I think Karin Smyth wanted to come in on this point.

Jon Rouse: I just want to make the quick point that the prioritisation we have done around which conditions to tackle and which interventions to put extra funding into has been partly driven by that cost-benefit analysis. In a sense, we are backing the NICE-approved interventions, which we know—based on the literature reviews, the evidence and the studies that have been done—give us the best bang for our buck.

Simon Stevens: We have actually published that evidence here, the Committee might like to know: "Priorities for mental health: Economic



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report for the NHS England Mental Health Taskforce". It's all there, setting it out.

Chair: I think one of the previous witnesses showed us that as well. We will get a hold of that.

Q95 **Karin Smyth:** On this point, I asked the pre-panel about financial incentives for the various people involved in supporting people with mental health problems, and if they were correct. Mr Rouse and Mr Stevens, I would be interested if you would give a view about financial incentives for the different parties involved, and whether there are any plans to look at those or change them.

Jon Rouse: That's a good question. One of the things that has hamstrung us over the years around mental health is that so much of the spend is hidden within block contracts. I think one of the pre-witnesses actually said that it is very difficult to make judgments about whether that money is being well spent if you are getting a fixed sum almost regardless of how many people you are treating and whether you are treating them well.

That is one of the reasons why, over the last two years, we have put so much effort, behind the scenes, into reforming the mental health data set and changing some fundamentals about it. One is that, going forward, we will be building up the data from the individual episodes of care, so that when somebody is referred, that referral becomes a new episode that the data attaches to. The reason why this is so important is that you begin to be able to relate the money being spent to the outcomes being achieved, particularly as we are now using a new data collection mechanism called SNOMED. The important thing is that it is a consistent approach to how you capture data about outcomes. Once you can start relating data on outcomes to spend, you can start properly measuring value for money.

There is one other critical thing that NHS England and NHS Improvement are doing that you need to complete the circuit, and that is to do away with block contracts and put in place a choice between two different options. Either you have a proper capitated budget, where you as a provider are responsible for that population with spending transparency, or you attach the funding to the episodes of care themselves.

Q96 **John Pugh:** I will come back to that last point a bit later. Can you regard this as not an inquisition but more of a counselling session where we get to the bottom of your problems?

Chair: I don't think Dr Pugh is a medical doctor, but he's got a good bedside manner.

John Pugh: Group therapy, maybe. Clearly, we all share the same laudable ambitions—parity of esteem and so on—and you are using two devices to improve how things look. One is to add resources. We can argue about the right level of resources; I think it is probably impossible to say what the right level of resource is. If you go back to the 1950s, I think we were spending 20% of the NHS budget, but we were warehousing a lot of people in doing so.

In terms of looking at the targets, everybody knows the targets are distorting and lead to gaming and people incentivising the wrong thing. We have had a sense of that in some of the comments made by the pre-panel. I get the impression that you share that perception, and that at some point in time, having employed these targets, you are going to evaluate what the targets are actually doing in terms of overall outcome and performance. Am I correct in thinking that?

Simon Stevens: Yes, I think that's right, although we are 25 years on from when the NHS first introduced waiting times targets for routine surgery—for having your hip or knee or cataract done. The way that was done, as you know, was layered in over time, so that when they were first introduced, it was two years maximum wait to have your cataract out. Then it was brought down to 18 months, then six months and then it included your outpatient appointment as well.

Now the average wait has fallen from 18 months to a maximum of 18 weeks, with a median wait of 10 weeks. That has been a journey that has taken place over a long time. I think there would be a benefit in introducing waiting time standards for mental health services. We have done that for the first two areas this year, as you know. We have talked about IAPT and the early intervention in psychosis service. We want to do the same for eating disorder services, and then layer those into a broader range of services because it helps to highlight the gap between need and treatment availability, it helps to focus management and funding efforts, and as we do that, it also improves patient outcomes.

Q97 **John Pugh:** I am not arguing against targets full stop. I am arguing for a sensible review of what targets are doing. We had a piece of evidence from the British Psychoanalytic Council, which represents 10,000 psychotherapists. Their evidence suggests that IAPT therapies, simply because they are marked for in a sense, are chosen in circumstances where they might not be the best clinical options. They are already pointing to an instance, as it were, where what people are being marked for, assessed for and targeting can divert clinical practice. I am not saying that that is a cast iron case against doing it. I am just saying that there has to be some review of it.

Simon Stevens: The evidence base for IAPT is incredibly strong, not just out of the research literature but also from the 3.5 million people who have benefited since the programme has been introduced. It is the strength of that evidence base that is leading us to want to expand by another 600,000 people, who are getting access to these services over the next five years.

There is a question within IAPT as to which is the right psychological therapy, and there is a debate among some practitioners about the pre-eminence of cognitive behavioural therapy versus other therapeutic modalities. I think that only 17% of people who received IAPT services said that they did not get the therapy of choice that they wanted, but NICE has set out a range of different therapies within the broad remit of IAPT and it is that broad range that should be made available.



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Q98 John Pugh: Specifically on that, in their submission they say that 85.1% of people referred to the IAPT programme are not moving to recovery from their mental health problems. That conflicts with the evidence in the NAO Report. Do I take it that your view is that they are just wrong and this needs to be corrected?

Simon Stevens: On the recovery rate, yes. The recovery rate for February 2016 was 49% against a goal of 50%. In the NAO Report for the year for which they had the data, 2014-15, it was a 45% recovery rate. It is now 49% against a 50% goal. That, together with improved access and speed of treatment—86% are now getting seen within six weeks compared with 79% in 2014—actually, this programme is not only working, but getting better.

Q99 John Pugh: Broadly, you are saying that you are confident with the targets you have chosen, but you have not said that you are going to review them further down the line to see what effects they are having on overall performance, patient satisfaction and whatever other indices you want. Meeting your target is a proxy for people being cured and made better.

