



Health Committee

Oral evidence: [Children's and Adolescent Mental Health and CAMHS](#), HC 1129

Tuesday 4 March 2014

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Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Grahame M. Morris; Mr Virendra Sharma; David Tredinnick; Dr Sarah Wollaston

Questions 1-62

Witness[es]: **Professor Dame Sally C Davies**, Chief Medical Officer, Department of Health and **Dr Claire Lemer**, Consultant in general paediatrics and service transformation, Evelina London Children's Hospital gave evidence.

Q1 Chair: Good afternoon and welcome to the Committee, Dame Sally. You do not need any introduction to the Committee. I think it is your colleague Dr Lemer's first time here. Could I ask you to introduce yourself?

Dr Lemer: My name is Claire Lemer. I am a consultant in general paediatrics and service transformation at the Evelina London, which is across the road, and I was editor-in-chief of the CMO's annual report for 2012.

Q2 Chair: Thank you. For the first question, as a way into this subject, we would like to understand, of all the different priorities that face the Chief Medical Officer, what was it that made you focus on child health as the area that you were going to comment on at some length in your report last autumn?

Professor Davies: Thank you. I actually started training as—and wanted to be—a paediatrician, but it was so general; I am rather better specialised. I have, therefore, always had an interest, and what I understood, as I did my time in it, is that not only are the social, psychological and economic issues different in childhood, but so are the physiology and the pathology. Children are not little adults.

As I watch, I see an emphasis on the elderly, and I think that is very important, but I feel we have lost an emphasis on children over recent years. That worries me because I expected—and the report shows—that not only should prevention be the right approach as being fair and just, but that it would pay. I am concerned that we should not have

intergenerational transfer, and that we should look after children better and do it right. There is quite a lot of work—for instance, Ingrid Wolfe's—which shows that 20 years ago our mortality for children under 19 was similar to other countries in Europe, but now it is not as good. For instance, if you compare us with Sweden, we have seven deaths a day^[1] that would not occur in Sweden in children with long-term conditions. If you take something like diabetes and compare children with a marker of control called haemoglobin A1c of 7.5%—which I don't think is good enough, but there we are—we reach 16% in England, and the Germans get 34% of their children to that. It is not about children but something about our services and the effort we put into them. So I felt that I should try and pull a focus on to children and get the evidence. I discussed it with Ministers, and they were very keen that I should do that.

Q3 Chair: In the work you were doing, were you thinking about identifying what the issue was and challenging commissioners and professionals to do it better, or were you also thinking about the steps that need to be taken to convert the ideas into an experience on the ground of families in Grahame Morris's constituency, to take an example at random?

Professor Davies: I think rather more the former. I am breaking new ground with my CMO report in that I have a volume 1, which is surveillance on the state of the nation's health, just dry fact with only a little commentary, and a volume 2—this is the second of those, and the first dealt with infection and AMR—which is an experts' report. The way I have gone about this, which is unique, is to bring together a collection of recognised experts, have a workshop, debate what the issues are and ask them to write chapters, with a chief editor to keep the work going forward.

Claire, why don't you describe the process, because it was quite a heavy process for you?

Dr Lemer: The process was very much first about scoping what issues should be included. Clearly, it is a huge topic and we very much wanted to start at the very beginning. That is why the CMO's annual report starts antenatally and, using the WHO and UNICEF definition of childhood and adolescence, goes all the way through to 24, so not just stopping at a cut-off of 16, 17 or 18, which is where a lot of acute services stop. We took different life stages and also wanted to do a number of other important things.

The first was to look at the economic case, particularly in our current financial times. We can make a good moral and scientific case but we also need the economic evidence to back up what we are saying, so there is a chapter on that. There is also a chapter, which I think is key and comes back to your question, around the voice of children, young people and families. We really did want to listen to what people were saying, and we did that both from looking at what is published—because we did not want to repeat things—but also we did focus groups with children and young people through, for example, the Royal College of Paediatrics and Child Health. Also, we looked at specific focus groups to do with areas and worked with YoungMinds on mental health to try and understand those areas in more detail.

In addition to that, we looked at four specialty areas which are often not covered when you try and look at the whole of child health, including mental health, children with neurodisabilities and neurodevelopmental issues, and then at situations in which children find themselves where their health might be affected—children in the youth justice system and children in the looked-after system. In that way we hoped that we would look at the

general but also at the very specific, and we would try to look at it from both the health professionals' aspects and also from the families' aspects.

With respect to how the process went, we asked experts, they wrote their chapters, they were edited and we went through a sort of peer-review process. We had an external group, who then went through and made sure that they were not saying something that was out of kilter with other evidence. Then, as Dame Sally has said, we presented that back and talked with bigger groups of people, including stakeholders from places like YoungMinds and other equivalent organisations. We tried to test what we were finding as best we could to try to deal with both aspects of what you were just asking about.

Chair: Thank you.

Q4 David Tredinnick: Good afternoon. Last year, as has been said, you focused on antimicrobial resistance and antibiotic resistance, and, indeed, you wrote this book, a copy of which, for greater clarity, as they say in the House, I have obtained. To start with, do you think that antimicrobial resistance or antibiotic resistance was a major problem for children—because this is focusing on children?

Professor Davies: It is in two ways. First of all, they are big users of antibiotics because their parents take them to the doctors with coughs and colds. Antibiotics can be overused and therefore drive antimicrobial resistance. Admissions to hospital for children have gone up dramatically. I don't know whether you know the figure over the last—

Dr Lemer: Admissions from A and E have gone up by about 28% over the last 10 years, and in certain places—for example, across the road—we are looking at even higher increases in recent years.

