HOUSE OF COMMONS

Environment, Food and Rural Affairs Committee

Oral evidence: Rural mental health, HC 248

Tuesday 21 June 2022

Ordered by the House of Commons to be published on 21 June 2022.

Watch the meeting

Members present: Sir Robert Goodwill (Chair); Kirsty Blackman; Ian Byrne; Rosie Duffield; Barry Gardiner; Dr Neil Hudson; Robbie Moore; Mrs Sheryll Murray; Julian Sturdy; Derek Thomas.

Questions 202 - 261

Witnesses

I: Jacqui Morrissey, Assistant Director of Research and Influencing, Samaritans; Professor Jim McManus, Executive Director, Public Health, Hertfordshire County Council; and Kate Miles, Charity Manager, DPJ Foundation.

II: Sarah Connery, Chief Executive, Lincolnshire Partnership NHS Foundation Trust; Dr Jaspreet Phull, Acting Medical Director, Lincolnshire Partnership NHS Foundation Trust; and Dr Tim Sanders, Clinical Lecturer in Rural Medicine, Royal College of General Practitioners.

Written evidence from witnesses:

– Samaritans

Examination of witnesses

Witnesses: Jacqui Morrissey, Professor McManus and Kate Miles.

[*This evidence was taken by video conference*]

Q202 **Chair:** Welcome to the EFRA Select Committee, where we are continuing with our inquiry into rural mental health and some very sensitive issues in connection with suicide. Before I start, I will say for the benefit of the public in the room and those watching online that the first panel of today's session on suicide prevention will cover some potentially upsetting and distressing material. If anyone watching or listening to this session wants to talk about the issues raised, details of support organisations are available on the Committee website and the Parliament TV page this is being broadcast on and have been tweeted from the Committee account. I hope that if anyone does need help that they will get help. Indeed, organisations like the Samaritans are also available.

I would like the first panel to introduce themselves. Jacqui Morrissey, could you say who you are and who you represent, please?

Jacqui Morrissey: Good afternoon. I am assistant director for research and influencing at Samaritans. Samaritans is the UK's largest suicide prevention charity. We respond to a call for help every 10 seconds. We have over 200 branches across the UK and Ireland, many of them in rural communities. It is great to be able to provide evidence to you today.

Chair: Thank you for all the work you do, and your volunteers.

Kate Miles: Good afternoon. Thank you for the invitation to give evidence today. I am the charity manager of the DPJ Foundation. The DPJ Foundation is an agricultural mental health charity that works with the agricultural community in Wales. We provide a 24/7 telephone and text helpline, which provides a listening ear. We also provide access to fully funded counselling with professional counsellors, deliver training on mental health awareness, which includes aspects of suicide awareness and suicide prevention, and work to challenge the stigma that surrounds poor mental health in agriculture.

Q203 **Chair:** Thank you. We have just been joined, in a very timely fashion, by Professor Jim McManus. Jim, could you introduce yourself and explain who you are and who you represent?

Professor McManus: I am sorry, I had one or two wee technical difficulties.

Chair: Your timing was perfection.

Professor McManus: I will try that for future, then. I am the president of the Association of Directors of Public Health in the UK and I am director of Public Health for Hertfordshire. We are the professional voice of Directors of Public Health, and one of the things that we do across the UK is co-ordinate local suicide prevention plans, among other things like commissioning school nurses and health visitors.

Q204 **Chair:** Thank you very much indeed. I will start off the questioning on this topic of suicide prevention. Particularly what the Committee is looking at is suicide among agricultural and veterinary workers. There are concerns that agricultural workers and veterinary workers have an elevated risk of suicide, but the evidence is unclear. What is your view of the evidence in this area? We will start with Jacqui first from the Samaritans.

Jacqui Morrissey: Thank you. First, it is important to say that suicide is complex. It is rarely due to a single factor. It is usually the result of a combination of psychological, social, cultural and environmental factors. Our knowledge around the risk of suicide in agricultural workers and veterinary workers comes largely from data that are provided by the ONS and academic research. This shows a changing picture over time. Historically our understanding was that the risk of suicide was elevated in farmers and veterinary workers. More recent data that were published in 2017—so it is still not that up to date but it is more recent—by the ONS tell us that men are 1.7 times more likely to die by suicide if they work in skilled agricultural and related trades. They are twice as likely to die by suicide if they work in elementary agricultural occupations—those things such as harvesting crops. Therefore, there is an elevated risk related to people working in agriculture, but the risk is not the same across all jobs within those occupations.

We know, for example, that between 2011 and 2019 there were 813 people working in agriculture who lost their lives to suicide in England and Wales. We are hoping that the ONS is going to publish some new data around occupations and suicide in the near future, which will add to our understanding. This is going to be important, but we also have to remember that all of these data are about real people. This is about somebody's brother, somebody's son, somebody's friend and we know enough already to know that we should be taking action to prevent suicide.

Just to add, our suicide data only give us part of that picture. It tells us about who has died. What it does not tell us and what is also important to understand is more about those who have attempted suicide and those who have suicidal thoughts, so we need to add to that evidence base and listen to the experiences of people in these occupations who have had thoughts of suicide themselves. That provides an important part of this picture.

Q205 **Chair:** Are the data, in your view, robust enough in terms of analysing what is going on? In particular we talk about agricultural workers, but that could be somebody struggling on a very low income as a farmworker or somebody who has massive financial and other business stresses as a person trying to run a farm against the odds financially. How granular is the information that we have now and how could that be improved?

Jacqui Morrissey: Within suicide prevention we have various bits of evidence and data that we try to stick together to help us understand risk. There are the data around occupation, which I have just talked

about. As you say, there are lots of different professions within agriculture, so there are differences in different professions. We also have to understand the wider data around suicide, because we also know that suicide is an inequality issue and we need to understand more about social and economic deprivation in suicide. We need to understand more about gender. There is a whole range of risk factors, some of which are related to the occupation, but also there are lots of those risk factors that might be features of the job—around low pay and poor job security—which are also important to understand. We have to look at all the different factors around this area. Data give us part of that.

One of the issues with the data at the moment is the time lag. It can take quite a long time to get the data through because our official suicide data require an inquest to be concluded. That can take many months. What we want to see is a real-time surveillance system, which is being worked on by Government. It seems to be taking quite a long time, though. We want a real-time surveillance system up and running more quickly that provides data on suspected suicides. That will enable us to target interventions much more quickly in response to new trends.

Q206 **Chair:** Do coroners sometimes err on the side of caution, whether it is an accidental overdose or a deliberate one? Suicide is a very sensitive issue. Are the figures underrepresenting what is going on, or do you think that the figures we have are quite robust in that regard?

Jacqui Morrissey: There was a change in the burden of proof around what gets concluded as a suicide a couple of years ago. That removed the burden of proof from a criminal level. That has meant, we believe, that more deaths are probably being concluded by suicide because it is a lower level of proof that is required for that. There is likely to be underreporting still—of course there is. There will be some cases where it is very difficult to tell intent, but I think that we have enough already to take action on. We definitely need more timely real-time data so that we can look at suspected suicides, but the lack of robust data around specific occupations should not stop us from helping. We can still act on what we already know.

Q207 **Chair:** Thank you. Kate, does your experience shed any light on this particular area?

Kate Miles: In terms of the real-time data, as Jacqui was mentioning, and real-time surveillance, that is essential to be able to take action. Having information is great but if we do nothing with that information, it is a complete waste of time. Having that information in a timely manner where there is a suspected death by suicide would mean that services can be provided to provide support for those people who need it in that community and to potentially alleviate any further adverse impact.

One thing that we do see is that we have a suspicion there is an underreporting around agricultural workers potentially. From operating in regions within Wales, we have community knowledge of deaths by suicide, or suspected suicide, and the official data do not necessarily

accord with that. We work in the agricultural community. We do not just work with farmers or farmworkers—we work in that community, and we know that sometimes people will identify as a farmer but their occupation might be builder or gardener. They are doing off-farm work alongside having that informal arrangement to work on the farm.

Chair: Yes, I describe myself as a farmer, when I am on holiday at least.

Kate Miles: Precisely. It is that type of situation where we know somebody within the farming community has taken their own life, yet they do not show up as being within that community when the data come through. Unless you are able to look at witness statements at that level, which is obviously an intensive exercise and is unlikely to happen on a large scale, there is the potential for a bit of underreporting there. In terms of the data, they can be more robust, certainly, and the biggest frustration is that long time lag, that big delay in terms of getting information through.

Q208 **Chair:** Thank you. Professor McManus—Jim, if I may—can you shed any light on this area?

Professor McManus: Please do call me Jim. Yes, I agree with everything that Jacqui and Kate have said. The nature of this is that it is a complex problem. It is a bit like a diamond. You need to look at different facets, or all the facets of it, from different angles. Real-time suicide data, yes, we absolutely need that. National data we absolutely need. At the same time, the qualitative data that we used to gather—in the old days we used to call them suicide audits, and I have done them myself, where we would go out and talk to the coroner and trawl through every file.

That is a worthwhile exercise to do if you do it properly. In my area and in a number of areas of England we still do it because it does add value. For me, the value of having a local suicide prevention partnership that brings together data from all those sources, including community intelligence and community stakeholders, and then puts that into a local plan is still the only place where you are going to get the best picture, particularly in rural areas or complex urban areas, of the multiple causes, risks and issues around suicide. Therefore, my call would be both what Jacqui and Kate are calling for, as well as that incredible richness of local data from the local shop worker or the local postmaster or postmistress who knows the stresses that farmers are under, for example, and putting all that together.

Q209 **Chair:** I have heard hearsay discussions that one of the reasons that doctors, vets and agricultural workers are more prevalent in suicide figures is because of the access to drugs and firearms. Is there any evidence that that is the case, or indeed is there evidence that social media and other influences have more of an impact on people's suicidal thoughts that may sadly sometimes lead to taking their own lives?

Professor McManus: I would say that it is a mix. I would say that undoubtedly bad reporting about suicide leads to people thinking about it when they were not thinking about it before.

The risk factors among vets are multiple—long working hours, high community demand, high expectations, sometimes working on your own. They are all very high achievers wanting to do the best for their family. The level of trauma that a vet comes across from the pets that people own, particularly when the pets are dying, can be quite severe. Being a vet or working in veterinary practice is a hugely emotionally as well as physically and financially challenging issue. They have to run a business.