Simon Stevens: On IAPT, we have had strong, independent advice over multiple years from 2008 onwards from NICE and the research unit at Oxford. Lord Layard has been a strong champion of this. There is strong support for the IAPT programme but it is not the be all and end all. It is an important part of what the therapeutic arsenal should be. But the reason that we chose early intervention for psychosis as the other waiting time standard that we were going to introduce is because it is at the severe end of the spectrum, if you like. Three quarters of mental health problems first take effect before people are in their early to mid-20s, so that will benefit people right at the start of their use of mental health services.

Chris Wormald: May I add to that? There is a lot of literature about targets that points out all the upsides and downsides that you have described. One thing that is always written is that if you are going to have targets, they need to be clear and consistent over a reasonable period of time. People get rightly irritated when we change target systems all the time. The goalposts move and you cannot track, year to year, measures because—

Q100 John Pugh: I am not saying that you change them all the time. I am saying that you review them.

Chris Wormald: Do you have to keep an eye on the effects of your target? Of course you do. Do you want to be clear and consistent over a reasonable period of time? Yes. The point I was making earlier was not that targets are the only game in town. If you had an entirely target-drive system, you would have many of the risks you have described, but you have a lot here: you have what NHS England is doing to review across the board; you have what CQC does. Targets are part of a wider package that is about incentivising the behaviour we want to see.

Q101 John Pugh: May I bring Mr Rouse back in, particularly in connection with



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the discussion about funding incentives to targets. Obviously, this would not apply in physical medicine, but if you are going to be incentivised for, say, recovery, in the psychiatric world that can be a subjective judgment. If you are financially incentivised in that way, it could have a distorting effect on the performance of different trusts and different providers, and ultimately on patients. Is that taken into the equation in your modelling?

Jon Rouse: Yes. Nobody is suggesting we attach financial incentives to recovery in that way because of the distorting effects that you have pointed out. What you should do, of course, is to look at whether you are getting value for money overall from your investment in particular modalities and particular programmes, or whether one CCG is using its money more wisely than another, or one provider is performing better than another. That's the type of analysis you want to do to calibrate the programme. So if it is working particularly well in one area compared with another, transfer that practice from one area to the other. The problem is that we have not had good enough data up to this point to be able to make those judgments and we are going to in the future.

John Pugh: What an excellent lead into my next question, which is about data.

Simon Stevens: Would you willing for Professor Kendall to come in because he is a practising psychiatrist, medical director of the Mental Health trust and has led the NICE evidence reviews on many of the treatments that work? So I think he will have something to offer.

John Pugh: Excellent. Briefly, Professor Kendall.

Professor Kendall: It is worth saying that alongside the introduction of access and waiting times, quality improvement networks are being used. All trusts will be required to join quality improvement networks where they will be able to compare outcomes that are specified for each particular waiting time, so over time we will be able to see pretty clearly what the impact is of introducing the money and introducing targeted waiting times. I am pretty confident that over time we will get a national improvement, and if we don't, we'll know.

Q102 **John Pugh:** And you will be led by the evidence. Good.

On the data question, figure 4 is broad brush and inexact. We simply don't have good data not on how much we spend globally on mental health but on the individual conditions and so on. If that was the case with physical health, we would find it astonishing. We would want a breakdown. We wouldn't want half the budget to cover "other physical conditions". We would want something a lot more sophisticated. What steps are being put in train to improve the flow of diagnostic data through the system, if there are any?

Simon Stevens: From a clinician's point of view? We will move on to the HSCIC stuff in a moment, but from the other end of the telescope and treating patients—

Professor Kendall: Give us the question?

Q103 **John Pugh:** I am pointing to figure 4, which is prefaced in paragraph 1.10: "NHS England has no reliable data...for different mental health disorders." There is then a huge pie chart and when you take out substance misuse, dementia and schizophrenia, it leaves "Other mental health disorders". That doesn't tell you as much as it should and I just wonder whether that data could be improved at either local or national level, and whether any steps are being taken to do so.

Professor Kendall: With every waiting time standard we are introducing, there is a requirement for collecting data. We are handing that requirement for collecting data to the Health and Social Care Information Centre. It is then down to the centre to build that into the mental health service data set. It is happening, but we are not at a point right now—

Q104 **John Pugh:** It is massively uninformative now with "Other mental health disorders".

Chris Wormald: No one disagrees with you that historically that chart tells you something but it doesn't tell you what you want to know. It doesn't tell you much. What we are working towards—Jon can describe what we are doing at national level—is something that does give you in exactly the way that Tim described a much more—

Q105 **John Pugh:** On a small item of data—I am sure Mr Wormald you understand this—in terms of the drug budget for mental health, which doesn't feature in this report at all in any shape or form, what is happening to that, and could you submit some data to us? That would tell us quite a lot about what is going on: whether prescriptions are going down, up or varying.

Simon Stevens: Sure. I can tell you right away. CCGs are spending about £400 million on what are readily attributable primary care prescribing on mental health drugs and we anticipate that will go up about 4% this coming year.

Q106 **John Pugh:** So despite non-drug-based therapies, the drug budget is going up.

Simon Stevens: Exactly. To go back to the question about whether that spending would be visible to a mental health trust, the answer is that it wouldn't be.

Q107 **Mr Bacon:** Sorry, was that "would" or "wouldn't"?

Simon Stevens: Would not be, because it is showing up in GP prescribing budgets, not in the local mental health trust's income.

Q108 **John Pugh:** So the shift to behavioural therapies and so on is not doing anything to—

Chris Wormald: No, that doesn't necessarily follow, because—

Q109 **John Pugh:** Medication is as prevalent as ever.