Professor Davies: Much of that can be long-term conditions, but other admissions are to do with pyrexia—high temperatures—and trying to sort out what is the cause of that and what antibiotics, if antibiotics are needed, should be used. Then, of course, the role of antibiotics in sick children—whether they are sick neonates, premature or otherwise, or children with cancer, leukaemia or renal failure—is life-saving. AMR is central to their lives.

Q5 David Tredinnick: Have you had a chance to look at alternatives to antibiotics yet? I am thinking of just one example—Australian tea tree oil—which is used for dealing with infections and wounds. Is there any plan to encourage people to look at different ways of treating complaints that have traditionally been addressed with antibiotics, please?

Professor Davies: We need to rediscover hygiene in a way that we have not before and what other approaches will reduce infection. There is no doubt that phage technology plays a role, and there will be other natural substances that bugs don't like that may well play a role. Bleach is one, but I used tea tree oil for nits whenever I caught them from my children and it worked quite well.

Q6 David Tredinnick: Thank you. I must not monopolise the time this afternoon, but have you had any thoughts about your report for next year?

Professor Davies: Yes. It is under way with another wonderful young woman editor. It is on public mental health, and we hope to produce it—so we are continuing this theme in that children will be in it—before the summer. Again, the experts are working on that at the moment.

David Tredinnick: Thank you very much.

Q7 Mr Sharma: You may have given us some ideas as to the “why” in the question which I am raising now, but maybe you can go further into it. Why are we lagging behind other countries? How far is this discrepancy influenced by social determinants, and how far by differences in health care delivery?

Professor Davies: We have quite significant social inequalities in this country that feed through to health inequalities. For instance, there are more children in poverty—it is around 29%—than the average for the nation at around 26%. I can’t think of the right way of expressing it, but more children are in poverty proportionally than the rest of the population, and that does impact on health. We know that health inequalities impact on mental health particularly, but also on long-term conditions and many other issues. I think it is multifactorial. We will see what Claire, as an active clinician, thinks.

I think that we have not focused on children for a considerable time, policy-wise, and we have not spent as much time on working out the best care, self-management and family management of long-term conditions. From NIHR, we have done a research call for research to improve long-term conditions, and children’s care is one area which is crying out for more integration because it goes across not just the health service but into schools and other places. What is your perspective, as a clinician, Claire?

Dr Lemer: I completely agree; it is clearly multifactorial and we have good evidence that the UK has certain features, from a social policy perspective, that put us at a disadvantage. In the report we talk about the UK having the highest proportion of children living in a family where no adult is employed compared with other European countries. We come 24th out of 27th compared with European countries when we look at composite measures of pressure on family. But there is also an unanswered question when it comes to the evidence about what is the best way to arrange health care systems. We do a lot of comparisons across Europe, and it is difficult to unpick how much of the difference is due to social policy and how much is due to the way we co-ordinate our care. For example, in the UK, most children will be seen in the main by general practitioners and then referred through the system as required. Other European countries have models where there are primary care paediatricians. Some have hybrid models where paediatricians and GPs sit together. Those are questions that we have not managed to test as part of health service research yet because they are clearly very difficult to do. But that is starting to happen in the UK. In fact, at the Evelina we are starting to run pilots to try and understand how we can reorganise care along different models and trying to evaluate that to try and answer some of those questions.

Mr Sharma: Thank you.

Professor Davies: Perhaps it would be worth saying that general practitioners rarely get specialist paediatric training, yet they see many of the children with illnesses and they have to sift out the mildly ill from the ones that could be seriously ill or have chronic conditions. The Royal College of General Practitioners have made a case for extending their training, which I support, particularly if we could make sure that most of them got either paediatric training—child health training—or mental health training, or even both. That was also recommended by David Greenaway in his “Shape of Training” report.

Chair: Sarah would like to come in just on that.

Q8 Dr Wollaston: I have one follow-up point. Do you think it is time for us to change the way we measure child poverty, or would you like to see it stay the way it is currently measured?

Professor Davies: I have not considered that, though I noted the newspaper articles. There is always an advantage to continuing the way you do because then you can see change. So I generally am inclined to keeping what you have and can you add something else in to validate it?

Dr Wollaston: Thank you.

Q9 Mr Sharma: How significant are regional variations in children's health within England? What practical measures can be implemented to address them?

Professor Davies: The variation is quite significant. I can see Claire is looking to find it. At the back of this annual report, you will find the NHS Atlas of Variation in Healthcare for Children and Young People. It shows dramatic variation. With "Low birth weight: Percentage of live and stillborn infants who have" a low birth weight, you just have to look at the colours to see the variation across the country of that one which I have pulled out. That great variation shows us that, if we can pull people up to the best, we would have good services. But, again, the reason for the poor performance is going to be multi-factorial. It is not a click of the fingers, nor is it always throwing money at it. There is a real issue here.

Chair: Grahame, I referred to your constituents.

Q10 Grahame M. Morris: It leads on nicely to some questions I would like to ask, but, following on from earlier, could you clarify that for your report next year you will look into mental health provision, and will you also be looking at child and adolescent mental health within that? So it is going to be ongoing work.

Professor Davies: Yes. We are continuing a focus on that, so there will be a chapter which will develop the themes further and, I hope, have more data.

Q11 Grahame M. Morris: Excellent. I would like to go back to your earlier remarks as well where you were talking about the evidence base for early interventions and saying you have to quantify it in economic terms. I like the language you use about not saying that this is spending on young people but it is an investment to improve health outcomes. I think that is a good use of language and I agree with that approach. In your opinion, do we have the right mechanisms and tools, the right levers, to ensure that that investment—the early years interventions—actually happens?

