HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Community Mental Health Services, HC 566

Wednesday 12 March 2025

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Watch the meeting

Members present: Layla Moran (Chair); Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 56 - 127

Witnesses

I: Eve Mair, expert by experience; and Elizabeth Sutton, expert by experience.

II: Steve Forsyth, Chief Nursing Officer, Rotherham Doncaster and South Humber NHS Foundation Trust; Dr Lade Smith CBE, President, Royal College of Psychiatrists; and Dr Emma Tiffin, National GP Adviser Community and Primary Care, Adult Mental Health, NHS England, and Associate Director Mental Health and Learning Disabilities, Cambridgeshire and Peterborough ICB.

III: Rt Hon Sir Norman Lamb, Chair, South London and Maudsley NHS Foundation Trust; Samantha Allen, Chief Executive, NHS North East and North Cumbria ICB; and Jane Yeandle, Service Group Director, Mental Health and Learning Disabilities, Somerset NHS Foundation Trust.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of Witnesses

Witnesses: Eve Mair and Elizabeth Sutton.

Q56 **Chair:** Welcome to the second session of the Community Mental Health Services inquiry of the Health and Social Care Committee. We have three panels today. The Committee is developing a tradition of having experts by experience—the people most affected by these services—on the first panel, so we can all plant in our minds why we are doing this.

For the benefit of everyone watching, I will ask you both please to introduce yourselves: who you are, who you work for and why you are here.

Elizabeth Sutton: I am here because I am Eve's wife, and I have supported her through her bipolar diagnosis and journey so far.

Eve Mair: I am Eve Mair. I work at Bipolar UK as a senior public policy officer. I was diagnosed with bipolar when I was 19, and as a consequence of my own journey, I have worked to try to advocate for specialist care and decreased delays in diagnosis for people with bipolar.

Chair: Thank you both for being with us. I know it is intimidating but it is so important that you are here, and I really appreciate it. We will start with Paulette Hamilton, please.

Q57 **Paulette Hamilton:** Good morning. Eve, could you start by taking a few minutes to go through your experiences of being diagnosed with bipolar. Is it bipolar affective disorder?

Eve Mair: It depends. There are lots of different diagnoses, but it tends to be just bipolar disorder, I think.

Paulette Hamilton: Right, bipolar disorder, and your journey of how you accessed treatment in mental health services.

Eve Mair: Like I said before, I was diagnosed with bipolar when I was 19. Prior to that, I had experienced periods of low mood my entire adolescence, something that is relatively common with people who later get a bipolar diagnosis. When I was about 15 or 16, I went to my local GP and was prescribed antidepressants. However, antidepressants and SSRIs are a huge exacerbator for people with underlying bipolar.

When I was around 16 to 18, I started to experience these periods of high mood, increased energy. They were relatively beneficial to me in a way, which is why it is complicated. These hypomanic episodes helped me in a strange way, but with them comes an escalated version of the high mood. It worsens and, untreated, becomes more severe as time goes on.

When I went to university, I started to experience really low mood. The high moods started to worsen again, and they became more intense, scarier. I had the awareness and the insight to know that the moods were

not necessarily normal and did not align with what is generally diagnosed as depression. It got worse and worse.

I kept trying to access help during that period of time. I would go to my GP and had some quite shocking experiences in primary care, in terms of the rejection of the idea that there might be something beyond depression. I would turn up at A&E and be given sedatives. You got treated a little bit like a woman with "hysteria" would be treated in Victorian times.

There was a sense that what you were saying was untrue or baseless. It felt like there were these constant barriers to getting help until it escalated radically. I was 19. I was interning at a newspaper, and I started to experience quite severe paranoia. I was very, very unwell. After trying to access care and trying to access diagnosis, knowing full well that is probably what it was—having the insight to be able to know that—I then had to go private. I got a private diagnosis, which cost a lot of money, and I was a student at the time.

From there I was given medication. I think the main thing with this journey is that there is a huge delay in diagnosis. It is nine and a half years, on average, in the UK. There are 1 million people with bipolar as well, so that is pretty significant. After that, you are not necessarily put on to any pathway for care.

There is no specialist pathway for bipolar, full stop, even though the condition itself is pretty intricate. It is very treatable, but half of it is self-management. You end up in freefall. You are not actually put into anywhere. You might be put through to your GP, who then might choose to refer you on to EIP services—early intervention in psychosis services—but those services are only for people experiencing psychotic symptoms.

Vast swathes of people are not getting a diagnosis through the NHS because they cannot access a psychiatrist. If they get a private diagnosis, they are left in the wild. If they are really lucky, they might get put through to EIP services. EIP services are really great, but they do not necessarily address the core problem, which is that bipolar needs specific treatment and specific self-management, such as sleep and avoiding drugs and alcohol in order to be able to maintain your wellness.

That was my journey. It felt like there were constant barriers, and there was no continuity of care afterwards. I had pockets of excellence in GP surgeries. When I lived in Peckham, I had a mental health nurse who was incredible. That is probably the period when I was the most well, because I had somebody who knew what I had experienced, knew my journey, knew that I had insight and could provide insight into when I was becoming unwell and maybe get me a one-off appointment with a psychiatrist to do a medication review, but there has never been continuity of care for me.

Q58 **Paulette Hamilton:** Thank you. That is really insightful. Following on

from what you have just said, what hits me is the bit about no continuity of care, especially in 2025. I am not sure what year you went through this, but I hope that it would be slightly different today.

You work for the national charity Bipolar UK. What similarities have you observed between your experience and those of the people that the charity supports?

Eve Mair: That is what is funny about working at this charity. It is quite an interesting process for me, emotionally in a way, because you start to realise that those experiences where you felt incredibly isolated are mirrored by literally everybody.

Like I was saying, the delay to diagnosis is a huge and significant thing. That is for a mix of reasons. It is because of a lack of awareness in primary care of the symptoms and a lack of screening for high mood—that is exacerbated and worsened by the prescription of antidepressants—a lack of access to psychiatrists, which is another huge thing, and then eventually the lack of specialist care.

Together, all these things have created a community of people who I think are completely lost in the system. They feel alienated, distrustful of services because of so many persistent disappointments. Something that is mirrored constantly is that people cannot get access to care until they are in crisis, and that is not okay or acceptable now.

People have a diagnosis, and they know what they have, they know how to manage it, and they know what they need. People are often treated like they do not know what they need, but they do. That is a huge, huge issue. You should not have to get to a point where you are going to be sectioned before you get access to help. You should not be at a point where you become suicidal before you access any care. That is at the heart of what I see in our charity, in the work we do: we are persistently seeing this alienation, which is really endemic. It is a million people.

On top of that, 5 million people are impacted by bipolar because they are loved ones, because they are carers, or because they know someone with bipolar and it impacts their life. That is a huge swathe of people going through this pain, that alienation that causes so many problems later down the line.

Paulette Hamilton: You have explained it extremely well. I will now hand back to the Chair, and Members will ask you more detailed questions. Thank you for that brilliant start.

Q59 **Chair:** Could I ask a quick follow-up, Eve? You talked about your NHS journey, but as we know, it is very often more than that, isn't it? It is also housing, finances and other stuff that happens as a consequence of the diagnosis. Have you engaged with other services to help you through some of that? If not, what are the experiences of others? What kinds of things do they need that may or may not exist out there to help them?

Eve Mair: Personally, for me, I feel like this is something that gets forgotten in the conversation around severe mental illness in general. The physical implications of mental illness are huge. Medication is massive. Antipsychotics are prescribed widely for things like bipolar, schizophrenia and psychosis, and things like weight gain are massive. People with bipolar die, on average, 15 to 20 years earlier.

In primary care it is the luck of the draw. It is a lottery as to whether you get somebody who is persistent, and who has the time and the resources to dedicate to routine blood tests, to checking in and making sure that your physical health is as good as it can be.

In terms of the experiences of other people, yes, housing is a massive thing, and obviously work is a huge thing. We are having a conversation at the moment around PIP, which is obviously incredibly important for lots of people who are struggling with mental illness. Getting access to those things is really important, and so is having workplaces that are suitable for people with mental illness and that make reasonable adjustments, as per the law. Often I think that is something that employers are not necessarily aware of.

Services are really a missing point—this holistic approach that is necessary to understanding the whole person and the fact that they are not just one illness or a health case. They are a whole person with a job, a life, a family, a house that they have to maintain during these periods of difficulty.

Q60 **Gregory Stafford:** Elizabeth, obviously you have been through this journey with Eve. What has been your experience as someone who has been supporting Eve with bipolar? What are the good things, and what could be improved for those people who are helping, caring and supporting?

Elizabeth Sutton: If I was to try to sum it up in one word, I think "lost" is a very clear one to me. The system is quite confusing. When Eve was diagnosed, we had spent such a long period of time trying to find what felt like the truth or a diagnosis, something that made sense for her, for what she was experiencing. Once she received that diagnosis, I initially felt relief because I thought, "Fantastic, we understand what is happening here. There will be treatment plans. There will be support," and then it felt like we were cast to the wind.

I had no understanding of where to go when Eve became ill. I had no understanding of how to help her. There was no education for me. I had to educate myself and use charities, like Bipolar UK, and the resources they provide to gain any understanding of what she was experiencing, what she could experience.

That lost feeling came very much from: if she becomes ill, where do I go? There was no continuity of care. There was no clear clinician or support system in terms of: where do I go if I need to support and advocate for

her? Especially when people have a mental illness, it can sometimes mean that they do not always understand that they are becoming ill. As a partner, as a wife, anyone that is supporting someone with an illness, sometimes you spot these things before they do.

There is a point of interception, or there could be a point of interception, where I am expecting it. There is a lot of self-management that can be done to ensure that we do not reach crisis point, or we do not reach that high or low point. It feels like there is nowhere for me or Eve to go before it becomes a crisis point. At that point, your options are 111 or A&E.