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Chris Wormald: Well, no, because one of the very good things about this debate—and it came out in some of the things you said about schools earlier—is that there is a lot more recognition of the level of mental health issues that are out there in the community. What you could be seeing is just more people coming forward in those cases who require drugs, rather than a shift from some types of therapy to others. This is why we need a much better breakdown of these sorts of—

Professor Kendall: It is also worth bearing in mind that when it comes, for example, to early intervention in psychosis, a key part of what you are delivering is antipsychotic medication. The other treatments—family interventions, CBT for psychosis, supported employment programmes—are in addition to antipsychotics, not instead of them.

Q110 **John Pugh:** I understand that. Having actually once worked in a mental hospital with psychotic patients, I am well aware of that.

My last question is about structures. I struggle to understand how mental health services are delivered in my own area, because when people complain to me, I go to various ports of call—the CCG, the GP or whatever provider is there. Sometimes the provider that diagnoses is different from the provider that actually delivers the treatment. We talked in the previous session about the complexity and regretted it. I looked at how you were going to drive this forward and improve it, and I looked for some Napoleonic figure at the top of the tree who was going to coerce everyone and then I came to—

Chair: Which one of you is that?

John Pugh: I came to figure 11 on page 39, where I saw a similar level of complexity right at the top. I just want you to give me the confidence that despite the apparently byzantine structures that exist at both local level and national level, there is someone really driving this forward.

Jon Rouse: Shall I have a bit of a go?

Chair: You are about to go to Manchester, but for now, okay, go on.

Jon Rouse: First, at departmental level and also stretching across Government, we have a mental health partnership board, which is responsible for making sure that what we need from DWP, CLG, MOD and so on in terms of their contributions all comes together in one place, because the forward view and the taskforce report actually require those contributions. That is co-chaired by myself and Tim, and you have us both here today. Below that, within the five year forward view family of NHS bodies, you have a single delivery board, which will be headed up by—

Q111 **Chair:** So this is the mental health and parity of esteem board.

Jon Rouse: Yes, exactly, which will be headed up by the SRO within NHS England, and she will be held to account for delivery.

Q112 **John Pugh:** But I hope you appreciate the point that the level is more complex to the patient than it needs to be. They do not understand who



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carries responsibility when things go wrong.

Chris Wormald: There are two separate points here. There is accountability at national level, which actually is quite clear, and there is a strategy board and a programme board. That is pretty—

Q113 **Chair:** We now have a named person who is responsible, so we are happy with that for now.

Chris Wormald: Then there is the separate question of whether people know who to complain to locally, which I think is where you started—so if you want to come on to that question.

Jon Rouse: Locally, there is always going to be a relationship between your GP and whichever secondary physician is looking after your care at any given time. What we have tried to do on the primary care side—this has been re-emphasised in the recent “Five Year Forward View” document—is to say that everyone in primary care services should have a named accountable GP who is responsible for the oversight of their care. When that individual is referred to—let’s assume—secondary services, there should again be clarity. There should be a lead individual, whoever that may be—whether it is a doctor or a mental health nurse or some other professional—who is care co-ordinator and is responsible for ensuring that that person’s care is co-ordinated and stays in close contact with the GP during the treatment. That is one of the reasons why we made a strong statement in recent months about out-of-area treatment. When we start getting lots and lots of onward referrals to other providers, that starts to become complicated and opaque, and that’s when people start getting lost in the system.

Q114 **John Pugh:** I think this may lead into a question that a colleague may ask. In terms of integration and organisation, there are some people who have mental health problems but also alcohol and addiction problems—in fact, a fairly large number of them. They are defined differently and commissioned differently, from the NHS’s point of view. Is there any thought about addressing that? There really is a dislocation, certainly at a local level. If somebody presents with alcoholism in one form or another, it is considered not to be a mental illness, so it ought to be treated separately from any mental health aid they may get.

Professor Kendall: Every drug misuse or substance misuse service should be providing a so-called dual diagnosis service alongside that. I don’t think that is sufficient. I also think that, when people who have an alcohol problem or a drug misuse problem come into services, they should be treated mainly within that service—within wards or community mental health teams.

Q115 **Mr Bacon:** Professor Kendall, you wrote a paper in *The Lancet*, which was *Lancet* paper of the year 2004.

Professor Kendall: Thank you.

Chair: It is your first outing.

Simon Stevens: It's downhill from now on. Don't be misled—there is a sting in the tail.

Q116 **Mr Bacon:** It was on selective serotonin reuptake inhibitors—SSRIs—and the way in which the risk-benefit profile for the risks and benefits of certain drugs used to treat children who have depression changes adversely when one adds in the unpublished data, so the actual risks outweigh the benefits in a way that is not apparent when you publish or have available only some of the data. There is quite a lot of evidence that trials that have positive results are in some cases more than twice as likely to get published as trials with negative results. Do you support the idea of having a system in which the full methods and results of all trials on all uses of all treatments are available to doctors and researchers?

Professor Kendall: Entirely and totally. Following the publication of that paper, I appeared in front of the Health Committee for their investigation into the pharmaceutical industry. Out of that, the Labour party put in their 2005 manifesto that they would make it compulsory that everybody would publish all their trials. That has not happened.

Q117 **Mr Bacon:** Right. Mr Wormald, does the Department of Health support the publication of the full methods and results of all trials of all uses of all treatments, so they are available to doctors and researchers?

Chris Wormald: I am afraid that is not an issue that I looked at in preparation for this hearing, so I will need to come back to you.

Q118 **Mr Bacon:** Mr Stevens, does the NHS support the publication of the full methods and results of all trials of all uses of all treatments, so they are available to doctors and researchers?