You could say the same about farming. Those pressures will be dealt with by different people in different ways. What we need to do is identify the places where we can intervene early. People like the Farming Community Network, who I know have spoken to you, will look at the practical support that people can be given, identify the vulnerability factors and go in early and work on them. Stigma around seeking help is another issue that we need to resolve.

Q210 **Chair:** Are there any alert mechanisms in connection with, for example, bovine tuberculosis and herds having to be culled or individual animals being culled? Could that be seen as a precursor to suicidal thoughts among farmers? During foot and mouth, when whole herds were destroyed, many farmers felt very, very depressed and possibly suicidal.

Professor McManus: There are loads of indicators around real stresses on agricultural workers, including financial stresses and things happening to your animals. Farmers do care about their animals, in my experience. I have yet to visit a farm where that has not been the case. You could easily compile a list of indicators of serious stress where everybody should be getting around the table and asking what we can do to support the farmer, both local authority and national Government like DEFRA and others. It would not be difficult to do. If you can do it for young, urban, LGBT people at higher risk—because obviously they are because of other issues—you can certainly do it for farmers and vets.

Q211 **Ian Byrne:** To build on the excellent answers that have been given for the question, to Jacqui first, suicide rates do vary across the country but are there any broader risk factors for suicide associated with living in rural areas, beyond the associated pressures with the professions we have been discussing?

Jacqui Morrissey: We need to remember that suicide is an inequality issue. People who are living in the most disadvantaged communities face the highest risk of dying by suicide. That is true across rural and urban areas. We know, for example, that men who are less well off and living in the most deprived areas are up to 10 times more likely to die by suicide than well-off men in the most affluent areas.

There are many well-established risk factors for suicide such as relationship breakdown, unemployment and unmanageable debt. These can be experienced by anyone, but if you think specifically about rural areas there might be a number of risk factors that will be exacerbated for some people living and working in rural areas—if you think about social isolation and loneliness or poor working conditions, low pay, or limited

access to services. We know that in rural communities people can find it difficult to access support in person. Perhaps there is poor transport, perhaps they might have inflexible working hours. Perhaps they do not live anywhere near their GP. Perhaps they have bad broadband so they cannot get to online appointments. There is a whole series of practical things that might be limiting people's opportunity to access services and support.

I was going to come back on the point about occupational risk and job-related features around occupations. We think that it is not the occupation itself that increases a risk, but it is some of the features of it. It is things like low pay, low job security, not having much control over work patterns. Again you can see the socioeconomic risk where your deprivation level is increasing your level of risk, and you think about some of those features of those occupations as well. It is important that we think both about the factors that might be related to people's work, but also all those things that are not necessarily related directly to the occupation.

Q212 **Ian Byrne:** Thanks, Jacqui, a good answer. Jim, would you like to add anything to that?

Professor McManus: I agree entirely with what Jacqui has said, and it reinforces the need to take different approaches for different populations. The solutions are multiple, not just good mental health and resilience, but financial resilience and social connection.

Kate Miles: I echo what both Jim and Jacqui have said. In particular, we have seen examples where there is good practice in things like sanctuary services and 24-hour crisis support, but they are centred around urban centres. Those people in rural communities simply cannot get there when they are in crisis. They are relying on the police or ambulance services to fill that gap in already stretched situations.

We also feel that as well as having that rurality, the other aspect is community, which is important and vital. We have seen some suggestions—some early emerging trends potentially—around a drop in suicide rates at the start of the Covid-19 pandemic when community cohesion was so much higher. This is anecdotal evidence that is starting to come through in a small part of Wales. The suggestion of people feeling more connected at that time, even though they were isolating physically—everybody was isolating, but the community effort was increased—has now tailed off, and we are now seeing a rise again in suspected suicide rates.

In terms of community, we see a pressure on individuals within communities. In rural areas, community knowledge of one another is so much greater than being maybe in the centre of town. We are then seeing that individuals are feeling more pressure. They are feeling more pressure around their identity, around themselves, around having to be more stoic, and having less willingness to reach out for help. That is a generalisation, I recognise that, but it is a trend that we see coming

through our helpline service when people are reaching out for support—that concern that other people will find out about the fact that they are getting help. In rural areas, more people know individuals. The farming community in Wales is very small in terms of that knowledge and level of connectivity. That is a barrier to people seeking help in terms of worry that they will be, for want of a better word, found out that they are not coping and are needing help.

Q213 **Ian Byrne:** That was a fascinating piece of evidence, Kate. Connectivity saves lives and we have seen that during Covid. What lessons are we going to learn from that and how can we implement that?

Kate Miles: One observation in terms of connectivity from a rural and farming perspective is the vital role that agricultural auctions play, having those opportunities for people to come together. We also saw during the height of Covid-19 organisations like the young farmers' clubs stepping up to reach out into their community and increasing opportunities for befriending, I suppose, and checking in on people, on individuals, on families. We seem to have lost a lot of that as we have returned to face-to-face delivery and being able to meet up. We have lost that level of checking in.

Chair: Certainly we have that in North Yorkshire where the Church of England goes to the auction markets. They take their blood pressure and tell them to lose a bit of weight generally, but they also look out for other signals as you have drawn our attention to.

Q214 **Mrs Sheryll Murray:** Could I turn to factors that may play a role in suicides? What does the evidence say are some of the key factors for agricultural workers and veterinary workers in relation to suicide? Could I go to you first, Kate, then Jacqui and then Jim?

Chair: By the way, if you agree with what one of the other witnesses said, do not be frightened to say that you agree and move on, because we do need to make some progress as we get through this session.

Kate Miles: As Jacqui said earlier, there are factors, but they are multifaceted factors. It is rarely one thing that has led to somebody attempting suicide, which is where we pick up our data and a lot of our information from people who we have worked with who have either made a suicide attempt or who have had thoughts of suicide. What we are told is that the range of issues that bring them to that point are multifaceted—socioeconomic issues, finance, having limited prospects and concern about the future, that lack of hope and having so many things outside your control. That is something that we do hear from agricultural workers, that feeling that they are out of control, that they do not have that control over their future. That might be because of pressure from external factors such as uncertainty about financial support going forward, challenges from the media and social media, or anti-farmer dialogue. That is something that people cite fairly frequently, and events outside their control. In essence there are a number of factors.

The other factor that plays a role is alcohol and excess consumption of alcohol that we see.

Q215 **Mrs Sheryll Murray:** Thank you very much. Jacqui, if I can move to you next, as well as any additional points that you want to add to Kate's response, does any of the evidence on potential risk factors suggest where suicide prevention efforts should be focused?

Jacqui Morrissey: I agree with what Kate has said, very much so. It is important to see that complexity of those different risk factors. We have talked a little bit already about those job-related features like low pay and low security and lack of control over work patterns. We have talked a bit as well about access to means. That is important to understand for some jobs where people have access to the means of suicide. What we know about suicide is that you can move from having thoughts of suicide to feeling suicidal, to having a plan. Then in taking that step to end your own life, having easy access to means at that point or not can be the difference between life and death. It is important that we try to ensure that people's access to means is as safe as it possibly can be in order for them to carry out their jobs.

We have to go beyond this in suicide prevention. We have to think about why levels of distress might be higher in the first place. Kate has given us some good reasons why already on that. What that shows in where we might focus our suicide prevention efforts is that first we have to tackle it as an inequality issue. We also have to ensure that people have the right support in place when they need it and where they need it. For example, if we think about where people are, where are they going? Are they going to the local market? Kate gave a brilliant example of auctions. They are going there anyway as part of their everyday business. We have to make sure that support opportunities are there in the places where people are going anyway.

Some of the things we know, for example, about providing support for men—we often talk about men not seeking help, but what we know about that is first there is still massive stigma and taboos around talking about mental health. We did a recent survey and found that two-thirds of men living in rural areas said that there were a variety of factors that would stop them reaching out for support. The top three things that they said would stop them were stigma around mental health, not knowing who turn to and a lack of awareness of the support that is available. We need to make sure that support is out there in people's communities in the places that they are so that they know about it.

We also need to make sure that those opportunities are accessible. That does not necessarily always mean the same type of support. There are some nice examples where men are coming together with others, their peer group, doing things together. You have probably heard of Men's Sheds, where people come together and are building stuff and fixing their tools together. They are building these social connections with each other, which we have heard a bit about. If you can build social connections while doing things together, you are perhaps more likely to

have a chat about what is going on for you at the same time. You are breaking down these barriers and making it easier for people to talk about what is going on in their lives and therefore making it easier for them to get the support that they need.

Q216 **Mrs Sheryll Murray:** Thank you. Jim, do you have anything additional to add?

Professor McManus: The thing that I would say in addition to agreeing with everything that Kate and Jacqui have said is that I think of this as a bit of a triangular relationship. There is the person, there is the situation the person finds themselves in and there is the means. Tackling stigma and tackling the culture of self-resilience—of "I will not go for help"—are two things that you can do for the person. Making the means with which to lose one's live by suicide is another set of areas where we still could do better in the UK. The third area is making sure that the environment is such that it is supportive, especially on inequality. For agricultural workers and vets, that does mean coming down to financial security as well.

Q217 **Rosie Duffield:** Some of the key practical measures in different approaches to suicide prevention seem to focus on reaching out and asking someone if they are having suicidal thoughts. We are keen to know why that in particular is so important.

Professor McManus: I am happy to start if that helps. There are several reasons why it is important. First, there are some signs that you can spot and there is training—I know that Samaritans does it; in fact Samaritans is doing it in our area—that can make you feel that someone is at heightened risk, such as behavioural cues about the way that people behave. Sometimes reaching out can break that barrier. There is good psychological evidence around that, unless the stigma is so great that the person is in some difficulties.

Secondly, there are some people who are on different types of prescribed drugs where their risk of suicide will increase. Asking them can help and voicing it can help. There is also some evidence that the first stage of reaching out and talking about it can be a stage of de-escalating from the immediately opportunity. The fourth reason is that quite a lot of people in the situation where you ask them are in a situation where they may be about to attempt suicide, and that can de-escalate it fast. That is good.

What I would say from a public health perspective is that is only as good as the support that you then signpost them into or the other preventive measures around it. We do need to get much better at doing this soft intelligence-led approach to preventing suicide and suicide attempts. Jacqui and Kate, who may be more up to date on the research than I am, may well contradict what I have said.

Rosie Duffield: Thank you. Do either of you want to jump in?