My experience is that if Eve does not reach any of the criteria for sectioning, she essentially gets released back into my care. As a partner, that is a lot of pressure because with no education or explanation, other than what I have done myself, we are having to work together to make sure that we are able to keep her well without the support of medical professionals at this point.

Q61 **Gregory Stafford:** Over the time that you have been in this role, as it were—I forget the terminology—have you seen any improvements? I think Eve talked about pockets of excellence. From your perspective, have you seen pockets of excellence that you would like to see rolled out or expanded?

Elizabeth Sutton: Absolutely. For me, from my experience, the key thing is continuity of care. When we talk about mental illness, the trust that you have in someone you know is incredibly important, especially when you are experiencing some of the symptoms that may come with something like bipolar disorder. It is also that ability to have a port of call.

Eve referenced Kate, her mental health nurse in Peckham, who was fantastic. To your point, Layla, it became a consideration for housing and things like that, in terms of where we live, because we want to keep that support. We have since moved out of the area, and as a result, we do not have that support anymore and it feels like a bit of a postcode lottery.

For me, continuity of care and having that port of call—support for those that are supporting—is really key. It may be a crude comparison, but I have seen family members go through physical illnesses, and I have never been at that point. It is very scary when someone you love is ill but, with that, they have been in the right hands and receiving the right care. They might be unsure of what the outcome might be, but they are working towards the right pathway.

I think what I have seen with Eve's diagnosis and bipolar journey is that it is not that she was in the wrong hands. It was that she was in no hands at all. There was no support there.

Q62 **Chair:** Thank you very much. We are here to try to make recommendations primarily to NHS England and the Department of

Health and Social Care. If you could reimagine the world, having had the experiences you have had, and knowing what you know of others, what would it look like? What would good care look like for you guys?

Eve Mair: For me, first of all, it would be access to psychiatrists early on. When people start appearing in primary care with high mood, they are given access to a psychiatrist for a full psychiatric assessment. Once there is a specific diagnosis of bipolar, they should be given care that is specific to the condition—that care, like I said before, does not exist. A specialist care pathway is absolutely imperative with bipolar. It does not exist. There is no specialist care.

There are pockets of it within universities and services. There is one for young people. There is Ultima. There are ones that are across the country, but they are not NHS-wide. Every single person with bipolar should have access to a service like that to prevent them from experiencing this grief, which is the loss of years of your life. That is it: because of this condition, you lose out on so much that you should not have to lose out on.

There are so many people with potential and promise who are unable to fulfil it. That is the key to it. It is having people at every level—primary care, secondary care—who understand the condition. There should be specialist care at the other side of it, and the diagnosis should be done more efficiently, quicker, and with the empathy and care that everybody with a mental illness deserves to have when going to receive care.

Q63 **Chair:** Elizabeth, from your perspective as a carer, do you like the term "supporter"?

Elizabeth Sutton: Yes, I am a supporter. Eve is not in a position where she needs a carer. I am just a supporter in her journey and what she experiences with bipolar. I have said "continuity of care" a lot, but I think it is incredibly important, especially when people are at these vulnerable points, that they have continuity of care and the understanding of what bipolar is.

Something we have faced a lot is that professionals who have a general understanding but no actual understanding of what bipolar is. Sometimes I find myself explaining it back to them, which feels a little bizarre.

I think there needs to be a clear pathway, because when Eve got diagnosed and we asked, "What next?" there was no answer. There was no, "This is what happens now." When you compare it with many other medical conditions, that would not be the case.

Chair: We are eliciting lots of brilliant questions.

Q64 **Gregory Stafford:** Obviously this may be beyond the scope of your expertise, but would you say that this is a specifically bipolar disorder issue, or is it a mental health issue? Are there other mental health disorders or illnesses where they are getting it right that perhaps bipolar

diagnoses could mirror and use as best practice?

Eve Mair: There definitely is. As I said before, those EIP services treat schizophrenia and psychosis so effectively. They are rolled out basically across the country, and they are so efficient at what they do. Why this is a bipolar-specific issue is because there are treatment pathways for schizophrenia and psychosis. There are ones for eating disorders across the NHS as well. That is because those conditions are specific.

With mental illness, we do not treat the symptoms; we treat the overall. But there are certain conditions where you do need to treat the symptoms, where you do need to home in on it. Bipolar is one of them, psychosis is one of them and eating disorders are one of them, because they manifest in such specific ways that are so treatable.

At the moment it is a bipolar-specific issue, only by virtue of the fact that it does not exist yet. The problem is obviously wider.

Q65 **Joe Robertson:** Thank you. I have a question for Elizabeth that spontaneously came up. I can understand why you do not want to be referred to as a carer, but do you find that happens with clinicians or others within that world?

Elizabeth Sutton: Yes. There are points where I have to be an advocate for Eve, as I am sure that anyone who has supported someone through any form of illness is an advocate for them. It definitely feels like sometimes there is a reduction in your capacity, when you have capacity and can have full autonomy of your care, that I am just there as a supporting part. I am there to understand what the recommendations are, and how we make sure that we implement them at home.

As Eve said, especially for bipolar, there is so much self-management, like sleep and routine. There are a lot of things that, alongside things like medication and talking therapies, can be incredibly effective. That is what I see myself as—a supporter. I want to understand what those things are so we can be sure to implement them at home, to keep Eve well and ensure that she is living life to the absolute full. It is kind of polarising. It is either that I am not included at all, or that some autonomy is taken away from Eve and handed over to me, which can feel quite patronising.

Q66 **Joe Robertson:** In terms of terminology, you do not feel that "carer" is a word that is pushed or used too much? I know in other settings—say, for frailty affecting older people—the term "carer" is very often used, and understandably people do not like it. Is that term used a lot in your joint experience or not?

Elizabeth Sutton: I have not found it used so much. It is seen more as community support, because it is not just me. It is Eve's family. It is Eve's friends as well. I might be the person who Eve lives with, but there is a much wider supporting circle.

Q67 **Paulette Hamilton:** Mine is quite a quick question. As I said, the

continuity of care is what concerns me, and you have highlighted it over and over again. I will ask both of you, in your role both as someone living with an illness and as someone who works for Bipolar UK, what would good continuity of care look like for you?

Eve Mair: It would be routine access to a psychiatrist. As part of seeing someone in primary care who took care of the physical, you would also have access to a psychiatrist relatively routinely. I do not know exactly how frequent that would be, but I imagine every three months would probably be the ideal, just to check that your medication is okay, and that you have not experienced periods of mood.

It would just be a routine part of your calendar, "Okay, I have got my GP appointment, and I will be doing my bloods here. They will tell me about this, and then I know I have my psychiatrist appointment here, so I will be checking in there." To me, that is what good continuity of care is. It is just persistent access; just access to generally anyone.

Q68 **Paulette Hamilton:** Elizabeth, as somebody who supports your wife through her bipolar journey, for the sake of the discussion, what would good continuity of care look like for you so that you feel more confident with the services out there?

Elizabeth Sutton: I think it goes back to my earlier point. When Eve was diagnosed, I would go, "Okay, what next? What is the plan?" and there was none. That to me is what continuity of care is. What is the plan? How do we stick to it, and if it needs to change, who do we go to? You have a clear port of call to discuss that.

Q69 **Paulette Hamilton:** This is my last very quick point—if I have cut in, I apologise. Is it that Eve is not looked at as an individual? A package is like an individualised, personalised way of looking at her journey. When a baby is born, they get a red book that records their weight and everything, carrying them through for the first five or six years—I may be wrong, as I am a bit out of date. Do you feel that services are broken, that people do not know what is happening?

Elizabeth Sutton: When you present for any form of support, you have to start from scratch. You have to explain everything that has happened. You have to explain the diagnosis, how long ago it was, what medication we have tried, and what medication you have been on. Quite frankly, that is exhausting especially if you are presenting at a crisis point.

I dread to think what it is like for people living with bipolar who do not have support, because if you have to advocate for yourself in that way I just don't know how you would achieve effective support.

It is exactly that. It is that it is broken. Every time you present it is to someone new who has no understanding of any part of this journey. No understanding of the treatment plan or the experience, and you have to start afresh.

Q70 **Josh Fenton-Glynn:** Thank you for sharing your experiences today. You said that there are 1 million people with bipolar. The average GP sees about 30 people a day, so they will probably see four people who have bipolar every week. The thing I am trying to get a grip on is that you have to advocate for yourself on your journey. Is that universal? As GPs are usually the front door for our health service, how could they be more acutely aware of bipolar being a potential diagnosis?

Eve Mair: Obviously antidepressants are prescribed really widely. I think there were 8 million prescriptions of antidepressants in the last year. When people come in with episodes of low mood, I think all GPs should be given the tools or awareness to be able to say, "Have you experienced any high mood? Have you experienced any of these things, these symptoms, like lack of sleep or increased energy?" If so, there needs to be a more rigorous look at the prescribing of antidepressants.

It starts with education for GPs. Again, it is very luck of the draw, in terms of how knowledgeable they are of mental health, the training they have had and the awareness of something as specific as bipolar.

Q71 **Josh Fenton-Glynn:** A very simple thing within the GP training pathway, one would assume, is a flowchart they go through when someone presents with low mood.

Eve Mair: Exactly. It could be as simple as that. That it is almost like a screening.

Q72 **Jen Craft:** I would like to pick up on that. You say that every time you go for support, you have to start again from scratch, which is exhausting. Has that ever put you off accessing support, and is there evidence that other people might think, "I am not going to go to access this type of support because I am going to have to go all the way back to square one"?

Eve Mair: For me, it has, massively. I have developed a bit of a phobia of doctors. Even for physical health conditions, it has become a thing for me. Also, recounting those things is really quite traumatic. I would not speak about them on a day-to-day basis with anyone other than probably a therapist, so going and speaking to a medical professional, not knowing if they understand what it is like or what the next path is, you start to feel incredible alienation. I think that is routine among everybody with this mood disorder.