Professor Davies: I think we know what to do. I am told—I hope I get the actual figures right—that, if we put evidence-based practice as described in here into play, we would get a 35% saving. We would get better outcomes and a saving. There are two savings to be had: one is for society by investing earlier, and the other is, if we used evidence-based practice across the whole range, effectively there would be more money to spend on doing it.

Q12 Grahame M. Morris: Excellent. Following on from that, I think you have indicated that there is an issue with a lack of credible data to make an analysis. Have I got the right impression there? You are asking for an evidence base on which to plan policy interventions, but your report also provides an overview of children and young people policy initiatives since May 2011. How effective have they been, in your opinion? I was particularly

thinking about some practical examples with the new structures—the new architecture—we have. For example, are health and wellbeing boards playing their part in identifying policies for early interventions? Are they doing that in an effective way? It seems to me that, in my area, and perhaps many other areas which have high levels of deprivation, particularly for children, it is the norm to present to accident and emergency. Perhaps that is not the best solution in terms of longer-term outcomes if children need preventative interventions, follow-up treatments and so on. I just wondered what your thoughts were.

Professor Davies: I will leave the A and E bit to Claire. We don't have enough data on mental health problems in children. The last survey was in 2004, and there is discussion going on about whether the Department can find the money to fulfil the request I made that we should do a new survey to see what the disease burden in mental health in children is. That is very important because not only are we a decade out of date, but, actually, people tell us that self-harm, anxiety, depression and other stresses are going up. So it is important to have that survey. I have also asked—

Q13 Chair: Can I just interrupt you on that survey, because I think I am right in saying that there is a story today in *The Times* that led us to believe you might be about to announce that survey.

Professor Davies: There is a story in today's *Times* that I have also read and I am hopeful it means that the survey will be done.

Chair: Thank you for the clarification.

Q14 Grahame M. Morris: You did not quite answer the question I put to you in its entirety. Can you also think in your answer about the existing mechanisms that we have in place for the new architecture and why are they not delivering? Why have newspapers like *The Times* and *The Daily Mirror* identified service failures? Do we need, for example, a children's champion? Is that what is lacking? Would that explain the regional variations?

Professor Davies: Let me continue to try and answer. In any structural reform there is always perturbation of the system and we are just coming out of that, I think. Some health and wellbeing boards are doing a great job, and in their joint strategic needs assessment they are looking at the issues locally and then putting plans in place. But I don't think we have had a great focus on this nationally. I am not aware of anywhere that has stood up and said, "This is our prime focus." We did the economic chapter to try and give people that excuse.

Do I think we need a children's champion? I think this is too big just for a champion. This is about our culture: do we, as a society, care about our children enough to do this? I am absolutely delighted that you are looking at this and considering it, because it is like going into restaurants where children aren't welcome. Our health service and our system are not valuing our children high enough.

Q15 Grahame M. Morris: It is a fifth of the population as well, isn't it?

Professor Davies: Yes. This is a very big issue, as I see it. I will let Claire answer about the A and E, and then I think you wanted to ask me something else in there.

Dr Lemer: We know that the reasons why people use A and E are very complicated. Some of it is to do with convenience, some with cultural norms, some of it with where people feel they will get the best care, and some of it is to do with a perception of difficulty in accessing the rest of the system. We have started surveying families and young people in

Southwark and Lambeth to try and get a flavour of what that means locally. Some of the findings are really interesting. People don't understand how their system works and so they tend to go to—

Grahame M. Morris: It is the default option.

Dr Lemer: Yes, exactly—to A and E. For example, they don't necessarily understand the out-of-hours provision. Even though it is good, there is a perception that they can't get an appointment with a GP, when actually when you asked families how long it took them to get an appointment with a GP the vast majority, over 90%—and this is children and young people; we are not talking about adults—were seen within 24 hours, most on the same day. There is a mismatch between perception and reality. That is one of the challenges that we have to face. But there are also issues around how we, as clinicians, deal with uncertainty, how we manage patients when they present to A and E, and what messages we give them about where to go back for care afterwards. It is a very complicated picture.

Q16 Grahame M. Morris: It is. I will wrap it up with this. You mentioned that 28% increase and comparisons with what is happening in Sweden and other countries where there are specialists based in primary care. Is it too early to say whether, in your opinion, that is a contributory factor to parents defaulting to the A and E option, because they think, “Well, if it is meningitis or something more complicated”—with no disrespect to GPs—“I am not sure my GP will identify it because maybe he or she has not had the level of training that I have got complete trust in compared with A and E”? Maybe I am being unfair in generalising there. Is there an element of truth in it?

Professor Davies: Yes, but meningitis is rare. I used to say to my sickle cell anaemia patients that, if they had symptoms, to go straight to A and E because they would need the ITU services very quickly too. I do think we need to support our GPs to get the right training to be able to do that.

I want to come back on one other thing that I think you asked me, going back to mental health. We know that mental health disorders cost us at least £105 billion across the age groups every year, but only 25% of children with clinical mental health disorders get specialist care within three years. So we are not spending it in the right place for children. I don't have any data on it, but I hear stories like those in *The Times* that people with children are not able to access the services when they need them. I think there is something about how the changes have made it marginally more complex. It is a complex commissioning environment; it always will be, because you have local authorities, schools and general practitioners doing things; you have general practitioners in CCGs commissioning things; and then, of course, the highest tier of services is commissioned by NHS England. But there appear to be insufficient specialist services.