Jacqui Morrissey: We often hear concerns about asking someone directly if they are having suicidal thoughts. People are often worried,

"Will I put the idea into their head? Maybe I shouldn't ask them". Research shows that asking someone directly about it can help them talk about it. People say that it feels like they were given permission to admit how they were really feeling, to actually tell someone about it. That is one of the reasons it is so important and one of the reasons that we focus on reaching out and asking someone, because people may not want to admit it to anybody or may not feel that they can. People do not want to be a burden to others, do they? Asking someone can give people the permission to talk about it.

Q218 **Rosie Duffield:** Thank you, Jacqui. The next one is mostly for Kate. How can we provide effective support and training for people to deal with someone who may be feeling suicidal, and who should we be training? I know that DPJ does some specific agricultural mental health awareness training, don't you?

Kate Miles: Yes, we do. First, every touch we have with a group, whether we are doing a full training session or whether we are simply talking about what we do, we try to highlight the StayAlive app, which is developed by Grassroots Suicide Prevention, which is an organisation based in Brighton. That app is useful to somebody who maybe has concerns about somebody else—they have spotted some of those signs that Jim has talked about and they are not sure quite what to do. The app gives them confidence to be able to do something, to say the right thing and not say the wrong thing and also, vitally, to know the support that is available, such as the Samaritans or us.

It also is a useful tool for somebody who might be having thoughts of suicide themselves. What I like about this app is that it is double-pronged. We can promote it to people as something to help others but also, by having it on their phone, they also have a suicide prevention app to hand. They can create their own safety plan in there and also have some tools to be able to know how to seek help if they are in that place, where they can seek help for themselves, which is not always the case.

In terms of training and providing training around suicide prevention, essentially it is about what Jacqui said about ensuring that people ask directly about suicide and have the confidence to ask directly, to use the word suicide and not to be fearful and not to be fudging the issue, to leave any ambiguity. We deliver the training to as many people as we can, essentially. We originally were delivering mental health first aid training, but we found that that was too unwieldy for the groups that we were working with. It was too long and we could not adapt it. We developed our own based on a model of mental health first aid and mental health awareness training, which is shorter. It takes out some of the information that at a very basic level people do not necessarily need. They can use that as a stepping stone, then, onto a full mental health first aid course.

We have tried to train certain groups. Vets have been a focus group for us because they have multiple touchpoints with farmers and they can also help one another. We know, as we are talking about today, that vets

have high levels of poor mental health and potentially a heightened rate of suicide. Health professionals we have also been training, surprisingly. What we have found in working with rural nurses and some trainee doctors is that the level of training around mental health that they get is basic and simplistic. Being able to provide a little bit more on top of that helps them to be better equipped and more confident to have a conversation with somebody, which should be a fundamental part of that training but currently maybe is not, or is not in as much depth as it should be.

We work with farm machine runs, fallen stock collectors, anybody who can go on to a farm. They are going out to see farmers and potentially have a relationship to be able to notice changes in somebody—changes in their appearance, their personality. We have also trained postal workers and farming unions, and we have done quite a lot of work with rural police forces across Wales. Wales now has a rural police co-ordinator and we are working with him as well. Obviously police are very often the first responders in a situation where somebody is suspected of either having taken their own life or being at risk of suicide. We encourage them to have a compassionate approach, but also to be equipped to know what to do. That is how we have taken that forward.

Vitally, we work with agricultural colleges and students to ensure that at an early age, before they go out into the industry, those young people have a greater awareness and are more equipped to be able to both look after their own wellbeing and mental health but also to have an awareness of suicide and suicide prevention and knowing the help that is potentially available.

Rosie Duffield: Brilliant, thank you so much. We have mostly covered that.

Q219 **Chair:** To follow on from that, we have heard cases where farmers are going through mental breakdowns or having problems and that is manifested in their animals not being cared for and often the RSPCA is called in. Have you had contact with it? Sometimes I get the impression that it is more concerned with dealing with the livestock that are not being looked after and prosecuting the person, rather than looking at the underlying problems that have led to that particular farm becoming dysfunctional. Would Jim be best to come in, or do you want to come in on that?

Professor McManus: I would say yes, it just emphasises the point. I have seen cases myself where the obvious signs that somebody is in distress are there. If agencies had taken the opportunity, we could have intervened earlier. Thankfully we did intervene, but the more we intervene with the person and ask what else might be wrong and what else might be causing this, the better. I am sorry, I did not mean to interrupt Kate.

Chair: Sorry, Kate, Jim was nodding frantically and I thought that he was—

Kate Miles: We have not done work with the RSPCA, but we have with animal health and animal welfare officers and the APHA vets. We are trying to target them and it is still a work in progress. What we are conscious of is that negative information, bad messaging, can be delivered in a constructive way. We try to encourage anybody who has those contacts with a farmer at a time when they will be more vulnerable or may be more vulnerable to consider how they deliver that message so that they use more constructive language and look at dealing with the problem rather than making the person and their methods a problem, because that does then undermine their wellbeing.

Jacqui Morrissey: Can I add that there is a real opportunity, isn't there? We can hear from what Kate has said already about that range of people. When we think about training, we think about suicide being everybody's business. Everybody should have the skills to have a simple conversation with someone, asking how they are and then really listening to them. Then there is the next tier. We know from research, for example, that for middle-aged men who die from suicide, 90% of them were in contact with a frontline service or agency of some kind. That might have been primary care, it might have been mental health services, but it was also things like jobcentres and housing departments. So we need to be in a place where all frontline workers are trained in suicide awareness so that they can spot the risk and they can have those conversations as well.

Chair: Thank you very much. On the subject of vets, Dr Neil Hudson, our resident veterinary surgeon.

Q220 **Dr Neil Hudson:** Thank you to our witnesses for being before us today, for the excellent evidence and for the support that you give to people involved in this.

As the Chair says, yes, I declare an interest—a professional and a personal interest—as a veterinary surgeon. As has been touched on in this session and in previous sessions, vets unfortunately are sadly overrepresented with mental health issues and also with incidence of suicide. With that in mind, how can we improve the working environment and culture for both agricultural workers and veterinary workers to provide better mental health support and better suicide prevention support? I do not know who would like to kick off with that. Jim, do you want to go first?

Professor McManus: To me the fundamental is what a colleague of mine calls building a positive psychosocial environment. Jacqui and Kate gave the examples of the ability of the jobcentre, for example, to spot that someone is in distress. I am going to use a very unfashionable word, but we need to metaphorically wrap our arms around each other as a society and show a bit of love, care and kindness. There is very strong evidence that that works and there is very strong evidence that it helps people be resilient. If you see a workplace where there is a very strong psychosocial environment, you can see places where people can deal with all sorts of things and be open about them.

Q221 **Dr Neil Hudson:** Can I interrupt you there, Jim? How do we get that culture into the workplace of wrapping arms around each other so that best practice in work environments is shared among other work environments? How do we do that?

Professor McManus: First, it is about the political will or the will of the managers in the workplace. I have introduced it in multiple workplaces and I have introduced it in my own and I have been in places and worked in places where it was definitely absent. There are three ingredients. The first is leadership. You need the leaders to want to do it and they need to be trained and they also need to be aware of the myths and bias about belonging to the "pull yourself together" school of psychology, for example. So you start with the leaders. Then you build behaviours and do some training with the staff and the others and give people permission to say it is not all right. You give people permission to make suggestions about how they build the environment to a place where it is very positive. The third thing that we do is you keep on with that and you give people opportunities that are informal to raise where it is not happening and to support one another.

I have seen it happen in large veterinary practices where they send everybody on training on mental health awareness, psychological safety, how to keep one another safe and to say it is okay not to be okay. But it is cultural and behavioural that are the foundations. I suppose I would say that, being a psychologist.

Q222 **Dr Neil Hudson:** Thank you, that is very helpful. I will come to you, now, Kate. With that in mind, as Jim has just said, in big veterinary practices and public sector organisations that potentially is possible, but in the agricultural setting and in small veterinary practices, these are small, private businesses, are they not? How do we get that training and that awareness into the work environment? Is that through the associations? Is it through the networks? What would you say to the Committee, Kate?

Kate Miles: Something we have seen that worked quite well is we delivered some training commissioned by one of the supermarkets. They made it not mandatory but a positive for those farmer suppliers who attended that training around mental health awareness. We saw a strong attendance from farmers, including active farmers, on that training, and engagement as well. Those people have a way to financially boost and take a financial interest in farmers and vets taking part in participating.

As well as that, it is not just about sending somebody on a mental health course, it is also following through, as Jim was saying about that culture. Sometimes we do see organisations that engage us to deliver training but then it becomes apparent that there are fundamental issues within the culture of that organisation. We try to make sure that it is not just seen as a box-ticking exercise.

The other way is utilising farming unions and other industry bodies and encouraging them to prioritise mental wellbeing and mental health and to

try to challenge attitudes of stoicism. We hear about farmers visiting A&E for broken arms two weeks after they have sustained an injury, so it is maybe not surprising that they apply the same sort of idea to their mental health. It is trying to encourage people to seek help and breaking down those barriers.

Also it is about using positive language and trying to highlight the positive benefits of looking after yourself as a farmer or veterinarian. It can be difficult if you are trying to balance delivering the service that you are trying to deliver or delivering the work that you are trying to do on tight timeframes, on tight budgets, but how would you prioritise yourself if there is nobody else picking up the slack? Is there some way of upskilling around pool workers, people who are there available to allow people to take holidays? The RABI recently did a survey that suggested that some agricultural workers have not had a holiday for over 10 years. That is appalling. We would not allow that in any other industry.

The final thing is that we talk a lot about health and safety in agriculture but that focus is on safety rather than on health. We should try to encourage the Health and Safety Executive to focus on health, too, because health includes mental health and wellbeing. We do not currently have that.

Q223 **Dr Neil Hudson:** That is an important point to end with there. Jacqui, I will come to you if you have anything to add on this general line of questioning, but also it has been touched on earlier in the session that there are high levels of lone working among these professions in that agricultural sector and the veterinary sector. How effective are some of the initiatives to improve working environments compared to the provision of direct support services? Could you touch on that if you have anything to add as well? That is quite a big question to chuck at you in the end there.

Jacqui Morrissey: The answer is both. We absolutely need to improve working environments, but we also need to ensure that support services are there and available. It is both of these things. It is back to needing to understand what is causing distress and we need to make sure that people have the support in place to then support them with that. Lone-working environments are challenging and we need to think about communities more broadly. Rather than just thinking about the lone worker, who are all of those other people around that worker? They might not work for the same business, but they might have interactions with them on a daily basis.