Simon Stevens: Yes. The NIHR, under chief medical officer Sally Davies's direction, have been pushing for this. I know that a number of the medical journals themselves have been saying that they will now no longer publish trials that were not registered at the point of inception to ensure that there was no funny business going on after the event, in terms of skewing the results. I am sure we can get a note from Sally Davies to the Committee on the action that is being taken on that front.

Q119 **Mr Bacon:** That would be very helpful. We published a report on access to clinical trial information in January 2014. It is good to hear that there has been some progress, but if you could send us that, that would be very helpful.

Forgive me if you have answered this question either obliquely or directly and I didn't hear it because I was so busy scribbling, but my attention was drawn to figure 4 in the Report; this is the chart that shows the spending on mental health services by disorder. It is a total of about £11.3 billion in that chart, but that was a 2014 number; I think that elsewhere the Report says it is now about £11.7 billion. Of the money that goes on mental health—between £11 billion and £12 billion; £11.7 billion, or whatever it is—how much goes on drugs in total?

Simon Stevens: In the CCG spend, £420 million or so is the estimate for the current year, and then there will be some spending that is delivered by secondary mental health trusts themselves, so our consultant psychiatrists would be on top of that number.

Q120 **Mr Bacon:** Yes, but what is the total, roughly? I am not asking you to sign your name in blood and be held to it; I just want to get some sense of the proportion—

Chair: We'll get the figures afterwards.

Professor Kendall: The way it works is that someone will come to an in-patient unit or a secondary mental health service in the community and you will initiate prescribing as a consultant, but you will hand that prescribing on to the GP. It is not going to be massively greater than the £400 million figure, because the long-term prescribing is done in primary care.

Q121 **Mr Bacon:** You can send us the exact figures, but if the Report is accurate, which presumably it is, and £11.7 billion is spent annually on mental health, somewhere between £400 million and £500 million of that goes on drugs.

Professor Kendall: Yes; it is not a big percentage. Almost all the drugs in mental health are off-patent, so—

Q122 **Mr Bacon:** So they are very cheap.

Professor Kendall: They are pretty cheap. Yes, most of the spend is on people.

Q123 **Mr Bacon:** So most of the drugs budget, a significant chunk because it is now—well, I have looked it up and it seems to vary, and there is this payback scheme that has been going for a couple of years. Most of the drugs budget of £12 billion to £14 billion for the NHS goes on clinical treatments of various kinds that are not to do with mental health.

Simon Stevens: Yes.

Q124 **Mr Bacon:** Good. Thank you. One of you was at the King's Fund. Was that you, Professor, at one point, or was it—

Simon Stevens: I used to be a trustee of the King's Fund. I admire their work, but can't take any responsibility for it.

Chair: Mr Bacon, I just remind you that we did want to proceed—

Q125 **Mr Bacon:** I read that, shockingly, 10% of the total NHS drugs bill goes on diabetes—I just mention that in passing. But the total cost per head of drugs in the UK—of course, this goes wider than mental health—was £113 in 2000, and in 2010 it was £169. These are King's Fund numbers. Is it possible for you to send us the most up-to-date numbers for that?

Simon Stevens: Certainly.

Q126 **Mr Bacon:** And if possible, a breakdown within that of mental health.



That would be terrific.

I have only a couple of other questions. One is on behalf of Mr Phillips, who has had to go, unfortunately, back to his constituency—well, I'm sure it's not unfortunate for his constituents. *[Laughter.]* Well, some may take a different view, but I'm sure I don't. Mr Wormald, you will have heard him raise this question with the other witnesses earlier. Paragraph 3.27 states: "There is a considerable discrepancy between numbers that local providers estimate are required"—numbers of staff—"and Health Education England's forecasts. Trusts forecast...that their demand for mental health nurses will fall over the coming years. Health Education England, however, estimated that implementing access and waiting time standards would require the number of mental health nurses to rise from 39,000...to 42,000 by 2020, an increase of 7%".

Health Education England is planning to increase the number of training places as a consequence. You see on the following page, in figure 13, a graph that shows the different expectations of Health Education England and the NHS providers. Now, heaven forbid that different experts could come to different conclusions about an important issue, but what is your assessment of this enormous discrepancy?

Chris Wormald: I will ask Jon to answer, because he knows this better than I do.

Jon Rouse: The first thing to say, just contextually, is that we are, through Health Education England, producing a comprehensive new workforce strategy for mental health, which should be ready by the end of this year and which obviously is needed to make sense, in workforce terms, of the taskforce report and to make sure we get the right numbers of staff. But in terms of the specific question, it is partly to do with experience and how you are looking to the future. We find that providers tend towards a more pessimistic view, and that is partly based on their experience of what has happened over the last few years in reality, in terms of how much resource they have had to spend on staffing. What Health Education England are doing is taking that into account—bottom up, through the LETBs within the regions; the aggregation of those provider pictures—but saying, "Hang on: we also have a five-year ambition, backed up by significant resource, and our view is that actually, when we combine those two things, we end up with a much more optimistic projection in terms of the numbers that we need in order to fulfil the strategy."

Q127 **Mr Bacon:** So how far away are you from closing this gap in a way that is reasonably robust?

Jon Rouse: In terms of training adequate mental health nurses, I think HEE will be able to do that, in terms of the number of places they will be able to offer. The bigger concern, based on what has happened over the last few years, is whether that will translate into the right number of nurses that are actually employed—

Q128 **Mr Bacon:** By the providers. On the basis that providers have budgeted



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for fewer than that, and are expecting fewer than that.

Jon Rouse: Not just that, in that if those budgets change, and the reality changes for them, they will use that extra money to employ more people, but also because we have struggled with the attrition rate in terms of mental health nurses and keeping them in the provider organisations over the last few years. The number of people we are training is not translating into the number of people we are employing, and that obviously needs to change.