Q17 Grahame M. Morris: Can I ask one short follow-up to that, because you have opened up a whole new line which I am very interested in as to the lack of provision, particularly for mental health services for children, and in adolescence even? What is the view in relation to using some of the moneys that schools get through the pupil premium? Do you think that should be used to provide specialist support for children who are displaying behavioural problems, or do the schools say, “It's a health issue”? This Committee is very much in favour of integrated working and strengthening the links and integration between health, social care and mental health services. Is this a problem that is not being addressed?

Professor Davies: One in 10 children will have a mental health problem. That means about three in every class. We need the schools to be able to screen and give general support, but they are never going to be able to give the specialist support; they need to have linkages with the specialist support so that children get what they need. The other argument for moving in early is that we know the outcomes are better if you move in early and prevent or treat early. Fifty per cent of mental illness in adults starts before the age of 15, and 75% before the age of 18. So if we screen for it in children and get them treated early, we will save morbidity and money.

Q18 Dr Wollaston: Can I come on to the area of obesity, which is obviously a major cost for individuals, the NHS and wider society? Could you clarify your figure of £588 million to £686 million per year? Does that apply to the long-term costs relating to children? I have seen much higher figures quoted nationally for covering the adult population. I just wanted to clarify the figure first.

Professor Davies: I think I may have to come back to you with that.

Dr Wollaston: Is that all right?

Professor Davies: Yes.

Q19 Dr Wollaston: I am seeing figures quoted elsewhere being in the order of several billions a year for the cost of obesity.

Professor Davies: I think, as I have opened the page—which is chapter 3, page 8—it is just in children, but I will confirm with you.

Q20 Dr Wollaston: So that figure is just within children alone. What difference can health interventions make—such as exercise? Where would you see the greatest gain? Many commentators are saying that the greatest gain is just in calorie reduction. Where would you like to see the big shift, and should Government policy be much more directed in this?

Professor Davies: You know as well as I do that this is a very complex area and I see it as a jigsaw with many bits to it. Physical activity is important in its own right, but I do not believe it will sort out obesity. What we are comes off our plates; it is calories. We will need to continue to explore how we can help people reduce their calories. That gets you into culture. I am not very PC, but I worry that we have resized women's dress sizes so that a size 14 now was a size 12 when I was a student. We have normalised being overweight. If you look at the data of people getting larger and fatter, we have to find a new way not of ostracising people who are obese and making them feel bad about themselves, but somehow helping them to understand that this is pathological and will cause them harm. We have a generation of children who, because of being overweight and their lack of activity, may well not live as long as my generation. It will be the first generation that lives less. That is of great concern.

Q21 Dr Wollaston: Do you think it is time to be more directive rather than to have nudges? There has been some controversy this week about issuing vouchers for sugar-free fizzy drinks and even Uncle Ben's rice, as these might be slightly less harmful products. Is it the place of Government to be sending out product endorsements, or is it the place of Government to get tough and actually make sure that, at the point you buy, there is a price differential between high and low-sugar products? Should we be introducing the equivalent of some kind of taxation on unhealthy foods?

Professor Davies: It comes down to your philosophy, and I am, as you know, appointed statutorily to be independent and to advise a Government of any hue. I will work with either side to try and get the best for the public, but I do think that until the Government are strong with food and drink manufacturers—saying that they will regulate if they don't reformulate, resize and do things—they will not do it themselves. We need to be both strong and prepared to regulate. I think that the science is going in such a way that we will find that sugar is addictive.

It will be interesting to hear whether it is still the same in clinic. I looked after sickle cell patients in Brent, so many were very poor, although I saw lots of diplomats' children too. Mothers, in my experience, would come in with their children glugging away on orange juice. I'd say, "Uhm, orange juice!", and they'd say, "Yes, well, orange juice is healthy." One glass of orange juice is, but I don't think we have managed to get over to the public how calorie-packed fruit juices, smoothies, colas and the other carbonated drinks are. We want not only reformulation, but also we need to have a big education push so that people know that one is fine but not lots of them. We may need to move to some form of sugar tax, but I hope we don't have to.

Dr Wollaston: Thank you.

Q22 David Tredinnick: Following on from what Sarah was saying, is there not another problem related to these drinks, and that is the E additive problem, where you get hyperactive behaviour very often with children who are on these drinks for a long time? It also interferes with their ability to work at school—their concentration. Is that not something that we need to keep looking at?

Professor Davies: I know that some educational psychologists advise an exclusion diet for children who are overactive, to find what it is that contributes to their excessive activity, and on many occasions they find something. Clearly, there are dietary issues that, for some children, can contribute to their overactivity. I don't know enough about the detail to know what those are.

Dr Lemer: No.

Q23 David Tredinnick: I respectfully suggest to you that it might be well worth looking at because I think there is a major problem out there for some children who get very negative effects from these drinks.

Professor Davies: That is why an exclusion diet is a very good way—

David Tredinnick: Going back to what has been said about taxes and things like that, the Blair Government, to my recollection, excluded fizzy drinks from schools, and that made a very large difference to helping children get off fizzy drinks. They had to go out to a corner shop and actually had to make the effort to get away from school to obtain these drinks, which I think made a significant difference.

Q24 Chair: You may have noticed that the Committee published a report on Public Health England a couple of weeks ago in which we were critical of the ability of the record so far of Public Health England to develop a structured set of priorities and to follow that through from a policy perspective. I notice that 12—half—of your recommendations are addressed at Public Health England. What was the nature of your relationship with that

organisation, and how do you feel they are doing in following through the recommendations you made?

