HOUSE OF COMMONS

Health Committee

Oral evidence: Children's and adolescent mental health and CAMHS, HC 342
Tuesday 24 June 2014

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Written evidence from witnesses:

- Essex County Council
- North West London Commissioning Support Unit
- Derbyshire County Council
- Liverpool CAMHS Partnership
- Place2Be

Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Barbara Keeley, Charlotte Leslie, Grahame M. Morris, Andrew Percy, Mr Virendra Sharma and Valerie Vaz

Questions 227-335

Witnesses: **Barbara Herts**, Director for Integrated Commissioning and Vulnerable People, Essex County Council, **Steve Buckerfield**, Acting Head of Children's Joint Commissioning, North West London Commissioning Support Unit, and **Michael Upsall**, Children's Commissioning Manager for Derbyshire County Council, gave evidence.

Q227 Chair: Good afternoon and welcome. Thank you very much for coming. It is a great pleasure to be chairing my first session as Chair of the Select Committee. In doing so, I would like to put on the record, if I may, my thanks to Stephen Dorrell on behalf of the Committee for his exemplary leadership of this Committee. I hope to build on his very successful approach.

I would like very briefly to put on record that I have no financial conflicts of interest at all in this role but also put on record, as I have

done on many previous occasions, that I am married to a consultant forensic psychiatrist in the NHS who is with the Royal College of Psychiatrists, and acts as chair of their Westminster liaison committee.

Anyway, we are here to talk to you and hear your views, so thank you very much for coming. I wonder whether you could both introduce yourselves, perhaps starting with Ms Herts.

Barbara Herts: Hello. I am director for integrated commissioning and vulnerable people with Essex county council. I am also aligned to north-east Essex CCG. I am the lead children's mental health commissioner across the county of Essex.

Michael Upsall: Good afternoon. I am Michael Upsall. I am a children's commissioning manager in Derbyshire. I sit within the local authority part of an integrated children's commissioning team, which includes colleagues from Public Health and health commissioners too. My background is very much social care, but for several years now I have had the lead in relation to commissioning CAMH services.

Q228 Chair: Thank you very much for coming today. I know that Steve is going to be joining us shortly; he is on the way.

The first question is on the impact of moving in-patient CAMH services to NHS England. What do the panel feel has been the impact of that? Has it made it more difficult to commission preventative services and tier 1 services? Perhaps I could start with you, Michael.

Michael Upsall: At the point that the decision was taken that NHS England would become the commissioners of tier 4, manage it and manage the budget, we, together with Public Health, completed a survey of admissions to tier 4. One of the most striking things was the similarity between the needs of those who went into tier 4 and the needs of those who went into specialist children's home placements or other health provision—a very broad base of needs associated with abuse, neglect, substance misuse and domestic violence, but they of course have mental health presentations as well. We were at the point of wanting to talk about pooling budgets, treating them very much as complex cases with shared health and local authority responsibilities, with a particular focus on looking at all of their needs—not just their mental health needs and presentations, but their education, social care and long-term needs—in relation to improving their life chances. But of course that had to go on hold because the budget—the funding—moved to NHS England. It is not something that we have been able to take forward. We still want to take that forward. We are talking with NHS England about how we might do that, but not being in control of the

finance makes it very difficult. We can't invest in something different; we do not have the option. The other thing we also need to say is that our use of tier 4 has risen. It appears to have levelled off over the past six to 12 months, but it has certainly risen over the past three years.

Q229 Chair: Do you see co-commissioning as being the way forward?

Michael Upsall: Absolutely. It is a prerequisite.

Q230 Chair: Maybe I could ask you, Barbara, as well.

Barbara Herts: Similarly, in Essex we have seen a rise in our tier 4 provision. We have two units in Essex, one in the north and one in the south. The move to centralising the tier 4 commissioning with NHS England has made it exceedingly hard to plan and jointly commission, particularly for our looked-after child population. It has made it a very disjointed picture, and very difficult as well to get any kind of outcome data out of our NHS England commissioners. We receive quite a lot of activity data, but what we are not able to do, because of that separate commissioning, is step up and step down our children and young people from those units. We do not have the flexibility around the young person or the patient to meet their needs in the way that we want to for the best. Our experience has been that it has not been a very effective use of resources. We are terribly keen in East Anglia that we move to a co-commissioning model and we are working in the region very actively on that basis.

The other thing about tier 4 and NHS England is that we have had very little scrutiny from the Care Quality Commission, but we have had particular interest from Ofsted on the use of our tier 4 beds, and in wanting to meet the emotional and educational needs of the child and young person in the community. Wherever possible, we try to avoid tier 4 provision.

Q231 Chair: Thank you. We are going to come on to that in more detail later. Could you tell us how important you think tier 3+ services are and whether you commission them in your area?

