HOUSE OF COMMONS

Environment, Food and Rural Affairs Committee

Oral evidence: Rural mental health, HC 248

Tuesday 12 July 2022

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Watch the meeting

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

Questions 262 - 321

Witnesses

I: Claire Murdoch, National Director for Mental Health, NHS England; and Samantha Allen, Chief Executive, North East and North Cumbria Integrated Care Board.

II: Gillian Keegan MP, Minister of State for Care and Mental Health, Department of Health and Social Care; Zoe Seager, Deputy Director, Mental Health Policy Strategy and Delivery, Department of Health and Social Care; Rt Hon Lord Benyon, Minister for Rural Affairs, Access to Nature and Biosecurity, Department for Environment, Food and Rural Affairs; and Jonathan Baker, Deputy Director, Future Farming and Countryside Programme, Department for Environment, Food and Rural Affairs.

Examination of witnesses

Witnesses: Claire Murdoch and Samantha Allen.

[*This evidence was taken by video conference*]

Q262 **Chair:** Welcome to the Environment, Food and Rural Affairs Select Committee meeting. This is the fifth and final evidence session of the rural mental health inquiry. From panel 1, shortly to join us, we will hear evidence from a national and local NHS perspective and from panel 2 we will hear evidence from Ministers on Government policy. We have Ministers from DEFRA and the Department of Health and Social Care. I invite our first two witnesses to introduce themselves and briefly state their roles and the reason we have them here.

Claire Murdoch: I am the National Director for Mental Health in England. My role is to create a national mental health policy with and for the NHS to ensure that we are working well with partners and that we are implementing the policies that we fund and make.

Samantha Allen: I am the Chief Executive of the North East and North Cumbria Integrated Care Board, one of 42 new organisations established on 1 July, taking over responsibilities from the clinical commissioning groups, responsible for the planning of health and care for the population we serve, 3.2 million people in the north-east and north Cumbria.

Q263 **Chair:** Thank you. You are both very welcome indeed. The first question, the exam question: how does the NHS make sure it has an accurate picture of the mental health needs among people living and working in rural areas?

Claire Murdoch: In recent years, year on year we have been refining the data information that we gather and publish on health outcomes, access to health and investment in healthcare. When I began in the role a few years ago we had very little information but we have seen a sea change in recent years such that we can publish a range of data and we do that quarterly, right down to the region and places below the regional level. Most recently we published the data on the ICS footprint. These are multiple local authority areas that Samantha Allen covers and even below that level we can dice and slice the data into six categories from extreme rurality to city-dwelling and major conurbations. We can look at things such as access through those six lenses by the 42 ICSs.

We collect a lot of data. Together with my team and colleagues nationally, I am charged with implementing the long-term plan for local health. We are in year 3 of five for the long-term plan and the investment of £3.2 million in mental health services nationally. We have modelled that very carefully such that we are expecting to see an increase of 2 million people every year seen by mental health services. We know that of the services that have been prioritised nationally against which that spend is allocated, in particular children and young people's mental

health services, community mental health services and crisis services attract the big sums but some other important programmes, such as suicide prevention and street homelessness, also have material investments.

Q264 **Chair:** Are we better placed than we were in having good data that can be usefully used? Do we still need to make some progress?

Claire Murdoch: We are in a much better place than we were and the data is published. We measure against the objectives of the long-term plan, which is why I mentioned it. We have increasing access and increasing numbers of patients seen and we can cut that data now with much more granular detail in local areas but I would always say that we have further to go. I do not think we can be complacent for one moment when it comes to mental health. We are trying to close a long-standing, historic treatment gap. Over the five years of the long-term plan, we have been making significantly material and important steps forward but we have at least another five years to go to get parity across the country, including rural areas.

Q265 **Chair:** From a local perspective, Samantha Allen, what is your take on the picture in your area of the north?

Samantha Allen: I echo what Claire Murdoch said in that we do have an improving picture of the data. With the establishment of integrated care boards, one of our key goals is to reduce health inequalities and improve outcomes. We are getting better access to data, getting it down to postcode level and looking at a range of characteristics across our communities. We would be very interested in looking at not just the generalised population data but at gender, ethnicity and disability. One of the good learning points from the Covid vaccination programme is that we are getting much better data down to postcode level.

One of the first big tasks of integrated care systems is to develop our five-year health and care strategy and the 42 systems will be doing that over the next few months. We build it up from joint strategic needs assessment data, working with the directors of public health in our local authorities who are the specialists in this area. That is what we will be focused on over the next six months, drawing on the data available through the NHS and from our local authorities, which hold data that is different from ours, looking at social demography using council tax data, for example, pulling different types of data together to build a rich picture.

My final point is that it is not just quantitative data that is important in building up a picture of need. Qualitative data is also important in developing our health and care strategies. We will be out talking to communities, listening to them about their experiences, to overlay the quantitative data. The qualitative angle is as important as the quantitative aspects. What are people's experiences of living in rural communities? For us, in Northumberland, that could be right up in the

Kielder area, down in Durham, Teesdale or Weardale, and people's experiences of accessing healthcare and their health needs will be different from that of our community in Newcastle, for example. It is important, therefore, that we build the qualitative data alongside the quantitative data.

Q266 **Chair:** Will the money follow where the data leads, where you identify pockets of deprivation or particular problems in mental health in certain communities?

Samantha Allen: One of the opportunities with integrated care systems is how we use our funding to look after the needs of our population. I know that you have received evidence from the Nuffield Trust about the way funding is allocated. We need to do more to consider the needs of rural communities and the types of services we are providing there.

Chair: To questions on funding from the north-east to the south-west from Sheryll Murray.

Q267 **Mrs Murray:** DEFRA is responsible for rural affairs. How does it engage with the NHS on rural communities' mental health needs?

Claire Murdoch: In more recent years, we have had more engagement with DEFRA. We have been looking at cross-government strategies and the development of cross-government 10-year plans for mental health. We have done some joint work with DEFRA in particular in the areas of green social prescribing in rural areas, looking at green communities, and green prescribing. We have invested about £5.7 million in it and are piloting some test sites.

In preparing for this Committee, I have been very thoughtful about what else we could do together. In particular, I am keen to explore with DEFRA and other agencies the likes of raising awareness, challenging stigma, some of the cultural issues that surround rural communities in accessing health, to take the opportunity of the growth and investment in expanding mental services and the ICBs that became legal entities on the first day of this month to know the local population and challenge inequalities. If you combine the two, now is the time to do more jointly and I am undertaking to do that. We work with partners a great deal. We are used to working with the big charities and are comfortable working with a range of Government Departments but preparation for appearing here today has convinced me that we can do yet more and we will.

Samantha Allen: We would draw on the evidence that DEFRA publishes, for example work on loneliness being more common in rural settings, the impact on men and working with farming communities. Our directors of public health who work in local authority areas serving very rural areas have strong connections and are drawing on that evidence base.

As Claire Murdoch said, we can always do more and as we are developing our health and care strategy over the next few months we will be seeking to make those connections.

Q268 **Mrs Murray:** To Samantha Allen first, is there any input from DEFRA that would be useful for the NHS?

Samantha Allen: The information DEFRA has access to from working with rural communities would be very valuable—DEFRA's connections into those rural communities—supporting mental health first aid, signposting and how we can make greater connections in accessing services and reducing the stigma associated with accessing services. One of the strengths of rural communities is the sense of community but anonymity can be harder and greater stigma can, therefore, be associated with it. Working together to challenge stigma and to support and promote access would be very positive.

Mrs Murray: Do you have anything to add, Claire?

Claire Murdoch: We have lots of information about the different needs around the mental health of people living in rural communities and the stressors on mental health. Working more closely with DEFRA on at least a line of sight to major policy changes, perhaps around funding, or changes to the labour market, or work that DEFRA might be doing on digital infrastructure and connectivity that NHS services will be greatly reliant on would be useful. We have learned a lot during the pandemic and the opportunity to reach more people more easily for therapy and treatment through digital means. We have to be careful about digital exclusion and digital poverty and we have to be sighted on that, but knowing about major Government policies, particularly economic policies, that may affect rural mental health would be helpful. We would be keen to work proactively with the ICSs and other partners and the people living in rural communities on preparing for change and understanding the impacts.

Chair: On our recent visit to Somerset we picked up on how difficult it is to get farmers to come forward when they have mental health issues while living in close-knit communities where everybody seems to know everybody else's business.

Claire, I have forgotten to thank you for breaking into your annual leave. You are on holiday. That goes above and beyond the call of duty and we are doubly grateful to you for joining us.

Claire Murdoch: It is my pleasure. I thought this was such an interesting and important subject and I was keen to do it. As I sit here, Chair, the window behind my screen is a beautiful rural hill and countryside in Devon. It is my pleasure to be here. This is an important subject.

Chair: It is not Yorkshire, though. That is a bit disappointing.

Claire Murdoch: Next time maybe, another beautiful part of the world.

Q269 **Barry Gardiner:** Claire, you said we are three-fifths of the way through the implementation plan for the first five years. On top of the care

commission groups, the CCGs, we have the sustainability and transformation partnerships, the STPs, and I understand that they will become the integrated care systems, the ICSs. To somebody looking at this from the outside, it seems that there are a lot of acronyms and changes in systems, but tell me this: what actual practical difference will integrated care systems make in improving mental health care for rural people? That is what it has to be all about, not just about we spent so much money and we are now calling them something different. What is the practical difference that the ICSs can make that any previous configuration or acronym could not?

Claire Murdoch: I am sorry about the acronyms. I feel that we have more than one too many in NHS.