Q129 **Mr Bacon:** So this is obviously one to watch. One more question: how many prisoners in the HM prison estate have mental health conditions?

Jon Rouse: The best estimates are that it is around 70% that have two or more mental health disorders—

Q130 **Mr Bacon:** 70%? That is a very big change, because we have looked at prisons a lot in the last few years, and Mind sent us a note saying that their estimate was that 5,000 people within the prison population had a mental health condition, and the Prison Service at the time said, “We don’t recognise that number”, as if it was far too high, at a time when the total prison population was around 80,000. How has it gone from one sixteenth—five into 80, or thereabouts—to seven out of 10? That is a radical change.

Jon Rouse: I don’t know what their base for calculation was. It may be that they were excluding some of the more common—

Q131 **Mr Bacon:** But at that time, the Government was denying it and saying it was far too high.

Jon Rouse: The estimates that I am alluding to are based on the inclusion of anxiety and low-level depression, as well as the more serious—

Mr Bacon: I was not talking about somebody being sad because they are in prison and would prefer to be out nicking stuff.

Q132 **Chair:** I don’t think Mr Rouse meant that. So 70% of people have two or more mental health conditions. You say it includes every level, from low-level to more serious.

Chris Wormald: I think that number also includes addiction, doesn’t it?

Jon Rouse: I think it does.

Chair: That is a bit tangential.

Q133 **Mr Bacon:** Well, actually it is not tangential, Chair, because this report says “preparing for improving access”. I have one more question on this. What proportion of the prison budget, which from memory was about £2 billion something—perhaps someone will correct me—goes on mental health treatment? Presumably they have to buy in mental health treatment from providers. What proportion of the total prison budget goes on mental health in prisons?

Simon Stevens: NHS England is responsible for providing mental health and other health services in prisons, and we spend £493 million a year on our programme in the criminal justice system, of which a big chunk is prisons. We can give you the exact breakdown. There are a series of pilots that have been kicked off by Michael Gove now.

Chair: The Secretary of State for Justice.

Simon Stevens: There will be more control over prison health, but our point of view is that actually the quality of prison health services has improved dramatically since the NHS took on responsibility. I recently visited HMP Preston, for example, and it was pretty clear that by virtue of the NHS being involved, we are uncovering a lot of previously untreated mental health problems on the part of prisoners, and getting them the services that they need.

Q134 **Mr Bacon:** Just to be clear, is that £493 million on mental health or on health generally?

Simon Stevens: The £493 million is on the health in justice programme, including mental health in prisons.

Mr Bacon: How much of the £493 million is mental health?

Simon Stevens: I will have to get you the breakdown.

Q135 **Chair:** Does that include medium-secure and high-secure units?

Simon Stevens: No, that is separate.

Q136 **Mr Bacon:** Oh, so it is not the totality?

Simon Stevens: The medium-secure and high-secure are operated by NHS providers or third parties, and we are spending about £1.7 billion on CAMHS tier 4 and on forensic and secure services combined.

Mr Bacon: If you could send us a note that explains all of that, I would be grateful.

Amyas Morse: I want to pick up a point that was made by Mr Rafferty that I am sure you heard, Mr Rouse, about concern—in terms of stability and retention of staff in mental health—that a lot of issues are created by only having short-term funding for programmes; people were therefore on short contracts. That may cause instability and churn. Is there anything you can think of to help with that?

Jon Rouse: I hope that the way in which we and NHS England have gone about setting out the next five years, in terms of setting out what our ambitions are and then, as you will see in the implementation plan when it is published, giving more detail of the phasing in of that, plus the fact that the CCGs know broadly what levels of resources they are going to have over the next four years and the fact that NHS England hasn't imposed ring-fencing, means that those CCGs, particularly working through their sustainability and transformation plans, should give more confidence to the system, in terms of longer-term employment commitments.



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Chair: Well, Mr Rafferty is behind you and will have heard that, as no doubt will others.

Q137 **Chris Evans:** I want to flag up mental health in prisons. It concerns me that, according to the Prison Reform Trust—I expect these figures are in front of you—26% of women prisoners and 16% of men have said that they had mental health treatment before they went into prison. However, once they enter prison, 62% of men and 57% of women are diagnosed with a personality disorder. There seems to be a disconnect there. Why do you think we are missing those people before they get into the prison system?

Simon Stevens: Tim may have a better answer to the question than me, but I would just add the point that one of the things we are doing quite successfully is rolling out liaison and diversion services—in other words, mental health professionals interacting with the courts system and the police, so that when people who have a mental health need are at the point when they would otherwise be sentenced, they are getting diverted. About half the country has those liaison and diversion services right now. We are aiming to get it up to 75% next year and the whole country by 2020. That will mean that we pick up a lot more of these problems before people end up in prison.

Professor Kendall: I think it is also a question of the extent to which there are treatments available. Quite a lot of people who go to prison—probably about half—have a diagnosis of antisocial personality disorder, for which it is not easy to access treatment. I do not know if that goes any way towards answering you.

Q138 **Chris Evans:** There was a case in my constituency—I am sorry to just bring this up—where someone who was a schizophrenic left prison, could not or did not want to access mental health services, and ended up killing somebody within days of being released. There is a serious case review of it. It is a very infamous case.

As a former member of the Justice Committee, I have always been concerned about prisoners' mental health. That is not an isolated case. Obviously nobody could have guessed what was going to happen, but it is the case that prisoners are leaving and are not being discharged into the NHS and are not having the treatment they need. There is the potential for things to happen. Why is that missing? Why is there not a direct referral from the prison gate into the NHS? Why are we missing those people?