Barbara Herts: We think they are terribly important. We want to have the ability to step up and step down. Ideally, we want as few young people as possible to go into those tier 3 services. What we are bringing about in Essex is the community model of CAMHS because these tiers are quite old-fashioned, and it leads to GPs trying to identify children's needs. We have found that it has led to a "computer says no"

culture because we are constantly moving around levels of need that are commissioned by different organisations and different people. We are terribly keen that tier 3+ is for our most vulnerable, but we have a sort of step down as quickly as possible to get the child and young person back into the community and into their school.

Q232 Chair: Thank you. I do not know whether you want to add to that Michael. If you agree, it is okay just to say that you agree.

Michael Upsall: I would agree wholeheartedly with what has just been said. Continuity is so important and the ability of services to go that extra mile when they need to can make such a difference. So much can be lost when we hand over to another service, especially when that service is a long way from where the young person lives or where their other supports are.

Q233 Chair: How do you think we can best achieve co-commissioning? This is my last question.

Q234 *Barbara Herts*: There is a tremendous opportunity with co-commissioning to bring commissioning closer to primary care, with the CCGs—to work with the GPs and the CCGs to pool budgets and also to work from need. In Essex we are working very much on an integrated commissioning model and we want to do that particularly for children's mental health. We see such an opportunity there. At the moment the needs particularly of our most vulnerable—because they are commissioned by NHS England—mean that there is separation, and we need to work very much in the community to pool budgets and co-commission with our GPs locally so that we can meet the need in the community and also of course bring the voluntary and community sector into that co-commissioning landscape.

Michael Upsall: Again, I would agree with everything that has been said. I would like to add that we are very much focused on total spend—all the spend by all the services that contribute to children's emotional well-being. In particular, we are very mindful of the fact that large amounts of money are spent on expensive services for a small number of children, disproportionately so. We have to get that expenditure down the tiers—forgive me, Barbara; we do not really like tiers either—much closer to universal services, where they are accessible and visible.

Q235 Valerie Vaz: You said that it was lots of expensive services. Could you describe that?

Michael Upsall: For the weekly cost of a bed in a tier 4 placement, we could be talking somewhere between £5,000 and £7,000 a week—£25,000-plus a month. You can provide a lot of bespoke services in the community with a lot less funding than that.

Q236 Valerie Vaz: I am not quite sure what you are suggesting. Are you suggesting it is not needed for those particular people, or that they could use something else that is cheaper?

Michael Upsall: If local commissioners had easier access to that funding earlier, we could make the money go a lot further to prevent—or at the very least delay and shorten—the amount of time that a small number of young people end up in tier 4.

Q237 Rosie Cooper: Could I ask both of you how your budgets are affected currently—over the last three or four years? Are they going up or down? What is the net effect on your budgets?

Barbara Herts: Our budgets are, inevitably, going down, but with children's mental health services we made a decision that through our recommissioning we are going to keep our budget stable as we recommission a new service. We have been very careful in Essex that, when we commission new services, those budgets are protected. For example, we have a multi-systemic therapy service for looked-after children so that we can get rapid access in the community as quickly as possible. For a service such as that, we are protecting it and making sure that we have enough for vulnerable people in the community.

Q238 Rosie Cooper: Overall, what percentage effect has there been on your budget, either in each year or over the last three or four years? What is the net effect?

Barbara Herts: The net effect has been a drop of about 10% to 20% in that budget, across ourselves and the health economy.

Q239 Rosie Cooper: I will come to you, Michael, if I may in a second. What about the CAMHS budget?

Barbara Herts: We have kept our CAMHS budget more or less constant over the past few years. We wanted particularly to protect the services for looked-after children, so we have seen some reorganisation in our budgets. For example, we have had less management costs and we have tried to integrate as much as possible to share those costs with the NHS.

Q240 Rosie Cooper: Forgive me; this might show my ignorance of the field. I know their needs will be greater, but why are we separating out looked-after children? You have mentioned it two or three times so far—protecting it for that cohort. Why not all kids? What are you really saying to me?

Barbara Herts: We want to have a very high service for all children and young people, but we recognise that we want to keep children such as looked-after children—that cohort who have very persistent mental health disorders—in their foster and adoption places, and we want that help to go into their home.

Q241 Rosie Cooper: If you are in that category but you are not looked after, would you get less support?

Barbara Herts: No, you would get the same support, but we would have more rapid access for looked-after children, more fast-tracking into our children's mental health services.

Q242 Rosie Cooper: So if you are not fostered, you are saying to families, "It is your problem for a bit longer."

Barbara Herts: Not really, no. We would just offer a different—

Q243 Rosie Cooper: In that case, I do not understand what you are saying.

Barbara Herts: We like to offer an early intervention service—

Rosie Cooper: Not for everybody, though.

Barbara Herts: For everybody, but what I am saying is that for looked-after children we also offer a fast-track service. That is where we would bring in multi-systemic therapy and other fast-track services to keep those young people in the community and at school.

Q244 Rosie Cooper: They are getting a different service to save the placement breaking down and costing you more money. It is in your own interests that you are doing it, really. Okay.

Barbara Herts: That's it.