Professor Davies: I am appointed to be statutorily independent—a post that has been going for about 165 years. I am the professional head of the public health profession, despite having no formal training in public health, but I am getting to be quite good at it, and I meet with senior members of the profession on a regular basis. I have a monthly meeting with the senior doctors of Public Health England to share what they are working on, what the issues are that are concerning me, to have an evidence-based debate and to offer them my advice if they want it. I meet regularly with the chief executive to know what is on his mind and talk about what is on my mind. I think they have made a good transition; it was not easy from multiple areas. I think the health protection is excellent and it is something we can be very proud of. They have what I would call breadth and depth in what they do at every level, including the science.

What Public Health England is now trying to do is build health improvement. That is much more complex because that sort of public health is not something that anyone in the world really excels at. We have some pockets of good health promotion and ill-health prevention in some of the universities, but people don't want to come out of those and become civil servants. I, from NIHR, since I set it up in 2006, have steadily been expanding our public health research portfolio. We have £4 million or £5 million a year and an NIHR School for Public Health, which is doing evaluative research of interventions for health promotion and health improvement. It is a difficult area to develop and I think they have started just fine. Getting the best people is not always an option for them because the best are in short supply and are in the universities.

Q25 Chair: I was interested that you started your answer with the words that you are statutorily independent, which is of course true, and what we as a Committee were hoping to see and still do hope to see—we would not wish to be overly critical—from Public Health England is the embrace of that concept of independence in order to provide greater authority for the development of a public health agenda. We agreed in our report with what you say about the health protection activity of PHE, but it is the development of the health improvement/health promotion activity where we felt there was not sufficient focus. When you speak of independence, do you see independence in that context as giving you the authority to be a voice independent of Government and of other pressures—to speak truth unto power, in other words?

Professor Davies: I am that, but it comes from two things. It comes from my appointment, but it also comes from the way I function and my character. It comes from the fact that I am very careful to make everything evidence based and speak to the evidence. The advice I have given Public Health England is that, while they are civil servants and an agency, what they need to develop is not an advocacy independence but an independence based on that authoritative voice of knowing the evidence, knowing the situation and being able to speak to that, because I think that sits with the reality and is doable.

Q26 David Tredinnick: Dr Lemer, this is really for you. You worked at the World Health Organization, as I understand it, in public health, quality improvement and developing clinical leadership programmes. I imagine you are aware of what I understand is the World Health Organization's commitment to integrated health care. They have said that we now need to go beyond conventional medicine and integrate other disciplines such as herbal medicine, acupuncture and maybe homeopathic medicine. Is that something that you have

looked at yourself, and do you have a view on integrated health care, making use of a wider range of options to treat in the health service?

Dr Lemer: That is not my area of expertise, so I don't really feel qualified to answer that, I am afraid.

Q27 Grahame M. Morris: You mentioned a little earlier on about some of the work that you had done with parents and children. In your report you say that you can identify an "all-too-common mismatch between the expectations of children and young people and their families and the reality of healthcare delivery." In relation to the role of GPs in this, you are recommending that there should be a GP for each child suffering from a long-term condition. I wonder again about the specialist training that GPs receive in relation to either long-term conditions or, more especially, training in child health specifically, because I understand some GPs don't have that; they are very much generalists. How good is the service that we are currently providing, and what measures could rectify the inadequacies that you have identified in the report?

Professor Davies: I should say that I admire GPs. I could not do the job they do and I think most of them do a very good job. I would like to see them have more training, but this recommendation is much more like the ministerial request that there should be a named GP for every elder. If you have a long-term condition, you don't want to see a different doctor or nurse each time. You want someone whom you relate to, who can help you navigate the system. It may well be that it ends up that there is a named practice nurse who helps navigate the system. My patients used to come in with sickle cell disease—they are never cured—and they hadn't managed to navigate the system. They needed one person who could just say, "You need to do that," "I will make a phone call," or, "Actually, you don't need to do anything. You are fine." So it is that. It is wonderful if they have great expertise, and I hope over time that will grow, but it is about having someone who cares about them and helps them navigate.

Grahame M. Morris: Okay.

Chair: Mental health—Rosie?

Q28 Rosie Cooper: Do you know why the child and adolescent national psychiatric morbidity survey has not been repeated since 2004? Is there strong evidence of an increase in mental health problems among children and young people over recent years? If there is, what would you attribute that to?

Professor Davies: I don't know why it has not been done. I just note that it has not and I have asked for it to happen. We could think of 101 reasons and I don't know. Is there real evidence of an increase in morbidity? I hear stories and I think there is some evidence. We will have to dig it out and send it to you. I think there is some but very limited evidence.

Q29 Rosie Cooper: I note the exchange we have had previously. Your report suggests a survey to look at prevalence of mental health problems and also an annual audit of services and expenditure. Do you think a lack of up-to-date information would cause problems with commissioning these services?

Professor Davies: By definition, it does because you can only commission on either history or conjecture—but not on fact. You will know that I like the evidence. I think it will play another role. It will show us the reality, and that is important, but I think if we have that data it will provide a focus so people cannot escape. "If you have that many on your patch, what are you doing?" I hope it will make sure there is no place to hide.

Q30 Rosie Cooper: Great. As an MP, I regularly come into contact with families who have children who can't access services—the kind of things that you have said before. In fact people with children can't access services when they need them. It almost is that there is that problem. I have evidence of that problem—I see it far too regularly. There has been disinvestment in CAMHS, with those long waiting lists and thresholds being too high. If the very families you are talking about do not get that help now while their children are young, then we just build those problems for the future. How do we address that today?

Professor Davies: Everything is a question of prioritisation. I am told that Monitor and NHS England have said that the tariff next year should be minus 1.5% for the acute sector and minus 1.8% for the mental health sector, and the difference relates to the need for £150 million for the acute sector to address the Francis inquiry issues. That ignores the Winterbourne View issues or the Francis issues in mental health, let alone a historical lack of focus in the area. I am very worried, and you will have seen the papers from YoungMinds where they did an FOI and found disinvestment even at our jewel-in-the-crown hospital, the Maudsley. So I am worried that prioritisation is not looking after these people.