Jen Craft: Thank you. I can speak for myself. I have bipolar, so I have a very similar experience. I am one of the 40% who are in employment, and a good job as well. Thank you for being here.

Q73 **Ben Coleman:** I am struck by a couple of things you said. You talked about continuity of care, but it struck me that it is more the absence of care in the first place. That is right, is it? The second thing is that when you talk to people in the health services and you say to them, "I am going through this again. I have talked to six different people," do they

come back to you and say, "Yes, I know this is a problem, but we can't do more because of A, B, C"? What are the things they say that are inhibiting them from doing more?

Eve Mair: Absolutely. At a primary care level, it is that secondary care will not accept referrals because people are not essentially suicidal. That seems to be a really common thing that people are experiencing now. We work with clinicians as a charity, and we hear back from them that they are constantly trying to refer people to services and that is what they are hearing back, that these people do not meet the criteria when they really do. They are just going to end up in crisis anyway, but you are right, it is.

Q74 **Ben Coleman:** They are saying to you, "We are only going to get a response if people are in absolute crisis"?

Eve Mair: Absolutely, yes.

Q75 **Ben Coleman:** Nothing preventative?

Eve Mair: Nothing preventative about it. It is all reactive, I think. Proactive care is a fantasy for people with bipolar.

Ben Coleman: Thank you.

Chair: Thank you. That brings us to the end of a very rich half an hour. Thank you so much for coming.

Eve Mair: Thank you. It has been a pleasure. Thank you so much.

Chair: Absolutely brilliant. Thank you so much, Eve and Elizabeth. You are very welcome to stay for the next panel.

Examination of Witnesses

Witnesses: Steve Forsyth, Dr Lade Smith and Dr Emma Tiffin.

Q76 **Chair:** For the benefit of those watching, may I start by asking you to introduce yourselves?

Steve Forsyth: I am Steve Forsyth, and I am a mental health nurse and a general nurse. I am representing the Queen's Nursing Institute as a fellow.

Dr Tiffin: I am Emma Tiffin. I am a GP in Cambridgeshire, and I have a number of hats. I am the associate director for mental health and learning disabilities at my ICB. I am also the national GP adviser for the adult mental health team for NHS England.

Dr Smith: I am Dr Lade Smith. I am consultant psychiatrist and clinical senior lecturer at the Institute of Psychiatry, Psychology and Neuroscience, and I also work as a forensic psychiatrist. I am here primarily because I am the president of the Royal College of Psychiatrists.

Chair: Thank you all.

Q77 **Jen Craft:** We have just heard some most interesting testimony from the previous panel, and drawing on that, if we can start with what sorts of barriers there are to GPs. Emma, this question is probably primarily directed at you. From your perspective, what barriers do you see for GPs in enabling people to access community mental healthcare, specifically people with a serious mental illness?

Dr Tiffin: I would say that bipolar is on our QOF mental illness register, so we do know who our patients are. A lot of the problem is around what we do to support them, so a big thanks to Eve and Elizabeth for pointing out what I think has been a problem for years.

We have done a lot. My main experience on the ground would be what we have done in Cambridgeshire on the back of the community mental health framework. We had patients with lived experience. Lade and I were on that, looking at what needed to be put in place. As GPs, we do need specialist support. We have a primary care mental health service that wraps around our PCN. It is locality based and provides predominantly our specialist mental health expertise for patients like Eve. That is there, and waiting times are quite good.

It is interesting that Eve talked about how it is not all about clinical support. You do not always need a psychiatrist. It is around recovery, resilience and wellbeing.

We have implemented a digital solution supported by a face-to-face team supporting our local population with activities and wellbeing, and we have a lifestyle medicine approach. It was interesting, again, hearing Eve talk about sleep. We now have that reaching in. Tricia, who is our, "Hey, how are you?" expert, and that also reaches into our in-patient wards to look at sleep, appetite, exercise, social connection, all those things that are so important. As GPs, we have struggled over the years, while we have been busy putting that in place, and there needs to be a much more consistent approach nationally around that.

However, for us, I do think that quick access to specialist expertise is important. I have a lot of mental health background. Some of my colleagues do not have that, so training is an interesting area. In my era, you chose between psychiatry and paediatrics. I chose psychiatry, whereas others chose paediatrics, so it was a movable feast. We need to do something around that training.

However, if you have a specialist mental health function behind core general practice, you know that your patients with more severe mental illness will be supported, with all those needs, as well as that sort of community offer. I don't want to hog the session because I could talk for a whole hour on that. Can I just add one final comment about physical health? I think that is very important.

Patients die 15 to 20 years earlier, tragically, if they have mental illness, and others too, with more mild mental illness. Having a robust approach to physical health is essential. We have a team that offers annual reviews. Eve's point was important. Some of that approach should include a medication review, because antipsychotics cause weight gain and metabolic dysfunction. Literally overnight, within six weeks, you just see it go like that unless it is monitored.

Lade will talk about patients with more severe mental illness, but it is really important to have that review in place. It does not always need to be done by a psychiatrist—we do not have enough of them—and we can look at other ways of delivering that.

Q78 **Jen Craft:** We always have people who can talk for a long time on our panels. It is one of the joys of this place, and I would not want to stop you either, because we are here to tease out what is coming out of that. But I will address the next question to Lade and Steve.

How can the Government, and we as policymakers, improve access to community mental health services for people with serious mental illnesses? What kinds of policy interventions do you think the Government should make, whether looking at statutory interventions, guidance or even improved training in the primary care network?

Dr Smith: I think there needs to be a little bit of history. First of all, everything that Eve said is absolutely spot on. There is only one area I disagree with, which is that it is not just bipolar illness. This includes all severe mental illnesses, people with severe and enduring psychosis, such as schizophrenia and bipolar illness, and also including people with severe anorexia and eating disorders. We know, and people remember, that for many, many years—hundreds of years—we delivered the majority of mental healthcare through in-patient services. It was an asylum-based system, until about 40 years ago.

At that point, 40 years ago, we had 154,000 beds. We reduced our beds by 87%—we now have about 18,000 or 19,000 beds—and we deliver the majority of care in the community. Unfortunately, however, the money that was needed to make sure we had good community services perhaps did not follow as well as it could have done. It has not been used as efficiently and effectively as it could have been.

So, the current situation: Colm Owens, who is a medical director in Devon Partnership Trust, has recently done some modelling work, using NHS data, showing that, essentially in England, there are about 1.3 million people with severe mental illness, but we have capacity to provide care to only about 560,000 of those people. If you have the capacity to provide care to only 50% of people, it means that 50% of people get good care and the others do not—I think someone said that there was an absence of care—or you provide substandard care to 100% of people. What Eve described very well was the kind of episodic, intermittent approach.

She also described something else that I recognise, and I have been doing psychiatry for about 32 or 33 years. When I started, the care that we provided was continuous; there was continuity of care. You would see a psychiatrist fairly early—as soon as you presented. You would see a psychiatrist, you would get a comprehensive, biopsychosocial initial assessment that would essentially determine your treatment package, and that treatment package would be delivered over time. You would have a care co-ordinator, a key worker, who would see you regularly, and that would provide some continuity. You would also have input from a psychiatrist every three months or so. Eve said that is what we need now.

Unfortunately, over time, because of an erosion of services in the system, we cannot provide that kind of continuity of care in every single place. Some places are doing it really, really well. Eve described early intervention in psychosis services that are doing that pretty well, but not everywhere has an early intervention service.

Q79 **Chair:** When was it last good?

Dr Smith: I would say probably about 15 years ago it was good, up until about then. Then we started having a more episodic approach to services, unfortunately. We had the care programme approach, which meant we had rules of practice. We were required to ensure that we saw people regularly, and that if someone was discharged from care, they would be discharged only when they were mentally well and ready to be discharged. If they were discharged from hospital, someone would have to continue to look after them. Very importantly, we were required to be responsible for that person until we handed them over to whatever service it was.

We know there is good evidence that continuity reduces hospital utilisation costs by up to 27% and reduces emergency department visits by 17%. Also, it is something that patients want. It is what the staff want as well.

Q80 **Jen Craft:** You spoke of having a care co-ordinator. Would you see that role as key for the continuity approach?

Dr Smith: Yes. One of the issues that has come about is that we have significant staff vacancies, and care co-ordinators are often nursing staff—they can be other types of staff, such as occupational therapists, social workers or psychologists, but they are primarily nurses. On average, we have 20% vacancy in nursing and about 15% vacancy for psychiatrists. However, in some places, particularly in the community, we are talking about up to 60% or 70% vacancy in psychiatry.

Q81 **Jen Craft:** Does a care co-ordinator role have to be a clinical role?

Dr Smith: Emma mentioned the community mental health framework. A few years ago, we developed a new model of working and it is not all bad news. There are some things that we know, there are solutions that we

know would help. The community mental health framework works such that you use all aspects of what is available to you in the community. Someone mentioned housing, debt and employment support, and you can use the voluntary sector and partner with primary care and secondary care.

However, many of the people that we see are significantly impacted by their social situation, which is what causes them to become unwell and relapse. As psychiatrists, we can help get people better, but then we send them right back to the conditions that caused them to relapse in the first place, a classic kind of Michael Marmot thing. The community mental health framework requires us to partner with all the different agencies in the community. When you have community connectors who support people with their debt issues, their housing issues, et cetera, they are less likely to relapse.

Emma described having specialist mental health workers who sit co-located with primary care and the voluntary sector to provide that extra specialist support, which means that fewer people have to be referred to secondary specialist care. We know that when it has been implemented properly it has worked very well. It works in Cambridge and in Peterborough; it has worked very well in Tees, Esk and Wear, and it has worked very well in Hartlepool.