The latest changes are an evolution, not a revolution. The 2012 reforms made some major and sweeping changes in the NHS. This is a more organic development of the next step in the things that matter most to us when planning and delivering care. The duties of the ICSs and the ICBs towards challenging inequality, knowing their local populations, being able to reflect on how they spend their money and how they implement, for example, the plans that we devise nationally in a local context, how they decide to apportion the money, how they structure services, are things that the ICSs should be better placed to do, especially the duty to collaborate with partners. One thing is for sure in a country as varied as ours, the factors around equality and inequality are very varied from area to area. I would not go so far as to say each place is unique but something like that is true. The 42 ICBs, the ICSs, are charged to show how they are implementing things in a local context.

Q270 **Barry Gardiner:** CCGs are local. They are made up of local people and they understand the local challenges. Why was it necessary to have changed the structure to get an improvement in outcome and how will the change in structure do that?

Claire Murdoch: The structure of the NHS has changed. I can talk in particular about mental health services where we cannot afford to lose the place-based or local partnerships. We have to have links to communities, local councils, local infrastructure and local places. We cannot lose that. The ICSs cannot suck everything up to the footprint of 42; there has to be much more value than that.

For example, in my national plan for mental health there is a funding formula, a weighted capitation formula, that the health economists and the epidemiologist and people with frankly bigger brains than mine work to in allocating the resource of £2.3 billion to the 42 ICSs, but the ICSs have access to a very important tool that will break down the need to the granular level of clusters of GP practices. When they are making their decisions, together with partners, and having to publish plans to show how they will challenge inequality, we would expect them to be able to demonstrate how they are accessing all the kinds of information that Samantha mentioned—the views of local people, community groups,

charities and other local authority partners and the hard data on health usage. That is not revolutionary—we have always had a commitment to understanding local populations and partnership working—but it is the next development that will at least allow people like Sam and the other 41 ICS accountable officers and teams to move money more easily around their footprints to areas of greatest need.

Q271 **Barry Gardiner:** You have emphasised working with local partners. Let's look at what some of those local partners have been telling us. Sarah Hughes from the Centre for Mental Health said that the plan does not refer to rural populations clearly enough to understand what the needs are exactly. ACRE, Action with Communities in Rural England, criticises the plan for not having a clear commitment to making NHS services as a whole fairly accessible to the whole population, especially those living in rural areas.

I could go on but it seems to me that what you are saying is that you are sitting at the centre and are confident that this new structure will be able to deliver better on the ground. You have not articulated to me why that should be the case and how the change that you have made in structure is enabling local people to feel more confident that they can provide the outcomes that they need for people on the ground.

Claire Murdoch: By next year, I will have worked in the NHS for 40 years. I am still a registered nurse and I should have added at the beginning that I am the chief executive of an NHS trust that covers a wide footprint where one size fits all needs in the population simply will not do.

From looking at the data and information we gather, we can see all kinds of examples of where local areas have in the past, and will in the future, flex services to fit their local circumstances. In Somerset, which someone mentioned earlier, six clinics run by nurses from rural communities looking at physical and mental health do outreach to the livestock markets where farmers gather to do wellbeing checks and engage them in issues of their own health. We could not instruct Somerset to do that but we create the national framework and the expectation for the delivery machinery—those like Samantha charged with looking after their local populations—to publish how they will be tackling inequalities, showing how they have developed innovation and outreach with local people, the local workforce. You cannot specify that nationally.

Q272 **Barry Gardiner:** You will have a stronger process of accountability for local areas to show how they are doing that. Is that what you are telling us?

Claire Murdoch: Absolutely. There is stronger accountability and perhaps Samantha would like to say more about that. She is living and breathing some of these expectations, the frameworks and the guidance we set and the requirements to tackle inequality and demonstrate how

local people and local partners are being involved in delivering and developing health priorities.

Q273 **Barry Gardiner:** Give us your perspective, Samantha. Do you think that the ICSs will provide the silver bullet?

Samantha Allen: I think it is the people working in the system. There are structural changes, new legislation and we are going through a period of transition and implementing these new structures. The new structures offer a lot more local flexibility. Our first task is to develop our health and care plan. That is not being developed for me by Westminster. It will be developed through working with our local authorities, our community and voluntary sector partners, citizens and residents in our communities.

I have not done quite 40 years in the service as Claire has, but I have done 25 and think that there are some great opportunities from the structural reform. There is a legal duty to collaborate, so services need to work together. The success of integrated care systems and the populations they cover will be judged on their success as a system, not on how one part of the community is performing. There is no point in having one high-performing part and three parts not performing well. If we are going to meet the needs of the population in the north-east and north Cumbria, we will have to have models that fit rural, coastal and urban communities.

Collaboration brings new opportunities but I know that you will be keeping a close eye on this and the proof will be in demonstrating that we are improving outcomes. We have to be very clear about the outcomes we are prioritising, how we are measuring them and that we have accountability and transparency. On 1 July, which was our first day of operation, we had a public board meeting. All our papers were in the public domain. How we were going to tackle health inequalities and sustainability was a key item and we discussed rural health as part of that.

We have an opportunity here. Integrated care systems need time and support to enable them to lead locally and not, while they are doing that, be overburdened by central directives. Revision of the mental health plan would be helpful, would be a good steer for us. It will be my job to take it from Claire and her team, adapt it and implement it in the best way that fits our local population in the north-east and north Cumbria.

Q274 **Barry Gardiner:** Can I ask you about the increasing medicalisation of children and adolescent mental health services? Other witnesses, especially those from the charitable sector, told us about the importance of making sure young people are properly consulted when mental health services are developed but then they said about ensuring good transport access, looking more broadly at providing funding for youth services and creating opportunities where young people can see a future for themselves. If the basic social provision is not there, the youth services, the clubs, the ways in which young people want and need to socialise, if

that has all been eroded—and I think Claire or Samantha may have said this earlier—but because the health service is there still, everything is channelled into that rather than taking a step back and saying what we need here is better youth provision.

Claire Murdoch: May I respond?

Chair: Yes, but we do need to make some progress.

Claire Murdoch: I could not agree with you more. We know that there is a pre-existing treatment gap in specialist child and adolescent mental health services and we do have to tackle it so that when youngsters need access to specialist care, they can receive it in good time. That is right. However, the NHS cannot do it on its own. We would be supportive of what many of our stakeholders are calling for: youth hubs across the country where youngsters could get a range of advice, contacts and other kinds of support and which sit in the social domain. We believe in that and I am concerned that we may have seen a reduction of those sorts of services in recent years and that we may, if we are not careful, drive a crisis model of care in which we wait until the point where a youngster is self-harming and arrives at A&E.

Q275 **Barry Gardiner:** Excuse me for interrupting, Claire. I wholly understand and agree with all that you are saying but what representations are you making from the DHSC across to maybe the Department for Levelling Up, Housing and Communities saying that, "We need to tackle this together. If we tackle it together, maybe we will end up spending less money on it than more"?

Claire Murdoch: I am clear at all meetings that I attend—I was at a round table recently at No. 10—and with colleagues across the country in other national meetings that we need prevention, early intervention and social infrastructure that supports our young. We need 100% of schools to have mental health support teams. I am proud that we set up the first mental health support teams in schools during the pandemic. We said that by the end of this long-term plan we would be at 35% coverage but we will be at 40% coverage, so we are slightly ahead of the plan.

We have trained 2,000 new therapists to work in schools and colleges alongside a lead teacher for mental health where the teams exist and they have fast access to CAMHS services. If you visit the schools that have these teams, the head teachers, the students and the workers in the teams target mild to moderate mental health problems and offer psychological support sessions, so they are not at the treatment end. I see a future for youth mental health services where we have the social infrastructure, prevention and early intervention, mental health support teams across the entire country and timely access—one-week and four-week waits for urgent and routine referrals to specialist services.

Q276 **Barry Gardiner:** You are giving us very comprehensive answers but the Chair is catching my eye to try to move us on. Can I ask you, or perhaps

Samantha, finally how the integrated care system makes sure that the sort of preventative work that we are talking about is delivered in local communities? In your local community, Samantha, how will the ICS do that prevention, not the other end, not the extreme end but at that lower level that means that kids do not get to the extreme end?

Samantha Allen: It is our top priority. We will do it by working with our directors of public health, children's services and adult social care. They have lots of experience with young people transitioning from children's services to adult services at 18. I think that when we are looking at youth services we should be looking at 0 to 25 year-olds and not have the artificial cut-off at 18.

We will be drawing on all the evidence. How can we improve people's health and wellbeing? About 10% of it is through addressing access to services and making sure people have timely access to the right care in the right place. The vast majority of that is around having the best educational opportunities and living in a supportive environment with families, collaborating and recognising that the health service cannot continue to simply address illness.

If our integrated care systems were to do just one thing, it would be to tackle health inequalities and do prevention work. We will have to test lots of ways of doing things. We will have to have some different interventions and flexibilities. We will also have to have ways of sharing our learning across the 42 integrated care systems and we are collecting the evidence. In the north-east and north Cumbria, we have an applied research collaborative with our universities, which are gathering evidence on the interventions we are doing so that we will have the opportunity to scale and spread them.

Barry Gardiner: In other words, we need to remember that it is a national health service and not a national sickness service.

Samantha Allen: Absolutely.

Chair: I think I should put in a plug for the young farmers' clubs, which often give a lot of support and offer social interaction opportunities for people working in very often lonely jobs stuck out on the farm. Members can be up to 26 years old.