Professor Kendall: I cannot say why there is not a direct referral. It would make a huge amount of sense. I am aware from my own practice that a lot of people coming out of prison with a significant mental health problem are not always willing to engage. In my personal practice I work with homeless people, and quite a sizeable number of them have been in the prison system. You have to be very assertive to get to the people who need help. They are often very distrustful of professionals. It is a complex area, but I cannot actually answer the question about the exact reason for those numbers.



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Chris Wormald: Mr Evans raises a very, very important point. The proposal that the Secretary of State for Justice has made about focusing prison on rehabilitation goes straight to that point. It is an acknowledged issue in the system. We had better write to you on the research base of why that is happening.

Chair: We are also looking at rehabilitation on 4 July.

Chris Wormald: I would also make the wider point that parity of esteem needs to not just be about the health service. It needs to be about the reaction of schools, prisons, local authorities, employers and all those things. We will only get to the vision of the service that we have set out if all those services have the same sort of attitude to mental health that we are talking about here. I will write to you on the specifics, but you raise an important genuine question.

Q139 **Chris Evans:** It was such a high profile case that I actually spoke to the Justice Minister, Andrew Selous, and he said that the tension in the system is that when someone is released from prison, they are free. They are basically free of their sentence. There is no onus on the Government to look after these people any more.

Chris Wormald: Which goes exactly with Tim's point about—

Chair: A final word from Mr Rouse on this point.

Jon Rouse: There is one particularly well-known successful programme in this space called "Through the Gate", which was piloted in the north-west of England. The key to it was continuity of professional relationship, so the people they had been working with in prison were also the people they were working with when they went out into the community, rather than there being a cliff edge that people then dropped off.

Q140 **Chris Evans:** I have one final question. Obviously, a lot of the problems develop in childhood. We have seen a successful system in Wales, where we have a counselling system right across the board. It is not in England. We have also seen Natasha Devon lose her job as mental health champion. Why is coverage so patchy in England, while in Wales and Northern Ireland there seems to be more?

Chris Wormald: Your panel earlier gave part of the answer to that question. Obviously, I cannot comment on Wales and Northern Ireland. This is a big issue in the school system, as we have debated before.

Q141 **Chair:** Are you learning lessons from Wales and Northern Ireland?

Chris Wormald: I would need to go and look at what contacts are made. The Secretary of State for Education, as you know, has a big drive around schools' role in promoting both character and resilience, of which this is a key part. We also have some pilots going on between schools and NHS England about how schools and the mental health services can work together. It has been going up the schools agenda consistently. When I was doing my previous job, in the last two years, whenever I asked a headteacher, "What are your three top concerns?" this was one of the

issues for the first time, which came out of the ASCL survey that Mr Pugh was referencing. That is a challenge, but it is also a good thing in that schools are taking this very, very seriously. I can ask my previous Department to come back to you on the specific points.

Chair: The civil servants behind you heaved a sigh of relief that it is not them.

Q142 **Nigel Mills:** One key method of accountability in this area is the patient voice. What should the patient voice look like? Clearly, getting mental health patients to give you their views and feedback is perhaps not as easy as for other patients. What is your vision for patient voice in this area?

Simon Stevens: First up, ensuring that the priorities for improvement were framed as part of an open dialogue with users of mental health services and families. Rather than coming up with a strategy or blueprint for mental health in the basement of the NHS England building or somewhere in Whitehall, I took a somewhat unusual step by saying, "I would like the chief exec of Mind and Rethink, the patients' advocates and a broader group of stakeholders, including the Royal College of Psychiatrists, to produce that blueprint." In doing so, they engaged very widely with tens of thousands of people who use mental health services, have benefited from them, are frustrated by them and can see huge problems and gaps that need filling. So first, frame the priorities based on the evidence not just from the likes of Professor Kendall but from what service users and families themselves say.

Secondly, in terms of then being transparent about the progress we are or are not making, we need to set that out, so that we can be held to account nationally and locally through those same mechanisms. That is why, in terms of the CCG assessments, as I said earlier, we have a panel that has independent third-party patient advocates involved in doing that.

Thirdly, there is 30 years' worth of action in the mental health services that has often been ahead of other parts of the NHS, frankly, in giving service users more direct control and influence over the way local services are shaped. That has to get built into a lot of the change programmes that this implies. If you think about the big shift out of long-stay institutions into community-based services, that was not always got right, but where it was, it was partly harnessing the power against the inertia and resistance of the way the NHS has sometimes done stuff, with people saying, "This is an inhumane way of providing care and it's got to change." We have to channel that same energy, and sometimes that anger, in order to drive improvement locally as well. I am sure that Tim wants to supplement that.

Professor Kendall: In my former role, I produced NICE guidance for about 15 years. One of the most important pieces of guidance we produced, and a quality standard, was service user experience in adult mental health. Without boasting too much, I think it was well ahead of the physical health equivalent one and ought to be implemented.



Chair: Good advert there.

Jon Rouse: I just want to make the point that this includes children and young people as well. When we did “Future in Mind”, the taskforce on children and young people’s mental health, in 2014-15, we adopted exactly the same principle and involved over 700 young people in the development of those proposals. Just to be candid, if I have an anxiety at the moment it is about the local transformation plans for children and young people’s mental health across the country. Are they all doing as much as they should to properly include children and young people’s voices in the development and implementation of those plans? I think it is quite variable.

Q143 **Nigel Mills:** Okay. The reason for asking is that my local CCG has effectively downgraded the funding for an independent mental health voice group, effectively taking away the support and funding for patients to do that. Are you expecting CCGs, even at a time of fiscal constraint, to be making sure that there is money to enable representative groups of mental health patients to give the patient feedback that the system clearly wants?