Q245 Chair: Before we go on, may we welcome Mr Buckerfield? Would you like to introduce yourself to the Committee?

Steve Buckerfield: Yes, certainly. I am sorry if I was late. I was expecting to arrive at 3.30, according to the letter I received, but perhaps I misunderstood. My apologies anyway.

My name is Stephen Buckerfield. I am the acting head of joint commissioning for the inner-London commissioning support unit and I am employed by the Royal Borough of Kensington and Chelsea, so I am seconded to the health service from the three local authorities known as tri-borough.

Chair: Thank you very much. You are very welcome. I am quite keen that we move on.

Q246 Rosie Cooper: Can I just ask about the budgets again, please?

Michael Upsall: In Derbyshire, the providers are subject to deflators. I cannot comment on whether or not they are applying those deflators across all services. The sort of cuts we are talking about are around 1.7% to 1.8% per annum. The local authority also contributes to these services and, to date, their contribution has been maintained, but I have to say that there is a lot of pressure on local authority budgets and I do not know for how long that position can be maintained. To date, they have not taken any money out.

Q247 Rosie Cooper: Your services and CAMHS have not been reduced at all.

Michael Upsall: No; to date, no.

Steve Buckerfield: We also have a deflator; I think it was about 4% last year. The substantial budget stayed the same but the overall contract value was deflated by 4%, so there was a marginal impact and, just like my colleague, our three local authorities explain to me that they are facing up to a 25% reduction in grant or support over the next three years, and that is likely to impact on the local authority commissioned CAMH services, which are often tier 2, as it is called—early intervention, some support for looked-after children—although our numbers are going down.

Q248 Chair: You sent in a very helpful submission on this. How important do you feel co-commissioning would be in actually allowing you to manage more effectively within that budget?

Steve Buckerfield: Absolutely key. Without it I think we are in difficulties. We are one of the few commissioners—across the three—

who have a clinical nurse. She works to me, so I have the advantage of a clinical background as well as commissioning. She has made a tremendous difference during the last 18 months when she has been employed with us. She is co-employed between the three local authorities and our three CCGs.

Q249 Andrew Percy: Before I ask what I was going to ask, Steve, did you say that your demand for service is going down?

Steve Buckerfield: No. The contract value was deflated by 4%.

Q250 Andrew Percy: I thought for a moment that you said your demand for services was going down, which would have been contrary to everything we have heard from everybody else.

Steve Buckerfield: No. We are hearing of a 10% and 20% demand; it will be going up.

Q251 Andrew Percy: I just wondered if something different was happening in your area.

In your written submission and also in Barbara's, I think you both argued that CAMHS are overlooked; it is the poor relation when it comes to mental health services. Can you tell us why you think that is, and what you are doing to address it in your particular localities?

Steve Buckerfield: I agree that it is entirely overlooked. It is overlooked and neglected not by intention but because it is mostly bundled with adult mental health services. Our adult mental health services have enormous volumes, enormous difficulties and their own possible inquiry into the problems they have in relation to budgetary considerations and providing safe treatments and places for people. Children, I think, in the health service traditionally have been brought somewhat belatedly to the table. It is only very recently that posts like mine have existed, and we spend all our time going round saying, "And the children's point of view in this particular debate is?" If you do not have that, difficulties in other areas just subsume the agenda. The agenda in health is enormous. Unless you have people banging on about children and their mental health needs—and indeed other needs—they do not get heard, if I am frank.

Barbara Herts: I have a very similar answer. In Essex our children's mental health is part of the big adult mental health contract, which has a lot of demands on it. In our posts in Essex as directors of integrated commissioning, we are always saying, "What about the children? What

about children's needs?" As Steve said, the huge volume of activity in the NHS often overlooks children's needs. Historically, CAMHS has always been the poor relation to adult mental health. For example, in adult mental health we have had adult mental health tsars and more ministerial ambassadors, but that has not really been reflected in the children's world.

Steve Buckerfield: This year, because I had Jacqui Wilson, who is my commissioner, she was able to climb inside the contracting machine, which in the health service turns every year. Last year we signed the contract only to get ready to start the whole process again, which is a complete waste of resources, if I am honest about it, but because I had somebody who could get involved in the process, we now have proper service specifications, and we have a hand on the tiller that we did not have hitherto in relation to CAMHS and how things were being organised locally.

Q252 Andrew Percy: We are probably going to go back to another issue, but I have to leave, because I have another meeting, although hopefully I will be coming back. On tier 4 beds, Michael, in the evidence you submitted, you say: "The rising investment in more Tier 4 beds is funding the symptom, not the problem." Can you expand on that a little bit? Also—perhaps it is one for everybody to answer—obviously, with regard to this inquiry, we have had a trail of people who overall are responsible for local budgets up to now, and we have heard how terrible it is that commissioning for tier 4 beds has been taken away from the local area, blah, blah, blah. In my own area, we did not particularly have tier 4—we have no tier 4 beds in my locality and never have—and users have to travel quite some distance. To play devil's advocate, isn't there some sense in that service being commissioned nationally rather than locally, where you get potentially huge gaps in service provision across the country, and where you cannot guarantee a standard of service at that level across the whole country? I understand from a local point of view that it must be frustrating, but is there not a case to say that it makes sense on a small scale, which it is relatively, and for a small user group, to have it commissioned on a national basis? Could we start with Michael?