Q277 **Rosie Duffield:** We do have questions written by our clerks and they are good and pertinent to our inquiries but, Claire, I have been an MP for five years and we have MP's surgeries every week. I have never yet held a surgery when I do not have a parent or grandparent bawling their eyes out because they cannot get an appointment with CAMHS for an initial assessment for two to four years and we are talking about conditions such as ASD, which the school recognises and is absolutely desperate to get help with. I cannot let the opportunity of you there on the screen facing me go by—and I wish every MP in England had your phone number—without saying that you have just painted this paradise-looking

picture of what you want it to be like but none of it relates to what my constituents go through. Some of them have suicidal children. I do have a rural seat, the most rural seat in England for the Labour Party. It is all the things that Samantha mentioned—coastal, rural and urban. None of the head teachers I speak to have the fast access to CAMHS that you mention. What is going on? Is it just my area or does everybody face this crisis?

Claire Murdoch: We have a challenge in children's and young people's mental health services. While I am absolutely clear about what needs to be done about it, it is not a rosy picture; it is deeply practical. My team can cost it and I know what the workforce implications are and so on, but that doesn't mean that there are not some very big gaps in the journey ahead.

At the beginning of the life of the long-term plan, we modelled the access and need nationally and found that one in four children or young people who needed access to specialist services were getting it. If one in four children or young people who needed access to diabetes services were getting it, there would be outrage, and I want everyone to be outraged. It is not good enough. The point of the plan is to close the treatment gap. There will be mental health support teams in schools in your area but not all schools will have them yet because we are still rolling them out.

Q278 **Rosie Duffield:** I used to have access to early intervention services when I worked with four, five and six-year-olds. That has all but disappeared now. It is very unusual for those children to be able to get those services now.

Claire Murdoch: There will be mental health support teams in schools in your area. There will be other advances. We are seeing 170,000 more children and young people this year than we saw last year. We have grown the CAMHS workforce by 40%. There will also be other things in place in your area now—I know that—that were not there three years ago. However, is that treatment gap unacceptable? Do we need a plan for the next five years as well? Do we need another 40% growth in the workforce? Do 100% of schools need mental health support teams? The answer to all those questions is yes. If I give the impression of something rosy, I am sorry, but I can say that we are seeing more children and young people, as well as more adults, than ever before. We have a range of services that did not exist five years ago, for instance specialist perinatal mental health services. However, we need to make the next five-year plan now because the next two years will go quickly.

Q279 **Rosie Duffield:** That all sounds good but if you are a parent who has waited for between two and four years for an assessment and you have a 12 or 13-year-old who you think is possibly suicidal, that is a lifetime. I have friends who work for CAMHS in East Kent, including someone at the very top of the service. Their bosses, the people who get the tender, change, sometimes every six to nine months. The headed paper they get their instructions and HR information on is from a different health

authority from somewhere nowhere near Kent. We have had Surrey, Brighton, all kinds of people, providing the CAMHS service. It does not help.

Claire Murdoch: One of the big changes that ICBs will bring in is the far more collaborative development of services and far less procurement and competitive tendering. I was not the Government and I did not make the rules about competitive tendering, but the NHS has made some clear statements about wanting to develop local services for local people through collaboration. We do still have issues with local authorities that run children's services, addiction services, school nursing, behavioural psychology, health visiting and so on. Many of them do still tender those services out every three to five years.

I urge local authority colleagues to work with ICB leadership to develop local services through collaboration more than through competition. Let me be quite clear, I am not opposed to competition. Where you have a failing provider that is not delivering, first you need to look at supporting them, developing them, and trying to enable them to turn their delivery around but if they are not doing it, fine, give it to a provider who can deliver. I recognise what you are saying but there is a commitment to the collaborative development of services now.

Honestly, while there is breath in my body, I will be determined to expand children and young people's mental health services further. Amanda Pritchard, the chief executive of the NHS, has ring-fenced and protected our funding and carried on the commitment that Simon Stevens before her made. I never want my acknowledgement of and setting out what has changed and what has developed and expanded to undermine the great need that sits there and that we must tackle and address. It is not one thing or the other. We have to do both.

Chair: We have about 20 minutes left and I want to get three more questions in, so can we keep an eye on the clock, please?

Q280 **Dr Hudson:** I want to move on to the concept of shock events. We have taken evidence about situations that occur in rural communities and we have had a protracted shock event in rural and urban communities over the last two years with the Covid pandemic but my part of the world, up in rural Cumbria, is sometimes at the forefront of shock events, extreme weather events—storms, floods—and, very sadly, major catastrophic disease outbreaks such as foot and mouth back in 2001. We have taken evidence, and as a constituency MP I am very aware of it, that there is still residual memory, trauma and shock from foot and mouth in 2001.

Coming first to Claire for a national perspective, how does the NHS as a whole plan to make sure that it can help rural communities deal with the mental health impacts of such shock events—pandemics, floods and outbreaks of animal diseases? How does the NHS deal with those things at a national level? Is there a strategy?

Claire Murdoch: We have seen many rural shock events, as well as urban terror events—Grenfell, the 7/7 bombings—and I know that Samantha joined her post shortly after the big winds struck and there was devastation in Cumbria as a result.

Sadly, shock events will happen all the time in the country and are hard to plan for. However, the NHS now has a wealth of expertise and knowledge about things such as post-traumatic stress disorder services and what an immediate response should look like from a mental health point of view and also what the response to trauma months and years later should look like, when to intervene and when not to intervene. Generally speaking, where there is a shock event that affects a larger area, the local authorities will lead and co-ordinate what the joined-up response will be, in which NHS is an important partner but not the sole provider. Education and industry may also be involved as well as local authorities and primary care. Generally, the planning will be predominantly through local authorities.

My own trust was involved in the 7/7 bombings. That was a long time ago but it is no different today. When there is a major event, the lead local authority and lead health agencies will be involved up through the health line and the local authority line to Government. The NHS, for example, can flex its budget just so much to provide additional support to a certain area but largely our money is already allocated each year. Now it is allocated to the ICBs and we would expect flex and we always do go back and look at what additional resource we can make available to support mental health in this case, but at a certain level that is a Government responsibility and we would liaise with the Department of Health and Social Care. It would liaise with the Departments for Levelling Up, Housing and Communities and Environment, Food and Rural Affairs and others and decide what additional funding is available and what a multi-agency plan looks like. It is complex but in all my years in the NHS, that is how it has worked.

Our role in the NHS is to flex what we can, work with people such as Samantha and more local health chiefs to see what support they need and make sure that we are providing the best evidence on clinical intervention and what you do immediately that works but also what you do over the next year and years 2 and 3.

Q281 **Dr Hudson:** Thank you. That is very helpful. I will come to Sam for the local perspective. In our evidence sessions—and, Claire, you have spoken about the trauma of the shock events—we have also taken evidence and that is a huge part of the mental health impact in local communities: the shock, the trauma, the post-traumatic stress. Equally so, there is the anxiety and the worry in rural communities—in flood-prone areas potentially—of worrying about the events that may come, and the increasingly frequent extreme weather events.

Claire has talked about the joint approach. What planning can you say that you have done at a local level through your care board, making sure

that there is a joined-up approach to help local populations deal with these shock events in the short term? We have also heard evidence that there is a real worry in communities that when the blue lights leave, the communities are left to fend for themselves, so it is pre, during and post. What can you do in a joined-up way to help these people?

Samantha Allen: I think that there is lots we can do and lots that happen. To try to cover the pre, during and post, some of these events are predictable. We know that there is a strong likelihood that they could happen at any time and, therefore, preparedness is key. On 1 July, integrated care boards became what are called category 1 responders under the emergency planning and resilience response framework. That effectively means that we would co-ordinate and work with our multi-agency partners to react to an event, as you described, but also through the local resilience forums—and there is one in Cumbria—work with our partners on the preparation and also the learning post an incident for how we can strengthen our processes.

I am new to the area. As Claire said, I came up to the north on the back of Storm Arwen and I was really impressed by the local resilience and response. What I would say, though, is it was quickly dealt with; it went away. Neil, you referred to post-traumatic stress. In preparing for today, I received some information from our psychologists in Cumbria who still talk about the impact of animal disease events on the farming community and that event in 2001 you referred to. Some are still suffering from that event today and a high level of trauma in the community.

When we think about the pre, we have got an opportunity not in just preparing our resilience and how the agencies work together but thinking about high-risk occupations, impacts on individuals and communities and how that impacts our suicide prevention plan. The summary response is that there is a lot we can do pre, during and post, and we have established forums to do that and draw on the evidence. This is something we need to continue to put under the spotlight and locally do a bit more work on the planning and preparation.

Our local system here has demonstrated how they have responded. It is how we pick up the legacy impact, particularly the trauma over the years following the incident. In the heat of the moment, when it is under the media spotlight, it is gathering attention, but quite often the mental health impact still exists in those communities years later. Therefore, we need to weave the learning from how we respond to emergency incidents, shock events, into our prevention work, our suicide prevention work and the work we are doing to address those inequalities across our communities.

Dr Hudson: We are going to touch on some of those issues in subsequent questions, so thank you.

Chair: Neil, as a vet, you were involved in the foot and mouth epidemic. In Somerset, we also picked up on the stress of the TB testing, if you get

a reactor, and also the farm assurance tests, which was almost like Ofsted for farms, which were also putting a lot of pressure on farmers in addition to other pressures they had before. I will turn to Ian Byrne now.

Q282 **Ian Byrne:** I will direct this one first to Sam. We have heard during the evidence sessions that rural areas carry extra costs—higher staff costs, higher travel costs, more fixed costs to provide services—and that has come through loud and clear on the evidence that we have had so far. How does the NHS manage these extra costs?

Samantha Allen: We get our funding based on a weighted formula, based on population needs. As you have received evidence from the Nuffield Trust, the challenge comes in sustainability and the costs associated with rural healthcare. The answer to that at the moment is we absorb those locally in how we use our funding and the way in which we make funding decisions. The Nuffield Trust has shown that in some of those areas, particularly the most rural areas, the organisations are more challenged in retaining and sustaining workforce.