In Hartlepool, they have found that they have reduced the number of people being referred to specialist secondary care from about 40% to 2%, which is phenomenal. People are still getting the support they need, but they are getting much more of the relevant support they need in the community. Then those people who do become unwell get referred to secondary care, but we have more time to provide them with the continuity of care and the more thorough assessments and interventions they need. Unfortunately, the problem is that care co-ordination does not necessarily mean that you get an actual intervention that helps you to get better. That is what is missing.

Jen Craft: Steve, do you have anything to add?

Steve Forsyth: I will probably give a view not from my role as chief nurse, but as a brother to my brother, who has bipolar. What he would probably say is that there were multiple handoffs, and to Eve's point, he would often either be in crisis or be not known to services, wherever he may be. The only time he felt it worked, and probably felt that it worked better for him, was when he was in Wales. Of course, Wales has the mental health measure, part of which means you can refer yourself back into services straightaway.

I think there is a focus on this being doctor-led. I am not suggesting that the panel is recommending that, but certainly from a committee group, there are amazing professionals, and not just nurses. If you remember, there were care navigators as well. Once assigned, they provided support, particularly in physical health, to make sure there was a single

point of contact. The problem is instability in the workforce. Having been a care co-ordinator in the 1990s, it was a stable job for me. Now, however, with the cost of living crisis, you see that lots of people will jump and move quickly through the bandings, through Agenda for Change as well.

Q82 **Jen Craft:** So a care navigator would be a fairly low-banded role. Is that right?

Steve Forsyth: It could be any banded role. The problem is around consistency. You can look at Dialogue Plus, so moving from the CPA model that Lade spoke to, which created a two-tier model of enhanced CPA or non-CPA. Dialogue Plus looks at meeting the needs of the individual. The problem for my brother or Eve—and I do not mean to talk on their part—will be that they repeat their story so many times because they are seeing so many different people, and each organisation uses a different electronic record.

Just quickly, while I am on it, where I work—Rotherham, Doncaster and South Humber—we have set a number of targets. We have set a target for people with a severe mental illness. Not the QOF register, but determined by our organisation, which increases the number of people who will be seen. We see 95%. They have an annual health check, but the important bit, and what Emma and I have spoken about previously, is the subsequent intervention, because there are about eight different physical examinations that they will need to take, and not all of them are done at the same time, because, for instance, somebody may have a needle phobia, but it is about the right person doing that with them. Dialogue Plus covers some of that.

Q83 **Jen Craft:** Is there a digital component to Dialogue Plus, or is it entirely person-led?

Steve Forsyth: It is both.

Q84 **Jen Craft:** Okay. Both of those being in place is key for it to work, so you would not be able to replace it with entirely digital technology. There has to be a person at the centre of it as well.

Steve Forsyth: Yes, absolutely.

Jen Craft: Thank you.

Q85 **Chair:** Thank you, that is very helpful. Lade, can I pick up something you mentioned? You said that something changed 15 years ago. Can you pinpoint what it was that changed?

Dr Smith: It was not all at once, but a number of things have changed over time. There was the integration of health and social care, and that took a while. It meant there was a kind of—how can I put it?—a kind of dissolution of roles, and people were a little unclear about what they were meant to do. That probably did not help.

Then—and this is probably because of resource implications—there was a push towards saying "Why do you need to have this continuity of care"? Also, there was the working time directive. Doctors were working ridiculous hours, and far too many sessions. For example, when I first started as a consultant, I ran a ward and also ran the community team. That meant that when people were becoming unwell in the community, I could bring them in early, and then also move them out of the ward quite early. I was the person who looked after them everywhere in my catchment area.

It was decided that we needed to have a different approach that allowed people to work just the 10 sessions. So, you decided to become either an in-patient doctor or an out-patient doctor, a community doctor. There was also a recognition that certain types of people did better with specialist teams, so early intervention teams were born. Some areas, for example, had specialist affective disorder community teams. There were specialist eating disorder teams.

Of course, when there is a new team, everyone wants to go there because that is where the resources are pumped in. So, a few things were happening at the same time. You had to be an in-patient doctor or an out-patient doctor. If you were going to be a community doctor—and this was not just doctors but nurses and everybody else—it was like, "Okay, let's go and work in the sexier teams, such as the early intervention teams."

Bear in mind that the more specialist teams had quite strict criteria. Most people with mental health problems, severe mental health problems, do not have just one problem. There is often comorbidity, particularly with substance use and alcohol. A good 48% of people with mental health problems have comorbid alcohol or substance-use issues, and they are people who are more likely to die by suicide. The changes meant that those people, who are often more complex, did not fit the criteria for the more specialist teams, so they would end up in the community teams with fewer people looking after them.

Chair: Very helpful and instructive.

Q86 **Andrew George:** I was a member of the Health Committee 15 years ago, when we looked back at CAMHS. At that stage, it was not in a very good state, and we were looking backward then. That is probably a conversation for another occasion.

I now want to look particularly at the issue of integration. What you have described today about the presentation of mental health services 15 years ago seems to be one that was relatively well integrated. From the point of view of those sitting outside, who need the services, and then have to interface with the system, it is not for them to fathom the internal workings, wiring and plumbing of how everything operates within the service and its administrative and financial arrangements.

Would you say that the service we have at present is one that users find is integrated and that they don't need to use their sharp elbows to be able to get the service they require? Is that the case at present?

Dr Tiffin: I would say that it depends on where you are. Lade and I had a conversation about the system and, as he said, the framework very much supports integration with primary care, the voluntary sector and specialist services. Some systems have embraced that and have gone quite far. There are various tips. A lot of it is around relationships, it really is. If you get on with them, you know who your consultants are, you know who your key leaders are.

We have gone all out on leadership within primary care. We now have clinical mental health PCN leads. That has made a massive difference because you will find that clinical directors are so run off their feet in PCNs, and not all of them have an interest in mental health, so we have contracted. We have not just done the champions. We have contracted those sessions, and they interface with their practices. They bring back knowledge of what services are out there. They will feed back if there are any problems with their primary care mental health service. That has made a huge difference in terms of patients being able to address those problems.

Likewise, we have GPs working in our mental health trust. We have GPs working in eating disorders, ADHD and now on the in-patient ward, interestingly, and our long-stay ward and our early intervention in psychosis service. That has made a difference, just because it is about relationships. The specialist staff understand what we do in general practice, and vice versa.

In a similar way, we have gone the other way by having primary care mental health service staff, who are employed by the trust, mapped on to the psychiatrist that brings the specialist support out to the GPs at the individual practice level. Our neighbourhood teams have hubs where they discuss patients, usually anonymously. There is also housing and the WorkWell people.

It is not perfect. Not all our areas have this yet, but we have been rolling it out. They all come. They, or our third sector, can bring patients. One of our great examples is of a patient who had schizophrenia and whose life was kept well by watching cricket on TV, but his TV broke. The psychiatrist said, "Well, what do I do?" I said, "I don't know. What do I do?" Anyway, sure enough, it got sorted out at the hub because it is not rocket science to find a TV for somebody.

Those are some examples. Tricia has worked on virtual mental health networks. The leads know each other, and I think it is key to integration, if people know each other in their patch. I am a fan of neighbourhood teams, as you will have gathered, that local approach.

My GP colleagues and I all yearn for the days when there was a CPN in each practice. We do not have that now, but we have a better, wider solution. However, as Lade said, it is not everywhere nationally so we need to share some of these ideas. Nothing will ever be perfect, but let's slowly start to roll out some of these initiatives. Leadership, the governance around integration and those relationships are critical.

Q87 **Andrew George:** So, the CPN in every practice is obviously—

Dr Tiffin: Sorry. Community psychiatric nurse. I am terrible at acronyms.

Andrew George: That is right, of course, but as I understand it each primary care network is entitled to one such specialist within each network of up to 100,000—

Dr Tiffin: It is not that straightforward. They are entitled to one mental health practitioner, and there is quite a broad classification of what that means. It depends on where systems already are. We already had our primary care mental health teams for each PCN. There is a band 7, a very senior member of staff, who triages referrals, so our wait time is under four weeks—they will also see the complex patients. A band 6—that is already there, so we used our practitioner PCN offer around community connector roles, who are sort of social prescribers with expertise in mental health. A lot of social prescribers will tell you that my colleagues sometimes give them quite tricky patients, so it is a bit too much. You need somebody with a bit more mental health expertise. The mental health practitioner role does vary a little, but it has been very helpful, I think, in bringing that awareness to mental health and that extra support to primary care.

Q88 **Andrew George:** Steve, from your perspective on the community health teams working in primary care, are you happy that those relationships are easy, and that the integration is now well established?

Steve Forsyth: There are so many different models, and I think that is the point that Dr Tiffin was making. We have tertiary services. We have middle services that interface with primary care but also work within the CMHT. A big problem within mental health is the waiting lists. If you ask anybody, when people see their GP or see somebody else, they will want to know when they are going to be seen.

If someone is having bloods done and needs to see a diabetes specialist, they will know roughly when their appointment is. If you are going to see a psychiatrist or a CMHT, or if you need an ADHD assessment, in some parts of the country you can wait up to 10 years for that first appointment. I have to plug the organisation I work for, because one of our 28 promises is that we will see you, no matter what service you need to come into contact with.

We operate wheelchair services and health visiting services through to a psychiatrist appointment within four weeks. Against a backdrop of other

organisations announcing waiting lists of years, at RDaSH you will be seen within four weeks. That makes it really clear to people that they will have to wait no more than four weeks to be seen.

Q89 **Andrew George:** Lade, you gave very good examples from Cambridgeshire and Peterborough, and Hartlepool, of where the community mental health framework is working well. That sounds extremely encouraging, I must say, in those places, but you are suggesting that it is clearly patchy. What can we learn from the places where it has worked well? How can it be rolled out—or can it be rolled out?—so to other areas can benefit from the successes that others have experienced?

