

Health and Social Care Committee

Oral evidence: Community Mental Health Services, HC 566

Wednesday 23 April 2025

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Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Josh Fenton-Glynn; Gregory Stafford.

Questions 128-181

Witnesses

[I](#): Christina Taylor, expert by experience; and Christian Taylor, expert by experience.

[II](#): Peter Devlin, Co-Chair of Association of Directors of Adult Social Services Mental Health Network and Director of Adult Social Care and Mental Health, Essex County Council; Councillor Lorraine Francis, Chair of the Adult Social Care Committee, Bristol City Council.

[III](#): Penny East, External Relations Director, Think Ahead; Stephen Parker, National Head of Service for Mental Health, Turning Point; and Duncan Tree, Director of Strategy and Relationships, Association of Mental Health Providers.

Examination of witnesses

Witnesses: Christina Taylor and Christian Taylor.

Chair: Welcome to the Health and Social Care Committee and the third session of our community mental health services inquiry. Today we will have three panels, the first of which is experts by experience Christina and Christian Taylor. Thank you to them for being with us. We may hear some very emotional and distressing testimony, but we are grateful to them for providing it and giving context to what we will hear later. In our second panel we will hear from local authorities and in the third we will hear from the third sector.

Q128 **Danny Beales:** Thank you so much, Christina and Christian. Hopefully I will get you the right way around at all times, but if I do not, please do correct me. It is lovely to be joined by you both online. Thank you for joining us and agreeing to share your personal experience today. I am sure the team have already talked to you about this, but when people share lived experience we really appreciate that it is their lives—it is not an academic exercise—and that it can be emotional or difficult at times. If you ever need to take a break or a moment out, that is absolutely fine. There really are no wrong or right answers: it is your experience, so as much or as little as you want to share about any or all of my questions is very welcome. It is great to be joined by you today.

First, I am going to ask some open questions. Christina, could you take a few minutes to tell us about your experience, and particularly your experience of trying to access community mental health services?

Christina Taylor: Thank you for inviting me today. It is a real privilege to be able to speak to you all.

I was diagnosed with anorexia when I was 13. The treatment I received in child and adolescent mental health services was really good. It was ongoing between the ages of 13 and 18. The real challenges in my care arose when I was discharged from child and adolescent mental health services into adult services, which were basically zero. Once I turned 18, I sort of wasn't anyone's problem.

I went to university. I had not really got any coping strategies for being at university, so I had a pretty immediate relapse. I started drinking excessively, which I had been doing on and off for a little while before that, and abusing laxatives. At university, I would take up to 90 laxatives a day, and I would make myself sick around 10, 15 or possibly more times a day. I still had anorexia—atypical anorexia—and my purging behaviours really increased.

I was very fortunate in Leeds to receive really good care. Around the time that I was 21, a week after my final exams, I had been seeing a doctor and he insisted that I needed to go into in-patient treatment. I was very much of the idea that my BMI was not critical. I had been told previously



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that when I got to a certain weight it was a really bad thing. But because of the purging behaviours that I was exhibiting, he convinced me that I needed to go into an in-patient facility, which I was in for around four months.

I do not believe now that, if I was at the weight I was at then, I would have been admitted into services today. I believe the demand is so much significantly higher. My BMI was around 14 or 15—something like that—but I think my BMI would need to have been lower, because the services are under so much greater demand now, and I would need to be more critical.

The whole time that I was in in-patient treatment, I did not feel that I needed to be there. I felt that I was bigger than other people and it wasn't really necessary. Obviously, retrospectively, being aware of how unwell I was, I know that I did need to be there, but I felt that I could leave any time I wanted. During that time, nurses told me that if I did not eat, they would kick me out, and the place would be given to a more deserving patient.

The areas that I really want to talk about—the real failings in my care—came when I was discharged from in-patient treatment. Within about three months I had a relapse and tried to take my own life. They had discharged me, I was eating, and I was of a body weight that was fine, so I was not really getting much care around my eating disorder. It continued to worsen and I moved back home to Norwich, where I live now.

Moving back home to Norwich was the critical flaw really, because I went between health services. The services I had had in Leeds were good. West Yorkshire had really kept an eye on me. They were not able to do much, but they had made sure that I did not really drop off. When I came back to Norwich, I was very aware that another relapse was very quickly taking over.

I went to my doctors, I wrote to community eating disorder services, and I said, "I'm less than a year out of in-patient treatment. I really need some help." I received a letter from them saying that, unfortunately, my BMI was 21, therefore I did not meet their diagnosis criteria and they would be unable to help me. The result of that was that I lost a significant amount of weight and tried to take my own life again.

I was then only able to access paid care. My parents supported me with paid care. I was around 22 at this time. I could not have done that myself. I did not have a job. My parents paid for me to go to therapy for around 18 months. I continued that therapy when I met my husband Christian, who has joined me today, and he attended. We found that I had to travel quite a long way for the therapy—about an hour each way—and I had to pay every time I went. We were on very low wages at the time and we did not have a car, so my dad had to drive me to therapy. Nowhere in Norfolk could help me—I had to drive to Suffolk for help.



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The real problem in my care that I want to talk about today was during my pregnancy. I was told throughout my eating disorder that I would find it very difficult to get pregnant, so it was a huge surprise to me and my husband when I discovered I was pregnant when I was 26, and I was on the pill—probably because my eating disorder made the pill not absorb very well.

I really never expected to be pregnant, I was thrilled to be pregnant, and I wanted to have a healthy pregnancy. I told my midwife that I had a long history of eating disorders and I really needed support. I did not know how to gain weight—I only knew how to lose it—and I wanted to have a healthy baby. My midwife did not really know what to do with it, because “Pregnant women don’t get eating disorders”—that’s what they felt. She said, “Oh, don’t worry.” I was discharged by that midwife because we moved house.

I continued to make myself sick throughout my pregnancy and I really wanted help. I really wanted my baby. I was very, very worried about it. I went to see my doctor and said, “Please, please help me. Please refer me to a dietician. I need help. I can’t stop making myself sick. I’m so frightened that my baby is going to die and that I’m going to get ill.” My doctor looked me dead in the face and laughed at me, and said, “Well, don’t worry, if you don’t eat enough, your baby will eat you.”

I received no help. I was 16 weeks pregnant at this time. I received no help until, at about 32 or 33 weeks pregnant, I had a fall. My midwife lifted up my top to examine me and said, “I can count your ribs. What on earth is wrong? Are you okay?” And I said, “Well, no. I’ve been asking for help for weeks and weeks and weeks. Every appointment I’ve been to, I’ve said I need help, and no one’s helped me.” I was immediately referred to community eating disorder services. I had a great therapist and they took care of me until my daughter was born.

My daughter was born healthy. She is now 13 and she is wonderful. I am so proud that she wasn’t affected by my illness. I was affected by my illness: I weighed about six stone four after I gave birth. I was very unwell.

I went back to community eating disorder services—sorry, this is very long—and was seen by them for the next year and a half, until I was pregnant with my son. I expressed real concerns over the failings in my care with my previous pregnancy and how unwell I was. I had started to gain weight in a more healthy way, but I found that they were not equipped to deal with my illness during pregnancy. Every time I got on the scales I cried, because I was gaining weight, which was my biggest fear, and eventually they said, “I don’t think we can really help you. Why don’t you come back after you’ve had your baby?”

So my treatment fell to the care of my midwife, who referred me to a specialist obstetrician who had an interest in women with eating disorders. I do not believe that my son would have been born healthy—or even at all—if I had not received care from these two individuals. They went above



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and beyond their jobs. They saw me every two weeks. They were wonderful, and I really want to use this opportunity to say how incredibly valuable they were and how much I appreciated their care.

Post pregnancy, I was bounced around services. I got stuck in-between them. Every time I tried to access any kind of help I was told, "You've got an eating disorder. You need to be treated by eating disorder services." When it was post-natal depression, they said, "You're too complicated. We can't deal with you." So I spent around a year just trying to access help for anything. Whenever I went back to eating disorder services, they said that I wasn't ill enough for them to help me, and when I went to any kind of mental health services, they said that I had an eating disorder and so they could not help me.

I was fortunate to be referred to Eating Matters, which is a charity in Norwich. I had to pay for my care, but I found a therapist there who was really helpful. I spent around a year with them and it was transformative, and I was able to recover from my eating disorder at the age of 30. I would also like to use this opportunity to recognise how important Eating Matters is, and the services of Beat. I had to pay for the service, but without them, I probably would still be very unwell at the age of 40.

I hope that is a bit of a summary. I know it was quite long—I apologise.

Q129 Danny Beales: No—thank you so much, Christina. There is so much there to unpack. You mentioned that you now have support from the voluntary and community sector, and you are also a volunteer for the national charity Beat. In your work and the connections you have made with the voluntary sector, how much do you see the experience you have had reflected in the experience of others you have met or seen through those voluntary services? Is your experience quite common?

Christina Taylor: Yes, it is extremely common. As I alluded to previously, I think it is much harder for people to access care. Particularly in the last 10 years, I have seen a really dramatic increase in eating disorder cases when I am speaking to organisations—I particularly speak to corporate organisations but I also train medical students. It is great that because of the increased awareness around eating disorders, more people are recognising the symptoms and getting help. However, they are not getting help: they are coming forward and saying, "What's happening?"

I have heard horrendous stories. I have a very close friend who requested help a number of times and was told that as he was a man, they did not really know how to help him. He now has a stoma and he is permanently disabled and unable to work, in his late 20s, owing to failings in his eating disorder care.

Almost everyone I have come across who has an eating disorder is also diagnosed with a neurodivergent condition. I have ADHD and was diagnosed later in life. Those links seem to be missed. There is a large number of people self-medicating—people who have ADHD with an eating disorder, and particularly autism with avoidant/restrictive intake feeding



disorder. There seem to be huge links with those conditions that are perhaps being missed by neurodiversity pathways and care teams.