Michael Upsall: I would agree with what you said. NHS England is better placed in some respects than local commissioners to deal with those issues about standards—what should be in a contract, the price and stuff like that—because its ambition is to raise standards, and contain costs right across the country. But when you get to those smaller populations, local populations and their particular needs, it is "How does that engage with NHS England?" that we now have to turn our attention to. One of the consequences of having a gap there, rather than a partnership—rather than co-commissioning and working

together—is the risk that we see the gap widening, and more and more young people ending up in tier 4 provision as a consequence. In relation to self-harm—the comments I made in my submission—from where I sit, the information that we are getting from young people, from schools and other front-line services, is that they see a lot of young people under stress and with depression struggling to cope with bullying, cyber-bullying and all sorts of things, who start to self-harm. Instead of getting services to help them with that self-harm, they are more likely to end up in tier 4. That is the concern.

Q253 Andrew Percy: That is your comment with regard to its funding the symptom, not the problem.

Michael Upsall: Yes. Self-harm is a symptom of all the pain, anguish, stress and so on that they are experiencing. That is what we should be addressing. That is what we should be commissioning services for. For some, there will be a bit of tier 4, I am sure, but the rapid increase in the numbers of young people ending up in tier 4 for reasons of self-harm is very hard to explain in terms other than, "Where are the services below that threshold?" They are not there to match the demand for them.

Q254 Andrew Percy: Do you think having that designation of tiers is reinforcing that?

Michael Upsall: I think that we would very much like to be focused on needs and levels of need rather than on tiers, which are a way of describing different kinds of provision. "Different levels of need" is an analysis, and an understanding of that should give shape and direction to services, and inform the commissioning process.

Chair: Complexity of commissioning is something that Charlotte was going to address in her question.

Q255 Charlotte Leslie: Yes. Can you elaborate a little bit, all of you, on the impact that the complexity of commissioning has had on the landscape, and in particular on providers who are able to be commissioned, particularly local providers?

Steve Buckerfield: The good thing, I think, is that as a result of the NHS reforms, I now meet more doctors than I have ever done—unless I am ill. Previously there would be one or two that you knew, because they were sympathetic to engagement with other services. Now I have a lead GP in each of the CCGs. I even have a GP who is interested in CAMHS. Then you get into other specialist areas. Having those

clinicians with me when I go to a provider and say, "This is what we think we should do," makes a tremendous difference and is definitely an advantage. I would agree with the argument that you probably need a national approach to securing enough beds across the country because of different patches. In north-west London we had a collaboration of eight PCTs—as was—and it was good, but the rest of London was very patchy, and we lost the argument about whether or not we should maintain control. I am a collaborator; I do not mind who does it, but I want you to force people to collaborate with me because NHS England do not. That is probably not because they are unwilling but because they are currently too consumed with their own process. They explain they are still trying to find the contracts, and they do not understand how it works with their area teams and specialist teams. You remain sympathetic, but then you go back and they will not tell me who is in hospital. I used to know all the children who were in hospital; now I don't—they tell me to go and ask my provider. That lack of exchange of information with clinical commissioning groups is ridiculous. That is the bad side, I would say, and the answer is to force people to collaborate.

I would point to the Children and Families Act; we are now forced to collaborate between CCGs and local authorities, with education now talking to GPs. That was never happening before in any numbers, and that is as a result of the code of practice that has just been published and the legislation that goes with it. It is a long road, but I really think that forced joining up of the local welfare state is the way to go in relation to CAMHS as well as disabled children.

Q256 Charlotte Leslie: When you say "collaboration," on what sort of metrics?

Steve Buckerfield: Commissioning: making sure that if a child goes into hospital the same organisation has some incentive to make sure they come out quickly. In the evidence I read, there was lots of talk about tier 3.5 and a process to try to avoid children going into hospital or making sure that they had somewhere to come out to quickly. We had one of those, I think in Harrow; there are question marks over its future, because any money they save is now saving money for NHS England rather than the CCG. There is just no incentive, which is perverse. That was not the intention and we need to find a way to put it back together and get NHS England sitting down with local commissioners so that we make plans together with local authorities.

Barbara Herts: I would agree completely because, certainly in Essex, in our experience of commissioning by NHS England—although we have valued their quality impact in looking across the country for beds—it is

clear that there are not enough beds to meet demand. It has led to not getting any activity or outcomes data to plan for those needs locally. We need to be thinking more about an alliance of commissioning, where co-commissioning is taking place at a local level. The bureaucracy of some of the NHS England structures has been very difficult to work with, particularly when you are trying to place very vulnerable children at short notice and keep them in their own county rather than having in-patient beds that are often populated—as, for example, our beds often are—by children from other counties. We have not really seen planning by NHS England take effect as it was promised.