That is where it comes back to seeing those wider communities, those wider social connections and how important that is, alongside having the availability of good support services in the right places when people need them that they can access, along with addressing those factors such as low pay and all those pieces that we have talked about around deprivation. It is the combination of things that will make the biggest difference, I think.

Chair: Thank you. I will turn to Julian Sturdy who, like me, is a farmer and so is particularly interested. As usual when we have such interesting and well-informed witnesses, time is becoming quite pressing, so can I ask for punchy questions and equally punchy answers?

We just passed Julian a note to say not to ask the second bit of his question. That is why he was a bit surprised.

Q224 **Julian Sturdy:** Again from me, thank you to the panel for taking the time out today. It is an important inquiry. What assessments have you made of the effectiveness of the UK Government's national suicide prevention strategy in relation to our rural areas and our rural communities? A particular reference, as we have already discussed, is veterinary workers, and agricultural workers, too. Jacqui and Jim, that is probably more towards you.

Jacqui Morrissey: Shall I start? Jim, I am sure that you can add to this. To try to be brief, it is an important and timely question because our suicide prevention strategy is 10 years old now. There is currently a consultation going on around what should be in the new suicide prevention strategy. Overall, we know the Government have failed to reach its target to reduce suicide by 10% by 2020. We know that there has been some great progress, though, with every local area now having a suicide prevention plan in place and these plans are very much centred around responding to local need and understanding the needs of that local community.

However, we have a real problem, because there was a small amount of funding. There was £57 million dedicated to local suicide prevention through the NHS long-term plan. That provided local areas with a small amount of money for three years, but around half of it only ran until 2020-21, so that has already finished. The rest of that funding finishes in 2023-24, so by the next financial year, by 2024, as it stands there will not be any dedicated central funding for local suicide prevention. If we want to be effective in our suicide prevention for rural areas and meet the needs of high-risk groups, we absolutely have to have good local delivery of suicide prevention and that has to be resourced. At the moment there is no future resource dedicated for that.

Julian Sturdy: Thank you for that. There were some important points and I might just follow up on a couple of those. Jim?

Professor McManus: I agree with everything that Jacqui said. I would make three points. First, on the national plan, we could do a lot better. The next national plan has an ability to do better and it is great that people like Louis Appleby are engaged in that. Secondly, there needs to be funding. There absolutely has to be funding. The public health budget has been cut by over 25% in four years. The only funding we have for suicide prevention is the national funding Jacqui talked about. Interventions that save lives will stop if there is not money to deliver them.

Thirdly, we know that local works. Jacqui and I worked together for four years on the local suicide prevention plan review and implementation. We know that local works and we know that local partnerships that understand the local area—North Yorkshire is very different from Hertfordshire, which is very different from Tower Hamlets, for example—are the best-placed partnerships to bring down suicide in their areas. Why would you not build on success?

Q225 **Julian Sturdy:** Chair, I know you want to move things forward into the next panel. You said that the Government have not reached their 10% target. How far off reaching that was it? Jacqui, you mentioned that.

Jacqui Morrissey: Yes, I did mention it. We can provide the Committee with the figures. Let us write to you with those figures; I do not have them to hand. It was too far off; it was too far. That is the problem. They should have met it.

Q226 **Julian Sturdy:** Missing those targets and any missed prevention is too far off, isn't it? Yes, that information would be helpful to the Committee, so if we could get that, that would be brilliant.

The local delivery element that you touched on and the fact that funding was running out in 2024, you both mentioned. Obviously for rural communities I would say that is essential. Is there anything else you need to add to clarify how important that might be before we wrap up this session?

Professor McManus: I would say two things. Some of the funding has come through the NHS. The NHS is the National Health Service—it is not health in general and there is a lot of health that sits outside it. Some of the funding has tended to be weighted to areas of deprivation. If you look at the rural areas, although there is a lot of deprivation, they will inevitably lose out. There needs to be a rural bias, a fair bias—that is a silly thing to say but I hope you know what I mean—towards rural areas in funding.

Q227 **Julian Sturdy:** Can I just interrupt you very quickly? We are all familiar with how the NHS funding formula works and that rural communities are affected right across the board with NHS services on that basis. Are you saying that that same calculation, that same formula, represents what you are discussing now?

Professor McManus: Yes, we need a formula that takes into account the differences of rural areas, the access problems of rural areas, and all the problems that Kate and Jacqui have spoken eloquently about, and makes a positive step towards putting money into rural areas to make them safer and to save lives. The places to do that are the local suicide partnerships. Your elected Members in rural areas will know the farmers, they will know the local charities, they will know the director of public health. Who better to bring all that around the table than a local suicide partnership?

Q228 **Julian Sturdy:** Thank you. Jacqui, did you want to add anything quickly?

Jacqui Morrissey: Yes, I completely agree with that and the point about those local organisations. The point about that funding is that while it went through the NHS, it did not stop within those clinical services. That is really important. There is money going into mental health services already. The money that we are losing, as Jim says, is the money that ends up in community-based organisations and in those voluntary sector organisations—you heard a lot about them today—that are doing so much to build those supportive relationships with individuals and groups at risk. We need that funding to be targeted at groups at highest risk. We need it to be recognising suicide as an inequality issue and we need it to help develop non-clinical support services, which are an absolutely key part of the picture.

Q229 **Chair:** Thank you. I think that the point that Jim made is music to my ears in North Yorkshire, because we have high life expectancy, therefore we do not attract the same level of health funding as a place like Liverpool or Hull where for various reasons—industrial disease, alcohol and smoking—they tend to be targeted. It is quite expensive to deliver treatment to very old people in North Yorkshire, and certainly suicide prevention.

We do not have a Welsh member because Geraint is not here today, so Sheryll is going to ask the Welsh question.

Q230 **Mrs Sheryll Murray:** It is down to me, a Cornish woman, to ask a Welsh question. It is just for you, Kate. Could you tell us about any key lessons from the Welsh Government's approach to suicide prevention that have worked particularly well in relation to agricultural workers? I know that we are becoming quite pressed for time, so if you could give me a succinct answer, that would be helpful.

Kate Miles: Certainly. One thing that has worked particularly well is in relation to the collaboration between the agricultural department, where agricultural workers would be represented, and mental health services. "Talk to me 2", which is the suicide prevention strategy, is under review at the moment. The Welsh Government agricultural department is seeking to be represented on the revision body so that it is directly inputting in. It also co-ordinates a farm support group meeting that meets bimonthly of all the charities working in agricultural support, but also with mainstream mental health charities so that mental health is on the agenda at the agricultural side as well as the other way around. That is something that is quite effective. Equally having a focus on postvention—support after suicide—is something that is growing at the moment but is looking, at the early stages, to be something that will be a very valuable service, provided it can be done properly.

Chair: Thank you. Ian has the penultimate question.

Q231 **Ian Byrne:** This is to Jacqui. The Samaritans has called for more early intervention and a joined-up public health approach to suicide, to prevent people needing crisis intervention. How do you think that could be done?

Jacqui Morrissey: To give you one example briefly, if you think about adults and some of those key transition points that put people at increased risk—so job loss, marriage breakdown, becoming homeless, suffering from poor physical health—all those key transition points tend to have contact with someone. Someone will know about it within the system, so we need to think about how we can pick up those people or, as Jim says, wrap our arms around those people at those points of transition, which then stops them getting to crisis point. If we put our resources into early intervention—and at its earliest that is about children and young people and skilling them up, but even just thinking about adults—we have more chance of stopping people getting to that crisis point in the first place.

Q232 **Chair:** My final question is for Jacqui, and this I hope will be a question that will be important in the conclusions from this report. The Samaritans told us that DEFRA should be an active stakeholder on the Government's suicide prevention strategy. What would a more active role look like and what is DEFRA not doing now that you would like to see it doing? You have a direct line through now to the Secretary of State at DEFRA. What should he be doing?

Jacqui Morrissey: My understanding is that DEFRA has responsibility for sustaining thriving rural communities and supporting rural industries. We want to see the Department focusing on ensuring healthy workforces, futureproofing this rural workforce and so being an active stakeholder in the Government's national suicide prevention strategy. That will be critical, so they should be feeding in now to the actions that DEFRA want to see within the new strategy. In the most recent progress report, the only mention of the Department is related to nature and social prescribing, so that is a specific policy. It is welcome, but it feels like a fraction of what DEFRA could be doing. It has a responsibility for making rural environments places where people can connect with each other, where they can access the support they need and where they can help ensure that community services are there, connected and supported. There is a range of things that can ensure that we have positive rural spaces, where people can better connect and have healthier workforces.

Q233 **Chair:** Understood. So, in short, they should be hugging a few people as well as hugging a few trees. Is that what you are saying?

Jacqui Morrissey: I think they should be using all the tools at their disposal, definitely, and be an active member of that national strategy. I hope that when the new strategy is published we have some clear policy commitments from DEFRA within it.

Chair: That is very helpful. Thank you for giving such good evidence this afternoon, but also for all the work that you do in your different ways within your communities, which does make a difference, and certainly groups such as Samaritans and Kate's group in Wales, as well as professionals, are making a difference. We are seeing figures coming down in terms of suicide and everyone will need some more of that. Thank you very much indeed.

Examination of witnesses

Witnesses: Sarah Connery, Dr Phull and Dr Tim Sanders.

Q234 **Chair:** To start this session, I will ask our witnesses to introduce themselves and tell us what their role is. We will start with Dr Tim Sanders.

Dr Sanders: I am a GP based in Cumbria and a senior clinical lecturer in rural medicine at the University of Central Lancashire and I am here today representing the Royal College of General Practitioners.

Chair: Fantastic. You are coming through okay, but I would not go further than that. Let us hope the line improves. Living in Cumbria is a bit like living in North Yorkshire, where the broadband is not always brilliant. Dr Jaspreet Phull?

Dr Phull: I am acting medical director and a consultant forensic psychiatrist working at Lincolnshire Partnership NHS Foundation Trust. We are an NHS provider providing secondary mental healthcare to the whole of Lincolnshire. We cover areas in relation to child mental health, older adults, adult mental health and forensic services.

Chair: Thank you very much. Our third witness is Sarah Connery.

Sarah Connery: I am the chief executive at Lincolnshire Partnership NHS Foundation Trust, joining Jas today.

Q235 **Chair:** You are very welcome. My first question is about identifying need, and if I could start with Tim, in your local area how does the NHS make sure it has an accurate picture of mental health and what the needs are among people living and working in rural areas?