Dr Smith: Thanks. The work that Emma and her colleagues are doing in Cambridgeshire and Peterborough, and in the Hartlepool area, and clearly the work that Steve is doing in his trust is fantastic, but I need to tell you that that is unusual.

Andrew George: Unusual?

Dr Smith: Unusual. They are exemplars of what can be done.

On waiting times and access standards—this Government inherited I think 9.2 million people on its elective waiting list. Of those, 7.4 million have physical health problems and are being attended to in the elective reform plan. However, the 1.6 million people who have mental health problems are not counted in that number, and the number is growing. In a year from now, it will be 2 million people.

There are no waiting time and access standards other than for early intervention in psychosis and certain children and young people's eating disorders, and I think there are some dementia waiting lists. Generally, there are no waiting time and access standards, which means that you get places like Rotherham, where Steve works, where they will decide that it is going to be four weeks, and they try hard to stick to that. Other places cannot make that decision. It is about what the capacity is at the time.

Q90 **Andrew George:** How have they managed to achieve four weeks in RDaSH?

Dr Smith: I really do not know.

Q91 **Chair:** Steve, tell us. How have you done it? It sounds amazing.

Steve Forsyth: Our chief executive, who comes from a DGH—district general hospital—background, has made a number of commitments and promises. It is a collective approach. We are going to do that by 2026. We have also made a commitment to return everybody who is an in-patient out of our local area. We will not have anybody out of area because of the impact that has on mental health.

We have 28 clear promises to our community, and we have invested all of that within and with the community. That is why we set the standard, that 95% of people with an SMI will have a physical health check against the previous QOF, which was 75%.

Dr Tiffin: Yes, 60%.

Q92 **Andrew George:** Steve, if you were transferred and moved to Wales and had circumstances where a patient could self-refer, as your brother was able to do es, what impact do you think that would have on your service? Would it actually drive improvement, or would the service fall over?

Steve Forsyth: I used to work as a director of nursing in north Wales, so I have had experience with the mental health measure. If people were missed within the percentage, they were not carried in the next month. There were a number of flaws with the mental health measure that are being revisited, but the ethos and principle of it were the right ones, that people should be able to refer themselves back in without the bureaucratic process of getting a GP appointment, getting an assessment, waiting to be seen, and potentially seen again. That is what CPA tried to do, that continuity of care, which is where there are a number of hopes with Dialogue Plus—laying it at the door.

Q93 **Andrew George:** Do GPs act as gatekeepers, or do they simply respect the request of every patient?

Dr Tiffin: It is variable. That is why we put in place the support. You ask an interesting question. The reason we set up our original primary care service in 2015 was because of desperation. Cambridgeshire had the biggest referral rate in the country. We had over 16,000 referrals a year, and it was chaos; it was a single point of access. When we looked at those, 90% were returned back to the GP with all but a minimum of advice, and they were going round and round. This was crazily inefficient.

We have got our waiting time under four weeks by setting up a primary care mental health service that actually does something for our patients and does not just give advice. It accesses the community and the housing. We have social workers in the model, the things that our patients need. I am not saying it is perfect, but it has made a big difference. That is how we got our times right down. Ours were months and months, and people were just going round—to Eve's point—telling their story for the 55th time in a year.

For my GP colleagues, the feedback, which is how I judge things, is very favourable on what they now have available and the support that that gives. A lot of it is on social interventions, not medication, but obviously medication is very important in physical health. Those staff are only band 4, which is very low. I would say that you do not need a psychiatrist, much as I love our psychiatrists, for everything. We do not have them, so it is looking at different functions rather than form, what we need and then putting that in place.

Dr Smith: It is important to say again that these are exemplars. The fundamental issue is that in mental healthcare we do not have standard, set waiting times and access standards. These are not across the country, and they should be. If they are not, it will mean that where you have places like Cambridgeshire and Peterborough, where people really, really care about this and they think about it properly, something will be done about people with severe mental illness. However, we cannot forget that unfortunately there is significant discrimination against people with severe mental illness. There is significant health inequality for people with severe mental illness, and they are very easily forgotten.

It should also be remembered that a significant proportion of people with severe mental illness are from minoritised ethnic communities who are doubly impacted, and they are much more likely to access services when in crisis, which means that people are much more likely to end up being detained. Having waiting time and access standards, in the same way that we do for physical healthcare, would not only introduce parity of esteem but would significantly help to improve and drive improvements in quality.

Q94 **Andrew George:** Do you mean national standards or targets?

Dr Smith: We should have national standards in the same way that we do for cancer care.

Dr Tiffin: NHS England is working on that. There is a four-week community mental health waiting time for meaningful intervention, so that is happening, in its defence. However, Lade makes the right point that everything is patchy at the moment. There are also standards that are being worked on for community mental health, which are must-dos for patients with more severe mental illness. Those are also coming, and it is then about implementation and delivery.

Dr Smith: We have known this for a long time, and we have needed this for a long time. There has been patchy implementation of the community mental health framework. It needs to be implemented properly; it works.

Q95 **Dr Beccy Cooper:** Thank you so much. I echo what you say. Having been in the healthcare business for 20 years, it is a very familiar conversation.

I want to go back to severe mental illness and physical health. You have outlined that there are severe discrepancies between physical health outcomes in this particular group of people and the general population. We also know that is true for other groups of people in our population. What do you think the specific barriers are for this particular group of people, and how might we start to overcome those barriers? I am sure you are doing work to address that already.

Dr Smith: First, I must say that people with severe mental illness, particularly people with schizophrenia and bipolar illness, die 15 to 20 years earlier than the general population. Suicide is very, very common,

but it is not the commonest cause of death. That is cardiovascular disease and respiratory disease. There is something about the illnesses themselves that increases the risk, we know that. There is certainly something about people's lifestyles. The medications that we give unfortunately impact in a negative way, and it compounds a problem that is already there.

However, one of the biggest problems is access to physical healthcare. There is the QOF that Emma spoke about. GPs are expected and incentivised to provide physical healthcare. There is a national audit of psychosis and that requires, particularly in early intervention services, the provision of physical healthcare. That national audit has been showing improvements over time, which is positive. It shows that if you are required to measure it, you will do it. When we are not required to measure it, people do not do it so well because we are all very, very, very busy.

One of our concerns is that in the recent planning guidance the expectations of providing physical healthcare have dropped off a little bit. They are not really in there, and it is a bit arbitrary. It depends on the ICB. That is a problem because we already know that if you have severe mental illness, you will not get access to care. If you have cancer and you have severe mental illness, you are 50% less likely to get treated for that cancer. That is simply discrimination. Therefore, we would argue and advocate for the most marginalised people in our society to get the best care. If we design care around the most marginalised group, everybody else will benefit.

Dr Tiffin: Lade is absolutely right. There was a target for physical health checks, and I used that in my ICB to haggle for additional funding. We set up a bespoke service for all patients on our QOF SMI register. I would love to do more, but at least they all get the annual review that you have heard about and a proper physical health check. That happens in conjunction with the GPs.

My biggest mantra is, "Don't just screen, intervene." Those staff have the capacity in their job plans to support patients to access stop-smoking services. They know which local authority services commission stop-smoking services, smoking cessation, weight management, all those things. They have that relationship. They go into CMHTs and deliver health checks for patients who do not engage, where it is tricky to engage. It needs to be a system approach, but you need to invest and have quite a specific resource.

My last comment is that parity of esteem is interesting, and we have Lade sitting here. We get cited for not thinking about mental health—not me because I always do—for the physical health lot, GPs and physical health consultants, but sometimes it is the other way around and our consultant staff or specialist mental health staff do not always think about physical health.

The stuff that Trish has worked on, putting a lifestyle medicine programme into in-patients and into the hospital, and bringing in what is wellbeing and those five pillars that the Royal College of Psychiatrists devised for lifestyle and what is important has been really, really good. We are starting to see a cultural shift in the specialist mental health settings, saying, "We can do blood pressure and weight management. We are nurses, and we did do that at one point." I am being facetious, but it is important that it is both ways and that there is a whole cultural approach to physical health.

It was interesting hearing what Eve said. We need to intervene early. It is cardiovascular disease that kills people, sadly, and two thirds of that is preventable. It is not good enough. We have done some physical health guidance in NHS England, but we need to look at levers to get people to engage with that and roll it out.

Dr Smith: Emma is right that, in mental healthcare, practitioners sometimes do not feel confident about physical healthcare, but there is a very good reason for that. A good 20 years ago, there was a thing called Project 2000. Steve will know about this. A decision was made that if you were to become a mental health nurse, you did not need general health training. Psychiatrists go to medical school, we become doctors, we train in all the other parts of medicine and then we specialise in psychiatry. The same was true for nurses. Nurses trained as general physical nurses and then specialised. A decision was made that that did not need to happen, so it meant that there was a generation of nurses who were not so confident in physical healthcare.

Psychologists do not do physical healthcare, and social workers do not know how to do physical healthcare. As there was an expectation that they do more, we are asking people to do more. But it is one thing to ask them to take someone's blood pressure, but if they have never been taught how to take blood pressure, why would they know how to do it? That is changing now, but it is not because people were simply being lazy or anything like that; it is because they had not been trained. We now recognise that that is a problem, but there is a significant issue everywhere for people with severe mental illness. My plea is to bring back physical health monitoring into our guidance, because if it is not there, it will not get done.

Dr Beccy Cooper: That is a very worthwhile plea. Steve, is there anything that you would like to add?

Steve Forsyth: Unless you are in RDaSH, because we will have 95% of people. I was in the class of Project 2000 in the late 1990s and had 18 months of physical health training. I remember Sister Black on D17 at New Cross Hospital. She taught me how to use a sphygmomanometer, and I was not allowed to leave the shift until she was content.