Q257 Chair: The whole point of it was to avoid gaps in provision, but we have heard from several witnesses so far that those gaps exist, so it has not achieved its stated aim and it is getting in the way of having integrated pathways. Would that be your view?

Barbara Herts: That would be completely my view of how it is on the ground, yes.

Steve Buckerfield: They would probably say it is evolving, but they could do with some encouragement to speed up because we need to see some improvement.

Chair: Do you want to add to that, Michael?

Michael Upsall: No.

Chair: I come next to Grahame to talk about another aspect of CAMHS.

Q258 Grahame M. Morris: It follows on from the complexities of CAMHS contracts. In your submission, Steve, you said that "Currently CAMHS contracts are very short," and you raise concerns about the annual renegotiations in terms of what that means for staff time and expert resource. I met with the North East Ambulance Service NHS Trust and, similarly, there were concerns about the CCGs, the number of commissioners and having very short contracts. Is that an issue for you in CAMHS as well?

Steve Buckerfield: Absolutely—a complete waste of resources. We have a floor of people endlessly going round this contracting round. A member of my staff has got very involved with it and she now understands it, but I feel I have to pull her back, otherwise she would just spend all her time inside the contracting process getting ready for the next line because there is so much detail. It is important to get it right, but you end up being a contracting person rather than somebody

commissioning services for children who have mental health problems. They should run for two or three years and then you might have some chance to see what works.

Q259 Grahame M. Morris: Why do we use such short contracts?

Steve Buckerfield: I have no idea.

Q260 Grahame M. Morris: Barbara and Michael, do you have a similar view?

Barbara Herts: A very similar view. For me, commissioning is all about meeting need and it is impossible if all your resources are tied up in a very expensive contracting process, rather than meeting that need for an area. Our policies are very much that when we commission, it is for three to five years; we are going for a long span of time in order to meet the need. I see a lot of wasteful activity in those short contracts.

Q261 Grahame M. Morris: I wonder what the rationale could be. Is it to deal with changes in demand? But there does seem to be an ever-increasing pressure on the service.

Steve Buckerfield: It is not just CAMHS. We do this with our acute hospitals. Everything is on a yearly contract. When I have asked the question, my local authority colleagues cannot understand it at all. They keep talking about, "When are you going to go to the market?" I keep saying, "Well, aren't there European rules about this?" I have to try to find a way to explain why we do not do that and why we roll them over each year, which is difficult to do. The only explanation I get is that the money is so enormous that it is very difficult to manoeuvre; you want to have the maximum scope to manoeuvre and a 12-month contract allows you to have that. That is a national position, not just my CCG.

Q262 Grahame M. Morris: Earlier, when you first came in, Steve, you mentioned the impact of the tariff deflator on CAMHS; you said there was a 4% year-on-year reduction. Could you clarify that in terms of what it means for the local authority element of the commissioning process?

Steve Buckerfield: It meant that that was also subject to 4%. We are now expecting that, because of the pressures they will be under over the next three years in relation to austerity expectations and savings, they will have to look at where they deploy their CAMHS resource, which is predominantly, in some of the boroughs, early intervention and

particularly looked-after children where, if I do not come up with a suggestion for reducing by 25% over those two or three years, they will have to go somewhere else and look for a larger reduction. It is a very awkward situation.

Q263 Grahame M. Morris: The local authority element is 25%.

Steve Buckerfield: That is what I am told—over the next three years for our three local authorities.

Chair: Grahame, you were going to follow that with one on expertise.

Q264 Grahame M. Morris: I was. In terms of your submission, you said that specific expertise about CAMHS commissioning is in very short supply. Is this just the case for CAMHS? What kind of impact is that having and how can we address it?

Steve Buckerfield: My commissioner wants me to tell you that the jobs need to be attractive to clinicians. We have managed to attract her to stay with us for 18 months, but there were some difficulties about pensions when she moved to us because she moved from a provider trust to us. The main thing is that you need to attract a mix of people; not everybody can have clinicians on their side on the commissioning process, but it has made a tremendous difference to us locally and helped us engage in a meaningful way in the contracting process and also with our provider. I read CNWL's submission to you and I could have written it—I agreed with virtually everything they said—which is a testament to how we both have a commissioning and contracting relationship, but agree about a number of things, which makes it quite a strong local offer for young people, albeit one that is under pressure from demand and finances.

Q265 Grahame M. Morris: Could I ask Barbara about the submission from Essex? You said that "it has become increasingly hard to find out about best practice since the abolition of the CAMHS national support service." What are your thoughts on the sort of support and guidance that CAMHS commissioners need, and do you have any particular views on that that you want to put on the record?