Obviously, these people are languishing on both eating disorder waiting lists and neurodiversity waiting lists. My son is currently on one that is around six years long, so I know the kind of waits that people are facing. I have heard stories from carers of people waiting a year or two years for treatment when they are watching their children die in front of their eyes, and being told that they are responsible for keeping their children alive.

One of the biggest concerns during my pregnancy was that I would have a relapse and be sent away to an in-patient facility, away from my family and my young children, so I overcompensated during my pregnancy to make sure that I would not relapse when I had them. I think a huge part of my effective recovery was the support of my husband, and being able to be with him. I think Beat mentioned in their reports how important it is to have a strong infrastructure and be around family and loved ones. I would particularly like to outline—I'm sure my husband will also say this—that the set-up for recovery is only really targeted around the family when we are talking about parents; I think there is a failing when it comes to partners.

I work with a young lady who lost her mother. She was a young carer from when she was in her teens, and there was nobody like her. Her story has been featured in the awareness campaign this year. For anyone who does not fit the mould of a young girl with an eating disorder, there are definitely some challenges around that. Even in the reporting on this, you always see mention of force-fed young girls, but it is not just young girls: a quarter of eating disorder patients are male. I think that really does restrict people's access to care. If you are over 18, you are not seen in the same way.

There is also ethnicity—there are so many factors that restrict people's access to care. I certainly would not have recovered if I did not have the financial support of my parents, so I do not know how anybody who did not have access to additional support and funding would recover, given the way that services are and have been in the time that I have been unwell.

Q130 Danny Beales: Thank you so much. You have talked about interacting with quite a lot of services at different points—with your midwives, doctor and obstetrician; with lots of parts of the health system—but still struggling to get heard and to get access and referrals to adequate services and support. Do you feel that a common theme in your interactions was low understanding of your experience and the condition you had? Do you feel that anyone had adequate training, knowledge or awareness of the issues you faced?

Christina Taylor: I certainly do not think my doctor had adequate training. One part of my role as an ambassador is training medical students, and one thing that I have observed while training them is that they are very frightened of eating disorders, because they are very



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complex and there is not really an easy solution to them. I think that is reflected in a lot of health professionals. One treatment does not cure in the way that it does for a lot of other conditions. If you've got a broken leg, a cast will fix it; if you've got an eating disorder, something you have tried with one person will not work on the next person.

With eating disorders, we lie a lot. I had to restore trust with my husband enormously throughout our marriage, because I lied so much about my eating disorder, so it is very difficult for health professionals to trust that you are telling them the truth. I think there is a lack of confidence about dealing with eating disorders because eating disorder patients are so deceptive and complex. I have campaigned for GPs to receive more training, and I am so grateful that they have done that. I contributed to that campaign particularly because of the failings in my care.

Again, if I was a 14-year-old girl and I was anorexic, I think there is an easier pathway for people to follow. The treatment that I received in my teens, in the '90s, was perfect and by the book—everything was done really well—but as soon as I started to fall outside of the stereotypical category of someone with an eating disorder, people did not really know what to do with me. The issue of confidence possibly contributed to their lack of understanding or support when I was trying to access support.

Also, things just were not joined up. The services were not talking to each other. When I would say to one that I was not getting treatment from another, they would look confused and act like they were not aware of what was going on. As a user, you think that the NHS is one service, even though it is not. You need help, but you do not know how to speak to all the different parts. You expect them to do that for you.

When I asked my doctor for help, it was the first time I had asked for help in 13 years, and it was almost the last, to be honest, because of his reaction. I really want this Committee to know how difficult it is for someone with an eating disorder to say, "I need help." Your self-confidence and your belief that you deserve help and deserve to recover is so low. Getting a negative response to that first request for help—it was so critical. You lose people if you tell them they are not worthy of help.

Q131 Danny Beales: Christian, we have heard from Christina how central you were to her support system. Could you talk about your experience as the partner of someone dealing with these issues, and about your view of the journey Christina has taken and how that has affected your experience as a husband and supporter?

Christian Taylor: Yes, of course. As you will appreciate, I am probably going to echo quite a lot of what Christina said. Christina and I have been together since our early 20s, so my experience of her accessing services started when she was pregnant with our daughter—our first child. Supporting Christina during this time, both during and after pregnancy, was a real challenge that with hindsight, as a 23-year-old at the time, I was ill-equipped for. Seeing the partner who you love and care for really struggle during an already stressful phase in life was very difficult, and



that is why we were pretty desperate to receive mental health support at the time.

Preparing for the Committee and looking back—it was quite some time ago; I’m definitely not 23 any more—I mostly recall Christina getting herself through it. Once she discovered she was pregnant she forced herself through a number of immediate lifestyle changes for the benefit of our first, at the time, unborn child. She sought the support and chased it up when it was lacking, as she attested to. She was basically the strongest person I have ever seen, during a time that must have been terrifying for her. Pregnancy for someone suffering from an eating disorder is not an ideal scenario. She persevered through it all, and I am very grateful that we have got two very healthy, lovely children now.

To go back to the point about her journey of accessing mental health services and support, as she attested, she reached out directly to health services for support on a number of occasions, during and after pregnancies. The experience from my perspective—again, Christina has already covered this—is that the overriding feeling was during those periods the health system either did not have the local infrastructure to ensure that she was referred to the correct resource, or did not have the support available to help a pregnant person with an eating disorder. On the first point, regarding local infrastructure, Christina was passed between different NHS support areas due to being pregnant or post-natal—she sought support after pregnancies as well as suffering from an eating disorder. A significant amount of time was spent waiting for referrals and then receiving letters stating that one area had assessed her criteria and subsequently deferred her to another area, like the examples Christina gave earlier. She was passed from pillar to post, essentially.

Regarding the support itself, once support was confirmed and taking place, the level of quality varied greatly from practitioner to practitioner. The GP who Christina already mentioned was pretty flippant, and there was a dietician who was about 25 miles out to get to—we did not have a car at the time—who just listed a series of foods that Christina could try a little of and see. In fairness, I think some of that was probably caused by the issue of local infrastructure. The services did not know where to place Christina, and therefore sometimes felt that any support was better—it was not necessarily all a good fit.

I apologise: I rattled through that quite quickly, but I am conscious that a lot of it has been covered by Christina. Those health services did not know where to place Christina so that she could get the required support, and whether that support, which felt niche at the time but in reality is not, was available or not. It was a pretty scary time for the both of us.

Q132 Danny Beales: Christina mentioned how vital family and you were to her. People exist within families and support networks, and they can be crucial to their health, physically and mentally. Did you feel as a partner that you were just observing Christina through that process? Did you feel unable to influence it or were you included in those discussions when Christina had appointments or access to some services, for good or bad? Did you go



along, what was your role in it, and how involved or not did the system make you feel?

Christian Taylor: I was there at almost all of them. I would say for support and practical reasons, to be honest, at the time. I could borrow my Mum's car; I was the only one who had a driving licence. Going back to what I said, there was a varying degree of involvement, from practitioner to practitioner. For some of it, I was essentially just in the room and the focus was primarily on Christina. Maybe those examples, such as the dietitian at the time and the GP, was more because the support was not necessarily what Christina required.

With some others, there was more involvement. For example, I cannot find a better way to articulate it, but homework, essentially, would be set. Christina would be set challenges to help her and support her through. Therefore, I would be involved, in the sense that I would essentially have to ensure that we covered that challenge, so that by the time we came back to the next appointment, we could say that we followed through. Christina, do interject if you feel I am misremembering. Overall, I think the focus was primarily between the practitioner and Christina. I was not widely involved in all the support services that were given.

Q133 **Danny Beales:** Thank you. My time for questions is coming to an end, unfortunately. I could talk to you both all day, because it is incredibly valuable for the Committee to hear your experience. Reflecting on the report we are going to write, which will recommend changes for the Government and the NHS to make, I would love you both to think of one or maybe two things that you think should be included in our report for the NHS and Government to change, to remedy the experience you have had—an experience that, as you said Christina, many other people are having at the moment. I will come to each of you in turn. Whoever is ready first can go, and then I will come to the next person. Tell me one or two things you would like to see changed.

Christina Taylor: I would like to see more comprehensive support offered to carers, and a rethinking of what it looks like to be a carer. My husband alluded to his being 23. The support offered was that he could go to a carers' group and that carers' group was full of parents who were instructionally telling their children what to do; they had a very different relationship supporting the people in their care from that of a husband and wife.

My husband did not have anyone to talk to during my illness. He was watching me almost starve myself to death while pregnant with his child, and he did not have a single person to talk to. Because he wanted to protect my privacy, he did not want to discuss it with people close to us. He did not have an outlet for that, and he carried that with him for years.

People don't really look at the fact that eating disorders do not have a type or a particular look, and the people who support them are in exactly the same mould. They get missed in the people who are not teenage girls. I would ask services really to look at the diversity of the people who are

suffering from this illness and the people who care for them, making sure the service is fit for purpose for supporting them. If my husband had had better support, he would have been in such a better place to help me. Both of us would have found a really frightening time a lot easier to navigate.

Q134 **Danny Beales:** Thank you, Christina. Christian, what are the one or two things you would like to see us recommend for change?

Christian Taylor: Piggybacking on what Christina just said, in terms of support for loved ones and partners, at the time, when you are there as a husband and partner to support someone who is in need of mental health help, you do not really think about support for yourself. Hence, the reason why I did not bring it up myself at the time, earlier on in the session. That would certainly be something I would be keen to see included in the report.