Professor Kendall: I see absolutely no reason why trusts cannot do this for themselves. In my trust, and I think it is true for a lot of trusts, we are now building into our plans peer support workers in different groups whose prime job is to represent service users. We are recruiting service users who have used those services to stand up for current service users. In my trust we set up a service user experience monitoring unit—a horrible name—run by service users, and they collect data and interview patients as they come out of the in-patient unit, and those sorts of things. It is early days, but I think that every board should have a section that hears about what the service user experience is like in their trust in different services. I don’t think it is something about which trusts can simply say, “We’re not funded to do it.”

Q144 **Nigel Mills:** I suppose the key thing I was saying was that people who are really quite vulnerable are relatively unlikely to come forward wanting to give their experience, especially if their experiences are fairly negative. In some ways, you need to have some support infrastructure there to support, encourage, enable and maybe even drive them to come to those meetings. Are you saying that, whatever the model is, there should be some resource to make sure that we are getting the right patient feedback, rather than it perhaps being distorted?

Professor Kendall: I think mental health trusts, more than any other trusts, have to take the view of the service user as their starting point. If you are very depressed or, worse still, if you hear voices and develop schizophrenia, they are the times when you need someone to act as your advocate, someone who has to be beside you and is absolutely for you, to defend your rights, and so on. Even more so when it comes to mental health, where your rights are taken away. I don’t think that trusts can say, “Look, we are not funded to do that.” It is absolutely bread and butter, and it is every mental health trust’s responsibility.



Q145 Karin Smyth: I want to return to my question about financial incentives, which Mr Stevens didn't get to answer earlier. You now have that opportunity. Since then, we have had a discussion about the GP being the central point of holding on to someone and being accountable, and you referred, Mr Stevens, to the tier 4 mental health services. We have evidence here, following freedom of information requests, about the number of people, particularly young people, who are having to travel long distances for care. MPs see that all the time. This is a yes or no question. Are you looking at the realignment of, or changes to, financial incentives in order to look at a more integrated system?

Simon Stevens: Yes—full stop. And I can tell you how, if you would like.

Q146 Karin Smyth: Okay. I think we will probably move on. We might want to come back to that one. My final question is about the armed forces covenant. I did some work in Bristol before I had this lovely job, and the problem for the armed forces covenant in terms of making it work was partly due to the fragmentation of the health service and where people go. Access for people who have recently served, and for the families of our armed forces, is really important for mental health. Could somebody talk to us a bit about where they feel the armed forces covenant is in terms of mental health access?

Jon Rouse: I genuinely think that we have made huge progress in the last three or four years, and I hope that the armed forces charities recognise that as well, because we have worked in very close partnership with them. That is not being complacent; there is still much more we could do, but we now have 10 regional teams for mental health liaison, a 24-hour helpline, which Combat Stress runs for us, and Big White Wall, a digital group that is all about peer support and access to professional support. That group has 9,000 members—1,400 in the last year. We have put £8.4 million into mental health support for the most vulnerable, including for post-traumatic stress disorder. I could go on and on, but I genuinely think that under the Covenant, working very closely with the Surgeon-General, NHS England and most importantly, those representative bodies, we have made a lot of progress in the past four years.

Q147 Karin Smyth: Okay. That is one thought. Do you feel that the NHS in its day-to-day operation understands what the armed forces covenant is asking of it, and is that possible given all the other demands on the service?

Jon Rouse: At a national level, I am absolutely confident of that. The work of Kay Davies—

Q148 Karin Smyth: At a local, operational level?

Jon Rouse: The regional networks are really very important. I cannot say that there is the same level of consciousness and commitment in every single locality, but there is a lot of downward pressure and the work of the armed forces charities at local level, which means that the overall position is improving.



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Q149 **Karin Smyth:** Access to mental health services is important to a huge population, such as prisoners, who are affected by mental health problems. We need to consider that as a baseline in our forward look.

Jon Rouse: That is true. In terms of prevalence, there is not a significant difference between armed forces and veterans and the general population, with one exception: high levels of post-traumatic stress disorder for those who have been in combat situations or early leavers. The key issue is 'access' and we must recognise some of the barriers to those services and therefore tailor them accordingly.

Q150 **Chair:** My final point goes back to what I raised with the earlier panel about the differential rates of mental health. I highlighted the issue of black men with psychosis. In all the forward planning, will the data monitor who accesses services and what the outcomes are for people broken down by ethnic group, age, gender and so on?

Jon Rouse: That is exactly the change that we have made to the mental health data set. It gives us that information. It also includes children and young people for the first time.

Q151 **Chair:** But when will it be meaningful? It has been a long-running concern for a number of us, and it is raised with me often by people who are in the system and by their families. When will the way that health services are delivered be changed to provide a more equal outcome for those people?

Jon Rouse: Talking therapies are already making a difference. We can see how the demographic data attach to the outcomes in terms of recovery and then we can adjust services accordingly. We know that there are certain ethnic groups who are not accessing those services as much as they should or are not experiencing the same level of benefit.

Chair: Can you name any groups?

Jon Rouse: We have already talked about some of the barriers in terms of the African-Caribbean community, and also some parts of the Asian community.

Simon Stevens: If you compare the recovery rates from psychological therapy for people from Pakistani or Bangladeshi heritage compared with white British, there is about a 10 to 12 percentage point lower recovery rate. That brings us to Karin Smyth's question. As we are funding and incentivising IAPT providers, we need to link more of the total funding at stake to the outcomes that they achieve, which will then help address part of the problem, although there are various other things that need to be done. If you look particularly at the experience of black and minority ethnic patients in the mental health system, we see a dichotomy in that fewer adolescents from BME backgrounds are presenting into the child and adolescent mental health services, but for adults more BME men are represented, particularly in the in-patient and secure part of the service. So race and mental health has been a long-running sore that is still clearly a work in progress. It is not solved as yet.