Q31 Rosie Cooper: How would you recommend that we as Members of Parliament highlight this fact and start to address it? This is a very serious and hidden problem, and I know Sarah is going to come on to another part of what I think is a really serious problem about access to beds and things like that. How do we address this?

Professor Davies: It needs a focus and I am delighted you are looking at it. I think the policy of parity is a very important policy, but it is not being played out on the ground if the tariff works through in that way. I understand there is some renewed discussion about it. That is why I did a report; that is why you are looking into it. One of the objectives of my report, when we started the work, was the hope that with the timing it would feed through into the manifestos of all the different parties, because this is an important area.

Q32 David Tredinnick: Can I come in on a couple of things here? I think earlier on you said that 75% of children's mental problems start before the age of 15.

Professor Davies: I said 75% of adult mental health problems start before 18 and 50% before 15, excluding dementia.

Q33 David Tredinnick: When we looked at personal budgets a while back and we had a presentation from the Department about this in another Committee, it was clear that people were choosing to get benefits from yoga, tai chi and even piano therapy—a whole range of different things which might not be seen as mainstream. To what extent are you focusing on children with mental problems having access to mindfulness—I mentioned yoga and tai chi—and meditation generally? If you can get people to have that moment of quiet—it used to be at prayer in the classroom, but that seems to be less in vogue now—a moment of peace and to be able to do breathing exercises, fourfold breathing or hatha yoga breathing, simple breathing exercises, I put it to you that this is one of the ways of reducing the stress and mental problems in children and is very inexpensive.

Professor Davies: School has a massive role in reducing anxiety through many things like that or physical exercise as well, and that will help a number of children. But I think I am even more worried about those children where, despite good schooling, self-harming is increasing. My children have now just left school, but I was quite horrified to see their friends who were self-harming and how this was becoming almost acceptable. They need real specialist input to have the support so that they stop self-harming.

Q34 Chair: Is the key in that word “specialist”? I wonder how you design a service that responds to what you describe as the increased awareness, at the very least, of self-harming and eating disorders and such things. Is it just increased awareness or is it increased prevalence, and how do you design services that address those patterns of behaviour as effectively as we would want to?

Professor Davies: I am clearly not an expert. I think we are more aware that there is more self-harming and I think there are also more eating disorders. I did get the experts to help describe in chapter 10, page 8 what an acceptable child and adolescent mental health service would look like. I would go back to the comment I made earlier that we do have the data that, where people stick to the evidence base and delivered evidence-based services, the outcomes are better and there are financial savings. So I do think we need specialist input.

Q35 Dr Wollaston: I completely accept the point about this being an investment to prevent worse problems, but even with that investment there will be some children who need tier 4 services. Do you share the view that in tier 4 services the bed shortage is completely unacceptable at the moment? In my area, the response has been to invest in two members of staff to be bed managers, so, rather than in investing in having beds locally, it is investing in people to be on the phones trying to find them a bed elsewhere. Is that an issue that you recognise?

Professor Davies: I have seen the newspaper reports and I have heard the stories, and it is unacceptable for children who need secure accommodation to end up in police cells or even miles away. So that does need sorting. But that is a small problem. When I discussed this whole area with Professor Dame Sue Bailey, the outgoing president of the Royal College of Psychiatrists, who is a forensic child psychiatrist, she was very keen that we all recognised that if we did more at the preventive early end we wouldn’t need so many beds. Some of this lack of beds is because the children are not being picked up and dealt with when they present, so they spiral downwards.

Q36 Dr Wollaston: So we should be focusing our efforts on prevention.

Professor Davies: We need to put a big effort up front on prevention and early intervention, as we recognise we need to do in adults with mental health problems.

Q37 Chair: Is that not a familiar story—and not just in mental health services either for children or for adults?

Professor Davies: It absolutely is and it is the theme of this that there is a return on investment for doing prevention and early intervention, yes.

Q38 Dr Wollaston: Following on from that point, where you have children who are using tier 4 services, an issue that has been raised with me on a number of occasions is the transition to adult services. Only this week I heard from the parent of a child with severe difficulties where, for years, she had tried to access some arrangements about the transition and in fact nothing happened, and, on the day, they are just abruptly told that the service is going to be terminated. How prevalent is that and how do you think you can actually change that practice?

Professor Davies: There is a very big problem with transition and there is a big piece of work going on at the moment. It is called “Closing the Gap: Priorities for essential change in mental health,” published on 20 January. That is happening and it is important.

I did reflect, and I would invite you to reflect, on the UN definition of children, which does not stop at 18; they are under 25. If you look at the development of the brain, it is in utero the first two or three years of life and then rewiring in adolescence, when you can have most impact. Transition is most painful and difficult. It did cause me to reflect—I have not put it in this report because it is not evidence based—on whether we are trying to transition too early, and would it be better if we took some investment, continued with these young people until the age of 25 and then transitioned them?

Q39 Dr Wollaston: As they do elsewhere. Thank you for that. That would be your main reflection on it.

Professor Davies: It is a new reflection that I am beginning to debate.

Q40 Chair: Is it true, as Sarah says, that the transition takes place in other countries at the later age?

Professor Davies: I think it does for some things.

Dr Lemer: I don't know about mental health, but definitely for physical health other countries transition later, and in this country we are starting to think about holding on to young people while they go through university, because it is slightly strange to transition into an adult service and then go to a totally new adult service when you move. We are starting to think about the point of transition and how we do that more effectively.