Going back to my previous points, I guess the other thing would be changes regarding the referral routes and process. Ideally, Christina's experience when seeking mental health support, during and after both pregnancies, would have been much more efficient, and we would therefore have secured appropriate local support a lot sooner. That local infrastructure and processing would be one change I would like to see.

Danny Beales: Fantastic. Thank you so much, Christina and Christian, for your time and for sharing your experience with us. It has been incredibly valuable.

Chair: Thank you.

Examination of witnesses

Witnesses: Peter Devlin and Councillor Lorraine Francis.

Q135 **Chair:** Welcome to our second panel, which involves representatives of local authorities. Would you mind, for the sake of those watching at home, telling us who you are and what you do?

Peter Devlin: I am Peter Devlin, and I am here on behalf of the Association of Directors of Adult Social Services. Thank you very much for the invitation. I have a substantive role with Essex County Council as a director for adult social care responsible for mental health, and I also continue to work as an approved mental health professional a couple of times a month in Essex County Council.

Cllr Lorraine Francis: Thank you so much for inviting us. My name is Lorraine Francis, and I am representing the great city of Bristol. I am the lead member for adult social care, so I chair the adult social care committee that we run in Bristol. Like Peter, I qualified as a social worker many decades ago and only recently stopped working as a social worker in an integrated team within one of the local authorities. I come with a range of experiences, not only as a social worker—qualified and still practising—but also as a councillor, so I feel that I have a community perspective on

this. I am also a person who is from a global majority background, so I come with that wealth of knowledge around being from a different culture to others and understanding the journey that people experience. I am hoping we will get the opportunity to explore that.

Chair: Thank you very much.

Q136 **Ben Coleman:** It is very good to have you both here this morning. Thank you so much for coming. I want to look at the relationship between the community mental health framework and what local authorities do. The community mental health framework has lots of ambitions for integrated—that famous NHS word—and person-centred care, but how can local authorities best support the process of making that happen?

Peter Devlin: Local authorities have a substantial and long-standing role. The extent to which local authorities are involved across the country does vary at the moment. I would probably start by saying, from an association point of view, that we see mental health, and our responsibilities to mental health and mental wellbeing, as being a societal consideration before a health consideration. I would take you to the population health analytics, which clearly indicate that a substantial 80% of good years of life, and length of life, is related to wider social determinants.

Chair: We are going to come back to that in much more detail later.

Peter Devlin: Yes. Some 20% is related to specialist health. I appreciate that that is a generalisation. We have to hold on to the fact that there are individuals who are more substantially affected, on a longer-term basis, by their mental health needs, and we therefore need to understand the inequalities and the issues that they experience and ensure that there is provision for them. But for a large amount of individuals we over-rely on a medicalisation and pathologisation of illness.

Ben Coleman: Which is why I was particularly talking about the role of local authorities. It would be interesting if you wanted to focus on that.

Peter Devlin: Local authorities have a civic responsibility first and foremost. When we talk about the social determinants of health, most of them relate to local authority duties in one way or another. When we talk about prevention and public health initiatives, again, local authorities are the lead in that space. When we move on to the commissioning of non-NHS community care, local authorities tend to have established and trusted relationships with the community, voluntary care sector and faith enterprises, so they are in the fabric of our communities.

On the mental health transformation, the funding flows and the targets that have been set have been very diagnostic-specific, so we have had a focus on understanding people as patients and on symptoms, rather than on understanding people as people with needs and focusing more on the need rather than on the need to silo diagnostic pathways in the first instance.

Q137 **Ben Coleman:** Thank you; that is very helpful. Lorraine, do you agree



with that?

Cllr Lorraine Francis: Yes. One of the things the community mental health framework was supposed to do was reduce the barriers between physical and mental health. It was about integration, working together and prevention, to ensure that we are person-centred. We want to be able to be person-centred, which in real life—in real terms—means huge resources, a huge amount of staffing and a huge amount of time, because person-centred means working with you on your journey. The previous witness, in her specific area, needed at least six teams around her in order for her needs to be met. That is a person-centred approach. But without the resources to back that up, we are running up the hill backwards. That is one of our real challenges.

In Bristol, one of our teams—the MINT team—is working in partnership with the ICB, for example. We have social workers, as part of those teams, working around service users to try to ensure that their needs are met from a social perspective and from a health perspective, because that is the whole process of working together with the ICB. We are trying to problem-solve earlier to prevent the revolving door of services, but that is incredibly hard when we talk about mental health, because mental health is not an entity for which you can just do a tick box and resolve it: it is ongoing and always changing.

Q138 **Ben Coleman:** Absolutely. You are trying to bring everybody together. I appreciate the desire, certainly from Peter, not to take a diagnostic approach, but we none the less do need to work closely with the NHS. What difference do you think the 50% cut in funding for ICBs will make to what you are trying to do?

Cllr Lorraine Francis: If that is what is now going to happen, and we are going to have a 50:50 pooling of our budgets—you will know, because we have given evidence here before, that is not currently the case in Bristol; it is 70:30, or thereabouts—and if we were to have a more pooled budget, with a split, we would save a lot more money from our social care budget. That will then help us to do more preventive work. Our section 117 funding, as you know, is in crisis at the moment, because we are funding it much more than the ICB is. I wonder whether the challenges with the upcoming changes will affect that as well.

Ben Coleman: That is what I was wondering. Peter, maybe you have a view on that as well.

Peter Devlin: The obvious thing is our retrenchment on prevention and community provision, with the resource being focused on those with critical needs. The position that we are in could be entirely against the NHS 10-year plan if we are not careful. That is a big consideration for us. This obviously comes at a time when we have the Mental Health Bill and legislative reform going through as well. We are hoping to see more people outside of hospital, in community provision. The direct cuts to the NHS could mean that what we would consider to be the preventive side of things—the softer interventions earlier on—could be scaled back further.



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I think we already see the challenges in public funding between local authorities play out in relation to section 117 responsibilities—I am sure the Committee has heard that—and the lack of clarity around that in CHC. The more that the financial constraints hit public services, the greater the risk that we have cross-boundary disputes over finances, which get in the way of the provision of good-quality integrated care.

Q139 Ben Coleman: When it comes to the ICS and ICB, do you feel that you are equal partners with the NHS, or do you feel that they run the show and let you in a little bit? I suppose I am asking for Bristol's particular experience, which sounds different, as well as about what you, Peter, think the general feeling across the country would be.

Peter Devlin: There is a big cultural bit in local systems that relates to the relationship with the ICB. In north Essex, we have a very good relationship with our ICB; it feels like there is a genuine willingness to partner and, culturally, the environment is a healthy one. Overall, the majority of funding in mental health comes through NHS lines. As a consequence, local authorities have struggled to lean into that and to be equal partners in decision making, whether in terms of setting strategy, involving communities or delivering in such a way that it is a shared investment.

For example, most local authorities across the country have not seen a benefit in relation to funding flows as a consequence of the community mental health transformation and the SDF funds that came into the system. Thirty per cent of local authorities across the country have seen a financial flow into their services that has enabled them to commission greater community provision. Most of it has gone into specialist clinical interventions.

That goes back to my initial point: clinical interventions are absolutely required for some individuals with complex needs, and there is no doubt about that, but there is also a lot of support that can be provided by our community sector, with the right societal infrastructure in place—the community mental health teams you will hear from later, families and what have you—but that has an investment requirement.

Cllr Lorraine Francis: From a local authority perspective in Bristol, the relationship with the ICB has been relatively good. There has not been conflict with the ICB; the conflict has been around funding and not having a clear Government strategy or guidance around spend. That is what creates the tension between the ICB and local authorities. With the greatest of respect, I do not think my role is to knock what the ICB is trying to achieve; it is more to do with the funding. Its hands were tied just as much as ours. We ended up, as in social care, having to deal with the deficits: you cannot not let people have access to care, so you have to fund it. One of the outcomes of that is that it is social care that is predominantly funding it, but the relationship itself has been positive.

Q140 Chair: Let us pick up on that theme and talk about funding and joint commissioning. That is possible under section 75 of the National Health

Service Act 2006, but it does not always happen. What is your experience of joint commissioning, and where is the best practice in the country that we can look at?

Cllr Lorraine Francis: We have some examples, as I was alluding to with regard to the MINT team, where we jointly fund with the ICB to ensure that we have practitioners across—

Q141 Chair: How easy was that to do?

Cllr Lorraine Francis: It was something that needed to be done. I am not on the ground delivering that, but from what my colleagues tell me, that was incredibly important to achieve. We have a men's house in Bristol that caters for only 10 men. When we talk about complex cases—and I guess this is where our knowledge will come in—we are not just talking about the incredibly profound testimony we just heard from one service user around eating disorders. We are talking about psychosis, psychotic illnesses and non-psychotic illnesses. Within all those streams, you have varying degrees of complexity.

We also have the added factors that are driving some of these issues. We are talking about housing inequalities. We are talking about race inequalities. We are also talking about—this is quite important, and the previous witness spoke about it—the growth in the number of young people who are unfortunately experiencing challenges with their mental health and wellbeing. In about five years' time, our 14 and 15-year-olds will be in adult services if we do not weave in preventive services. Some of you will not be old enough to remember that, 20 years ago or so, we used to have counsellors in schools. They were pulled out, and now we are in a situation where we have critical levels of young people going online and—

Q142 Chair: We know that the Government have a plan to reintroduce some of this, although we have questions about the money allocated to achieve it.

Cllr Lorraine Francis: Absolutely. It is all about how we do that without funding.

Peter Devlin: I will go back to my first statement: mental health is a societal issue, so I would like to see the section 75s extend further.

Q143 Chair: And there is a consultation that has reported.

Peter Devlin: There is a consultation at the moment, which we are feeding into. I would like to see housing and education be part of the opportunities for section 75 pooling, because we need to make sure that there is accountability and ownership across the public sector as a whole. It is well established that the fabric of our societies has a direct relationship with the population's mental health. Unless we tackle some of those more systemic issues in the first place, we will not move the dial on that.