We have a situation in one of our most rural areas where our two main hospital sites are 40 miles apart. The impact of that is also on citizens with transport costs. This is not just a cost on the NHS but a cost on the population as well and the inequality around the population and the costs that they have to access services. We will be working, as an integrated care board, to understand this better and how we can support those organisations. How the funding for the NHS is allocated is very much a matter for Government.

Q283 **Ian Byrne:** Transport infrastructure figured very strongly in the evidence sessions. Are you making representations to local politicians on the elements of what is required?

Samantha Allen: It is early days for us; we are in day 12. I have certainly met with not all of our MPs—I will be meeting them. If you look at the deprivation and the inequalities in the north-east of England, they are significant. I am saddened to see today that the north-east is the highest place for children in poverty. In nine of my local authority areas, the quality of life deteriorates at the age of 60; four out of 64 of the areas are in the south, so we do have inequalities. As I said, the funding formula is a matter for Government to address the needs of our population.

Q284 **Ian Byrne:** Do you want to touch on that, Claire?

Claire Murdoch: Just to say that there is a formula that epidemiologists and very smart health economists work on that gives us our spend and determines where it goes, the weighted capitation formula. We are working with ONS at the minute, looking at a health index that will try to make a more sophisticated analysis of things like healthy people, which are focused on health outcomes, healthy lives with health-related behaviours and personal circumstances, and a third category of healthy

places where the wider determinants of health are calculated and fed into that formula.

This is a piece of work that is under constant refinement. In the current weighted capitation formula, as I understand it—and definitely I can get our team to write to you about this to set it out more clearly than I ever could—there are weightings included on things like type 1 A&Es that may not be generally sustainable but need to be where they are because they are in more rural areas. They might not be as busy but they are just as essential, and so there is weighting for that.

There are other factors about weighting called "demand-led aid"; where you have more services in conurbations, urban areas, people use them more. We know that the absence of people coming forward does not mean there is not a need, so there is a formula for that as well for more rural areas. There are things that—

Q285 **Ian Byrne:** Claire, I am sorry to cut across you. I am conscious of time and I wanted to make a point. On the formula, the Nuffield Trust argued the system is, "unclear, unfair and fails to fully compensate remote and rural areas for the extra costs they face". Do you recognise that?

Claire Murdoch: The development of the formula has never sat in my direct work. It is the epidemiologists, the health economists and people in finance who really understand the multiple areas that they have to weight for. I would be loth to say I recognise that because I think it is a highly technical, highly skilled part of health prioritisation and investment, and it is outside of my area of expertise. I could certainly get somebody from within health who is an expert in that to set out more clearly for you in writing the multiple—

Q286 **Ian Byrne:** That would be really welcome, even if it is focused on the mental health aspect of it as well rather than urban areas.

Claire Murdoch: There are things on mental health that are in there as well. There are other things such as age. The formula is weighted for age, and we know that there are more older people in rural areas. There are other things that might not be called "rural weighting" but that would affect rural areas differently, and in that instance, more advantageously. We should set it out. We should get an expert from our—

Q287 **Ian Byrne:** I welcome that written evidence. I am getting eyeballed by the Chair. Thank you, Claire.

Claire Murdoch: I am sure it is my fault, but we will write in on that one.

Chair: Wait until you get back from holiday before you do that, Claire, please. Neil will finish our session with some questions on suicide.

Q288 **Dr Hudson:** I want to talk now about suicide prevention and awareness and mental health first aid awareness as well. I declare an interest again.

As the Chair said, I am a veterinary surgeon. We have taken evidence that vets are potentially over represented with mental health issues and, sadly, instances of suicide. Also we have taken evidence that suggests that similar trends lie in some sectors in the agricultural and rural world.

How well is the NHS working with partner bodies to try to look at that and reduce suicide prevalence but increase mental health first aid training and awareness among people in these sectors, in the veterinary world and in the agricultural rural communities as well? What is the NHS doing to address these issues?

Claire Murdoch: There are a few really important things. We now have 24/7 NHS all age crisis lines in place, as of May 2020. We pulled that forward as a priority because we were so worried about isolation and people being able to call the NHS day or night and get expert help, so we have pulled that forward. We have had a big campaign on talking therapies called "Help us, help you" to try to encourage people to come forward for talking therapies. We are growing access to talking therapies hugely, by hundreds of thousands, and we are trying to make that easier and easier for people to come forward and ask for help, for example digital online and so on. We are running some big programmes nationally to enable individuals to get help either for talking therapies in a crisis—

Q289 **Dr Hudson:** If I can press you on that, there are national programmes, and we have taken evidence that these sectors have their own bodies set up. There is Vetlife and there are farmers' networks as well. What is the NHS doing to help these, to give professional support to these people who are trying to signpost people in rural areas and veterinary areas?

Claire Murdoch: I was trying to say that we are doing some big things nationally that advantage all areas. Our main suicide prevention plans are wholly geared around funding and supporting local areas to come up with multiagency plans of their own. We absolutely recognise that we can do various things nationally. We can provide some additional funding, we can provide the expectation and requirement that all areas will have a multiagency suicide plan, but we also know that the key factors that develop the best suicide prevention plans are ones that are about partnership, are locally driven and locally owned.

We made it one of the priorities of the long-term plan that all areas would have a very active suicide prevention forum with not just funding but also a network of knowledge and evidence base to support them making their local plans. I am going to hand over to Sam because her area will be driving its local suicide prevention plans and that will look very different from Brixton's local suicide prevention plan or Morecambe's suicide prevention plan. We are clear that the biggest impacts are local multi-agency plans that work with third sector, farming unions, Royal College of Vets and so forth.

Q290 **Dr Hudson:** Thank you, Claire. Before I hand over to you, Sam, I will get you to cover my follow-up question. The Samaritans have told us that

there needs to be a joined-up approach between professional bodies, local outreach groups, the NHS. In your answer, can you address have there been any potential barriers with that joined-up approach in trying to get suicide awareness and prevention into the frontline?

Samantha Allen: As Claire said, we have a local multiagency prevention plan and it has focused much more on specific groups. Indeed, the area that I worked in previously, for example, we knew that we had an increased suicide rate in men between the age of 30 and 45, and therefore we had some really targeted social media campaigns. For example, if you went to the petrol station, when you lifted the nozzle off the petrol you would see how you could contact mental health services.

We have got a range of targeted marketing campaigns that promote things like our 24/7 crisis lines, of which we have got full universal coverage across England and locally here also in the north-east, north Cumbria. I do think though, Neil, we need to do more in understanding the specific needs of our rural communities. You talked about veterinary surgeons and that community; we have got the farming community. We know that DEFRA has told us that these communities suffer more loneliness.

If we look at the targeted work we have done in veterans mental health care, it has also involved upskilling and training NHS staff in what is the week in the life of a farmer like. If you look at protective factors, holidays are not going to do it because it is much harder for them to take holidays and have a break. I think we could do more there, and I do not think there are barriers to work in the community and voluntary sector. In fact, we have got good infrastructure here in the north-east, north Cumbria; we have got strong relationships.

It is about using the data to drive the prioritisation. When we have looked at the data, we have looked at more homogenous groups such as men, where we need to look at our rural communities as some of the areas we need to have a more targeted focus on for suicide prevention and then co-design our solutions to that. We will not have the answers, the community and the voluntary sector organisations will, and bring them together to focus our plans around those communities.

Dr Hudson: That is really helpful. That is a very important take home, that you are saying that there will be targeted, bespoke working with local communities to understand and deliver the support that they need.

Q291 **Barry Gardiner:** I do not know how we are going to judge you guys. You have talked in generalised objectives, campaign services, programmes; you have not given us metrics and targets—how many fewer suicides means that this will be a success, what percentage in reduction of young people needing the most acute services? Give me that in 30 seconds.

Claire Murdoch: We could probably write with some of our metrics to you. Thirty seconds? Sorry, I am not trying to duck it, it is just where to

begin. These metrics are really important. We are collecting more data than ever before, we are looking at who is accessing services, where they are coming from, the metric they are out of—

Q292 **Barry Gardiner:** We need to know what success looks like, not just what data you have gathered. What is the target; what are you going to achieve; how do we judge whether this whole plan has worked or not?

Samantha Allen: Chair, if I may come in?

Chair: Very briefly. We are right against time.

Samantha Allen: As I said, we are day 12. We are developing our structure over six months and we will have outcome measures and metrics, and we will be measuring our success on that. Reduction in suicide rates is an absolutely clear one and that links into the 10-year plan on mental health that is being developed as well. We are developing our plans and we will have metrics and measures to demonstrate our success.

Chair: Thank you very much indeed. It would be very helpful if we could have some data on suicides in rural areas, particularly where there has been a medical intervention already and where there has not been any medical intervention. I am sure they are two different cases. I thank both our witnesses for giving us such good evidence, in particular, Claire, for taking a break from your holiday. I hope you will make sure you get your clotted cream and jam in the right order on your scone down there. Thank you very much, indeed.

Examination of witnesses

Witnesses: Gillian Keegan, Zoe Seager, Lord Benyon and Jonathan Baker.

Q293 **Chair:** We are starting our second session with Ministers from the Department of Health and Social Care and DEFRA. Can you briefly introduce yourselves and introduce the officials you have brought with you, starting with Gillian?

Gillian Keegan: I am Gillian Keegan; I am the Minister for Social Care and Mental Health, and I also have responsibility for integration of the NHS and social care as well, the new ICBs and ICSs. This is Zoe.

Zoe Seager: Deputy Director for Mental Health Policy.