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Jon Rouse: Just to finish that off, one of the recommendations of the taskforce report is to ensure that there is prominence to this as we go forward and appoint—I don't particularly like the phrase—some form of equalities champion that will keep challenging us and keep saying to us, "Why are there these differentials?" and making sure that as we get more data around EIP, eating disorders—

Mr Bacon: VIP?

Jon Rouse: Early intervention psychosis.

Mr Bacon: Oh, EIP.

Jon Rouse: Yes, so that we can consider those equalities dimensions and those—

Q152 **John Pugh:** Just on the eating disorders point, I meant to bring it up earlier. There have been stories recently about vulnerable children having to travel some considerable distance to get treatment for eating disorders. Clearly, provision is very unevenly spread, because it is a specialist provision, across the country. Whose role is it—this is just a simple matter of fact—to ensure that we get a better configuration of services with respect to what you might call specialist commissioning in mental health?

Simon Stevens: It is NHS England. We are working on that. If you look at not just eating disorders but also the so-called child and adolescent mental health tier 4 in-patient provision, there were huge geographical inequalities across the country that we inherited when this became a nationally commissioned function, so we have added tier 4 CAMHS beds. We have increased the number by 178 since January 2014, a 14% increase, and in particular we are now looking at areas where there is geographical under-provision and we will be specifically increasing capacity there.

The south-west and Yorkshire and Humberside would be two extreme examples of that. In terms of the number of in-patient beds per 1,000 children compared to a national average of about 11 beds per 1,000, it has been five in the south-west, seven in Yorkshire and Humber compared with 14 in the north-east or 12 in the east midlands. So we are putting in extra capacity in the places where it is required, but, crucially, are aligning—connecting—the local children and adolescent mental health services with these specialist in-patient units, because part of what has been happening is that, as those local services have been stripped back, that has instead placed more pressure and funding increases in the tier 4, so I have appointed a guy called Stephen Firn, who is the outgoing chief executive of one of the best-performing mental health trusts in the country, Oxleas. Stephen is now working with local mental health trusts such that they can take control of the patient flows and indeed therefore the funding that would otherwise have been going to these out-of-area placements and repatriate it and use it to build up local services. That will drive efficiency in the system in a way that Tim Kendall has seen in



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Sheffield, which is an example of a trust that I think has essentially no out-of-area placements at all now.

Professor Kendall: None in the acute sector at all for 18 months.

Q153 **Chair:** This brings me to my final point to Chris Wormald about joined-up Government. Kevin Foster, a member of this Committee, and I did a representative visit for the Committee to Devon and Cornwall police. This mental health bed issue cropped up. If you have an adolescent and mental health problem, even if you have got a bed, if it is in Cornwall and you are on the wrong side of Devon, it is a long way to go and ties up a lot of police time. We have had a look at the indicators on mental health around poverty and socio-economic deprivation. My borough is among 20% of the most deprived areas. The incidence of statutory homelessness and overcrowding increases mental health problems. These are all issues that particularly affect my constituents, although I know other colleagues have these problems, too.

If the Government are serious about tackling mental health problems and preventing them, what conversations are you having with other Departments about making sure you are not cost shunting? If you get the housing right with the disposal of public land and make sure there is good secure housing, that has one of the biggest impacts on people's mental health. If you don't have police officers chucking kids across the counties into prison cells, that will have a benefit for their mental health. Are you having those difficult conversations with the Departments?

Chris Wormald: Oh, yes.

Q154 **Chair:** Any outcomes?

Chris Wormald: We had them on the specific issues. Jon is about to become a living case study of this. It is that sort of joined-up issue that the devolution deals are there to deal with, particularly around the join-ups of health and other services. That is going to be your job, isn't it?

Jon Rouse: It is in Greater Manchester, but there are three things in particular that we can point to as, to a lesser or greater extent, work in progress. One is the join-up with the police. We did the crisis care concordat about two and a half years ago. As a result, we saw a more than 50% reduction in the use of police cells by the end of March 2015. I predict that we are about to halve that again in the figures for 2015-16 and to pretty much wipe out the use of police cells for children and young people; indeed, that will become illegal now under the police Bill going through Parliament at the current time. That's been a really positive relationship and has included investing an extra amount of money through NHS England into more places of safety where there weren't sufficient places of safety.

The second one, which is further back, is the relationship with DWP around mental health and work. We are now working together on the Green Paper, and we have launched—this week actually; we have written to the devolution areas about them signing up for this—our new work in health



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innovation fund, which will focus in part on better approaches for integrating mental health and employment support.

The final one—the third of these, but this is not exhaustive—is with CLG, around housing and mental health. There is some really good dialogue going on around homelessness and mental health, and housing more broadly, but there are some issues that need resolving if there aren't going to be roadblocks in the way, one of which is to get clarity about what we are doing around the local housing allowance.

Chair: I won't divert us into the housing issue—

Mr Bacon: Go on.

Chair—but in my constituency we have more than three times the national average number of people living in overcrowded conditions, and that is just the official figures. I know from my surgeries that there are a lot of people who are below the radar, and the stress and strain that causes for people's mental health and the cost to the local health service, other parts of the economy and ultimately the taxpayer is immense, so I am heartened that there are some discussions going on. I will certainly be challenging that personally and I am sure the Committee will in its own way as well.

Thank you very much for your time and patience. We recognise that this is a journey and I think you get the message that there is strong support for trying to get this right, but we are going to be harsh with you and critical along the pathway to get you pointing in the right direction. I think you will sense that there is a nervousness about the amount of money available in the system, because yet again we have got a budget that is a large chunk of the NHS budget that needs more money putting into it and there is just not enough money to go round, so we will be watching this and other parts of the NHS very closely over the next four years.

Our transcript will be out in the next couple of days, as ever, and we will obviously send you a copy and our report. Thank you very much.