Barbara Herts: There is a great deal of need to share practice, to learn from the range of commissioning that is taking place across the country. A lot of that commissioning, as Steve said, is quite inexperienced. Since the loss of the national CAMH support service there has not been that sharing of practice to enable commissioning to go forward in a way that is really helpful for local authorities and clinical

commissioning groups. It is absolutely vital that we get more clinicians engaged in commissioning. In Essex, locally, we have created a clinical reference group which has membership from our local GPs, and they are a very active part of our recommissioning process. I emphasise the importance of sharing and learning, because, reading the other submissions for this Committee, it was very valuable to see those different approaches, even across different local authority areas.

Q266 Grahame M. Morris: Who should the guidance come from now? Should it be from local reference groups of clinicians? Is that what you are suggesting?

Barbara Herts: It could be from national organisations such as YoungMinds. We know that there has been some very helpful guidance issued recently by the royal colleges. I would like to emphasise the importance of that guidance having input from the royal colleges and clinicians, as well as from the voluntary and community sectors.

Steve Buckerfield: You do need that, but you also need to push back against it sometimes, because you need to have an understanding of what works—performance—and what is acceptable for families and children. It helps to have had some life experience, it seems to me. How long can families wait when they are concerned about their children? You sit in meetings with people who say, without parents being present, "The trouble with these parents is," and I am sitting there thinking, "I am one of those people. I would make a fuss about my child. I would want the best." It helps to have that understanding in a commissioner, because you have to demand the best results and standards of people who sometimes are in a difficult place to deliver them. If you just say, "Well, okay, because Dr So-and-so says so," you are losing it. You have to stand up to that.

Q267 Chair: Michael, you were very keen to come in on that last point as well.

Michael Upsall: Without wishing to detract from the importance of CAMHS expertise, our ambition in Derbyshire is very much about integration and the contribution that all services make. It is important that those services and users—the people who will benefit from getting it right—are engaged in helping commissioners identify what ought to be in the spec for services, and emphasising the contributions that all services make to children's emotional well-being and the part within that that specialist CAMHS take. It is so important to get that balance right and very important to bring it all together, to have documents, to

have strategies that we can show people that evidence the joining up, the bringing together.

Chair: We do not have an awful lot of time left. Rosie?

Q268 Rosie Cooper: The submission from Essex states that you "had significant difficulties in piecing together even a basic set of information about the numbers of children and young people accessing services." In Derbyshire you state that the "data gap is impacting on strategic decisions and planning." I would like to pose two short questions there and then come back. What does that lack of data cause for commissioners and what data do you need?

Barbara Herts: The lack of data causes almost a planning blight, because we know from the data that we have growing numbers of children with mental health disorders and that population is growing. But what so often we get as a complete gap is any data on outcomes. We want to know the impact, treatments and what the evidence base is. We know that this is an enormously complex subject, but I think it is where the children and young people's IAPT programme can be very helpful, because it is structured against interventions that are measurable and quantifiable. As commissioners we want to know that we are buying the most effective treatments, so I would make a plea for clarity in outcome and activity data, which, of course, is very complex when you have commissioning split across very many different organisations. Bringing it together in one place is quite a challenge.

Steve Buckerfield: I agree; IAPT is the way to go. You need outcome measures and performance measures that you can hold back to people and say, "Why is it as it is?" The other element—going back to the Children and Families Act experience—is the co-production that comes from having families involved, which has been very strong with disabled children, much less so in relation to families where a child has a mental health problem. We failed miserably to organise anything like that locally, for years of trying; but we got involved—I think with some Government help—with an organisation called Rethink, with young people. We now have young people who will come and talk to us about their experience of using our services; we are now using them. We launched some work with local councillors, GPs and young people, because we had Rethink working with us to support the young people that came along and talked to them about their experience. That is an important element.

Q269 Chair: But doesn't the NHS focus on things that can be counted? It can sometimes happen that, if it cannot be counted, it does not count, and you can end up with that kind of—

Steve Buckerfield: But if you have parents or young people contributing, their testimony can change things, even when the numbers are not there, because they will say, "This happens a lot," or, "Well, our services are like this," and then somebody turns up on a co-production process with our patient and says, "Actually, my experience was really difficult." It is individual—only individual—but it makes quite an impact when you are sitting round making a decision about what you are going to commission.

Q270 Rosie Cooper: So far you have talked about outcomes, which are really important, but I have been reading the Children and Young People's Mental Health Coalition's really fabulous document. It is very clear that not only should we be talking about outcomes, but we do not even understand the needs. I talk to professionals who say, "We commission in the dark, when it comes to CAMHS." For example, local authorities have little or no data on the real picture regarding needs within a local population. The data that you have is outdated—10 years out of date—and the rise of social media, which we will come to a bit later, in the last 10 years is seeing a new level and set of stresses out there for vulnerable kids. The only bit that you are really capturing is hospital admissions and the real almost crisis end of this, which reflects the themes that you have been talking about, but you do not have a clue what the needs are out there. Then I am told that means that the real issue of increasing provision for early intervention and cutting wait times for tier 2 and 3 services is not captured. Do you agree with that? Do you share that view? I am told that some local authorities do not have data in their joint needs assessment documents. That breaks the law. Is that true?