Lord Benyon: Richard Benyon. I am the Minister in the Lords for DEFRA. I am the Rural Affairs Minister, among other responsibilities. I am with Jonathan Baker.

Jonathan Baker: I am one of the Deputy Directors in the part of DEFRA that is informing agriculture policy in England.

Q294 **Chair:** The reason we have got you both here together is that sometimes there is a bit of buck passing between Government Departments, so we

hope that if one of you drops the ball, the other can pick it up. Starting with Gillian, we have heard concerns that the NHS does not have an accurate record of mental health among people living and working in rural areas. What is the Health Department doing to bridge this gap of understanding the granularity of the information that we have?

Gillian Keegan: It is true to say that we have data on the prevalence of mental health conditions through a survey that we do, which is called the Adult Psychiatric Morbidity Survey and NHS Digital 2017 Mental Health of Children and Young People in England Survey. However, they are about the general population and they do not look at prevalence in different types of rural or urban communities. We know that there is some good work in this space to understand mental health and wellbeing in rural communities, such as the Royal Agricultural Benevolent Institution's big farming survey.

We recognise that there is a lot more to do in this area. Through a call for evidence, which closed last Wednesday, we have called for evidence to inform our new 10-year mental health and wellbeing plan. In that, we have asked many questions, and one of them is how can we improve data collection and data sharing to help plan and implement and monitor improvements to mental health and wellbeing. On information about access to mental health services, we have got the new integrated care system set up a week last Friday.

Chair: We have heard all about that in the first session.

Gillian Keegan: You have heard a lot about them. They are responsible for decisions about the provision in their area and they will have access to more granular data. They will be informed by other information in their area as well and they are best placed to understand local population. In some of the earlier sessions, you have probably also heard about the fact that in mental health we do not have a great deal of data. We have one waiting time standard today but we have consulted on and we are looking to introduce more as well. It is fair to say that there is a lot of work, investment and improvement going on to make sure that we have the capacity to keep up with the need that has exploded, in some cases.

Q295 **Chair:** In the first session, we heard a lot about health inequalities and how outcomes vary considerably between different parts of the country. One of the real challenges facing rural areas, if you look at simple stats like life expectancy, you have got people who are very healthy. In urban areas, we have social issues, industrial illnesses and so on, and money has been in the past funnelled into those areas where people die earlier. Does that not mean that some rural areas, where you don't have quite the same incidence but you have pockets of deprivation in pockets of areas, cannot get the funding? Is the Department concerned about that and seeking to address it?

Gillian Keegan: It is always a challenge to get as much in the detail of what is happening in a particular area. They do differ, and that is why the

42 new integrated care systems or integrated care boards are designed to try to get that at the right level. You are always going to want more data and more information. We also have a 10-year suicide prevention plan, and a lot of that is trying to understand more about risk factors, whether it is particular instances, particular age groups, particular parts of the country or particular occupations even.

We are always trying to get a greater understanding, because the more you understand the better you can fit your services to make sure that you reflect the needs of the population. I live in a relatively rural area as well. There are some formulas that look at deprivation, needs and some other things as well to try to allocate money across the country. In my experience, there has always been a push not to forget rural communities because sometimes the way they look in the average does not reflect how much need there is in specific areas.

One of the things we are doing for children particularly—which is one of the big initiatives of mental health support teams in schools—is making sure that we are rolling those out and that they are going into the rural areas as well, and they are quite spread across the country as we try to provide that better support to our children and young people.

Q296 **Chair:** In the first session, Rosie Duffield raised the issue of people coming to their MP surgeries and there may be a two-year wait to get a child assessed with mental health issues. Have you had people come into your surgery? Are you aware that this problem is one that needs to be addressed?

Gillian Keegan: Yes, I hear about CAMHS appointments a lot; I hear about it in the Chamber a lot as well. I often get that question. The waiting times that we measure are actually for eating disorders. We have consulted on five new waiting times, which I think you heard from Claire earlier that they have now in the NHS, and they are working out how to implement those. Certainly, there is a lot of pressure.

The pressure, by the way, is largely due to the fact that demand has quadrupled. It has gone up massively, particularly during the pandemic for some services. To grow that capacity, we are investing more than we have ever invested in mental health in the country. We invested in the long-term plan, which was done in 2019, and set out increased spending to get to many more people, but obviously that—

Q297 **Chair:** Have you reached parity between mental health and physical health in terms of—

Gillian Keegan: Parity in terms of what?

Chair: In the way that Government see the priority of dealing with mental health on the one hand and physical health on the other.

Gillian Keegan: There was some discussion and amendments put in the Health and Care Act that went through very recently to make sure that

we had the investment standards for mental health and that also people had to report and publish their spending. It is about transparency to make sure that we understand how the money is being spent and also how we shift to more preventative things.

The thing about mental health is if you do not address it, it usually gets worse. We are always trying to address it as early as possible, and that is why we have invested a lot in things like NHS talking therapies, which anyone can self-refer anywhere around the country, and also the mental health support teams in schools. They are all designed to try to deal with things that are lower level to prevent them getting even more serious.

CAMHS is where it gets more serious, but there is a lot on the waiting lists. There is quite a lot of appointments for diagnosing learning disabilities as well, which is another factor. We have been looking at alternative approaches, potentially, for diagnosing learning disabilities. We are aware of the issue and we are trying as much as possible to take some of that pressure off CAMHS, as well as the investment, which I am sure Claire talked about, in the workforce to get more people who can provide some of these clinical services.

Q298 **Chair:** I am conscious of the time because we are expecting a division at 4.30. We may have to write to you on some of the other questions, but we will try to get through as quickly as possible.

Turning to Lord Benyon, Richard, DEFRA is responsible for rural affairs. How does it engage with the NHS on the mental health needs of rural communities and occupations of people working in agriculture and veterinary workers? Do you two sit next to each other at meetings regularly to talk about these things, or is this the first time you have had a joint meeting?

Lord Benyon: No. We attend the quarterly meetings at the Ministerial Task and Finish Group on Mental Health and Wellbeing, chaired by Gillian—we had one last week—and the Paymaster General. NHS England, the Office for Health Improvement and Disparities and mental health directors also attend. We are leading on the green social prescribing programme, which is exploring the increased use of and connection to the natural environment. There is increasing evidence now that the natural environment is a fantastic means of healing people and preventing them from getting mental illness. That is a £5.8 million cross-government project, which involves NHS England, the Department and many other different organisations, and that has been running now since October 2020 and the programme in its current form finishes in April of next year. We work alongside other Government Departments as well to rural proof their policies.

We are about to publish our second annual rural proofing paper, which focuses on this issue a lot. We are also working with the Department on the pharmacy access scheme and targeting the enhancement recruitment scheme for GPs, both of which have a big impact on rural communities,

and our future farming countryside programme regularly engages with farming charities, such as RABI, which Gillian mentioned, and others via its charity farming forum, which is a key component in trying to make sure that our future farming policies—remember that we are dealing with people and change is always difficult. We want to address that and no doubt we will come on to talk about that.

Lastly, there is the Rural Insights Forum. That is a stakeholder group that we regularly engage with, so lots to do with the Department, lots to do with other Departments and very much fundamental to our rural proofing ambitions.

Q299 **Chair:** What evidence is there that DEFRA's rural proofing policy has actually impacted on how mental health services are delivered in rural areas?

Lord Benyon: We do measure this and we are working closely with those organisations to make sure that we are impacting this. One of the great inequalities is, of course, the fact that any form of deprivation is exacerbated by rurality. You mentioned the way we measure deprivation and sometimes that is not clear in how it is affecting rural communities. We are doing a lot of work with the Department and across government to try to address that.

The Index of Multiple Deprivation is owned by DLUHC, so we are doing a lot of work with it. It helps that it is in the same building as us and there is a ready flow of Ministers and civil servants to make sure we are doing that. We look at health outcomes in the context of rural proofing but, by and large, those are the property of the Department of Health and Social Care.

Q300 **Chair:** We hope that there will be 40,000 seasonal agricultural workers in the country. Has any consideration been given to their mental health issues in areas where they may have all sorts of problems, being away from home, having quite difficult work experiences in some cases? Is that something that—

Lord Benyon: There will be votes in your House and in mine, but I hope we will have time to talk about what we are doing across a range of different organisations that interface with farmers, with the people who work for them, as well as rural communities because there are a great many people doing fantastic jobs. While it is absolutely right that the Government should have strategies, policies and money, it is also about working with organisations that are helping these people locally and on the ground.

For the Government's mental health strategy, which is now being rolled out by local authorities in areas like suicide prevention, locally is the best way of identifying. For example, in the eastern counties, where there is a large number of migrant workers who come in under our seasonal agricultural workers scheme, that is something that gets picked up

locally. In other areas where there are not so many of them, it may be that the real problem lies with other sectors. Those local plans really are the best way of delivering it.

While we want to have clear strategies, clear targets for what we want to see and the Government distributes the money, we want to make sure that we are not constraining the local element, very often the basis of some emotional capital. People who get involved in those local organisations, who you will know through your constituencies, are very often people who have been affected by this themselves. You have heard from YANA and other organisations. They are doing wonderful things in those areas.

Q301 **Rosie Duffield:** We know that health services are often centralised, located far away in rural areas with poor transport access and limited opening times. What is the Government's plan to make sure that rural health services provide full and fair access for our rural population? That is probably for Gillian.

Gillian Keegan: Of course, there will always be health disparities. We are always looking to find where they are and to try to tackle them. That is part of what we do, and sometimes they move around as well. It is a priority focus. Our Health Disparities White Paper, which will bring out new ways to tackle the wider drivers of ill health that impacts certain groups, is particularly looking at health disparities, socioeconomic deprivation and the impacts of that and by geography.