Q41 Dr Wollaston: Or to make it more flexible so that you transition at the point that is most appropriate—

Dr Lemer: —you are ready. There is a lot of work going on trying to accept that transition is not a single moment. You have to first come to understand your disease and your disease management as a family, and then as a young person. That is a process, and different people do it at different speeds.

Dr Wollaston: Thank you.

Q42 David Tredinnick: Staying with early interventions, we have heard that early intervention is especially important in children's and young people's mental health to prevent problems worsening and to reduce the need for in-patient care. You have emphasised the importance of early interventions, but your report acknowledges: "There may also be reluctance for agencies to invest in interventions when they themselves may not benefit from any savings accrued, for example by providing early intervention." In your view, how can early intervention in children and young people's mental health services best be promoted? Some of this we have obviously touched on, but do you have a view on how best we can promote these interventions?

Professor Davies: I suppose the more linkage you have to later, which might again argue for a later transition, the more argument there is for investing earlier because it is your same service. You could say that extending the service would help. As we move to more integrated services, NHS social care in adult life and trying to make the children's services more joined up, I think it will become more obvious that we have to do the early work. But it is the magic grail. If we could work out how to persuade people to spend money now to save it for someone else in society, we would.

Q43 David Tredinnick: Okay. May I ask you a philosophical question? You have, I think often, talked about evidence-based medicine and you mentioned it in the report, but,

traditionally, there was also another way—and that was observation of parents and observation of what has happened. Does it worry you that the recognition of observations of GPs and nurses has become less important and that we might be getting now to a point where we are over-reliant on evidence in terms of double-blind, placebo-controlled trials? Have we lost the human touch—the common sense? We have people coming in front of us in our surgeries—advice bureaux we should probably call them—on Fridays and they may have four, five, or 10 minutes, or maybe longer if it is needed, and we very often have to make very difficult decisions based on observation. We don't have the files. We have simply the person in front of us, and we may have to judge whether they are lying or telling the truth or how serious it is. I have been in the House for over 25 years and, hopefully, have developed some skills in observation, and one hopes we can get some of these things right, but I wonder if sometimes we haven't just let that side of doctors' skills slide.

Professor Davies: I don't think they have atrophied. I think that the mark of a good doctor is someone who can listen and who can examine a patient. I was discussing with a colleague recently how important laying hands on patients is. When it comes to having made a diagnosis, the treatment is best evidence based. Observation—which takes many forms—is key in that diagnostic stage, and in the management of the patient and building that relationship. Humanity remains a central core of a good doctor, and if I lose it I would not be a good doctor.

David Tredinnick: Thank you very much.

Q44 Chair: But if you become concerned that your professional colleagues are becoming inadequately focused on the evidence, you will be the first to tell us.

Professor Davies: You know I will, but humanity and evidence are not in tension.

Q45 Dr Wollaston: Can I come to the point about how important you think building resilience is within preparing people for preventing problems later on with their mental health, and what forms do you think give us the greatest return in terms of building resilience?

Professor Davies: I very much like Sir—what's his name?—Rutter—

Dr Lemer: Michael.

Professor Davies: —Michael Rutter's metaphor that we use. Sorry; we have a Harry Rutter, who does obesity, and I was going to come out with the wrong Rutter. Sir Michael Rutter's metaphor is that we inoculate children with dead bugs or modified bugs to protect them against infection. We need to do the same socially and psychologically to develop their resilience and protect them against the knocks of life. I think that does explain it. If children are mollycoddled and protected and do not learn how to take risks or cope with what we might see as normal life, how on earth will they build the resilience they need? It is there in the management literature about leaders. The ones that are really good leaders have usually gone a distance from head office or wherever; they have made mistakes, have learned from their mistakes and have learned how to lead. All of us, as children, as teenagers and adults, have to make mistakes and then rectify them to learn from them. I think resilience is incredibly important in children.

Q46 Dr Wollaston: Particularly, presumably, with things like exercise, with so few children actually taking exercise.

Professor Davies: Yes, because they might fall off. Oh dear, I might get into—

Dr Wollaston: —the health benefits of cycling.

Professor Davies: Absolutely. In my annual report that is due out at the end of this month, I have the data on cycling and the risks. The deaths are no higher than walking, but severe injuries are higher so we do need to do something about making cycling safer. But that does not mean people shouldn't cycle.

Dr Wollaston: Thank you.

Chair: Good. You were going to ask about training too.

Q47 Dr Wollaston: I am going to be back on my bike in a couple of weeks.

Coming back to the issue of training, we touched on your comment that GPs have a pivotal role here. Do you share some of the concerns that the position of GPs within LETBs and deaneries is being downgraded, and that, if anything, we are seeing more of a focus towards the hospital specialties and less of a focus on the needs of GPs within the training? Are some of the concerns something that you are aware of?

Professor Davies: That has not come to my attention. I will keep an eye out.

Q48 Dr Wollaston: Is it something about which I could forward you an e-mail from a—

Professor Davies: Please do.

Dr Wollaston: Thank you.

Q49 Chair: We were talking earlier about the fact, whether we are looking at children's or adult mental health or, indeed, the full range of health and care services, that there is a huge need for the system to put more emphasis on early intervention and prevention, and on joining up the different bits of the system. One of the things your report places emphasis on in child services is the importance of joining the schools into this process. Coming back to the question, in his absence, that Grahame was asking around levers, given the full agendas, the budget pressures and all the other pressures of real life, how, in practice, do you think the schools can be engaged more effectively in a joined-up delivery of services for children?