We also need to move away from trying to distinguish people by different categories and cohorts. That is not to detract at all from the need for specialist interventions where that is required, but we see so many people



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who have multiple diagnoses and are excluded from services. There is an inverted care system, almost: the more complex you are, the less likely you are to receive the right kind of care and treatment. That needs to flip. It needs to be about need, because there is so much that can be provided if we look through the lens of need first of all—understanding the person in their context, in their social systems and in their communities.

The individuals who are most affected and disadvantaged in terms of inequality, which results in premature death, premature ageing and disability, are those who are marginalised and excluded by society in all those domains. Until we start to think about reasonable adjustments in the education system and in all aspects as being something that is incumbent upon all ministerial portfolios, we run the risk of continuing to compound inequality.

Q144 **Chair:** Would you agree that the best place to do this is at local government level, not decrees by central Government?

Peter Devlin: Yes.

Chair: So is there an opportunity in the devolution agenda?

Peter Devlin: There is, definitely. There does need to be a paradigm shift, though. The platform is burning for mental health.

Q145 **Chair:** That is a very strong set of words you just used: “The platform is burning for mental health.” What do you mean by that?

Peter Devlin: I suppose what I see in acute care is an increase, year on year, in Mental Health Act assessments that are having to take place, so people are entering into a state of crisis before interventions are forthcoming. I sometimes see a political focus on acute hospital care, old age and frailty. In Essex—and I think this is common across the country—I see more and more people having to go out of area to receive hospital care, being completely dislocated from their families. Going back to the social determinants of health, we know that is not good for them medically.

I think we now need to shift the paradigm towards need. We need to bring it back to local government. We need to think about how we reform the funding structures so that there is more of a balance on prevention—we need to protect prevention. We also need to look at non-clinical interventions as having parity with, and as being as important as, clinical interventions.

Cllr Lorraine Francis: I would add that our data in Bristol tells us that there are fewer people training to be AMHPs, for example. If you look at the situation in Bristol, the majority of AMHPs are older, and they are leaving the service due to burnout. When we talk about what community looks like under the community mental health framework, we are talking about staffing, and about professionals being able to deliver the work.

Q146 **Chair:** What needs to change to turn that around?



Cllr Lorraine Francis: What needs to change, I think, is that we have a situation of them and us. There are the practitioners and then there are the people who use the service. They are always pitted against each other. There isn't a coming together of, "I need help, and this is the team that can help me." It is very separate. A practitioner might be labelled, day in and day out, as being incompetent and not being able to deliver. In fact, during the covid period, we saw 30 staff come and go in my team. Staff were literally walking through the door and out again, between 2021 and 2023, because the work was too intense for the people coming into the services. It was the older practitioners who were able to cope with it. We need to see more people in training and more support. This is basic stuff—it is about having more staff in teams and smaller caseloads to be able to deliver that person-centred approach. If you are stretched, with 30-plus cases, and you are trying to deliver a service within a complex network, you are going to get staff burnout. If we do not address that aspect, we will continue to see staff leaving the service and not being replaced.

When we talk about community, what exactly do we mean by that? We are getting more service users with neurodiversity issues and, with respect, learning difficulties—and we are seeing working-age adults using services because they have to. Also, we cannot fail to mention the issues around people going online to get advice, and then having to come back into services when it all goes terribly wrong. I know work is being done on that.

Q147 **Chair:** Can you give some examples of what you mean by that?

Cllr Lorraine Francis: Let me make sure I give you nameless experiences. We have had service users come in, they go online to diagnose themselves and then they come back to services and say, "Yes, but I've read that this is what needs to happen." You end up in conflict with the very people you are trying to support, because online groups say, "No, this is what you should be doing, and this is how you should tackle your health issues." Unless there are some restraints and an ability to shut down those sites sometimes, we would always say, "You need to refer to the NHS website if you want to get advice, because the advice you are getting is not helpful."

Q148 **Chair:** Have you seen an increase in this kind of presentation recently?

Cllr Lorraine Francis: Absolutely. I stopped working in adult mental health services in September 2024. I have now gone into a different setting, where I am working with younger people. I am trying to be anonymous. It is a different setting because I work part-time in another setting, providing therapy. However, I am seeing different presentations.

Q149 **Chair:** Is this an emerging trend that we should be looking at?

Cllr Lorraine Francis: Absolutely. Online is creating major problems for practitioners who are trying to deliver a service.

Q150 **Chair:** That is very helpful. Let us move properly to the wider social determinants. Could you describe, from your experience, the relationship



between local authorities, the NHS and the third sector? How does that interplay, Peter?

Peter Devlin: The local authority tends to have a commissioning relationship—an established relationship—with its community sector partners. Certainly that has been my experience. A local authority tends to be the lead commissioner for any non-NHS services. That has changed a little with some of the community mental health transformation, where we have, on occasion, ICBs and sometimes NHS provider trusts commissioning through to community partners.

Q151 **Chair:** That relationship is potentially going to change. Jim Mackey said that he wants ICBs to be much more about commissioning and far less about providing those services. Do you think that will be a shift from how it is currently? Do you have any opinions about that?

Peter Devlin: I would welcome the shift, but I think the funding—

Chair: Would you prefer it if the ICB was commissioning?

Peter Devlin: I think the local authority is best placed to commission, because I think we need to ground this in need. What we do not want is for an NHS commissioning framework to be imposed on a community sector that needs to have a different feel. It is not just about activity and performance outputs. We need to recognise that the ICBs generally have a relationship with big NHS providers, and that they commission in quite a contractual way. There is a lot of infrastructure and a lot of contractual reporting around that. Local authorities tend to commission from VCSE sector providers, which are smaller. Their infrastructure is smaller, and they are often more locally based. For me, going through existing relationships that are already established and trusted makes sense. Local authorities understand their populations and are well placed to provide that. The health and wellbeing boards are well situated as a convenor for local systems and could be elevated.

Q152 **Chair:** What do you mean by elevated? I ask this slightly pointedly. When I hear people talk about health and wellbeing boards, they generally enjoy sitting on them. They have a great day out where everyone pats each other on the back, but in terms of what they are able to achieve and do—“What did I achieve that day?”—there is a sense that they talked a lot, but maybe not more than that. When you say they need to be elevated, how exactly?

Peter Devlin: There is the convening stuff. You have touched on the ceremonial and relational aspect and the conviviality of bringing partners together. Culturally, there is a relational component in all of this as well. I would say that health and wellbeing boards need to have more accountability. My experience is that they sometimes have that accountability, that collective accountability, and sometimes it does feel that—

Chair: Also, they do not have the teeth.

Peter Devlin: I would say that we need to go further with the accountability they have.

Chair: Is that what you mean by accountability? For them to have the teeth to be able to hold others to account.

Peter Devlin: Absolutely. And possibly to use them as the vehicle for protected funding in particular areas. Last year or the year before, the Public Accounts Committee made it very clear that, although we talk about parity of esteem for mental health, there is no parity of finance. The distribution of finance across the health economy is disproportionately weighted to physical and medical conditions against mental health. The mental health investment standard—I have touched on the better care fund already—is not spending on mental health generally when we look at it nationally. The health and wellbeing boards could be the vehicle for discharging local funds, which would probably give them more authority and sway in local systems.

Q153 **Chair:** What about the police? What kind of relationship do the police have with all of these organisations? They are often the last port of call for a lot of people in crisis.

Cllr Lorraine Francis: The police have a very interesting role when it comes to mental health. If somebody in the community is unwell, most people would call the police to help. If somebody is walking in the road and putting their life, or somebody else's life, in danger, it is often the police who will be called out. They used to have the ability—I am not sure if they still do—to section 136 people to keep them safe while services consider whether they need a Mental Health Act assessment. I think the police were becoming overwhelmed by that and were stepping back from that direct role of being responsible and accountable.

The police have a role in dealing with crime, and having a mental health episode is not a crime. That reliance on the police to manage challenging behaviours in our communities is unfair on the police and definitely unfair on the service user, because having a mental health episode does not mean you are committing a crime. You are unwell and need support in that moment. That would be my answer to that really interesting question.

Peter Devlin: My truth on this is that over the past two decades the police have been drawn into more mental health-related work. That does correspond with a reduction in investment and a corresponding increase in demand on mental health issues.

Where there is an immediate public safety threat that cannot safely be contained, there will always be a need for a police response, together with a mental health response. The principles of right care, right person and doing the right thing by individuals means ensuring safety in the set of circumstances encountered, while providing it in the way that is least restrictive and most personalised. Those principles are very sound and solid.



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The police are right to rebalance the work that they do, but that does mean that the health and social care system needs to step in to the potential gaps and voids that that creates. It needs to be done well, collaboratively, at the local level, with a set of principles that guide it and a process by which systems and their constituent parts can properly evaluate, to ensure that gaps are not left. Otherwise, we might end up in a system and situation where the individuals are left without the right care and support.

Q154 Chair: I will ask you both this question. Maybe you could weave in your comment, Councillor Lorraine. Do you have a view on what the perfect system looks like? Is it that health and wellbeing boards set objectives with teeth to hold others to account, with pooled budgets, which means that there is no fighting over scraps and targets that align? What is your view, given your vast experience, of what a good system could look like?

Cllr Lorraine Francis: First, can I go back slightly one step regarding the police, and why in Bristol their involvement in mental health was becoming increasingly problematic? We know that when your skin is brown and you have had decades of being over-represented in the criminal justice system, when the police intervene in mental health, it adds another layer to that and is increasing the data. That is an important perspective.