Dr Sanders: I hope you can hear me a bit better now. I will start by saying I am not sure that there is a very accurate picture of rural mental health needs that comes across. I understand that data are gathered by public health and fed into local health and wellbeing boards, but I think that is on too large a level to pick up the unique needs of the small rural populations that we serve. As has been said before, if you have seen one rural place then you have seen one rural place.

We welcome the recent Health and Care Act amendment that requires NHS England to set standards relating to data collection on inequalities, access and outcomes. We hope and anticipate that because of this, better data on our rural populations will become available, but only time will tell if that takes place. There are major challenges in gathering data that is meaningful, given the wide variety of the populations that we look after.

Q236 **Chair:** Is there a difference between rural needs and rural healthcare challenges and those in urban areas? Is that something in your practice in Cumbria that you recognise?

Dr Sanders: Yes, there are. The core features and diagnostic criteria for major mental disorders are the same wherever you are, but the way that

people present with their mental illnesses can be quite different in rural areas compared to urban areas. I have worked in both. Rural communities tend to be very close-knit, and they tend to celebrate stoicism and resilience. As Kate Miles generalised in the previous session, there is a close-knitness of rural communities on one level, but due to their relative isolation they are often outwardly a bit more private and look to manage their needs without recourse to others. That tends to lead to a more stigmatised view of mental health that can mean delays in presentation, reluctance to accept treatment or an overall focus on mental ill health being because of social stresses rather than seeing it for what it is. There are differences.

Studies suggest that outcomes for patients with major mental health conditions in rural areas may be poorer as well, but access to services for those patients from rural areas tends to be poor.

Q237 **Chair:** Most people's first contact with their GP would be through a telephone call possibly to the receptionist or practice manager. How adept are they at identifying the problems? Certainly, since the pandemic in my part of North Yorkshire I get complaints from constituents that they cannot get to see their GP even when they have obvious physical ailments. Is there a risk that people may not get through to see people and get the help they want because of the way that more remote medical assistance is given?

Dr Sanders: It is a very good point and we are very challenged currently within primary care to respond in the context of the pandemic. As we recover from it, we have seen a very significant increase in workload, as was predicted by me and many of my colleagues at the beginning of the pandemic when patients acting as very good citizens did keep some of the problems that they perceived as being maybe less urgent to themselves.

Q238 **Chair:** I think they were worried about getting infected as well. It was not just good citizenship. I think they were quite worried.

Dr Sanders: I think people tried extremely hard, and we as a profession value the support that they gave us. I accept that the motivation was not always to support us, but people were extremely supportive. We are now seeing the outcome of that staying away in the workload that is coming through. I and my colleagues are working extremely hard to try to provide that access to people.

To give some figures, it is important to understand that GPs carried out 11% more consultations in November 2021 compared to pre-pandemic in November 2019. The move to using the telephone as the first port of call for patients to access their GP has resulted in an overall reduction in the length of time that people wait to see their GP face-to-face, from several weeks pre-pandemic down to just under half taking place on the same day that the patient made their initial contact. I am not saying it is perfect, and I absolutely accept that patients are struggling to get through to their GP, but in among some of the rhetoric there is some

good work being carried out by practices and by my colleagues in some extremely difficult circumstances.

You asked about the practice manager and the reception team and their ability to identify patients with distress and potentially serious conditions when they come through on the phone. I think we can be extremely proud of our receptionist teams in being very good at doing that, but I would argue, and I would be supported I am certain by agencies such as the Care Quality Commission in saying that it is not acceptable that we place either our patients or our receptionists in that position where the receptionist is the only person who holds the gate to access to the GP. Again, the principle that a patient phoning up on the day will speak to a GP on the day, provided we have the workforce to deliver that, is something we should not throw out with the bathwater. Even if it is just a telephone consultation to start off with, that does give us as GPs an opportunity to identify who very genuinely does need to be seen on that day.

The workforce issues that I think are well-documented are causing a massive amount of strain on GP surgeries, and particularly rural surgeries, which are disproportionately impacted by workforce planning issues and issues of under-recruitment.

Q239 **Chair:** We are all in awe of the fantastic work the NHS has done and if it is anything like our part of the world, recruiting GPs in rural areas can be a challenge and that often manifests itself in difficulty in getting appointments. I will ask the same question of Jaspreet from his experience.

Dr Phull: I echo some of the comments Tim has made. We need to understand the prevalence and abundance of mental health conditions in rural areas, and I think we ought to do more. Increasingly our tone is towards that need to look at the prevalence and look very carefully at those factors around how frequent are different mental health conditions. From the literature, there seems to be a close similarity with the prevalence of mental health conditions, but we do note that suicide rates are often higher in rural areas, as often are intellectual disabilities, as an example.

The onus on providers, so secondary healthcare providers, on responding to need is often based on national priorities such as the long-term plan, and of course working very closely with our commissioners and the joint strategic needs assessment to formulate the right response for the population. As time goes on and as we move into integrated care systems, we are moving much more towards population health management. We as an organisation are very keen to modify, develop and adapt our services accordingly, and I think as time goes on we will have the opportunities to describe that in a bit more detail.

The challenges in rurality are multiple in delivering healthcare services. Those have been already discussed, and include issues around access, and access is often about digital challenges, inequalities and the rural

network, so it is about infrastructure and moving from one place to another, but the challenge relates to outcomes, costs and productivity. It is important to highlight that.

We also know that in rural areas there is oftentimes an older population, and that brings with it an elevated risk of comorbidity, and other conditions, for example dementia care, and other forms of physical health-related problems. We also have the challenges with fuel poverty and what is going on politically now makes a rural area particularly sensitive to that, having to transfer from several distant sites to another. Isolation and social exclusion are so important to start to tackle.

In terms of the perception of mental health, we hear about the farmers and farming groups and the vets and that perhaps the sense of stigma sometimes overrides the need to get help or access support or talk to someone. It is so important that we address those and educate and inform not just the population but also providers of care in the broadest sense so that those questions can be asked at those transition points we heard about earlier.

We need to improve our digital infrastructure. We have the lack of broadband and the lack of connectivity, which of course from Tim's feedback is an important way now to access services. It is about that hybrid connection that we need to get right. With deprivation, housing and the challenges with the workforce—it is a characteristic of rurality that workforce is a huge challenge in trying to deliver a service.

We have quite a few high-risk professions. We talked about veterinary surgeons, farmers and agriculture workers. We also talked about healthcare, and they are important components of the rural economy and areas that we need to pay particular attention to.

We also have transient populations. In Lincolnshire we have gypsy communities come through and we have had refugees come through, and that brings its own challenge in dealing with the sorts of mental health conditions they may be suffering from themselves. Delivering services in rural areas is also quite challenging, because of the economy of scale and moving from one place to another. One thing that we are learning that is so important here, and this is a critical point, is the need for good evidence. Currently the evidence base for rural mental health in the UK is quite limited, and we in Lincolnshire are very keen to think about this. We have started to think about developing a centre for rural and coastal mental health, because of our geography, and trying to think about the evidence base and trying to adapt that so that we get the right evidence-based interventions.

Of course, the question about DEFRA is what you can do and what can we do as a community. It is trying to highlight these issues and look for common solutions to them. That is what I wanted to say in terms of that response.

Chair: Sarah, we have not forgotten about you, and I rather suspect that

Sheryll's first question will be one appropriate for you.

Q240 **Mrs Sheryll Murray:** Yes. I do have one short supplementary for Tim first. Tim, I did 21 years as a doctor's receptionist in a rural practice before I came to this place. You said you did not want to see your practice managers and receptionists put in a position where they were perhaps compromised because they are not clinically trained. Have you found that quite often if you have a receptionist who has been working there for a long time they are familiar with the patients and they can pick up and detect a change in somebody, and do they often flag this with you when they put through a call?

Dr Sanders: Absolutely, and the teamwork is one of the beautiful things and one of the things that makes working in a small practice such a pleasure, and you are absolutely right. In stark contrast to the doctor team, which as a general rule comes from outwith the area, the receptionists and often the practice manager are usually from the community and they know the community and the people. They are such a valuable and valued resource for the patients and for the medical team. Yes, without question it is so important. It is a tricky balance between recognising that without overburdening and without putting people at risk or assuming that they are going to always get it right, although nobody should expect any member of the team, myself included, to always get it right. Unfortunately, that is not always possible. We play best as a team.

Q241 **Mrs Sheryll Murray:** Sarah, I want to turn to the planning services for rural communities. Does the local planning and commissioning in your area make sure it builds in access to primary care and mental health services for the local population? Charities have told us that too much reliance is placed on child and adolescent mental health services, or CAMHS, in rural areas, when what is needed is more early intervention or prevention work. What is your experience? If the gentlemen have anything they would like to add to that, could they indicate afterwards?

Sarah Connery: Thank you for having me here today to provide evidence. In terms of the planning, I want to build on Tim's earlier point about the role of the integrated care system going forward, in terms of population health management, which must start with population health intelligence. It is fair to say that we are at the start of quite a long journey in building that up. We all operate with different IT systems. You think it would be easy sometimes to connect that data in a meaningful way and for us to make commissioning and planning decisions, but that is not the case, so there is lots of work for us to do as secondary mental healthcare providers and primary care providers as well as the voluntary sector and physical healthcare providers in terms of making meaningful connections between that data so that we can plan going forward in a meaningful way.

We have started on that journey in Lincolnshire, so we can already see some of the benefits in working what we call at primary care network level, which is a cluster of general practices and looking at the needs of those populations. For example, we have 15 primary care networks in

Lincolnshire, ranging from very leafy suburbs in the south of the county to—as Jas talked about we are also a coastal county—highly deprived areas of Skegness and Mablethorpe, and each of those populations need something very different. It is fair to say that they are all starting from a different point in terms of the services that are being provided there and the community assets that are in place in those areas. We are keen that we work very closely with our voluntary sector organisations. As Jas has pointed out, we do have problems with workforce and being able to recruit and retain sufficient staff to do everything we need to do, so we want to work closely with the voluntary sector to make sure that we are looking at things from a skillset and prevention point of view, rather than just secondary mental health services, so what we can do at the intervention level.

We do have some examples—due to that population health management lens looking at specific needs based on age factors, for example, in those communities—of what is required to keep people living well within their own communities, which is ultimately the vision for our health and care system.