Professor Davies: It will be multifactorial. I will start and then the expert can come in. At the moment PHSE is not obligatory. I think, although it is very variably taught, from good to poor, it is important and children should learn it. There is something about the offering from the school routinely: it is PHSE, exercise, plenty of water and good food. Then: how do they offer more? There is some work going on at the moment about trying to refresh school nursing, which I think will play an important role, and school nurses are commissioned by the local authority public health budget. Then there is how they link up with other bits of the system. One of the things we miss is a shared number. I would dearly like education and social care to use the NHS number so that we can link children where there are problems. We don't need to link them if there are no problems, but where there are problems it would be very helpful to support those children if we knew about those things.

Q50 Chair: Is it also something to do with the skills available to the people actually in the schools—the teachers and the support workers in the schools?

Professor Davies: I am sure.

Dr Lemer: There is an element of that, but it is also thinking about the role of school nurses: how much they are supposed to cover; how much of their time is currently spent, rightly, on child protection and safeguarding; therefore, how much time they have to deal with long-term conditions in school, and how we can manage to change that balance safely without affecting one versus the other. There is also an opportunity—

Q51 Chair: Can I interrupt? Is there not a danger, if health and care in the context of school is seen as the preserve of the school nurse, that we are entrenching the silo rather than breaking out of it?

Dr Lemer: Absolutely. I was going to come on and say that the other part of that is using the whole school as an opportunity both for health promotion and health improvement through things like resilience building, physical activity or other activities. We know, for example, that when children engage, often, in extracurricular activities it builds what is called school connectedness and that can have a very positive effect on reducing exploratory or risk-taking behaviours among children and young people. We know it is more than just about what school nurses do. There are also opportunities in schools to help young people and, indeed, their families better understand health care systems, because children are often the people who guide their families through systems if English is not their first language and things like that. So it is more than just about school nurses, but I think school nurses are a key touch-point where different parts of the health care system can connect into the school and they need support. As Dame Sally was saying, that is being looked at, but there is probably more we could do with that group.

Professor Davies: What we have not talked about is pre-school and support for parenting, support for women in pregnancy who have a history of mental health and might develop perinatal or postnatal depression, and the emerging evidence from the Family Nurse Partnership that intensive input can really turn some of these families round. So there is a pre-school element as well, which is very important.

Chair: That leads neatly into the question that Grahame was going to ask. I asked the question about the relationship with schools in your absence.

Grahame M. Morris: Forgive me, I had to go and do something else in between.

Chair: It is team work.

Q52 Grahame M. Morris: Yes. Just leading on to that—and you touched on it—have you addressed the issue about school nurses and the role that they could play?

Professor Davies: Yes. We have just been talking about that.

Q53 Grahame M. Morris: School meals and so on. I will read the transcript. In relation to the role of parents in supporting children, could you share your thoughts with the Committee on that?

Professor Davies: Clearly, parents, or whoever is the guardian, are key for children, and not all people who have children know how to parent.

Q54 Grahame M. Morris: I was thinking specifically about mental health, and what support should the institutions and the professionals be offering to allow parents to provide the necessary support to get the best possible outcomes for children?

Professor Davies: If there is no illness—mental or physical—in the children, then we need to support them to be good parents. If there is actually illness, then again we come back round to the services that need to be provided, starting from the general practice in primary care and making sure that it wraps round the child effectively, which is why for children with long-term conditions, which includes mental ill health, I asked for and there needs to be a named GP.

Grahame M. Morris: Yes.

Q55 Chair: That includes support for those children in the school.

Professor Davies: Yes, absolutely.

Q56 Grahame M. Morris: Just to recap, fundamental to that is the named GP for children with long-term conditions.

Professor Davies: Yes.

Q57 Grahame M. Morris: You have also identified support that should be available through the school, either formally or informally, through the school nurse or counselling.

Professor Davies: They clearly need support in the school if they have problems, and, in my experience, school nurses and school teachers themselves play a key role.

Q58 Grahame M. Morris: From my experience as well—we have a high percentage in the numbers you quoted earlier: one in 10 in East Durham and in some schools it is one in three—there is also a role for that specialist support staff to provide support to the parents as well, because sometimes the problems are at home.

Professor Davies: Yes, and the parents, if they are supported, will understand the issues and be able to cope better and maybe wind the worst bits down.

Grahame M. Morris: Thank you.

Chair: Sarah, I think, has a concluding question on youth offenders.

Dr Wollaston: I wanted to touch on the issue of section 136, but you addressed it earlier on, so thank you.

Q59 Chair: I think that covers the main points that arose for us out of your report. Is there any other thing that you came hoping that we would talk about and we have not talked about?

Professor Davies: No. I am delighted that you have looked at it, and anything that you can do to help shift the debate away from putting a sticking plaster on something that is wrong to moving to prevention and early intervention would be very welcome. We, as a nation, need to shift to that. I also welcome any support you can give to raising the children's agenda up the priority list because they are our future. Economically, we are sunk if we don't make sure that our children come through all right.

Q60 Chair: If the purpose of an intervention is to achieve the maximum improvement in quality additional life years, then you start out with an advantage if you start young.

Professor Davies: Yes. It is a no brainer.

Q61 Chair: Yes. It is a pity, however, if all the discussion about the effectiveness of intervention is expressed in terms of money saved rather than improvement in the quality of individuals' lives, which is ultimately what it is supposed to be about.

Professor Davies: I agree; of course I do.

Q62 Chair: On that note, perhaps we can thank you for coming at very short notice, as we wanted to take this opportunity, and thank you indeed for what you have had to say and for your report. We look forward to your next one.

Professor Davies: Thank you.

Chair: Thank you.