Your question about what is ideal is interesting because we have been having conversations about the health and wellbeing boards. I sit on the health and wellbeing board, and if the chair is not around I will chair; I have no role other than that, but I am part of that. One thing that has come up politically about the role of health and wellbeing in Bristol—they will hate me for saying this—is whether they should come under the banner and be more integrated into adult social care. It sits under adult social care but as a kind of concept. Yes, we sit around and talk, and we have different partners come in and talk about their areas. Very briefly, take the dentistry issue, for example: you would think the health and wellbeing board would be the place to find a definitive response, but they will default to the NHS; we have no role in fixing that problem. It does bring into question how much power they have as a health and wellbeing board and what else could be done.

This is what needs to be done. Health and social care has been the headline for decades and yet we have a split service. Health and social care are not integrated and not working together as an holistic whole. When people go from the community into a hospital and come back out again, we need to work holistically. We do have case studies around that, and I can send them if you need it.

Chair: Please write to us; that would be very helpful.

Cllr Lorraine Francis: We have examples of where that is working with regard to housing, but we know that we need more staff, more funding, and young people training, because social work numbers are dropping as well. I do not know about other parts of the country but we are seeing a



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dip in people stepping up into social work. We are losing the very essence of social work, which is social workers and social care.

We need professionals; we cannot default to a system where we do not have trained practitioners who have an entrenched understanding of services. We need to work in partnership with voluntary organisations because we have devolved all our services.

Q155 **Chair:** Are there barriers to that that we should be live to?

Cllr Lorraine Francis: With regard to the voluntary sector?

Chair: Yes. They are up next, so I will ask them the same question.

Cllr Lorraine Francis: Yes. In Bristol, there are specific voluntary groups that we go to, and it is not all perfect. Is there enough? That is a question. We have a fantastic organisation called Nilaari, which has been working for quite a long time with people from the global majority, and they are entrenched in our communities. We also have other named services.

I do not know—it will be interesting to hear from our partners shortly—whether we need more localised services, because I do not know whether we will have the expertise, because it takes time to build your reputation. It tends to start really small and they tend to evolve. Do we need more voluntary sector organisations? We are spending millions of pounds on commissioned services for domiciliary care and the other care services, but we do not invest in any way, shape or form in community resources, and we do not invest enough in preventive services.

Q156 **Chair:** Peter, what is your ideal system?

Peter Devlin: That is a great question.

Cllr Lorraine Francis: I don't think I answered it.

Peter Devlin: No, I think you did.

Chair: Or just elements of it. Core principles are fine.

Peter Devlin: I would go first to population health management stuff—the things that tell us about what people need to live well—and look at the extent to which they are in the fabric of our societies and infrastructure. We need proportionate universalism, and we need to invest in areas. This links to the Government's levelling-up agenda and local councils' levelling-up agendas. There is something about getting right the fabric and the conditions for people to thrive and remain well and to be well and recover.

We need a much more targeted focus on second-layer prevention that is led by public health and recognises the population demographic and individuals who could tip into unwellness, and what they might need in relation to something that is more purposeful and targeted. There needs to be an integrated approach that really recognises and balances the importance of the way that social care and the whole personalisation,

thinking about individual strengths, seeing them as individuals, and systems, and in communities—

Chair: We have a sister inquiry that is nearly there on social care.

Peter Devlin: Yes, it is absolutely looking at that. With that, there needs to be sufficiency planning. What is your population need for those individuals who are likely to require social care services relating to their mental health?

Q157 **Chair:** Why is that not already happening? I thought the whole point of the health and wellbeing boards was to come up with a strategy that took all this into account, and then ICBs were meant to help to deliver that, or at least have regard to that strategy. Why is that not happening? In theory it should be happening.

Peter Devlin: In theory it should be happening—

Chair: Why isn't it, in your experience?

Peter Devlin: I think there are a couple of things. We need to make sure that the funding flows into the system and that the system is the guardian of what its population requires, rather than the NHS.

Q158 **Chair:** Would you like to see the health and wellbeing board managing the overall budget?

Peter Devlin: I would like to see the health and wellbeing board having a much more solid and robust role in relation to managing the finances of health and care, and making strategic decisions against priorities.

We have asked for a sufficiency plan to provide support for, and an impact assessment to report on, the reforms in the Bill, because we know that unless there is the right community infrastructure—both in terms of its volume and type and integrated with health—that we will not shift the dial on people moving into specialist mental health services and into hospital services. That needs to be addressed.

This needs to be underpinned, whether or not we use existing infrastructure and bits of legislation. We spoke about the opportunity to open out section 75 as a facilitative means to support local systems to pool funds. We have the better care fund; should we have a ringfenced component to be spent on mental health? Should the mental health investment standard go into social care—mental health as well—to make sure that we have a balanced range of provision? We could use some of our existing infrastructure and funding flows, but pivot them, if that was what the Government were minded to do.

Q159 **Chair:** Lorraine, you mentioned Bristol City Council's recent innovations, particularly around housing. Could you give us a sense of that? Where are we with this project? That is my last question before we move on.

Cllr Lorraine Francis: We have an integrated housing and care offer. We have a situation wherein housing and care work together—we are funded



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partly by the ICB as well—so when you are in hospital, we are trying to look at how we can provide housing.

We have two great things going on. We have our housing strategy, where we are looking at people living in the community, and their healthcare is paid for, but their housing is paid for by the normal housing benefit, which means we can have a situation where you are not having to provide the whole package of care for somebody living locally or living in the community, and that is proving to be excellent.

We have two major projects going on at the moment. We are working with voluntary sector housing to provide specialist housing in communities. The health element is paid for, but the housing side is paid for by benefits. This is an excellent way of looking at care in a localised way, because without that, what is happening is that we are funding 100% of care for people living in the community, and we just do not need to be doing that. This is a great way of saving money, and that is really important.

We can send in more evidence to you, because I won't be able to give you the complete, the perfect, answer. I want you to have the perfect answer, so we will ensure that you get that.

Chair: We are extremely grateful. Please do that.

Cllr Lorraine Francis: With regard to the health and wellbeing board, it is a really important and big issue, which I am going to bring back as well. It is about how best it could work for the betterment of the greater city and so that it is much more effective in what it is trying to do. I think that is a really good point.

Chair: Thank you both so much. We really appreciate your time with us this morning.

Examination of witnesses

Witnesses: Penny East, Stephen Parker and Duncan Tree.

Q160 **Chair:** If people at home are wondering, the two microphones at the end on one side are broken, which is why we have everyone on the other side, but it also means that from certain angles we cannot see all the nameplates. As we said to the last panel, please will you introduce yourselves and what you do?

Penny East: My name is Penny East. Thank you so much for the invitation to be here today. I work for a charity called Think Ahead. We were set up about 10 years ago to better embed a social approach to mental health provision throughout the NHS and local authorities. We do that by recruiting, training and developing mental health social workers specifically. Through that, we have trained about 1,200 and we have built up real expertise in the challenges more broadly around the mental health workforce.



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Stephen Parker: My name is Stephen Parker. I am the national head of service for mental health in an organisation called Turning Point. Turning Point is a large, national VCSE organisation that works in relation to mental health, learning disability, autism, substance misuse and sexual health as well. I am a nurse by background—a psychiatric nurse. I have been qualified for a very long time and I spent about 25 years in the NHS, so my experience goes between the statutory and the non-statutory sector.

Duncan Tree: My name is Duncan Tree, and I am director of strategy and relationships with the Association of Mental Health Providers, which is the national membership body for 300-plus voluntary and community sector mental health providers in England and Wales. Eight million people in England and Wales access some sort of mental health support from the voluntary and community sector—2 million of those people via NHS-funded VCSE-delivered services. The services that the sector provides include in-patient, residential and community-based care and co-ordination, and some of the specialist services that your previous witness, Christina, talked about in relation to eating disorders. Many of our members also provide related care and support to people with learning disabilities and autism, who may be homeless and have needs around drug, alcohol and substance issues. Thank you for inviting us.

Q161 **Dr Cooper:** We heard from our previous panel about the relationship between local authorities and integrated care boards. I will start the questioning by asking for your thoughts about your relationship—the voluntary, community and social enterprise relationship—with commissioners and providers. Is it a genuinely good relationship? Is it an equal relationship—are you equal partners? If there is room for improvement, what policy levers do you think would enable that improvement? Let us start with Duncan.

Duncan Tree: It is not an equal relationship. It cannot be an equal relationship because it is premised on, in the first instance, the commissioning or the procurement of services. I think the extent to which it is a good relationship varies in part. In some parts of the country we have seen the community mental health transformation agenda or narrative translate into more meaningful authentic relationships between VCSE organisations, local authorities and the NHS.

Q162 **Dr Cooper:** What facilitates that and why is it varied?

Duncan Tree: The example I would give you is in Durham, where the leadership arrangements, or the facilitation of the voluntary and community sector's engagement in community mental health transformation, has been led by the local authority. It is the local authority that has invested in the VCSE alliance there. There are other examples in other parts of the country—for example, north-east Somerset and the work that is being led by our colleagues in Rethink—that exemplify the extent to which some colleagues in the NHS have facilitated meaningful and authentic engagement with VCSE organisations. But in many instances the default will be to the larger providers, and many of our

smaller members, particularly those working in specialised services, may have felt excluded from some of the alliances and the discussions that led to them.

Q163 Dr Cooper: I am picking up that there is definitely a strong relational element there.

Duncan Tree: I think there is a relational element, and it points to a wider issue about an acute and ongoing focus on the system and structural requirements in relation to improvement of services. Your previous witnesses alluded to some of the behavioural and cultural considerations that are critical. Those are embedded in the power relationships that we have talked about. There should be a stronger focus on cultural and behavioural considerations.

Earlier, the Chair referred to the extent to which there should be greater devolution of responsibility for delivery. We would like to see a clearer focus on national outcomes and national expectations in terms of the nature and the integrity of those relationships, as well as the extent to which local systems are held to account, both in terms of investment in the VCSE sector and the authenticity of the delivery agreements.