One area where we can plan effectively in healthcare at the moment is around the community mental health transformation. Colleagues earlier talked about the long-term plan. This is one very firm strand of the long-term plan, which is about making services more accessible for communities. It is not specifically pushed towards rural counties, but we are doing what we can with what we have in making sure that it is not one size fits all but is very much dedicated to the needs of that community. It is an integration at a place base between general practice, so we have social prescribers for example who connect people in with community assets, walking groups and allotmenteering, in terms of green mental health and the value of being outside connecting with people. I must say it has been tricky through Covid in terms of getting some of these groups and activities off the ground, but as we emerge post-lockdown we are building the community assets there. That has taken additional funding through the long-term plan for mental health, but already we are seeing some results from that, as in our secondary care caseloads we can let go of people, because they will be held in their communities as opposed to being held on our caseload as a secondary mental healthcare provider.

One of the key points about the community mental health provision, and it has come up in a number of themes today, is being able to signpost people to those community assets and to training. We have 24/7 helplines for example now that people can call and that is all ages—not just adults, but children and young people. There is a lot going on there.

I will pick up now about children and adult mental health services in particular. It is definitely a feature of Lincolnshire in that reliance is placed on our secondary mental healthcare services because there just are not those rural community assets for people to access. We have night light cafes, for example, that adults and older adults can access out of

hours if they need a cup of tea, somebody to talk to, somebody to connect with. We do not have those for children and young people, so we are working with our local authority to do a large-scale piece of transformation work in co-production with our children and young people and their families in building up and plugging the gaps in those community assets.

We have also been collaborating closely with our local authority and our local schools to ensure that we have mental health support and mental health training and awareness. There is not sufficient funding to roll it out to all schools, but we are trying to be as innovative as we can with the resource that we have to make sure that from a very early age we encourage children to talk about and explore their feelings around mental health.

Q242 **Mrs Sheryll Murray:** Jaspreet, I saw that you had indicated that you wanted to add something and, Tim, if you have anything additional to add as a GP from the primary healthcare sector, please do.

Dr Phull: I want to add to some of the comments that Sarah made, to say that there is a very helpful Centre for Mental Health report looking at rurality and the delivery of child and adolescent mental health services. It is called "The Space Between Us" and it was published in 2020. It gives a helpful insight into some of the challenges of delivering rural mental healthcare to the child, adolescent and young person population and does point out the key aspects of healthcare that are critical. It is about getting funding and resources right, improving that digital infrastructure—because of course children engage with health services generally in a very broad way versus other population groups—encouraging the sense of research and evidence-based practice delivery and having an all-party approach towards rurality as a specific issue, and of course it is helpful to be in this forum for that. It is also about the recognition of costs, understanding that productivity gap, the use of the voluntary care sector, as Sarah was saying, and how we can integrate that within our community assets and how we can improve our offer in that sense. Also, it is about having a local authority focus on rural mental health child and adolescent factors. All of these are included in the approach we are currently taking in looking at child and adolescent mental health services in Lincolnshire.

Q243 **Mrs Sheryll Murray:** Tim, did you have anything additional to say?

Dr Sanders: With respect to the integrated care system and the changes that we are seeing there, as I am sure you are aware, primary care services are uniquely positioned. You told us your experience earlier in your life with being the front door to the NHS, quite literally. The majority of patient contacts happen with us and the majority are resolved with us. We know our communities, and as we described we know our communities because we have outreach into our community through members of the practice team living in the community.

There is a high level of local intelligence that helps us to determine what local needs are. My concern, and it is certainly shared by the Royal College of General Practitioners, is that as we move towards the integrated care systems—and I accept we do not quite know how that is going to look in its entirety yet; the devil will be in the detail—that the voice of primary care, the voice of GPs and other primary care colleagues will be diminished in the new ICS, because there is maybe a lesser focus on the primary care voice than has come through in the legislation that set up CCGs. There is a bit of anxiety there to try to work out how we can ensure that the people who do know their populations are able to feed into the services that are commissioned and delivered.

Q244 **Mrs Sheryll Murray:** Do you have any suggestions on anything that you would like to see change in the integrated care systems?

Dr Sanders: The devil is going to be in the detail and what I hope will happen is that primary care networks will be able to take on and be given a seat at the table at a high enough level to enable them to provide that more granular level of detail than even the CCG, which in North Cumbria covered two large urban populations as well as the various rural areas and quite a variety of different sets of needs. It had a good appreciation of those but ultimately the networks will bring better granularity.

How can we move forward? We are struggling for capacity now. From a GP's perspective we desperately want to see our patients. We are not trying to avoid seeing them—quite the opposite—but we just often do not have the time to see everybody who needs to be seen. It is emotionally quite trying, recognising that there is unmet need and commonly we are meeting with people and we do not have the time to give the support they need. From a solutions-focused perspective it would be beneficial to look at maybe moving on from the system, for example the quality and outcomes framework system that we use to manage the health of our most vulnerable patients and moving away from a system that maybe focuses a bit too much on bureaucracy and towards enabling GPs and the team to focus more on those patients who need the most care at that given time and to cut out the red tape and box-ticking that has become quite engrained.

Trying to look at ways to cut other unnecessary workload and bureaucracy, reviewing contractual requirements and looking at the ways that patients flow through the system has to be top to bottom, but the fact is that we run our hospital system so hot. If you compare with other countries in Europe that have similar health systems, such as Holland, they express surprise that we run constantly at near 100% bed occupancy. I think that makes us extremely inefficient and makes it very difficult to respond to bulges in need when they come through.

Other things such as changing the regulations so that appropriate other members of the practice team might be able to sign prescriptions or fit notes, within safe regulatory frameworks, to reduce some of the burden on the GP, to enable them to do what only the GP can do, would be

valuable in making it possible for us to respond to the needs of our patients. That is at the level of commissioning and of the ICS.

Q245 **Mrs Sheryll Murray:** Very briefly to both Jaspreet and Sarah, do you have any suggestions on how we can make sure the new integrated care systems address challenges with the accessibility to mental health services for rural communities? Over to you, Jaspreet, and then Sarah.

Dr Phull: It is about ensuring that we put parity of esteem as a central concept for us as part of an integrated care system. That is having an equal regard for mental and physical healthcare. For a long time of course mental healthcare was looked at in a fairly disparaging way in the healthcare community, looked at very differently and the funding is very different from physical healthcare. Putting that as a central theme to all our discussions is absolutely vital.

The ICS is meant to be a body created of secondary health organisations, PCNs representing GP practices and other parts of the care system. The idea is to integrate all of those, to look at those pathways, to look at those challenges and to use that collective strength to ultimately address the difficulties. It is about ensuring that we get the right formula for the right area and of course in a rural setting that is recognising both the strengths and weaknesses of the areas. We heard earlier about small teams having greater cohesiveness, but equally having to deliver some services for quite a dispersed and wide population area. Trying to understand that and being able to respond to that is absolutely important.

Also it is about using those partnerships from the voluntary care sector to start to deliver the need within the population. As Sarah was saying, having that population health management narrative is vital, as is trying to tackle some of those social issues or economic issues, be it housing, homelessness or other factors that are important to get right. I think that is critical for the ICS to consider.

Q246 **Mrs Sheryll Murray:** Thank you very much. Sarah, final word?

Sarah Connery: I was delighted in the Health and Care Act that a mental health lead has a seat as a partner member of the integrated care board. I think that is an important change from the primary suggestions in terms of making sure that that voice is heard and that there is parity of esteem between mental and physical health.

Chair: Could I encourage short, punchy questions? It is always at this stage of the session, when we are three-quarters of the way through, that we start to worry about time.

Q247 **Dr Neil Hudson:** I want to get on to shock events now. I thank all the panellists for being before us and for all that you are doing in supporting our communities. I declare an interest, as rural Cumbria is unfortunately at the forefront of some of these extreme events, whether it is flooding, storms or infectious disease outbreaks in animals.

I am going to come to Tim with the first line of questioning. What plans

do you have in place to deal with some of these shock events that can occur in rural communities, such as animal disease outbreaks, foot and mouth, floods and so on? These events can impact rural communities and potentially give rise to additional need, and certainly in my part of the world there is a lot of anxiety when you are worrying about these events coming and then there is the trauma when they happen. Tim, I know this is your part of the world also, can you give us your perspective on that?

Dr Sanders: If you will indulge me, I will briefly describe, and echo Jim McManus's comments in the previous session, the burden of animal husbandry and the very strong moral imperative that is so keenly felt by the farming community to care for the lives in their charge. I do not think that is well understood, the impact of the loss of a flock. It is not just the loss of money. That is a secondary concern. The loss of a flock is a very devastating moral affront, it is felt so keenly and it has a very lasting impact.

I remember one of my community who diligently moved a flock to a field out of the reach of floodwaters only to find that they lost the entire flock when the flooding came. You will see from my response that was a difficult story to hear and it is a difficult story to remember—the distress that was shown. We know that more support is required when these events happen, but there is no additional resource. Ultimately the community responds, and we simply respond and try to see our patients through the difficult time.

In Appleby where I have had the pleasure to spend time working, flooding impacts on the town as well as the community and sometimes cuts the town in half and makes it extremely difficult for the surgery to respond, or even sometimes to reach the surgery because the ancient bridge that crosses the river there when it is flooded is too dangerous to cross. There are some very distinct challenges.

How we respond is by doing what any close-knit community does and we try to pull together, but it is often only after the waters have receded and the silt has been washed away that people draw breath, and it is at that point when they need a lot of support and we see a lot of people who are struggling.

Q248 **Dr Neil Hudson:** That is helpful, and I am glad you mentioned Appleby. It is so important, but unfortunately it is very much the resilient nature of Cumbrians and people across the UK to roll their sleeves up and support each other. I say this as someone who represents that area but also participated on the frontline in the foot and mouth crisis and was involved in supervising the culling of many animals and saw how upsetting that is for all involved. If I can throw it open to all of you, yes, people roll their sleeves up and the community mucks in and supports each other, but what plans can we put in place to make these communities more resilient so that they can cope and then bounce back in areas like Appleby? This is something that happens across the country in rural areas and when towns and cities are also flooded. What can we do to put plans in place? Jaspreet, do you want to have a go at that one?