You heard from Sam Allen earlier, who was formerly the CEO of my mental health trust so I have worked with her a lot in the past and she is fantastic. She has now moved and she has a big role with ICS. Ultimately, it will be the ICSs that have to use all the tools that they have to work with their local authorities and have that duty for them both to co-operate, which is really quite important, and obviously we will be looking at and monitoring ICPs as well.

With those local partnerships, all of us know that many different people have been delivering quite vital services, and particularly rural communities are spread out and we need to make sure that they are formally part of the system, it is recognised where they are and they are commissioned to give them sustainability where that makes sense. That is a big part of why the ICBs and the ICPs are trying to tackle and bring in the third sector as well, because in some cases people rely on it being there. If it wasn't there, there would be a big problem. We need to make sure that we understand all those aspects of how health services are being delivered and that is how we are doing it, making sure that we have some good examples. My role then will be to look at the really good examples.

There is one. The Somerset NHS Foundation Trust operates a health hub for farmers, agricultural workers and their families specifically in that community. I think there is one that does them at cattle markets and

things like this. You look at the best examples and then spread those and make sure that you spread the word to other areas so they can pick and mix which ones work for their local population. This will take us a while to get right but it is absolutely the right focus. The more I speak to the ICS chairs and the CEOs, the more I think this is the right approach.

Q302 **Rosie Duffield:** That is brilliant. Thank you. If the ICS identifies that, say, in my area Kent County Council has just cut loads of rural bus services, what can it do about that? It is all very well knowing that and talking to the other authority. Will the ICS have any power to stop that or to intervene or let the Government know and get them involved if that is the cause of one of the problems?

Gillian Keegan: It is a really good example, with the local authorities working much more closely with the NHS. That is something that everybody has been trying to get going for a while. In one way, the pandemic massively helped get rid of some of the barriers to that happening. They saw how important it was to work together, how much better they could do. The vaccine rollout obviously was a fabulous success in that way. What happens in those cases is you end up either with ambulances having to take people or taxis taking people or other people taking people. There is still a consideration for everyone, which is how somebody can get to an appointment.

Having those sorts of joined-up practices—and they may decide to come up with another solution, maybe there is a different solution—hopefully, they can innovate with what is the right thing for the people that they are there to serve, which is what we are all here to do.

Q303 **Ian Byrne:** I will go to Minister Keegan again. The lack of broadband infrastructure has been highlighted as a major problem when it comes to accessing mental health support. Of course, digital exclusion is off scales as well, Minister.

Gillian Keegan: Yes.

Ian Byrne: What are the Government doing to ensure that the NHS can deliver equal digital access across rural and urban areas?

Gillian Keegan: Actually that was my old job, the skills brief, but it is right that we need to make sure that people have the digital skills and have access to broadband and devices. There also will be some people for whom we need to have an alternative; that is not going to work for them.

Talking therapies, which is a relatively new service and certainly one that we are growing, in the past could have been a bit more difficult because they used to have to travel long journeys. They used to have to go to particular places to receive their therapy. However, a lot of that changed in the pandemic and we now have therapy being delivered via the telephone—one-on-one still but via the telephone—by SMS messaging, e-mail, digital, obviously online. Having the patient and the therapist there online together, so they are getting that one-to-one service but they

don't necessarily have to travel to do it has added a great deal of flexibility.

Q304 **Ian Byrne:** We need data on that, Minister, to make sure that no one falls through the cracks. Obviously Covid went towards digital. I am sure that there were many people in rural areas who would have much preferred one to one and did not have the skills and no access as a result. Have the NHS departments collected any data?

Gillian Keegan: I don't know if we have any specific data, no.

Zoe Seager: The IAC dataset records whether the sessions were delivered remotely or in person, so we measure that and it has obviously changed during the pandemic. NHS England is working with systems to make sure that—ultimately it is down to what the patient prefers. During the pandemic, services had to be delivered in as safe as possible way but now it is much more about capitalising on that kind of transition and making it available as whatever works best for the patient. That is trackable and NHS England reviews that.

Q305 **Ian Byrne:** I hope both Departments have that handy. How is digital exclusion going from a rural inclusion perspective, Lord Benyon?

Lord Benyon: Absolutely fundamental. It is a really good question. We think that Project Gigabit is the key to the levelling up or levelling out, as I call it, of the cities, towns and villages up into the hills where too many people have not been able to access. It is very often talked about as an economic driver and it is. Of course you can run a fintech company from the North York Moors if you have good digital connectivity.

It is also a social justice issue. It is about getting equal access to services for people who sometimes are extremely vulnerable, whose problems, as I said earlier, are exacerbated by the rurality, by the fact that they are a lone worker, their isolation and very often cultural difficulties about wanting to share and talk about your problems.

We think that Project Gigabit is making a huge difference and will make a considerable further one as we roll it out; 30% of rural premises now have access to gigabit capable. This is in addition to the broadband. That is a huge leap forward from 2019 when only 9% of all premises in the UK could access it. Now 85% of rural premises can access superfast-capable broadband and I can give more detail about how we are trying to get that out to some of the remotest parts, such as Dr Hudson's constituency, where it will transform healthcare. It can deliver a real change particularly in areas like mental health and one-on-one therapies.

In addition to that, there is mobile phone connectivity. As well as its economic value, of course, it is all about safety. Safety can be reporting an accident but it can also be somebody who is having a mental health crisis and they need that connection instantly. That is why we are driving forward the shared rural network, 5G rollout. We have the 5G testbeds

and trials programme on digital exclusion, and we are determined to get into those very hard to reach premises.

Q306 **Ian Byrne:** Do you have a timeline on that? You talk about that in the information, so if you could write to us with the timeline, because we are conscious of time.

Lord Benyon: Yes, certainly, Mr Byrne, we will write.

Q307 **Barry Gardiner:** I want to pick up on something you said, Minister Keegan. You said that there has been a quadrupling of the demand for mental health services in rural areas. When you saw that figure, I assume the first thing you turned to your officials and said was, "Why?" What was the answer they gave you? We have heard in some of the evidence we have been given that it is the loss of other social provision, the youth clubs, the centres, the things that go on in rural communities where people socialised and did not then need to go through to acute mental health services because they were not lonely, they were engaged, they felt they had a purpose. What was the answer officials gave you and what is the action that you have taken to look across to the Department for Levelling Up, Housing and Communities and other Departments to sort that out?

Gillian Keegan: To be clear about the quadrupling, the need for mental health services has gone up in every single area. I think the quadrupling probably refers specifically to eating disorders in young people, which over that period of the pandemic was a very big rise. That is why we have put more money into eating disorder services very quickly, as soon as we could.

There is a number of factors. There is no doubt that the social isolation for some people was devastating and people's worlds became smaller and smaller. There is no doubt that for children not being in school—again, something that every single one of us did every day and normally moaned about it, to be honest, but I think all of us saw when the kids were back how excited they were. I think they really missed all those aspects of school. Obviously, everybody at home was trying to do the same thing on the same bits of equipment. It was all very difficult, and of course you had the uncertainty as well, whether that is health concerns, job concerns, "Will I get to go to university?" or exam concerns. It was quite a difficult time. I speak to my counterparts in a number of places and this has pretty much happened in most countries where there has been a very similar reaction from their population.

In one way we were quite fortunate because we had the NHS long-term plan. We had already started to build up some services, in which we have invested what will be up to £2.3 billion extra per year by 2023-24. In addition to that, we put another £500 million in and it is all about workforce. You know this. You need the people to be able to provide these very people-intense services. The mental health support team

rollout has gone faster as well, so that probably will be about a year ahead.

Q308 **Barry Gardiner:** You are telling me what you have done in response. My question was digging back more to causes and connectivity. You have located this rise very much with the pandemic and nobody doubts that that has been a huge exacerbating factor, but the increasing problems have been going on over a long time. If you had been here for the earlier session, Rosie excoriated one of the officials who came to us on the previous panel about CAMHS in her area. This has been going on for a long, long time. What other factors have you sought to speak to colleagues across government about for levelling up and social provision? We have all seen over a long time the loss of youth clubs and youth services. We know that these things are not statutory services and local authorities do not have to give the level of provision that may mean that we are scrimping in one area only to give ourselves huge costs in another.

Gillian Keegan: This is the challenge in Government: to work together to have the view to make sensible decisions based on data that you get and collect. Then you can measure and monitor what you are doing.

There is definitely a recognition that we can do more to work together across Departments. Mental health is everybody's business. It is not just mine; it is the mental health Minister's. We talked about employers who are employing people coming here for seasonal agricultural work. We talk about many things in the community that can help or if they are not there can be a problem. Therefore, I think that mental health is everybody's business. With the cross-departmental 10-year mental health and wellbeing plan we tried very hard with the ministerial team to make sure that we are—with DCMS colleagues who have the lead on some of these areas as well. They have the lead on youth clubs and also looking at maternal mental health and getting the best start for life for young people. There is a lot of cross-government work.

Q309 **Barry Gardiner:** The Chair is going to pull me up if I don't ask you about what I was supposed to be asking you about, which is funding. The Nuffield Trust told us that the current system used to allocate funding actually disadvantages rural areas. Do you agree with its analysis? If you do agree with the analysis that it has made, how are you redressing the balance?

Gillian Keegan: There is a range of different adjustments that are made and some of the differences between rural and urban areas also come into this factor, such as the tendency for rural populations to be older. They are naturally taken into account in the formula.

The allocation of funding is the clinical commissioning groups, or the ICS as it is now, to support them in commissioning services. This formula is apparently very complex. It is NHS England's duty to have regard to the need to reduce inequalities between patients in their ability to access

services and the outcomes they achieve as well. Therefore, these are reflecting the target formula, which produces apparently a target allocation or a fair share. It is based on a complex assessment of factors, such as demographic, morbidity, deprivation, the unavoidable cost of providing services and so on—

Barry Gardiner: You are blinding me with science, Minister.