However, I went back to do my general nurse training for that very reason. Being a community psychiatric nurse, a CPN, what I was skilled

at doing was completing benefit forms, doing blood pressures, referring to the diabetes nurse and engaging with the African Caribbean Community Initiative in Wolverhampton, because I was the care navigator. It is the reverse. You get too many handoffs when people need a physical health check, because often if it is done in QOF and GPs. The person then has to go and present to the GP, negotiate a receptionist and explain that they need a physical health check. Often they will not continue past the person who holds all the keys to access the appointment at the GP surgery.

Again, there is some national deviation. In parts of Rotherham, Doncaster and South Humber, the GPs have allocated the QOF money to our services, so we provide that. In others they do not. We enhance and support the GPs in making sure that people get physical health checks.

Dr Beccy Cooper: You have outlined the issues well and succinctly. Going back to what Lade said, the outstanding stuff that you are doing is fantastic. It is just the lack of standardisation across the country, which we are hearing loud and clear. Thank you.

Q96 **Chair:** I have one final question for all of you. You have a 10-year plan coming up. What would you like in it? You can have an extra one if you want, because you have been very clear about the targets.

Dr Smith: I would like mental healthcare waiting times and access standards. There is a recognition that the system as it is currently designed will allow us to provide care to only about 50% of the people who we need to provide care for. Instead of there being vertical prioritisation of care—what do I mean by that? At the moment, with the elective backlog, the focus is on physical healthcare—hip operations and so on. That means that it would be quicker to get your bunion sorted than it will be to get your bipolar illness reviewed.

Therefore, we would prefer horizontal prioritisation of care. I know that would mean some difficult choices have to be made, but it should be about thresholds. We have lots of clinical expertise to help you make those decisions. Horizontal prioritisation of care instead of vertical prioritisation of care would mean that people with severe mental illness would hopefully finally get the proper care they require and need.

Dr Tiffin: I would like to see a focus on community mental health and primary care mental health particularly. I am a bit gutted that physical health is not in the planning guidance. We will go the inequalities route, but it is not quite the same. On our third sector, it is so difficult to shift funding pots around. That is one of the difficult bits. We have done well with the community framework, and it has improved, but we need to see more ability to shift funding streams because so much of what matters to our patients is stuff that we cannot do as medics or in health. That is what will have the biggest impact—housing and employment. There is great stuff going on with WorkWell and IPS. That is what I would like to see, an ability to shift funding around.

Steve Forsyth: As a nurse, I would like the staffing Act to become law, as it is in Wales. The other part that I want is Core20PLUS5 to be embedded across all organisations.

Chair: Thank you very much, all three of you.

Examination of Witnesses

Witnesses: Sir Norman Lamb, Samantha Allen and Jane Yeandle.

Q97 **Chair:** We definitely have a "last but not least" panel. For the benefit of the people watching, please could you introduce yourselves and what you do.

Samantha Allen: I am Sam Allen, chief executive of the North East and North Cumbria Integrated Care Board.

Jane Yeandle: I am Jane Yeandle, the service group director for mental health and learning disabilities at Somerset NHS Foundation Trust.

Sir Norman Lamb: Norman Lamb, chair of the South London and Maudsley. I worked in this place for a few years and was the Minister responsible for mental health for about two and a half years.

Chair: After that you were Chair of the Science and Technology Committee.

Sir Norman Lamb: I was, so this is a bit of an odd experience.

Chair: You are in a different spot, but it is lovely to have you with us.

Sir Norman Lamb: Do not be too cruel.

Q98 **Ben Coleman:** It is very good to see you all. I would like to start with some examples, and we have seen information and submissions of good work that is going on.

Sir Norman, can I talk about what is happening at the Maudsley with the pilot that you are running on the community hub model? I am interested in what is happening with involving local authorities as one of the partners. I warn you all that I will be asking about that, because we are talking very strongly and understandably about what needs to happen in the NHS, but it seems to me that there is a much wider requirement.

Sir Norman Lamb: Totally right, yes.

Ben Coleman: Would you talk a bit more about what is happening where you are?

Sir Norman Lamb: The starting point is why we are doing it. I went back and read the evidence of the people with lived experience in your first session, and I listened to the very powerful testimony this morning.

You cannot help but conclude that the system is not working effectively for very many people. There are some great stories of recovery and there are brilliant staff working across the system, but the design of the system does not deliver continuity of care and does not deliver the opportunity to build relationships with people. There thresholds are too high, so you cannot get in until you are very sick. We preach the principle of early intervention, but we deliver the very opposite.

Therefore, it feels to me like there is a case for fundamental change of the design of our care system, and we have started to work on developing those ideas. We also started to talk to NHS England, which came up with a plan to invite trusts around the country to trial new models of care. We were selected as one of six trusts doing that. We have learned a lot from Trieste in northern Italy. I was out there two weeks ago, and I have come to know a guy called Roberto Mezzina, who led the service for several years and has worked in it for two or three decades. He is a wonderful, inspiring man, and I would very much encourage you to explore that further.

Chair: The Committee is going to Trieste, and we will meet him.

Sir Norman Lamb: I had an indication that that might be happening, and I am delighted that you are doing it. I have been twice now. I went just before I started at the Maudsley, and I found it inspiring. It is a very different culture, where people build relationships; there is an open door. It is based around a community centre that is open seven days a week. That just does not happen routinely in community services in this country. They have long opening hours. They call it 24/7. In each of these community centres there are six or eight beds where people can go in a moment of crisis.

Q99 **Ben Coleman:** That sounds very interesting. I am looking forward to exploring that with my colleagues. Let's say we go to Trieste and come back hugely inspired. What are the barriers that we will face if we want to see it introduced here?

Sir Norman Lamb: One absolutely critical barrier is that we need to invest in the infrastructure of our community facilities. One of the things that you will see in Trieste—I went to Gorizia a fortnight ago, which is right on the Slovenian border. It is a beautiful place, the community centre. There is art on the walls from local people, not necessarily people with mental ill health, but it is the community space.

I think about our four boroughs in south-east London—Lambeth, Southwark, Lewisham and Croydon. There are no nice facilities for people with mental ill health in those communities to go to. There are rather dilapidated, locked offices. There are a few crisis cafés, but you cannot routinely go to a place in your neighbourhood between 8 am and 8 pm, which is my aspiration and what we will do in the trial in Lewisham. Therefore, we need to be able to somehow invest in new, smart community facilities.

Q100 **Ben Coleman:** How are we doing that in your part of the world? Where is the funding coming from?

Sir Norman Lamb: Funding does not facilitate it. We are lucky to have a relationship with the Maudsley Charity and are getting support from it, which we massively appreciate. However, one of the recommendations that I would encourage you to think about is to allow greater innovation in how these facilities are funded. It could be public-third sector collaborations, it could be public-private collaborations, providing we learn the lesson of PFI from the past. There is a recognition that there is a shortage of state money, so we have to find innovative ways of investing in community facilities. Then there is a close collaboration between statutory services and community organisations and, critically, general practice as well.

Q101 **Ben Coleman:** Thank you very much, that is very helpful. I will involve everyone in the questions, but that is a good and useful start.

Samantha, can I talk about what is going on in Cumbria and the ICS there? How have you worked with other partners outside the NHS, such as the voluntary sector, local authorities and social care, to get this integrated community-based support? Is there anything particularly challenging that you found in bringing everybody together, or anything particularly innovative that you have done that we should be aware of?

Samantha Allen: I have the immense privilege that our ICB includes Hartlepool, which is the example cited by the previous panel. We are the largest ICB in the country, and we cover 13 local authority areas. We work closely with all of our 13 local authorities, and we are coast to coast and cover the whole of the Scottish border right down to the north-east.

We have been very fortunate that, in the west of Cumbria, we have been able to have one of the five 24/7 mental health community neighbourhood models, which is very much built on the Trieste model, and I am sure you will come back very inspired. The work that our two mental health trusts have been doing, with a range of our community, voluntary sector and local authority partners, has been about a "no wrong door" approach and how we can destigmatise mental health services.

Norman's example of using assets in the community is a good one. In Hartlepool—and I would love you to come to Hartlepool as well as Trieste—we have the most amazing community asset, which is the library, right on the high street. These assets do exist, but it is the will, vision and opportunity of partners to come together to say, "We're going to give up the ground floor of our library, and that will be our community hub." When you come to Hartlepool and sit in the hub, you will not be able to tell if somebody is having an assessment with an exercise referral co-ordination service or with a specialist mental health worker. It is destigmatising, it is welcoming, it is open.

Of the clinical leadership there, I particularly want to mention Dr Ranjeet Shah, who has been instrumental in having a vision. Anybody who has worked in mental illness services, and I have worked in them myself for a number of years, will know that the services are not working. The models that we have just do not work. They are not rewarding places to work. We know the workforce has dipped over the last decade as well, and Darzi highlighted that in particular.

If we can have a model that enables people to get access to the help they need when they need it, and if they need more help—Eve's example this morning was really powerful, needing to see a specialist, needing to build up a therapeutic relationship and have continuity of care. In Hartlepool they found, as Lade mentioned, that they have reduced the number of referrals going through to the more specialist "getting help" part of the service from 40% to 2%. That means that the team can provide continuity of care.

Q102 **Ben Coleman:** That is very interesting. I would like to drill down on what is different in what has happened. Very often the specifics are interesting. For example, you mentioned the library. The library will be run by the local authority, I presume. You have come together, as the NHS and the local authority, and you are taking a whole-system approach. You are from an NHS background, I presume.

Samantha Allen: I am from an NHS background.

Ben Coleman: How do you find it? Did you say you have 13 local authorities? It is a huge area. How have you managed to work effectively and respectfully together, accepting that everybody is an equal partner in the game, or has that been difficult?

Samantha Allen: It is all about relationships. Rethink identified that as key. When you go out and talk to the community and voluntary sector, having them around the table in both the planning and the decision making has been critical. One of our community and voluntary sector leaders chairs our main committee on mental health and disability planning, which has been instrumental.