Dr Phull: That is an excellent question. We must put that into context. We are currently experiencing quite an increase in the frequency of extreme weather events, and I think as NHS providers, healthcare providers, I do not think there has been enough in the way of planning or resource management to support those extreme weather events, and not just weather events. You have foot and mouth and other shock experiences and they as we hear cause a lot of trauma—the idea of culling and so forth. That can have a subsequent increase potentially in the risk of suicide, depression, anxiety, even PTSD. There is an established literature to say that these shock events can cause an increase in all those and so you often have a combination of people's homes and livelihoods being destroyed, financial burdens being placed upon them as a result, insurers perhaps not paying up as they should because of people living on flood plains, and that has an impact as well, so planning of housing is absolutely vital.

Responses from healthcare and other institutional organisations is often done in a very ad hoc way. As Tim was describing, everyone rolls their sleeves up and joins in with the efforts, but there is often not the sense that we need to do something different and we need to push ourselves forward. What we tend to do as an organisation is again we signpost and try to work with our partners to identify those people at risk and try to put things in place, so increase the access and availability of services but as such there is not any increased resources or funding that flows towards that.

As I said at the start of my statement, I suggest that more thinking is put forward to these shock events, because we are getting more instability in the climate and we need to plan ahead. That is an area of need.

Q249 **Dr Neil Hudson:** Thank you. That is very helpful for us in making our recommendation. Sarah, do you have anything you want to add to that? We have touched on this in previous inquiries on flooding that when the blue light services leave, the communities are left to bounce back. Do you have anything to add?

Sarah Connery: I will add two points. One ties back to our lack of evidence and data. In the NHS, we are quite good at short-term planning but not necessarily forecasting those impacts. As Tim and Jas have said, sometimes the impact on people's mental health comes when the silt has subsided and everybody else has moved on, but it has lasting impacts on those communities. I am mindful in our county around the flooding in the Boston-Wainfleet area, so it is about more support for that longer term impact of the shock events in terms of people's mental health. Secondly, to build on Jas's point, the NHS is an anchor institution with a key role in being environmentally sustainable so that we are doing everything that we can to reduce the likelihood of those extreme weather events into the future because of the climate emergency. I suppose it is about making sure that the health and care system is a good anchor institution in our communities and making sure that we are environmentally sustainable.

Dr Neil Hudson: That is very helpful. Back to you, Chair.

Chair: Thank you, Neil. We are now going to turn to the challenging and perennial issue of funding. Rosie Duffield will ask the next question.

Q250 **Rosie Duffield:** This is mostly directed at Sarah. Compared with urban areas, do you see additional costs involved in providing primary care and specialist services for mental health in rural areas? If so, what are those additional costs for? You mentioned a lack of data so it might be just your view or experience.

Sarah Connery: In terms of our experiential evidence, I am not able to give any figures today, because the benchmarking data is not there. In terms of our experience and the little bit of benchmarking we are able to do, Lincolnshire is over 2,500 square miles with a population of only 750,000, so our workforce must be spread quite thin to make sure that we are accessible to our rural and coastal communities. Other colleagues have pointed out the lack of good road infrastructure in terms of the loss of productivity for our staff getting from one end of the county to the other to make sure that we are accessible and people can access us when needed.

In terms of recruiting and retaining workforce and attracting them to come to live and work here, where we are not able to do that we plug gaps with agency and bank staff, which comes at a premium. There is definitely a limited economy of scale in terms of in urban areas you can consolidate your services together, but we want to get the right balance. I talk often in our organisation about the balance between quality, access and cost and compromises need to be made. You cannot be everywhere because you would not be able to recruit the staff, so what is the balance between getting a good quality, sustainable workforce that does not involve service users having to drive for an hour or change on three buses to access that service? It is a constant challenge for us to ensure that we are getting the right balance of quality, cost and accessibility. We must have hub and spoke models to ensure that we have somewhere for our teams to come together. As Jas has said, we are working a lot with a hybrid model, so we do have to be quite innovative. There is never enough money to do everything that we want to do, so one of our values in our organisation is innovation. We have had to close wards because we cannot staff them sustainably but that means that we are able to pilot and test out community models, which ultimately reduce length of stay and mean that people are supported in their communities with better outcomes. Sometimes it is the mother of invention that we have some of those challenges.

We need to have additional estate to ensure accessibility and that comes with non-pay costs, backlog maintenance and the usual capital investment that is required to maintain those services. I am not able to provide examples in terms of pounds and pennies because I do not think that benchmarking has ever been done in a systematic way.

Q251 **Chair:** When you close a ward is that because of staffing and resourcing issues or funding?

Sarah Connery: It is because of staffing issues. For example, we were not able to safely staff our children and young person's ward that we had at Sleaford. We were not able to recruit sustainable medical workforce to keep the ward open but as a result we have been able to invest that resource, working closely with our local communities and carers and families, into a community crisis model. Because of that we have reduced the number of inpatient placements and reduced serious incidents, so it is using what we have more effectively to provide a better-quality service.

Chair: I think Ian wants to interrupt as well. I have already interrupted Rosie once.

Q252 **Ian Byrne:** Why could you not staff it? What were the reasons?

Sarah Connery: I think Lincolnshire is a fabulous place to live and work but others do not seem to agree with me. Where we have struggled before is we have never had a medical school in Lincolnshire and now we have one, and work in partnership with the University of Lincoln, so we hope over time where people train they tend to stay. They see the beautiful rural county, they spend a day at our coast, and they are encouraged to stay, so we put great hope in that medical school having a positive impact.

Chair: We have precisely the same problem in Scarborough. The Coventry University campus, which confusingly is in Scarborough, is now training nurses and we can train and retain nurses, so the point you make about the medical school in Lincoln is vital. Sorry, Rosie, back to you.

Q253 **Rosie Duffield:** It sounds similar to Kent. We have only just started our own medical school and retaining staff has been a nightmare. There are things such as cost of housing and travel issues.

Sarah—some of the others might want to jump in on this one—does central funding for mental health and primary care take account of those differences in delivery costs for rural areas, such as infrastructure, or are those areas not fully accounted for and you must make up the gap yourselves?

Sarah Connery: My feeling is it is not. I do not have firm evidence but I am not aware that the funding allocation takes any account of those particular challenges. It would be good if there was a piece of work to get to the bottom of that. Each health and care system has its own challenges. My staff drive across the Wolds, whereas if you are in the centre of Manchester you might be stuck in traffic, so it is an interesting argument but we need to do more work to understand it in a more systematic way.

Dr Sanders: It is helpful to comment on Sarah's answer to the previous question. I would say that the experiential data from North Cumbria where I work would run very much along those same lines.

As an illustration, the London Borough of Lambeth has approximately the same population as North Cumbria—325,000 people. Lambeth packs all

those people into just under 27 square kilometres, whereas North Cumbria covers approximately 3,300 square kilometres. I am absolutely with Sarah. It may well be that rather than sitting on a road behind a tractor in the countryside you could be sitting in queues of traffic in the city, but in its 27 square kilometres Lambeth has two major hospitals and supposedly the appropriate amount of healthcare provision for the population it serves. One would hope the same exists in North Cumbria, but I do not think the central funding is scoped now to take into account that you cannot run services from single sites in a sparsely populated area in the same way that you probably can in a densely populated metropolitan area. All those costs I do not think are provided for.

The other thing that has not been mentioned is that those multiple sites for provision are also smaller, which reduces their resilience to stay open in the face of potentially staff sickness or difficulties in recruitment. You do need a critical mass. Also, those smaller satellite sites can be fabulous places to work but they are rarely billed as centres of academic excellence. What we see as we add university medical schools into more rural locations is that is a draw for people. People are interested in having those opportunities to develop their careers and those opportunities, that flexibility, to choose to work in a different setting, maybe if they are not getting on where they are or they just want a change. All those things can be a major challenge and I do not think are taken into account when funding is set up.

Q254 **Rosie Duffield:** The Nuffield Trust told us that the current system used to allocate NHS funding disadvantages rural areas compared to urban areas. Do all three of you agree with their analysis? Jaspreet?

Dr Phull: I will echo Sarah's point that we would need to know a bit more about the way that the deprivation indices are calculated. It is likely that because rurality is often considered to be in pockets of deprivation rather than a fixed area in a particular region or local area then the way that rurality is perceived from a deprivation index may be slightly different. I would suggest that the current method of calculating that may need to be updated, but again I would like to know a bit more about the topic and have a compare and contrast.

Sarah Connery: The levelling up agenda is an important one for us, but I make a plea that we make sure we are measuring all the relevant indices in terms of rurality to make sure that it is accounted for going forward. There is something about us all talking about the same language in terms of what rurality means, because you can come at it from different angles. A common language would clarify what those impacts are in terms of what needs to be measured to understand the impact.

Q255 **Chair:** I will follow up with that on Tim. Often funding seems to be targeted at areas of poor health outcomes, and that is seen as poor life expectancy. From your experience in Cumbria is it cheaper to provide healthcare for an ageing population or for maybe an area where people do not live as long but have things such as Alzheimer's, hip operations and the rest? It is a leading question and I suspect I know the answer.

Dr Sanders: You probably answered it. I work in Appleby with one of the oldest populations at one of the oldest local authority areas in the country. It is a massive privilege to look after people as they age. It is incredibly time-consuming. The multiple medical problems and the interplay between them, the fact that as they become frailer they cannot come to the surgery to see us and we need to visit them at home, those elements are extremely challenging.

It is fantastic that population is living longer but I am not sure you can equate life expectancy on its own to having a close correlation with deprivation. The subjective experience of deprivation, particularly for people as they age, is underrecognised and represents a lot of unmet need of people struggling financially, particularly given the cost of living increases we are seeing at the moment.

Q256 **Chair:** In terms of the ageing population, suicide is sometimes associated with terminal disease. Do you come across that in your area?

Dr Sanders: Specifically related the elderly population, I think that is a really interesting question. No, I do not think we see high levels of completed suicide in the elderly population. But time and time again I have conversations with my patients where they voice that sentiment, and they are farmers as well. They say, "We would not let our animals suffer in this way". They are not just saying those words glibly. They are often extremely deeply felt, they feel like they have had their time and they are suffering and want to move on.

I would view that as being as important in terms of the burden of mental illness, in many ways. There is a considerable amount of distress felt and those patients need an awful lot of time. The services like the psychological services within the IAPT service are not scoped to provide the focused interventions that are required. That means that as GPs we spend time with those patients, we do it quietly and it happens behind closed doors. We are left picking up the pieces of that. We take that on. That is what we do. We take that on gladly, but it is extremely time-consuming.

Chair: Commitment of that kind is very much appreciated. As politicians, we get heartfelt letters on both sides of that argument in terms of euthanasia. On a more cheery note, Ian.