Stephen Parker: Turning Point operates across the country, so we have lots of different relationships with lots of different ICBs. My experience has been one of non-equality. But we have to put it in the context of the size of contracts and that VCSE organisations work in a specific area. For example, if you have got an ICB, we might have £1 million of business in that place, and obviously the NHS have got £100 million or whatever, so there is something about proportionality that I think is really important. There is also something about the sheer amount of VCSE organisations in any one area when you think nationally, so it is very difficult to get a single voice because we all have slightly different ways of thinking about things. So I completely agree with Duncan's posit that there needs to be some sort of national outcome tool or measurement that brings people together so that we can, not measure ourselves against each other, but kind of together see what works. Without that, I do not think we will ever be in a position where we can be at the top table in the ICBs; I think we are too small and individual. Duncan's organisation does some great work in bringing us together, but we only represent a small amount of the plethora of different organisations out there.

Penny East: We are a national organisation. Our partnership working is directly with NHS trusts and local authorities, rather than ICBs. In terms of that partnership working, I would say we have some brilliant partnerships, but the one big challenge is about multi-year partnerships. Unfortunately, because as a charity, our funding is uncertain and we are working with partners whose funding is also uncertain, long-term partnership will always be very hard when we are working in that context. I would say that has become increasingly challenging in the last year to 18 months; NHS trusts that we have had long-term partnerships with are unable to partner with us, citing financial reasons. That has definitely become more pronounced in the last 12 to 18 months. That multi-year partnership



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working where you really get to know each other, you really get to know what your local population need and you can adapt your work to make sure that the partnership is most effective, just isn't possible when operating in such funding uncertainty.

Q164 Dr Beccy Cooper: That is really helpful; we might come back to that later. I will move on to how the Department of Health and Social Care and NHS England are facilitating that relationship and helping you. You talked about national structures and national targets. In written evidence to us, they have stated: "There has been a substantial increase in the involvement of VCSE organisations as partners in the delivery of holistic care for people with serious mental health problems." So they think that things are improving in general. Penny, I wonder what more they could do to ensure that VCSE organisations and providers can feed into national policy and be a further part of that conversation; and whether you think it is fair to reflect that things are improving generally.

Penny East: As a charity, we are funded by the Department of Health. I think, in terms of reflections about how we could be better utilised, we have been going for about 10 years, and in that time we have built up a huge database of 100,000 people across the country who want to work in mental health. We have got a tonne of metrics and data about what drives someone to want to work in mental health, and indeed what might make them leave the sector as well. One of the frustrations is that we are not necessarily utilising that data in a partnership agreement with the Department or with NHS England, and sometimes it can feel a bit transactional, as a contractor who is delivering something, and meeting their key performance indicators and doing the best they can. Actually, what we would really like is some more collaborative partnership working where we can look at all the evidence we have built up over the last decade, which is so fundamental to building a really happy, healthy mental health workforce, and share that with the Department and with NHS England to drive policy change, particularly around the long-standing workforce challenges around recruitment and retention.

Q165 Dr Beccy Cooper: That sounds very sensible. Duncan, may I come to you? May we expand this conversation slightly? I am aware that at AMHP you have developed a map of VCSE services, and I wonder whether you could perhaps tell us how that has been utilised currently, perhaps at a national and a local level, and whether you think that can be better utilised to provide improved services through commissioners and providers in that wider national structure.

Duncan Tree: We have undertaken two pieces of work over the last two years—one of which involves the mapping of VCSE and other statutory services in relation to mental health and mental health social care and support across England and Wales. We have also, in the last six or seven months, produced a mental health social care workforce mapping tool that provides granular detail on the nature and extent of the mental health social care workforce, and the vacancy rates as they currently exist, and the need for investment across that workforce, which includes the need for firm and clear investment in relation to social work, occupational therapy



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and the wider care and support workforce in relation to mental health. We use the term “mental health social care” and “mental health social care workforce,” to make that distinct from a clinical NHS workforce, and we think it is a term that has increasing traction.

We work in partnership with our colleagues at the LSE and Manchester University through some NIHR-funded work—an incubator project that is looking to further exemplify the value and the investment requirements of the workforce. We have been encouraged by NHS England’s interest in the work that we have done, and indeed that from colleagues at the Department of Health and Social Care. I think the 10-year health plan provides us with an opportunity to utilise that more effectively at a local level, particularly in the context of the roll-out of the 24/7 neighbourhood mental health centres and the aspirations for neighbourhood health and care programmes, which the DHSC are leading on. We understand that they are really clear that social care and the VCSE will be clear and equal partners in those roll-outs, because the success of both programmes is contingent upon that meaningful engagement.

Q166 Dr Cooper: Those are really interesting terms to use. Thank you, Duncan. I think they are very clear, which is great. To clarify, is the mapping being used currently in national structures, or do you hope that it will be used further?

Duncan Tree: We have an indication from colleagues currently at NHSE, or NHS colleagues that will be returning to DHSC, that they see its value. We hope to be using it with them. On the back of those conversations, we expect some colleagues at ICB and local level to be utilising those more effectively. If I may, I think it relates to a point that I do not know if the Committee has heard to date: at the end of 2021, NHS England required all local systems to produce integrated mental health workforce development strategies and plans. The expectation was clear that they should be produced and delivered in conjunction with local authorities and the voluntary and community sector. We are not aware of having seen any of those. It would be good to see what was produced at the time, and indeed what, if any, intentions there are to reproduce those in relation to the commitments in the NHS 10-year plan.

Q167 Dr Cooper: That is really helpful; thank you. I am sure that we will all pick that up—thank you very much. I will move on to Stephen on the issue of meeting wider social needs. We heard from the previous panel about local authorities. There was a clear direction from the previous panel around the social determinants of health, particularly mental health outcomes. We are, of course, aware that VCSE organisations are already working around the social determinants of mental health. There are some great examples of best practice. What more do you think can be done—I am sure there is more that can be done—to ensure that local authorities and the NHS are supporting you to integrate more effectively with community mental health services? If you want to talk about those wider determinants and how you think you can better work there, that would be really helpful.



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Stephen Parker: Where it works well, it works really well. I have some really good examples. For example, there is a crisis house we have in the north of England that has just opened its doors to going into A&E services to take people out of A&E, so that they do not need to sit in there. That is in conjunction with both the NHS and local authority agreement. So there are some really good pieces of work that go on, and I see the VCSE work as the glue that holds the statutory powers and the work that NHS and local authorities do, which is really important work. VCSE kind of hold the glue to that; they are the ones who work with the service users on the ground. Quite often, they are the ones who have the relationships—they know them best. If you think about the supported accommodation, for example, people are with people 24 hours a day, so they know them really well. The way to help do that more is to allow VCSE people to continue to do that.

We were talking before about short-term contracts and the nature of one, three or five-year contracts. We are seeing that change a little bit, and we are just looking at some much longer ones, which is really useful, because then we can start to think about how we can help people in the longer term. It is really important for us to recognise that—Pete Devlin was talking about it a little bit before—while recovery is so important for lots of people, there is a significant cohort of the people we are talking about today for whom recovery is not an option in the truest sense of the word. When you have short-term contracts and you have recovery as a goal, it all leads to that kind of short-termism and not being able to get to the bottom of what you are talking about.

In that crisis service, we have a fantastic service user who works with us a lot. She is quite a high-flying person, but she has a severe mental health problem. She needs to come to our crisis service every now and again for maybe three days, and then she can go out and do her fantastic work again. I worry that it would be very easy to cut the funding to something like that because it does not fit the criteria of what people have to deliver statutorily. We are subcontracted. So what happens to that poor woman if and when the crisis house disappears? We will suddenly have someone who will be allowed to escalate her behaviour; she will probably get picked up by the police, get sectioned and put in a mental health unit. It will eventually ruin her life for a significant period of time. For a very small amount of money and long-term relationships, you manage to get people having happy, healthy lives. It makes an awful lot of sense to me.

Dr Cooper: Who would have thought that return on investment in prevention is so effective? Amazing.

Q168 **Gregory Stafford:** The Committee heard about the bureaucratic barriers that organisations like yours face, particularly smaller ones, when accessing funding. What do you think the solutions or policy levers might be to address those barriers? Let us start with Stephen.

Stephen Parker: There are some really simple things that we can do—well, they are really complicated, but obvious. For me, there is something about the length of contracts and the parity of esteem that we might have



with VCSE and statutory organisations. That A&E pilot I was talking about before was pulled after a year to save the A&E £80,000. Two years later, it reintegrated it, and we cannot work like that. We are hiring people and firing people. We have managed to get funding now for two years, I think, but it is not something that is sustainable in that way. For me, there needs to be an understanding. Having worked on both sides of the fence, there is a sense of looking down on VCSE people as the gofers who run about—“We do all the important work, and they just look after people when we aren’t there.” That culture needs to shift.

Penny East: For us as a charity to work more efficiently and effectively, it would be incredibly helpful to have national workforce plans that work across local authorities, the voluntary sector and the NHS. There are a number of different workforce plans for those different areas, but what matters to somebody in need of support are the workforces crossing all those three sectors. As a charity, we spend a lot of time navigating different sectors in different parts of the country, which all have different frameworks and different targets. As a national charity, that is a real challenge. Although we absolutely understand the need for those local agendas and priorities to be understood, national policy can work across both the NHS and local authority.

Our charity trains social workers, and there is a real lack of understanding that social workers actually work directly in the NHS. They are not in the NHS workforce plan. They are directly employed by the NHS, working in clinical teams; they are not just in local authority settings. Lack of understanding on a national level makes our lives much harder, in the sense that we sometimes feel like we are running through treacle. We need a clearer workforce plan that crosses the NHS, local authorities and the voluntary sector and understands that social workers work across all three.