To go back to the Hartlepool example, what they decided to do when they got to the point of saying, "Our services are not working today, and we need to fundamentally redesign them," is they brought everybody together over a period of a week. Everybody came into the room together and co-produced the model of care. They have worked hard over the last few years, because this is also a part of the country that has sometimes been on the map for the wrong reasons in terms of quality of care issues, but the trust has worked incredibly hard through building trust in an open and transparent way and saying, "We need to redesign these services together. We are not doing to people; we are doing with people."

They have also shifted resource out into general practice. Mental health pharmacists are a good example of that. Giving up some of the resource

that people were trying to access but could not always access and getting it back into primary care, located in a way that can work alongside general practitioners.

Q103 **Ben Coleman:** That is very interesting. I know a bit of this, and they are extremely interesting. They have gone through some challenges over the years, but it is great to see that happening, and great to see the statue of Harold Wilson when you come up from the station.

Samantha Allen: Yes. The one thing that I wanted to mention that is different about our area is deprivation and the impact of poverty. When we think about the challenges on services—I know this inquiry is focused on adult services, where we are seeing at least a 3% increase in referrals year on year, but for children we are seeing a 12% increase. These are areas of high deprivation, inequality and poverty, and the distress that comes with that is significant.

Q104 **Ben Coleman:** The argument that you are making, and forgive me for putting words in your mouth, is for a universal service that focuses more strongly on certain groups where the greatest poverty or the greatest need is.

Samantha Allen: Absolutely, and equity and a recognition that there will be some parts of the country that need more resources, and not always health resources. In fact, mostly not health resources but other types of resources. Housing and education are key, and therefore the multiagency approach is absolutely instrumental.

Q105 **Ben Coleman:** That is very helpful. Jane, you obviously have experience of implementing the community mental health framework in Somerset. Somerset has come up for a lot of praise. Why do you think it is seen as such as successful example of implementing the framework? What is it that you have done?

Jane Yeandle: There are a number of things. I would say that a good deal of the success is down to the fact that, right from the outset, we have co-produced the model.

Q106 **Ben Coleman:** When you say "co-produced", what does that mean to you?

Jane Yeandle: What it means to me is where you have experts by experience working alongside experts by learning to design and improve services.

Q107 **Ben Coleman:** How did you get people to agree to co-produce and to listen to the people who they were working with?

Jane Yeandle: We do not always agree, which is quite healthy. We had experts by experience involved in our service improvement anyway. We have a pool of experts by experience, and we asked them if they would like to be involved in the community mental health transformation work.

They were there three or four days after we knew that we had to submit a bid.

Q108 **Ben Coleman:** Why did you do that, and why do you think other people do not?

Jane Yeandle: My sense is that people do. Not everyone, but co-production is something that lies at the core of many mental health services. You do that because if you design services around the needs of those who are using them, you will probably design a good service.

Co-production has been very important. The other thing that I would highlight is the partnership that we have had with the voluntary sector, with Rethink as the lead accountable body, with 18 voluntary sector organisations now working as part of that alliance. Why that is important is that it is creating a sustainable voluntary sector within Somerset.

It means that we are able to use local assets, because some of those voluntary sector organisations are ones that you would recognise, like Mind and Rethink, but some are very specific to Somerset. It is a big geographical county with terrible transport links, so we need those voluntary sector organisations that reside in those localities.

Q109 **Ben Coleman:** That is very helpful, and it is interesting that you mentioned Rethink. It has said that the Government and the NHS should commission a national evaluation of the community mental health framework. What do you think? Do you think yes to that? Do you think that commissioners have enough evidence and guidance to implement the framework effectively?

Jane Yeandle: The guidance was incredibly helpful in terms of principles, visions and values, but I agree with other panel members that it has not been universally applied and that there are various differences. Yes to a national evaluation. I agree with that. I like the fidelity model that is used within IPS, the employment support services, where it is not solely about numbers and waiting lists. While they are important, there is something about not what you do but also how you do it, so a fidelity model that looked at the what and the how would be really beneficial.

Sir Norman Lamb: I love what they are doing in Somerset, incidentally. This point about community organisations. In Lewisham there is a very significant black population. I want to pick up on what Lade Smith said, absolutely correctly. People are disadvantaged in those communities and there is a lack of trust in mental health services.

Therefore, for our trial it will be critical to work closely with black-led community organisations that have the trust of their communities. We have to be open to working as equal partners with them. Reaching into those communities that are poorly served by the mental health services, that are not accessing support early and that are then over-represented when it comes to detention under the Mental Health Act, which is an

unacceptable feature of the mental health system that has to be confronted, and I think that this is the way to do it.

Q110 **Ben Coleman:** I agree with you. I would say that because black people tend to get less access to health treatment generally—less treatment and equally less good outcomes—it makes them have less confidence in the system, and there is no surprise about that. The NHS fundamentally, I suggest, has to do some work in that area, and not just in the area of mental health.

Sir Norman Lamb: There is also a fear. When I talk to patients there is a fear that their son, particularly their son, might be locked up, and therefore a reticence sometimes to access support early. "Why would I go there?" I have heard it said. There is an additional anxiety about the use of coercion and the impact on black men in particular.

Q111 **Jen Craft:** You mentioned black communities. I understand as well that there are a number of learning-disabled adults detained in your trust, as well as across the country. Do you have measures in place to makes sure they are able to access community mental healthcare before they slip into crisis mode?

Sir Norman Lamb: This is all under something called the Transforming Care programme, which I established in 2012. The truth is that it has not got people out of institutions, as we had committed to doing in 2012. Our trust is the same as most trusts across the country in having people in in-patient care who should not be there. Thankfully, we now have a person, Faye Rice, who is totally committed to getting people out of institutional care and into the community. I recently linked her up with Mencap, which does brilliant work on this. The moral case for getting people with learning disabilities and autistic people out of institutional care is so powerful and it is a scandal that this persists, in my view.

Q112 **Joe Robertson:** I want to look at digital integration in data. I assume there is widespread acceptance that a lack of digital integration and a lack of interoperability between systems are a problem, especially for smaller organisations. How do we deal with that?

Jane Yeandle: I can come to that from a Somerset perspective. It took many years, but we now have an interoperable IT system with our voluntary sector partners and with our GP colleagues. It is Dialogue Plus, so all partners are able to access, see and edit Dialogue Plus, which is the care plan.

We were in the process of celebrating and patting ourselves on the back on how well we had done in realising that. While it is a fantastic clinical tool, it is not a reporting tool, so we are not able to use it to report the incredibly valuable contribution that our voluntary sector makes to waiting times, activity and contact rates. It is a great care plan for a service user to have, which combines all the different elements of their care, whether that is provided by the NHS or by the voluntary sector, but it is not a great reporting tool.

Q113 **Joe Robertson:** How do you do the reporting?

Jane Yeandle: At the moment we are doing it by hand. Obviously, the NHS mental health dataset is automated, but the voluntary sector is doing that pretty much by hand.

Q114 **Joe Robertson:** It seems to be a major issue. When we had Penny Dash here last week or the week before, as the candidate for chair of NHS England, she acknowledged that it was a major problem and was not quite sure how to tackle it. These databases are commissioned lower down, aren't they? They are commissioned on a local basis.

Jane Yeandle: One of the things that the voluntary sector has said is that if we do not count it, it will not count. They have a real anxiety, because a good deal of their work is not being evaluated and counted, that they will lose funding.

Q115 **Joe Robertson:** Is this not part of the problem of why there isn't continuity of care and people have to have the same conversations every time they move on, because the systems are not talking to each other and are not passing those notes along?

Samantha Allen: This is a real issue. Having gone out and visited services and talked to colleagues working in them, this is definitely one of the top three issues that they are grappling with. Listening to Eve this morning and the other testimonies that have been given to you in evidence, continually having to repeat one's history is not a good experience and is not an efficient use of time either, if we look at productivity across the service.

We have started to crack this in some pathways of care. Maternity is a good example. In our ICB, we now have full coverage of BadgerNet, so if you are going through the maternity pathway there is a single, digital record. There are still issues on digital inclusion, particularly from a user perspective, that we have to work to overcome. Where this has worked, it requires dedicated resources and a real focus.

The other area where we still have some work to do is on sharing information and the governance related to that. Through partnerships, working in the best interests of patients and using their information, we try to prevent governance and bureaucracy getting in the way of that. However, if there was some clearer guidance or use cases for how patients' data would be used across a pathway where you have multiple interfaces across different providers, that would be helpful.

Sir Norman Lamb: I want to mention something that doctors at the Maudsley, and the Institute of Psychiatry, Psychology and Neuroscience have developed. They call it LUCI. I cannot remember what it stands for. We can provide more information if you want, but it allows you to analyse your whole patient population to understand where the hotspots of psychosis perhaps are across your boroughs so that you can then target your work more closely.

It allows individual clinicians to identify people who may be attending A&E more often and so might be at risk of falling into crisis. The combination of digital analysis with a more humane approach, that hopefully you will see in Trieste but is also present in places across our country, is the real answer.

When they presented to the board, I asked them what was the one thing that could make it more effective. They said being able to access information beyond the NHS, because the only data they have is NHS information, yet so much of what affects these people's lives—housing, employment, debt and so forth—lies beyond the NHS. Bringing data together could be a real game changer.

Q116 **Joe Robertson:** Thinking about not necessarily the interoperability of systems but the lack of data about mental health, as opposed to physical health, in our last session this was identified as a factor in the lack of parity. Do you see that we have a particular lack of data in mental health, compared with physical health, and how do we go about gathering that data?

Jane Yeandle: I can speak from the perspective of being an integrated provider. Somerset Foundation Trust is an acute provider to the acute community and mental health provision within Somerset. One of the things that I am aware of is how much data there is in acute physical healthcare, not just the amount of data but the quality of that data, and how poor the available data is in mental health. That is about holding us to account, as well as being able to monitor what is going on within our local population.