Q257 **Ian Byrne:** I want to touch on access to appropriate services and the challenges that face them, focusing on a young person's perspective. Dan Mobbs in a previous session told the Committee that for young people, isolation, a lack of transport and lack of local services you cannot get to under your own steam is the most critical issue—the fact that they cannot get somewhere and are stuck in their home and dependent on their family. He also touched on broadband connections and digital access being very poor in rural areas. Barbara Piranty talked about centralisation of services around conurbations leaving out rural areas. I direct this to Sarah to begin with. How have you designed services to address these challenges?

Sarah Connery: Particularly around children and young people, Covid-19 was a challenge in terms of some of the usual access points for professionals to pick up issues, such as school and primary care in terms of what we talked about earlier and people keeping away from the practice. Very swiftly we put in place a 24/7 children and young persons' helpline, 'Here for You', so people can access that service.

Telephone is not the best way for people, particularly if there is a safeguarding issue in the house, so we are pushing other areas. There is a text messaging service and also digital apps that people can use to look after themselves and build their own resilience from a self-help point of view. As we move through Covid-19 we have had great benefits from those and we want to keep them going, even though we are coming out of the pandemic, so we will keep those services in mind.

Back to what we talked about before, it is about making sure we have hub and spoke methods of delivery so we are not accused of being urban-centric, to make sure we have teams based out in communities as well, where it makes sense to provide those services. We want to make sure through our service planning that we are not exacerbating health inequalities through how we structure our services.

We also have some work ongoing with our voluntary sector about building community assets in those local communities at a primary care network level as well. It is easy to set up some of these services in, for example, Lincoln, which is our most urban and most densely populated area. It becomes more challenging to get some of those grassroots organisations connected out in Mablethorpe, for example.

Q258 **Ian Byrne:** On that point, in an earlier session they were talking about connectivity and Jordan Cole said it saves lives, and that is on record.

Sarah Connery: Absolutely right.

Ian Byrne: How can we talk about the voluntary sector doing that connectivity when there are no guarantees? Surely, we have to look at something far more sustainable. How would that come into your planning?

Sarah Connery: Sustainable is the key word. Before in Lincolnshire we have had the managed care network, where there were small pots of money to get grassroots organisation set up, but the money is non-recurrent on an annual basis. The key component of that was how we get them sustainable in their own right to access pots of money going forward. With Covid-19, those charities have not been able to do the events where they would be generating income. It is incredibly fragile for some of those voluntary sector organisations at the minute.

Ian Byrne: You cannot rely on the voluntary sector.

Sarah Connery: Part of that community transformation work is investing money. I cannot recruit enough nurses and doctors to do everything we would like to do, so we have to try to look at how we get the voluntary sector on a skills-base lens. What does this person need? Do they need

help with housing, benefits, employment, education? We put on some virtual courses to get people warmed up to get back into education. Do they have somewhere to live, something meaningful to do, some meaningful social interactions?

Sometimes it is the lower-level interventions that will stop people from going into crisis, so we need to make sure we have resource dedicated to prevention and early intervention as much as we have those secondary mental health care services. That is how we are planning the services going forward, trying to make sure we have the right balance of all those elements because we do not have enough nurses who can support someone to sort out their benefits. That is a different skill set. Somebody else can do that, but it is the lack of support maybe with their benefits that is causing them to suffer with depression and anxiety. It is making sure all those elements are covered.

Dr Phull: It is not just about voluntary care sector, as Sarah was saying. The voluntary care sector can address some areas that health care perhaps are not best placed to address but also signpost and connect with secondary and primary mental health care and become connectors into that system so there is the right response. It is not just about overreliance on the voluntary care sectors or third sector care. It is about using them and working with them in the best possible way for the patient and putting everything into the care of the patient that we can.

Dr Sanders: You asked specifically with relation to children and young people and I wanted to pick up that in the practices I have worked in I have been extremely lucky that we have been able to develop close relationships with our local schools. There is no doubt that the expansion in numbers of support staff within the schools has made a big difference in terms of our ability to respond to those children's needs, both from a safeguarding and a mental health perspective.

More often now I receive referrals from the support team of the school that are not just, "We need some help with this child" but, "We are seeing these changes over this period of time in their academic achievements". It has taken effort to develop with those schools a dialogue to help them understand what is useful and valuable to bring the system together around the child to help.

Q259 **Ian Byrne:** Just for the elements of the report, that investment of the mental health teams in schools has been extremely beneficial from your perspective.

Dr Sanders: From my perspective, yes, but there needs to be a better dialogue between medical and teaching professionals in making sure across the board there is clear understanding about what information transfer is viable, what the routes of referral are, what only I as a GP can refer for, what everybody can refer for, who the best practitioner is, who is the best professional person to make those referrals and what information needs to be transferred. At the moment that has very much been left to chance and good fortune, such as a local investment by those

with an enthusiasm in the subject, such as myself in local areas, rather than being joined up at the moment, unfortunately.

Sarah Connery: It ties in with something from the earlier panel about how suicide is everyone's business. Mental health awareness should be as well, so it is about having that mental health-informed society through schools. There is some additional funding for primary care roles, for example, around children and young people's mental health to try to ease some of the burden that Tim and his colleagues are seeing around mental health presentations in primary care.

I wanted to make the point about autism awareness. Behaviours that might challenge some can be seen as a mental health issue, and in terms of the prevalence of autism, indications are that that is on the increase as well. It is about autism awareness and a more autism-friendly society in how we embrace some of these children and young people and how their behaviours present.

Dr Sanders: I just have one last comment, and I agree with Sarah about autism, about the risk of being left feeling exposed. It is extremely frightening as a practitioner, whether you are a teacher or a GP, to be left in the situation where you have a child under your care who desperately needs help but for whom no help seems to be available. Funding for the child and adolescent mental health service for the children we identify as having those high-level needs to be seen rapidly is sadly sometimes lacking and extremely frightening.

Chair: We are into extra time. I do not want a penalty shoot-out so we will see if we can wrap this one up.

Q260 **Dr Neil Hudson:** We have heard today and in previous sessions about the challenges that agriculture and veterinary workers are facing. How are you responding to make sure you provide services that respond to the mental health needs of these workers in agricultural and veterinary settings?

Dr Phull: I want to echo comments made by the previous panel about the challenges in the agricultural workforce in relation to social isolation, the stigma of mental illness, the excess and range of health-related problems they may suffer from, financial worries, the work-life balance even, and trying to get that sense of wellbeing at the workplace, which is so important. There are limitations on infrastructure digitally and from a transportation perspective, and we talked about access to means as a potential risk factor for completed suicide. From a vet perspective as well, there is the financial position and the trauma, including from culling animals.

These are all important factors that then lead us into an understanding and that brings us to what we do about this. For me, it is about ensuring the access is right. We have a local suicide prevention strategy with our population. It is not just a mental health service provider suicide prevention strategy—it is for the whole community. That is really important. We have started to engage with farmers' unions and local

farmers' networks. We have the Lincolnshire Show this week, for example, and we have representation there to try to talk to farmers and agricultural workers and have that sense of discussion.

It is about ensuring we normalise those discussions, talk about mental health and say it is okay to talk and make sure that platform is there. It is also about engaging with the usual sources of contact. Things like chaplaincies in local areas are so important to have access points into and to be able to signpost for mental health support. It is about peer workers in local areas, local businesses of all sorts, and we heard some great examples from the previous panel about how you can do things differently. We are starting to have those conversations, be it men's-based activities or getting into some of the meetings that farmers have to talk about mental health, which are important as well.

I think it is about increasing our presence, our engagement, educating people and also training. There are some good training programmes to increase people's awareness so that when there are individuals that seem distressed, so that we are able to ask the question. As we have already established, asking the question does not increase the chances of suicide occurring, but does the opposite. It identifies and supports. If we ask someone if they are okay or if they have any suicidal thoughts and so on, that is really important.

Q261 **Dr Neil Hudson:** That is helpful. We are pressed for time. If I can go to Tim and Sarah, you have mentioned farm shows and we have heard from previous witnesses about auction marts as well. We have also heard about the stigma and people being reluctant to put their hand up in a local community where they are very well-known. How do you get into those farm shows and auction marts, and do it in a subtle, sensitive way so that people are happy to engage with you and are not looking vulnerable in front of their peers? How do you do the outreach?

Dr Sanders: Outreach is a real challenge for us in the GP surgery because we are not entirely driven by our contract with the NHS, but it does not form part of the core contract. We are struggling, as mentioned previously, and it is well-understood, to do the stuff that is in the core contract. The concept of getting out there to the auction mart and engaging with people where they are, not just from the angle of mental health but for type 2 diabetes and prostate cancer and all the other priorities we also share, that would be fantastic. But the reality is the reality and I am more focused on what I can do.

I am heavily involved in GP education. I run clinical training for our local urgent unscheduled care provider, Cambria Health on Call. I am a university lecturer. I am incorporating training on mental health in all my programmes and regularly. I hope it can be taken as read that every GP, and it is a fact, has demonstrated during their training a high level of knowledge in mental health care and assessment, but I am offering bespoke rural training programmes in the roles I do at UCLan and in urgent care, in rural medicine and mountain medicine as well. I am delivering CPD training to our local clinicians.

Picking up on that nuanced data that Jacqui Morrissey from the Samaritans mentioned earlier, it is not just about all agricultural workers or necessarily all veterinary workers. We need to be able to pick out the people where there is risk. The key things are making sure that people are asking the question about occupation—that is easily missed—and when they do ask the questions about occupation, you are really at the forefront of their mind, that understanding of the increased risk, and they are making a bespoke assessment of risk, as we do for all our patients.

Dr Neil Hudson: Thank you, that is really helpful. Sarah, did you have anything to add?

Sarah Connery: Peer support is so important, so we are running a social media campaign where we get members of the farming community to share their stories with little selfie videos and then share it wider, and we encourage members of the farming community to do Zero Suicide Alliance training as well.

Chair: I thank our witnesses for giving us such useful evidence. You are absolutely right that the stigma attached to mental health is starting to lift but maybe the last group that it will lift will be middle-aged agricultural workers, and that is the challenge. In terms of outreach in auction marts, in North Yorkshire the Church of England is very involved, as I mentioned. They test people's blood pressure, but I think when people come forward they start talking about other things that are probably more important. I thank you very much indeed for your time and appreciate you being so frank with us and giving us such helpful evidence.