Q169 **Gregory Stafford:** How does that potentially have an impact on how you access funding, or does it not?

Penny East: We are funded directly by central Government. We are a single-funder organisation, so in that way, it is possibly a lot simpler than it is for other charities. I worked in the charity sector my whole life, at Think Ahead and in previous jobs as well: until you work in the voluntary sector, you cannot have any idea of how much time is taken up by trying to work out where your money is going to come from. It is not just the uncertainty; it is also the fact that funders love to change frameworks and targets and ways of doing things, so you think you have got it down and then next year they have changed it and you have to change the way that you work. A significant amount of capacity, energy and skill internally is put into those challenges, rather than doing the work that you actually came in to do. It is working with funders to be far more supportive and not to change if it is not broken. Do not change things for the sake of it, because it really has an impact on our ability to do the work.

Q170 **Gregory Stafford:** Duncan, your organisation has argued for multi-year funding, which Stephen touched on. What would that model look like, and

how would that fit?

Duncan Tree: Stephen alluded to it. It would be premised on a better understanding of the fact that the recovery narrative does not work for everyone. Much funding and much procurement in commissioning—and actually much commissioning—is not commissioning; it is actually procurement, because commissioning would start with an identification of needs on a whole-population basis. Some of us are young enough to remember joint strategic needs assessments. We need to be thinking about that in the context of the conversation. That loops back to your point about what is required in terms of investment in the sector—that is an understanding that the sector is more than a provider of specialist services, and a meaningful strategic engagement that understands that the sector has a lens on, an understanding of and an ability to articulate and respond to needs that, in many instances, statutory services do not have. The covid experience was a very sharp, acute and uncomfortable experience for many that exemplified the extent to which voluntary and community sector organisations increasingly occupied a safeguarding space that was vacated by the state—by statutory services—and there has been no reset in many circumstances.

Earlier, you talked about prevalence and complexity. Many of our members see a change in the acuity of need being presented to services, and in the services that they provide. Some of that may be a function of the bar for access to NHS services being raised, but it may also be a function of a changing nature of needs which we need to understand at a clinical level, and more research is required. Steve and I have talked about this a lot with our colleagues. It is acuity as distinct from complexity and prevalence, and we are not entirely convinced that the national system has got a lens on that yet, or is sufficiently equipped to interrogate it.

Engagement needs to be strategic. It needs to be based on more than just a procurement relationship and an assumption that the third sector just provides meaningful activities that can keep people occupied between clinical services.

Q171 **Gregory Stafford:** You have explained the ethos and the circumstance there. Are there practical or systematic changes that would need to come about to get to the kind of funding model that you are hopeful for, or is it simply cultural?

Duncan Tree: I think it is cultural. As Stephen has been explicit about, it is a changing understanding of the value of the sector. We should not look down on it, but clearer national standards, targets and expectations have to be required of local systems if engagement with the VCSE sector, as both a provider and a strategic enabler and partner, is to be more than just an invitation to the occasional health and wellbeing board meeting. Let's face it: those don't have many teeth in relation to oversight and delivery of mental health services, because the architecture sits largely in, and has oversight from, the NHS, and that is where the funding flows. If we were to ask a question about resources, we should ask whether it is right that a substantial amount of the resources for mental health services

flows through the NHS, or whether we should be thinking about different funding routes.

Q172 Josh Fenton-Glynn: I am going to go a bit rogue and not ask all the questions I have got written down here, because there is a bit of an elephant in the room. The Government White Paper on benefit reforms has just come out, and a significant part of that is about people who are on various forms of PIP for mental health reasons. We have a significant mental health backlog in the health service. You have the frontline experience, so I will go along the panel and ask: what has been the impact of some of those announcements, and what more do you think we can do to reduce mental health waiting lists and support people in the way that you were outlining with some of your cases there?

Penny East: As a recruiter and trainer for mental health social work, we find that people on mental health waiting lists often feel like they don't have any support while they wait. There is a psychological impact of that—you cannot feel better, and you cannot get better, until you get the intervention that someone has told you that you need—but actually, from a social work perspective, they will have a lot of social needs while they are on the waiting list for the therapeutic or clinical intervention, so how can we support social workers to work with people much earlier? Your previous witness was talking about an over-medicalised approach, where both practitioner and service user are waiting for the clinical response. A clinical response, of course, is necessary for a lot of people, but it needs to be in combination with a social work response. A social worker understands the social approach and can look at things like poverty, housing, domestic abuse, and education and employment opportunities to give people that holistic care.

On the announcements about supporting people back into work, we are hugely supportive of employment as a health outcome, but it needs to be done in a safe, voluntary and appropriate way. As well as supporting the person to find work, it is about working with the employer. Employers need support in how to make reasonable adjustments to make their place of work a safe and suitable place for somebody with long-term mental health needs.

Q173 Josh Fenton-Glynn: As a social worker, is that something that you would support people into? Would social workers support people into work or would they work with employers as part of their remit?

Penny East: A social worker would definitely help with a lot of the attributes in terms of something like building confidence. It is very based on relationship-based practice—really individualised support—to make sure that the barriers to someone feeling able to find work can be navigated. That would be things like confidence, help with transport, and that kind of thing. There are also specialist support networks, such as IPS practitioners, and they are specifically there to support people to get into employment. Crucially, they also work with the employer to make sure that the place of employment is suitable.



Q174 Josh Fenton-Glynn: I will quickly move to Stephen. What are your reflections on the impact that that has had on people who are waiting for mental health support and the people who you are supporting? How could it practically drill down on those lists?

Stephen Parker: Sure. I agree with most of the things that Penny has said. We work across a whole wide gamut of different mental health conditions. We are talking about severe mental illness today. It is too early to tell, for people in supported accommodation and hospital accommodation, what the impacts will be. Obviously, people have not been reassessed for their PIP or whatever yet.

I am cautiously hopeful that it will continue to be recognised that those people are able to live fruitful lives but may not be contributing financially to society. I think we need to accept that sometimes. I am most concerned about the people who are on long waiting lists, as Penny was talking about, for talking therapies and psychological therapies, who have major depression, anxiety or stress and cannot work. I understand that those people are likely to be most affected.

I am a massive advocate of employment advisers, but our problem—as with all our services—is that they come in and out of fashion. They get funded, then the funding gets taken away. You get a year's funding for this and 18 months' funding for that, then a new thing comes in with a new set of metrics. We need to land on something and say, "Let's try that for a little while." It is very difficult to build relationships with people with mental health problems and have them trust you to get them into that and work with the employers if you are changing personnel the whole time.

Duncan Tree: It is a really important question. With our colleagues at the Association of Directors of Adult Social Services, the Child Poverty Action Group, the British Association of Social Workers, the Association of Directors of Public Health and the Centre for Mental Health, we published an open letter three or four years ago calling for a review of the efficacy of the social security benefit system and its alignment or otherwise with the objectives of our health and care system.

The rationale for that call remains, and is exemplified by the recent announcements in relation to PIP. We know that the NHS Confederation's work about four or five years ago identified that people's concerns with the PIP process were a significant feature in the mental distress of people in in-patient arrangements and any related discharge support.

The commission being led by Baroness Casey is an excellent opportunity to review that. We understand that the Department of Health is commissioning some work in relation to the utility of the attendance allowance or its current arrangement in relation to support for older people. More generally, the Casey review gives us an opportunity to understand the importance of mental health social care and the care and support system in relation to supporting people with poor mental health or living with mental illness and their unpaid carers in the community. We hope that opportunity is not missed.



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The point that Christian made about unpaid carers in his evidence earlier is absolutely critical. Too often, services commissioning approaches the needs of unpaid carers through a lens of homogeneous needs, and the needs of unpaid carers with family members in the mental health system are quite often distinct, not least because the system can feel very adversarial for them.

Q175 Josh Fenton-Glynn: With apologies to the Chair for going a bit rogue, I will get back to the broader questions on the role of social workers in enabling community-based mental health care.

You have argued, Penny, that a lot of opportunities are missed because we do not have the right mental health social workers in place. Could you tell us a little about those opportunities?

Penny East: Yes, certainly. As I say, we work with NHS partners and there are roughly 3,500 to 4,000 mental health social workers working directly in the NHS—not in adjacent services but with the clinical teams. It is proven that they have a real impact of widening clinical perspectives through being there to look at someone's whole person—at their social circumstances. They look at things that other practitioners might not necessarily have the training, capacity or time to look at.

One example would be that one of our lived experience partners was telling me that when she was in hospital, the clinicians would often come in and talk to her over the bed. She would be lying in bed as they were talking to her about her medication. It was a mental health social worker who intervened and said, "Why don't we all just sit in chairs, in a circle, so that we can be eye to eye rather than looming over each other?" It is social workers who look at the power dynamics between the service user and the clinician and can help the people navigate a system when the system can feel traumatising.

The system can feel really challenging and a social worker is there, placed to navigate it. What could be done? Increase the number of mental health social workers: 3,500 to 4,000 in the NHS is obviously a very small number. Think ahead: we are turning down hundreds of people every year who could be mental health social workers, but we do not have the funding to train them. They want to work in mental health but they do not have medical backgrounds; mental health social work is a really effective route for them to get into those teams, but it is a really small number—3,500 to 4,000. If social work is to be the answer, over the 10 years we would love to see a workforce plan that prioritised social work directly in the NHS and increased the number of people who became mental health social workers.

Josh Fenton-Glynn: That is brilliant, and it answers my next question, which was about what needs to be done to enable it. You would like to see it through the NHS long-term workforce plan.

Penny East: Yes.