Gillian Keegan: —including mortality. I guess what I am saying is that there is a very complex formula in the NHS. I would imagine that the—

Q310 **Barry Gardiner:** What I am asking is: do you agree with the Nuffield Trust who said that the very complex formula actually disadvantages rural areas? I do not think it does. Let's be fair here, if you think it is wrong about that then why? Do you want your official to give us a response to that?

Gillian Keegan: Yes. I think the weight that is given to adjustments for health inequalities and unmet need has a strong influence on the allocations to rural areas. This report from the Nuffield is not informed necessarily by evidence but a matter of judgment, so I think there is a disagreement on how it does the formulas. As you know, to do things within our world, or Zoe's world in particular, you have to have evidence that backs it up when you are looking at how you weight and adjust some of these complex factors. I believe that it has used different weighting but it is based on a matter of judgment. I don't know if you want to add anything to that.

Q311 **Chair:** A lot of it is down to the balance between life expectancy and age. People who live to a ripe old age often have their hips done, they probably survive a cancer, they may get Alzheimer's, whereas, people who die of smoking, lung cancer at a young age—this is a statistic we need to address but it does not help the GPs in rural areas with their many elderly patients who thankfully live long and happy lives but place quite a burden on the health service in their latter years, compared to people who sadly die more prematurely.

Lord Benyon: Can I contribute to this? I touched earlier on the Index of Multiple Deprivation. There is a big piece of work going on across government on this at the moment. You are right, it does not entirely reflect—for the constituency I used to represent, for example, the village was outwardly very affluent but the pockets of deprivation are less visible than they are perhaps in an urban setting.

The measures used to compile the IMD are designed to highlight challenges in urban areas more than they are in rural areas. For example, car ownership is a measure and car ownership in a town is less necessary. In the rural areas somebody on a low income will have to make it more of a priority because there is less public transport. We are working with other Departments—particularly with the Department for Levelling up—to make sure that we are reflecting the realities of life

because otherwise for somebody who is in need, in what is outwardly considered to be an affluent area or one that is not registering on the IMD, life can be much tougher than for somebody who is living in an area where it is more visible.

Q312 **Barry Gardiner:** Should we be spending more money on rural bus services, for example, which have been sadly depleted over a long time, and would that save us money in the health resource?

Lord Benyon: We are, yes. I think that is a very good point. For a start your Committee might like to—I mean I am the last person—

Barry Gardiner: Recommend what you are saying?

Lord Benyon: Yes. On the Index of Multiple Deprivation, to give some heft to that review that is going on now and to try to make it reflect those things, I think will make a big difference.

On buses, the national bus strategy is putting in quite a lot of money—over £1 billion announced in April this year—and is making a difference in communities such as Norfolk, Derbyshire, Cornwall and Devon as the rollout of a rural mobility fund, £20 million, which has seen 17 pilot schemes that have been very successful. We want to see if we can build on that. My Department is working on the Future of Transport: Rural Strategy very closely with the Department for Transport to make sure it is reflecting those needs. You can see buses driving round the countryside taking nothing but air and one or two people in them, but there are many different ways of delivering effective transport.

Barry Gardiner: Smaller buses.

Lord Benyon: Yes, and using technology. Demand-led schemes are working very well. The best one I have seen is Wheels to Work where a young person getting a job can get a loan to buy a moped to get them to work. That is the sort of lateral thinking I really like in rural policy.

Barry Gardiner: I was with care workers yesterday in north Somerset. I found that they had finished their shift and then had to wait three hours to get a bus on a Sunday to get them to the other side of Bristol where they lived, and yet they were back on shift that night. That is exactly what you are saying and the stress that that puts on people enormously.

Q313 **Dr Hudson:** My question is to both Ministers. I am encouraged to hear that you meet regularly about some of these issues. I want to move on to shock events and I touched on that in the first panel as well. Sadly, rural communities, such as the one I represent up in Cumbria, are sometimes in the front line for shock events, whether that is frequent flooding, storm events or, more intermittently but catastrophically, infectious disease outbreaks such as the foot and mouth crisis in 2001.

We have taken evidence that these are incredibly traumatic episodes for rural communities with the anxiety, worrying that things are going to

happen, the stress during the event and then the post-trauma stress. What are both Ministers doing to ensure that the NHS and DEFRA are working together across government with other government agencies, working with local government and community groups to respond to the mental health challenges when these shock events happen in our communities? I don't know which of you wants to go first, Minister Keegan or Benyon.

Lord Benyon: You are absolutely right. I witnessed this with the 2007 floods and the subsequent years—the levels of anxiety. The anecdotal evidence I got from GPs was that when heavy rainfall happened subsequent to that, the number of referrals of people with anxiety and other related issues was massive.

First, at a government level, we contributed, for example, to a Covid-19 mental health and wellbeing recovery action plan to make sure that mental health first aid training is available more widely. As a Department, we are responsible for a large number of people and agencies that interface in a direct way with the victims of those kinds of events, in disease outbreaks, farmers and the impact it is having on them; flood events, householders and communities. We have seen organisations like the Rural Payments Agency, the Environment Agency and others doing training, making sure that their people know how to direct and signpost people who are able to help in those circumstances, and your profession is another one where they are dealing directly with the causes.

I think it is important how we in Government talk about these diseases. For example, there are massive mental health stress-related issues coming out from bovine TB. Too often, as policymakers we talk about money. We talk about issues like animals, wildlife and things like that. That is entirely understandable, but we do not talk enough about the human impact and how we are supporting those communities when, year after year, they are having reactors in their herds, they are locked down and they are seeing prized animals, including cows in calf, being taken away to be culled. These are momentous events that have an impact on people in a variety of different ways.

Q314 **Dr Hudson:** It is encouraging that you are alive to that in DEFRA because we have taken powerful evidence during this inquiry. For example, a senior member of the veterinary profession talked about a colleague on a farm when there was TB testing going on. The stresses for the vet and also the farmer in that situation are horrific in certain instances, so the Government are alive to that?

Lord Benyon: Yes. Jonathan may want to come in here because through our farming transition programme we are deeply mindful that change in any form is stressful—as some of us in a certain political party may be finding—but change in farming is a particularly stressful thing for the sector to cope with. We want to make sure that, through the seven-year transition scheme, we are embedding the kind of support that we can

where we can and very often it is just about signposting. Do you want to say something about the work you are doing with the farm network?

Jonathan Baker: Yes, on the Farm Resilience Programme. We are about to start the third phase of that work. It has been live for a while, providing free business advice to farmers in England. I think we have had about 8,000 farmers sign up since we started it a couple of years ago. We have a target. We have been testing and evaluating increasing that number to 32,000 by 2024. This is about providing free business advice, not led by us or our agencies but rather by people who farmers work with and trust in local areas—land agents, some farming charities, others who have local expertise. They go out and talk to those farmers who are easy to admit, so farmers who are less likely perhaps to be signing up to gov.uk. They talk to them about their business, what they can do, what the issues are and how they can prepare for those changes. We are about to launch the third phase of that programme, so it is going down well as part of our commitment to making the transition work.

One point on the shocks—I think as well as mitigating and minimising the likelihood of those shocks, particularly animal health and welfare—we are doing that in a number of different ways. It is also that when those shocks happen we minimise. We do not want to be exacerbating that, so there are other easements we can put in place where your agri-environment scheme or your basic payment scheme, that situation has gone under water. We are coming in and communicating that we can put easements around that. There is force majeure for contracts, so we are going to try to build a bit—

Q315 **Dr Hudson:** We are going to come on to some policy side of things in a subsequent question. If I could pivot back to Minister Keegan now on how your Department would work with DEFRA, local authorities and so on in these sorts of shock events.

Gillian Keegan: Obviously, it is our role to make sure that we have the right support in place and we are there to support the people who have been affected by shocks. NHS England has clinical guidelines on dealing with major incidents, including providing psychosocial support for patients and staff in the immediate aftermath and also in the longer term as well. Sometimes these things take a while to flow through.

Also, the UK Health Security Agency has recently published flooding health guidance to provide information to assist health professionals in public health and public agencies to understand and mitigate the mental health risks posed by flooding, for example. This makes it very clear that mental health support should be provided. It should be made available and the local system should reach out and ensure that victims receive support if needed.

There have also been recommendations in our Covid-19 mental health and wellbeing recovery action plan to make mental health first aid training available more widely. I know some colleagues—

Dr Hudson: We are going to come on to that as a subsequent question as well.

Gillian Keegan: Okay, so there are a lot of tools that we put in place.

Chair: Do you want to take that now?

Q316 **Dr Hudson:** Yes, I could pivot to that sort of question as well. It is very encouraging to hear from both of you and your officials that you are talking both short term and long term. We have taken evidence that people in rural communities are very worried that once the shock event technically finishes and the blue lights leave, the communities are left to fend for themselves, so there is a long-term plan to help resilience for those communities.

Gillian, you have mentioned about prevention and signposting. Could you articulate more about what plans the Government have to promote mental health first aid training for those working in rural areas? Particularly, coming into this as a DEFRA brief, to make sure that the people who are trained and able to signpost are in the right places in the workplace, so they are at auction marts, they are everywhere that people can quietly access them in these sensitive rural communities where people are very well known.