Sir Norman Lamb: We fatally neglect the physical health of people with significant mental ill health. I totally agree with Lade's point about the training of our nursing workforce. There is also a lack of rich data on the people within our organisations. There is almost 100% comorbidity among older people with mental ill health, but even for people of working age the percentage with comorbid mental and physical ill health is very high, and yet we are not providing holistic care.

Samantha Allen: I have a slightly different view, which is that I think we are awash with data. There is a huge amount of data out there. I can look at our population. We have just developed our clinical conditions strategy, where we can drill right down in the GP record and look at the diagnosis. It is the quality of the data, and it is also the extent to which there is the analytical capacity and capability to focus on it.

Where we have inherent bias in the system, that inherently places a bias on the physical health side. We have teams of clinical coders, we have a payment by results approach, and your data quality is going to be slightly better than it is when you are looking at mental health conditions, looking at prevalence and understanding what is going on in services.

What has been drawn out by some of the lived experience examples is that if you are going on a pathway to hospital to have an ankle operation, a foot operation, a knee operation or you are going in for cancer care, you could have different pathways for different tumours. We do not have that level of sophistication in the treatment pathways that we are commissioning and are available at the moment, because quite simply there is a gap between the treatment that is needed and the resources available to support it.

Q117 **Josh Fenton-Glynn:** I will move on a bit to the funding models and the way we are looking at funding now, because one of the things that came out in the Darzi report is that, in community mental health, we are 86% lower—if I remember correctly—than the OECD average. What do you think the ideal model, the good model, of funding NHS services looks like? I will start with Samantha, with your ICB hat on.

Samantha Allen: I would start with the point that I made earlier, which is that funding allocations need to be fair. They need to be based on the need that exists within the population. I am not a funding expert, but there are a number of ways that you can look at that. You can look at the size of the population, you can look at the age, the demographics and then the socioeconomic need that sits within the population.

As I set out earlier, the population that my ICB serves has a high level of health inequalities, high levels of poverty and socioeconomic need. Therefore, my view would be that a fair funding allocation should be one that supports that population fairly. At the moment it does not. We are stuck in what we call a quadruple whammy where our population, sadly, lives a shorter period and lives longer years of life in poor-quality health. Because the funding formulas at the moment favour an ageing, growing population, which we are not, that is not fair. Therefore, the premise of funding allocation is that it needs to be fair. While we can have outstanding healthcare services, the true left shift needs to address some of the wider determinants.

Some people may say that they do not understand what housing has to do with healthcare. When two thirds of children are living in poverty, they have high respiratory needs, and they are of course going to be most regular attenders at A&E. Good-quality housing is one way of addressing that. I could go on.

Chair: A former iteration of this Committee did a report on exactly that.

Josh Fenton-Glynn: There is a big section in the Darzi report on the social determinants of health, and that is a debate we need to have.

Sir Norman Lamb: Before the session we talked about multi-year settlements. At the moment, these single-year settlements are disastrous. It makes it impossible to plan anything, so that is important. I totally agree with addressing the social determinants of health. So much of it relates to the work of local authorities. We quite often have problems

discharging people because there is a lack of resourcing of good-quality supported housing, for example.

Q118 **Josh Fenton-Glynn:** Can I push you a bit, Norman? If you had your time again and you had the chance to control the service back in 2012, how would you have a devolved it differently?

Sir Norman Lamb: Through the years from 2010 onwards, local government has been cut too much. I totally agree with that. There is always a temptation, whenever money is tight, to cut the preventative end of the spectrum. That is what we repeatedly do, yet it is the most stupid thing to do because it is the way to avoid people falling into ill health in the first place.

Q119 **Josh Fenton-Glynn:** Lade had some figures about the number of hospitalisations and A&E visits in the last session. She said 17% higher, but do not trust my stats. That is key to getting this right.

Sir Norman Lamb: I would also say, incidentally, developing much closer health and social care collaboration. We have not had integration between health and social care, and I would ultimately like to see a health and social care service in localities that are joined together with pooled funding.

Q120 **Josh Fenton-Glynn:** The next thing I want to follow up on is, with the ringfence of services going, is the investment standard the best way to fund community mental health? Or is there a better model that you would suggest?

Jane Yeandle: I think that the mental health investment standard has been a way of ringfencing, and it has been an effective way of protecting money for mental health services. I agree with my colleagues that we need to think about using that money across the system, and to think about the wider determinants and outcomes-based commissioning. I would want to make a plea for thinking about the application of funding in rural and coastal localities, where there can be particular challenges with local infrastructure.

Josh Fenton-Glynn: Being a recovering local government officer in a semi-rural area, I would strongly agree with that.

Q121 **Chair:** I will ask you the same question that I asked at the end of the last panel. We have the 10-year plan coming. What would you like to see in it as a top priority?

Samantha Allen: No silos and a true, joined-up integrated neighbourhood service.

Q122 **Chair:** Give me one more sentence under each of those headings. What do you mean by no silos?

Samantha Allen: See people as people and address their physical and mental healthcare together where you can, within an integrated team

that has access to the full range of specialisms that are required to do that.

Jane Yeandle: Hardwiring system leadership and having that as an approach to neighbourhood mental health. Waiting times need to be in there to make sure that we have the right parity of focus. I would also want to see the role of the voluntary sector and co-production recognised.

Q123 **Chair:** "Hardwiring system leadership", what exactly do you mean by that?

Jane Yeandle: I mean there being systems to support and almost force, although that is probably not the right word, the local authority to work alongside NHS primary care and the voluntary sector so that the design, implementation and delivery of services is done by the system.

Q124 **Chair:** What would that look like? What does that mean for the 10-year plan? What is central Government's role? "Force" is a word; let's use it. What should be in there to force the system to do that?

Jane Yeandle: Waiting time targets. That would be one way, because it is a symptom that things are not right. It means that, as a system, you have to look together at how you resolve that.

Chair: Thank you. That is very helpful.

Sir Norman Lamb: First, I mentioned the investment in community infrastructure. It is critical. There will be places where you can use existing community facilities, and other places where new facilities, bringing together local government, mental health and the third sector will be critical. And using innovation—not just relying on the Treasury, but innovative approaches.

Secondly, 24/7 support centred on community centres in the Trieste style. It brings together a lot of things where there is a clear evidence base. Lade talked about continuity of care, which simply does not exist in many cases under our current arrangement. That needs to be a central element so that you base it on building relationships with people and continuing care.

I would also make a plea for personal budgets for people with mental ill health. It has been developed brilliantly in local government, and it is a way of transferring power to people so that their priorities count. It is used in Trieste. They then use the money to invest in the third sector to provide support for people.

Q125 **Chair:** Does it work? Break that down a bit.

Sir Norman Lamb: A personal budget is agreed between the individual and the professional.

Chair: Then they buy services from the third sector?

Sir Norman Lamb: You will see that there is quite a culture of co-operatives in a locality, which then employ people. Employment is critical. It gives people a sense of self-worth and dignity. We know that they use services less when they are in employment, providing it is good employment. Those are the things that I would particularly focus on.

Q126 **Chair:** Thank you very much, Norman. You are retiring from your role at the end of the month.

Sir Norman Lamb: I am.

Chair: I would like to offer you a parting shot at the Government and the NHS. Having been a Minister, I don't know whether you are now a poacher or a gamekeeper, but can we have the benefit of your wisdom and experience? What would you say to them as they look to retransform these community health services? What do they need to focus on? What is your message to the Ministers?

Sir Norman Lamb: Yes, I have gone from talking the talk to trying to walk the walk, and it is a lot harder in the NHS to actually do it. First, do not lose the increased priority that has been given to mental health. I agree that the mental health investment standard has been an important way of protecting mental health. I would have some conditionality to it. I would say that it needs to be used to invest in the change to the sort of systems that we have been talking about today, rather than just going into a black hole that maintains a dysfunctional system, which is a real risk.

I would say grasp this opportunity. There is an increased interest around the country. You have heard examples of impressive approaches around the country—Somerset, the north-east, Cambridgeshire—and the trials of these new models of care. Within these we can see the emergence of a mental health system that is more humane, that is much more focused on preventing deterioration of health in the first place and that recognises that we have to confront the social causes of ill health, which we largely ignore at the moment.

We have to bring physical and mental health together. Somerset is the only integrated system, I think, in the country—an organisation that has both an acute hospital and a mental health system that talk to each other. There is still a long way to go, but this artificial separation of physical and mental health has been quite damaging. We are managing to fatally neglect the physical health of people with mental ill health, but we are also neglecting the psychological needs of people who have physical health problems as well. What an irrational way to behave, that we do not offer holistic care.

There is a lot of despair in the mental health system at the moment. Staff feel they are working in a system that is constantly under stress. Everything is full up; people are being sent out of area in the most appalling way. This is a disgrace, with people being sent to hospital beds

100 miles from home or whatever. It should be completely outlawed. Therefore, you have a sense of a system that is stressed and not working effectively. However, the exciting thing is that we can see that there is a route to a better approach that will be more effective at keeping people well, that will avoid people falling into crisis and, ultimately, that will be more financially sustainable.

Q127 **Chair:** Thank you very much. Eve, would you like to come on to the panel for one second? Having heard everything that you have heard today, do you have any more reflections?

Eve Mair: The reflection that I had—I went to the Labour party conference this year as well. There is so much well-meaning and so many people who know what the issue is and have the insight to be able to change it, but it feels like there is a blocker. I do not know what that blocker is. It is big picture, and all of these things interconnect, like the social and the cultural. There is a big problem here that feels like a rock that you want to chip away at. Everybody knows what it is, and everybody wants it to be fixed, but it is not yet being fixed. That is what my thinking is.

Sir Norman Lamb: I agree.

Chair: Thank you very much. That is what we are trying to do. Thank you very much to the panel. That was very illuminating.