Steve Buckerfield: No.

Barbara Herts: No.

Q271 Rosie Cooper: You do not believe that is true.

Steve Buckerfield: It is not true. We do have information. I can tell you what our wait times are—I have them broken down by percentages—but it is only as a result of hard work and dragging it from our providers.

Q272 Rosie Cooper: But I am not talking just about yours. We are here looking at—

Steve Buckerfield: I think it is very patchy, without a doubt.

Q273 Rosie Cooper: So there will be some that break the law, if not you. I am told that is true. How can that be? How can it be that there are local authorities who do not have a clue what is going on and what their children's needs are? And it breaks the law.

Barbara Herts: It is a statutory requirement to do a joint strategic needs assessment, and it is good practice for children's mental health to do that needs assessment on a very regular basis. I would like to echo what Steve said; the needs assessment also needs to be coupled with the soft evidence from co-design, from children and young people and from carers, about their experience of services on the ground as well as hard data. But certainly my recommendation would be around frequency of the joint strategic needs assessment, because that is the only way that commissioning can be based. But I think local authorities are at a very different stage.

Q274 Barbara Keeley: The next couple of questions are really about the issue that Rosie started to mine. How do you as commissioners monitor the quality and performance of the CAMH services that you commission? Do you use outcome measures? You talked about the need for formal outcome measures. It may be that you do, but it sounds as if this is patchy.

Steve Buckerfield: We have quarterly meetings with our providers through the contracting process. At the moment it simply says that they have to be working on IAPT with a view to developing the principles that allow them to do it, because they are not at a stage yet to start saying what those outcomes would be; that would be next year. We get all the standard KPIs, the indicators you might expect—how long people wait, how many people are seen, the difference between assessment and treatment. We are asking more questions about what treatments they use and if they are evidence based. Each year we build in more. Equally, there is a limit to how much time and resource the providers have to actually produce all that. You want to have the key things rather than too many; there are about 10 things that you need to ask.

Q275 Barbara Keeley: Shouldn't it be a requirement of your contracting process?

Steve Buckerfield: It is.

Q276 Barbara Keeley: Why are you holding back, then? If you need that information, why are you worried about them providing it? You seem to be on the one hand saying it would help you to have it, and clearly we can understand that; but then on the other hand—

Steve Buckerfield: It is particularly the IAPT that is evolving because staff are being trained and coming back, and different providers are at different stages with regard to whether they have staff that are trained and can produce it.

Barbara Herts: Similarly, in Essex, because our children and mental health contract is part of the big adult contract, we have found it very difficult to extract data for children and young people. That is why we want to move much more towards an integrated approach to the children and young people's IAPT, so that we have that measurable activity. Certainly our commitment to integration will bring about a greater improvement in the data. But, as Steve says, it is about focusing on those 10 essential things to get out of the providers. Because there is variability across mental health providers, it is sometimes difficult to extract that information.

Michael Upsall: I would like to add that—again, I am pushing for integration—the local authority is probably better placed at this point in time to evidence engagement with young people and families, through children in care councils and youth councils, where young people are not only involved in reviewing services, but are involved in appointing staff and advising us as to what sort of staff we should be looking for. The closer we bring CAMHS to that way of working and the better we get that integration, the sooner we get the impact on the provision of CAMH services. It is very hard for them to do it alone. Certainly the IAPT programme is a massive step forward in that direction. There is no doubt about that. The feedback from young people engaged in those services is immediate and regular.

Barbara Keeley: Obviously there are some points that Rosie has just made about places where this is not being done well at all. Could I just move on to the—

Rosie Cooper: I am sorry, Barbara, you misunderstood me. I am not saying that they have done it; they have not collected that information.

Q277 Barbara Keeley: I understand. North West London said in their submission that "CAMHS receives very little if any scrutiny from the Care Quality Commission." Could you expand on that and tell us what you would like to see changed, if you think there should be more scrutiny?

Steve Buckerfield: I have never seen a CAMHS team inspected in the same way as I see other parts of the public sector inspected. We have concerns about our tier 4 providers. We are currently dealing with several complaints about them and we have shared them with NHSE, but we are the people writing the complaints letters and talking to the families; we are having the conversations behind closed doors about, "At what point do we go to the Care Quality Commission about a particular provider that we are concerned about?"

Q278 Barbara Keeley: Is that the same with you?

Barbara Herts: Similarly, our experience in Essex is that we have not had much involvement from CQC in children's mental health services. We have had more advice from our Ofsted colleagues, but really a very poor service from CQC. We have had to be very proactive ourselves in dealing with complaints to NHS England and sorting out the complaints and scrutiny ourselves.

Steve Buckerfield: To add to Michael point's about local authorities and young people, he is absolutely right, but in a parallel universe all the CCGs are setting up patient committees and getting the patient's experience. They do not have young people. Again, you could force them to do it together—encourage them, if you like.

Q279 Chair: Can I clarify one point before we move on? Is it because you have asked and they have refused to inspect?

Steve Buckerfield: No.