Gillian Keegan: Yes. We have made the recommendations in our Covid-19 mental health and wellbeing recovery action plan to make mental health first aid training available more widely. There is a lot of tools that we have given to assist in this area but, again, I think it gets back to making sure that the ICS and the ICPs work together, in the local areas particularly, to put these services in place. If you have a trauma like that—and there is a lot of discussion about trauma and mental health and getting access to those services—we would expect them to work together to make sure that they use the tools that we have put out and then adapt them to their local area. There are some brilliant examples of that. We are right at the very beginning of that journey and I believe that when we are talking about this in two, three, four years' time it will look rather transformed. Is there anything you want to add, Zoe?

Zoe Seager: Yes. In the recovery action plan, all Departments who sit around the table at the ministerial group committed to promoting first aid training to their front-line services, where they had them, and their arm's length bodies. We track that through that group. We will be asking Departments about their progress in that and it will form part of the conversation as we develop plans into the future.

Q317 **Dr Hudson:** If I can pivot to you, Lord Benyon, the DEFRA voice, if these are being rolled back in what is needed in particular rural areas, whether it is livestock markets, farming communities, that side of things, your Department can feed into the NHS on what is needed?

Lord Benyon: You are absolutely right. When the emergency is going on good working is being done. For example, recently in Storm Arwen in the

north-east and the whole of the north, 24-hour a day phone lines were put in but, as you say, as the wind ceases to blow and people have to get on with dealing with the recovery, what support is there? Very often, the people who are accessing those are people like my old profession, land agents, like your profession and others. We want to make sure we are working with them and that they have the necessary training.

The Environment Agency, for example, set out in its national flood and coastal erosion risk management strategy—it works with the Government, other risk management authorities and public health services to ensure the mental health impacts from flooding and coastal change are factored into their long-term recovery planning, so it is not just short term. As part of this, the agency is establishing a rural flood resilience partnership along with rural stakeholder organisations—precisely the sort of people that I mentioned—to make sure that there is some long-term support going in and reassurance, because the thing that people fear most is that it will reoccur.

We have had a scare on disease recently. Mercifully, it was not foot and mouth disease but we can all remember what happened in 2001. We can learn all the lessons we like in trying to prevent that happening again and mitigate it if, tragically, it does. We also know that the impact of that two decades ago is still felt massively in rural areas. Other factors come in, whether it is change, spikes in prices of fertiliser, whatever it is, that just bring up the anxiety level. We want to make sure we—

Chair: Sorry, we are going to have to try to make a bit of progress. I think that we will be curtailed by multiple divisions at half past or thereabouts. Barry, can we have your characteristically short, pithy questions, please?

Q318 **Barry Gardiner:** Yes, indeed, Chair. The big farming survey, Minister Benyon, found that you were the problem, didn't it? The three out of the 10 major sources of stress for the farming community—regulation, compliance and inspection, loss of subsidies, so public policy pressures on the environment—are all part of your remit. How does DEFRA take account of the mental health impacts that you have when you are developing those policies?

Chair: We certainly picked this up in Somerset last week, particularly the farm assurance inspections. One farmer was saying that a farmer had been prevented from selling milk for 28 days because they had failed their inspection and the pressure, which of course is not necessarily DEFRA's responsibility. It is a separate scheme but we picked up this level of complexity as well in some of the environmental schemes.

Lord Benyon: Jonathan might want to give some of the granularity on that but, first of all, the new schemes are designed to be much less austere in how they are policed. There is a menu, which farmers can drop down different parts of to suit their business. There is an inspection regime around it, which treats it in a similar way as you and I are treated

with our tax returns, which is to believe that we are honest until proved otherwise. As the systems bed in, I think that will be appreciated by farmers who for decades have had a very top-down, rather soulless system of enforcement that sometimes leads to long periods of disallowance, which we want to tackle.

We also want to recognise that we have done this through bringing forward a six-month basic payment scheme to reflect current input costs. We can do that. We have the freedom to do that that we would not have had in the past, so I think there is a different and better approach. Once farmers come to terms with the changes and see that these systems can be of benefit to them, that they are done in a way that treats them with a lot more dignity than they were in the past, I hope that what you saw in Somerset will not be the case in the future. Do you want to add?

Jonathan Baker: Yes, just to add a bit of detail. The situation that we are now in for the delivery is that for our reforms to be successful farmers have to want to work with us. That is the fundamental. If we are going to have 70% of farmers in our scheme, it needs to be an attractive proposition. For us to achieve our own terms the schemes need to be simple and to be fair. They need to be easy and farmers need to want to engage with them. We know that has not been the case before, so we are putting in place quite a few ways to improve that.

It is completely mission critical rather than a nice thing that we have round the edges. If it does not meet that simple and fair test easily, farmers will stay away. Simple means self-service so farmers can log on. Farmers in a matter of minutes can run through the sustainable farming incentive process at the moment. They can definitely do that themselves. We have received some very positive feedback from farmers about their ability to do that without receiving professional advice. There is clear guidance that sets out what they need to do and have to do to meet the terms of their agreement. We have stripped that back to the bone, so there is a limited number of things that they have to do. Then we will provide some guidance around it, which can help them but it is not mandatory whereas before the balance was wrong. It is simplifying it as much as possible.

I think the stuff that will make a big difference—we know from talking to farmers that mental health is around inspections, monitoring for compliance, so we have taken out some of those and we have done some things—is when our field force goes out to talk to farmers, first, we give them a steer that they are there to advise rather than to go along and penalise. Then little things like when they have a conversation and when they leave the farm to describe what they found, what their headlines were. Again, small things that make a big difference. Even if things are okay, they send a letter whereas before we only sent a letter if they were not okay; little things like that. When the inspector leaves the door, the farmer has assurance of what that—

Barry Gardiner: The assurances?

Jonathan Baker: Yes.

Q319 **Barry Gardiner:** I have just switched hats and I am going to say to you: does simple, fair and easy actually give the maximum environmental benefit? We do not want a simple, fair and easy scheme that may make farmers feel a lot better but actually sees the environment go down the tubes. What is the balance here?

Jonathan Baker: The balance that we are talking of, I think we are definitely correcting it from not being simple or easy or fair enough. The ways in which we can get that balance right are by being clear that, "These are the things that are really effective from an environmental perspective", and working with our experts, Natural England and others, so that that central core is embedded and the way that we then inspect around that is understandable for farmers, so that they know what they are signing up to. When we come along and enforce it initially we are providing advice about how they could do things better. We are only coming along with a more robust tool where we see things otherwise.

Q320 **Julian Sturdy:** I want to touch on the Future Farming Resilience Fund. Lord Benyon, this is directed to you. How are we going to make sure this fund reaches the farmers who really need it and ensure it helps them make it through that agricultural transition? Also, how will the fund integrate mental health alongside the objective of business resilience?

Lord Benyon: As I have said, I think that the transition is a significant change for farmers. The Future Farming Resilience Fund is there to help them understand their options, to plan and to adapt.

Some stats on where we are so far: the number of farmers who have received support is 7,800. This is comprised of 1,200 supported in the initial phase and 6,600 so far in the interim phase. The numbers estimated to receive support by the end of the interim phase will be 8,000. That is 10% of farmers. There are 32,000 estimated to receive support during the scaleup, which will be October this year to March 2025, so hopefully really getting through to them.

The greatest benefit in mental health will be dealing with the evidence I think you have had, which is uncertainty. Uncertainty is a big driver for anxiety and related mental health conditions. Trying to give farmers the certainty that they can continue to farm and that they have a support network that shows them their options and how they can adapt their farming system to achieve that is really important. It is not the only show in town. There is the Prince's resilience fund as well and other organisations are doing this, but it really does make a difference.

Do you want to say something about the field force that go out to talk to farmers?

Jonathan Baker: Yes, I think it is worth touching on for the point about making sure it reaches those who need it and how integrated it is. We made sure that when we were awarding the fund one of the evaluation criteria was demonstrating connection with local communities and could reach out and then integrate mental health into business support. We run workshops with all of the providers to make sure that they have the signposting to professional mental health support or agricultural charity, so the specialists. It is factored in there so that the wellbeing and personal resilience can be provided by providers as part of this wider business package.

The reason we have that integrated package around wellbeing support and business support is that we got feedback from farmers and our farming stakeholders that farmers would be much more likely to engage if it was framed in that way, whereas a stand-alone wellbeing or mental health offer would be ignored. We needed this way into the door of many of the farmhouses and that is what we are seeing works quite well at the moment.

Q321 **Chair:** Thank you. In our last section we want to talk about suicide prevention. Minister Keegan, could you talk a little bit about the split between what we do nationally and what we do locally in the rural local authorities? Also, current funding for the local areas core suicide prevention plans ends in 2023-24. When are the Government going to commit to taking that forward? Will that be a continuing budget line and can you reassure people that that strategy will continue?

Gillian Keegan: 2012 was the suicide prevention strategy and that required all local authorities, all areas to have their own suicide prevention plans in place. An awful lot of training was done for people within many different touchpoints, particularly in the NHS. That is what happened over the last plan.

I chair a national suicide prevention action group and we are very live and active in building the 10-year suicide prevention plan. We will be looking at the call for evidence that we had for the mental health and wellbeing. There will be stuff in there that will also help us refresh and update that plan. They are both going along in parallel, but it is very important that we do work on reducing the stigma, in particular.

Male suicide numbers are higher for men in particular age groups, some occupations, some other risk factors as well. They are a harder to reach group in some ways so, as Richard was saying, we need to adapt to make sure that we reach out in language in places that they are there. We will be looking to do that as much as we possibly can but, yes, there will be an updated plan and it is very high priority.

Chair: Thank you. I am afraid we now have several divisions, so we are going to have to curtail the session. We have one or two outstanding questions on some of the suicide issues relating to DEFRA's policy. Could we write to you both? We were almost at the end of the questions and

colleagues have done very well. Thank you very much to all our witnesses, in particular your officials who have come along and been your safety net, which you have not needed very often.