Q176 Josh Fenton-Glynn: I am now going to move on to Stephen. My



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background is as a cabinet member for social care. In Calderdale, we did a lot of work to try to integrate health and social care and to get integrated teams. In 2020, we produced a report looking at the deaths of five substance abusers who had broader mental health problems. One of the things we found was key to that was integrated services and wrapping services around people. I also know that that is key to the work that Turning Point do. What work have you done to integrate services and bring in integrated services in such cases?

Stephen Parker: Thank you so much for asking me that question; that is my passion, if you like. I spent an awful lot of time as a dual diagnosis worker back in the day, when it first came out, and I have been close to comorbid substance misuse and mental health ever since. I am quite sad when I go back to my nurse consultant colleagues and they are still fighting the good fight in the NHS and still fighting the same things as we were in 2002, 2003 and 2004.

We had this big wave of dual diagnosis as the next big thing, and integration is really important. Concurrent services do not work. All the research was done back in 2005 and it has not been disproven yet, but with changes of Government, austerity and the rest of it all those things went away and people retreated back into their holes.

In Turning Point, we are very fortunate that we work in both mental health and substance use. We have some models of really good practice that, unfortunately, are not replicated around the country. It is very much a local commissioning decision to do this.

Obviously, substance use services are commissioned through public health and mental health services through health or the local authority, so it feels like there are lots of different funding streams. But it is very simple: you train up substance use workers to look out for symptoms of mental health issues. We know that something like 72% of people in substance misuse services have a significant mental health problem and that about 40% of people with a mental health problem have problematic substance misuse.

When you have services that say, "We can't help you because you have an alcohol problem and you need to sort that out before we can give you therapy," and then the person trots off to the substance misuse team, who say, "You really need to go on antidepressants before you can possibly give up alcohol," it all falls apart and people fall through the gaps.

I know that I am probably speaking to people who understand that, but the point is really important. It is very simple: you just get all the people in the same virtual or actual space—there is a lot of evidence to suggest that being in the same actual space helps. As the 24/7 hubs are thinking about, you bring substance misuse into that and then you have a one-stop shop for all needs around physical health, mental health and social health.

Q177 Josh Fenton-Glynn: One of my biggest victories when I was running those kinds of services was getting the mental health trust to actually look at people and help them when they had substance misuse problems.



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I do not know whether this is your experience, but we found that a lot of people were just self-medicating with the harder drugs—you ain't going to fix one if you are doing both. It is almost strange to me that we talk about multidisciplinary teams whenever we are in a healthcare setting, but when we are talking about social and healthcare that just gets dropped off. Could you reflect on that?

Stephen Parker: I worked at a time when most substance misuse services were also done by the NHS, so I managed mental health and substance misuse teams. Even getting those cultures together within one organisation was almost impossible.

For me, there is something about coming alongside the person. The “wider determinants of health” question is really important. If you have not got a house or stable relationships with people, if you are on heroin and you have schizophrenia that you are not taking your medicine for, getting your relationships and house sorted first will help because people are self-medicating.

But health does not deal with housing and social care does not deal with relationships—that is where the VCSE comes in, I guess. That triumvirate of support is together in one place—Maslow's hierarchy of needs, for those old enough to understand it, puts housing, shelter and safety at No. 1. You need food, water, housing and safety to do anything else. If we go back to that very basic tenet, we will have much more success than if we cherry-pick what do, as we do at the moment.

Josh Fenton-Glynn: I think the role of the voluntary sector has to be not to fill the gaps but provide the glue that sticks it all together.

Stephen Parker: Absolutely. That is my belief.

Q178 **Chair:** We have one and a half quick questions left. I want to turn to digital—the Secretary of State prioritised that as the top baby of his three babies. But we have heard today how important your sector is in being the glue in the mental health space; that applies to other sectors in health as well. What more needs to be done?

Penny, you started talking about this. You have data that you would like to share. I would love Stephen's and Duncan's perspective on that as well. Could we also talk about digital infrastructure? It is not just about having the data but about interoperability and being able to easily flow from one stakeholder to another. Penny, would you elaborate a little on your remarks? Then we will go to everyone else.

Penny East: As a national organisation, we have gathered a lot of data about how to recruit and retain people from a national perspective. But we have managed to map it on to local population needs as well, to be able to see what conversion rates you need when trying to recruit people. The recruitment tactics that you might need in Cumbria are different from those in, say, London. We can see that from a data perspective; we have those metrics. We are very eager share it with central Government and indeed commissioners.

Q179 **Chair:** Have you tried. Have you offered it?

Penny East: Yes.

Chair: What did they say?

Penny East: We do not necessarily have those types of conversations. We do absolutely offer those insights, but most of our conversations with our funder are more about the contract that we are set up to deliver. The metrics and data that we have learned over time are because we are trying to create the best and most effective programme possible. We are not necessarily being measured on it by our funders, so therefore it is not always at the top of the list.

In terms of digital infrastructure, obviously we hear a lot about AI improving efficiency. In social work, there is certainly a lot of evidence of it improving efficiency within a service. Where I think there is more potential is how it works across services as well; it is not just about improving efficiency in your bit but how AI can be used across the whole sector.

Before even getting into that, it is really important to get the basics right. When we surveyed our social workers, we found that around 10% of them do not have a decent wi-fi connection in their office, and we found that 60% to 70% of them do not have devices that can use the latest piece of software or system that they need to put up their case notes.

While digital transformation and AI is hugely exciting, it cannot work without the basic infrastructure. Do they have devices that work? Do they have a decent wi-fi connection? Crucially, do they have the training needed to use the new systems? Quite often, you put the money into building something fancy with no development costs and no training. People do not then know how to use it and it does not work, so we pay for another system. While there are loads of exciting developments in this area, getting the basics right has to be there as well.

Stephen Parker: Shared systems are really important if we are ever going to start looking at evidence of whether these things work. If we are talking about lifetime journeys through services, such as someone who maybe starts off in CAMHS and then ends up in a care home in their later life, how will we ever know what works and what does not?

We have real issues with getting data on keeping people out of A&E, for example. When we discharge someone from our crisis house, and they go off into their lives, we have absolutely no way of knowing. We do not have any right to the data—I understand that—but some way of accessing a shared pool of information, or being able to feed into a shared pool, would be really important.

I also want to mention the rising digital solutions for therapy, and I think that it is a very exciting time. I read some research last week that said one particular study found that AI was as good as a human therapist. I

wonder, after 30 years' experience of doing this, whether relationships are really important, and I do not want to lose sight of the relational aspect.

Within our talking therapies services, we use SilverCloud and various other systems. The outcomes are good for those people, but it would not work for everyone. I really worry that, because it is cost effective and easily auditable, we will sleep-walk into everyone having this kind of AI friend. It will not work for everyone, and loneliness is one of the biggest causes of mental ill health in the population. If we further keep people in their houses, it is only going to get worse.

Duncan Tree: There are two aspects to the question, but I will follow on quickly from Stephen's point about the fundamental importance of relational care that is premised on continuity and co-ordination. I think that was very clear to us when your first witness this morning made a point about co-ordinated continuity and the relational dimension to that care, as opposed to transactional. I think that the procurement relationship, or the requirement for commissioning, has introduced too much of a transactional relationship into care, where there is an end point at any given time.

We need to challenge those assumptions and stick to the principles of personalised care and support. We need to hear much more talk about the principles of personalised care and support, as well as co-production with people who use services and their unpaid carers in relation to mental health care services. We hear a lot about services for older people, for example, but less about services for people living with mental illness and experiencing mental distress across the life course, and that is a dichotomy we need to address. A number of witnesses today have alluded to the differentiation between children's and adults' services, and I think it is a real challenge for continuity and keeping people safe, as well as wider aspirations.

On the digital stuff—if I may say “stuff”—in relation to data, NHSE has done some interesting work with us over the last few months on improving the expectations of VCSE organisations about the data that they are required to return on the back of NHS contracts, and the extent to which the dataset is as helpful as it might be.

Q180 Chair: So do you think that they are waking up the fact that you have this data and it might actually be helpful if they collect it?

Duncan Tree: Data is required by the NHS from those organisations that are delivering certain specified contract services. Some have found that onerous, given their capacity to deliver it, so the expectation of reporting needs to be proportionate and reasonable.

There is also the issue with the extent, quality and intelligence of the data that VCSE organisations in the sector hold on local needs that is of value for the commissioning of services—perhaps that is not as well interrogated as it might be. Of course, delivering that comes at a cost to those organisations, because it is not cost neutral.



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There is the issue of digital access to services, and there are digital exclusion issues that we need to factor in in relation to poverty. Those in relation to the provision of digital therapy are slightly different, and I think they need to be unpacked. The conversation about digital mental health services is multifaceted. It is more than just a means of delivery; as Stephen has talked about, it is also the extent to which services can be provided by digital therapy.

Q181 Chair: Thank you very much. Obviously, we are writing this report as we go, so this is the hard question. Can I ask for one recommendation, and only one, that you think we should be making to Government?

Penny East: Can I make a quick clarifying point to your question about the data? I fear that I gave an unclear answer. When Government came in last summer and talked about expanding the mental health workforce, we wrote to the Minister and offered our data and metrics, and that was not shared. I felt that I was giving an unclear answer. We have directly offered to meet to talk about the expansion of the mental health workforce and our insights that we could share on that, but they did not take it up.

Chair: So you have offered and they did not take it up. Thank you.

Penny East: In terms of one recommendation, it will not surprise anyone to hear that it will be to increase the number of mental health social workers both within local authorities and, crucially, within NHS trusts.

Stephen Parker: Local services with people who know what they are doing, with a national infrastructure.

Duncan Tree: A requirement for all local systems, NHS and local authorities to engage with the VCSE mental health sector as a strategic partner, as well as a provider of services.

Chair: Thank you very much; that brings us to the end of today's session.