Q280 Chair: Surely it is incumbent to a certain extent on you raising concerns with the CQC and asking them to inspect. Is that something you are doing?

Steve Buckerfield: No, we have not done that.

Barbara Herts: We have not raised concerns yet to CQC, but we are regionally talking to them about how we could engage them in the future.

Q281 Barbara Keeley: Is it a capacity issue, do you detect, or do they not see it as part of their brief?

Barbara Herts: We have detected that they do not see it as part of their brief.

Q282 Chair: In future, do you plan to address that by directly asking them?

Barbara Herts: Yes, we do.

Chair: Thank you. Maybe that is something we could raise with the CQC next year at their accountability hearing.

Q283 Rosie Cooper: A CAMH service provider described a service in their local area, which had been jointly developed between several agencies, becoming "nobody's child" and deprioritised because no single agency owned it. Is that a difficulty that you as commissioners recognise, and how helpful are health and wellbeing boards in that event at promoting the integrated working and ownership of services that are supposed to be there?

Barbara Herts: I think the health and wellbeing boards have an enormous role to play in really forcing the integration of this subject, and in Essex we are committed to that integration at health and wellbeing board level. That is why, with an integrated commissioning model, we think we are going to have far more impact than separate strands of commissioning.

Q284 Rosie Cooper: I am almost confused, in the sense that you believe health and wellbeing boards have an important role, yet health and wellbeing boards produce the joint strategic needs assessment, which earlier on we acknowledged do not have the data upon which you could make those decisions. It all seems a bit stupid to me. What power do you think they have that would enable this to be delivered?

Barbara Herts: For instance, health and wellbeing boards have just received five-year integrated plans from local authorities and CCGs. There is a really good opportunity, in the integration of those plans for health and wellbeing boards, to scrutinise, challenge and promote integration in their local area. Again, it perhaps goes back to the point that children's health, compared with adult mental health, is more of a marginalised subject, and many health and wellbeing boards are not addressing children's issues as well as they could be. That is something that we need to grow and develop.

Q285 Rosie Cooper: Absolutely, but if they are the people who are not doing it and they are the people who are supposed to be promoting it, it is a really difficult bit.

Steve Buckerfield: Our JSNA does have children's information in it. It has CAMHS information in it. We have Councillor Robathan in Westminster council, a talented, passionate local politician, who tasked me to do a task and finish group on CAMHS and report to her in September. She came to the launch. With people like that in local authorities, health and wellbeing boards are in good hands. Maybe we are fortunate, but that kind of process has made quite a difference. She was very involved, and she expects a report back in a month's time; I shall be talking to her about this. It works. It is an enormous agenda; maybe we are fortunate.

Q286 Chair: We have quite a lot of things to get through. Michael, did you want to add to that?

Michael Upsall: Only very briefly. They are new—

Q287 Rosie Cooper: They are new with no power.

Michael Upsall: They are new in terms of still establishing themselves. Yes, there are problems with data quality, but they are helping us improve the quality of that data and it is getting better.

Q288 Chair: Can I return now to an issue you touched on earlier, Michael, which was the prevention services and particularly the role of voluntary services? Do you think there are issues at the moment with funding voluntary services that can help to prevent children coming into the system at higher tiers, at a point when they are more unwell, and how do you go about weighing up the evidence for funding voluntary services at tier 1?

Michael Upsall: Yes, I think, has to be the answer to that. The one thing that would make a difference would be if there was some transitional funding that would help us to put in place, get up and running and get started some of the early intervention initiatives, some of the things that we know the voluntary sector can do very well but we don't have the money to give them to get started. If they apply to Children in Need or for lottery funding, it is time-limited; it is going to run out. We have to find the money to keep it going. We need something to get us started. Once the savings are made at the higher end, it will become self-financing. It is how you get it started that we are struggling with.

Steve Buckerfield: Most of the funding of the third sector that was in health was in Public Health, so that has now moved into the local authority. It is ring-fenced in Public Health and they would be part of driving JSNAs and making sure information is better. Public Health is a real asset for local authorities to exploit, I think. But local authorities, of course, as I mentioned before, are subject to austerity, and the very same money you might want to use to grow your third sector—voluntary organisations—will be under scrutiny in terms of reductions.

Barbara Herts: I think the voluntary and community sector are absolutely essential for that early help offer. Bringing together Public Health grants, local authority grants and any CCG grants to concentrate on children's mental health is a tremendous opportunity.

Q289 Chair: We heard from witnesses at our users hearing and from the voluntary sector that they are just going from one three-month survival period to another. Is that happening in your area as well—that they are very vulnerable, with even more short-term funding than the ones you described earlier?

Barbara Herts: The pressures on local authority budgets have certainly led to a shortening cycle for crucial early intervention funding. In Essex, we are building an early intervention programme as part of our recommissioning of CAMHS because we want to include the voluntary and community sector in that recommissioning process, so that we are meeting needs at the earliest possible stage and making sure that we are using the best of our Public Health money as well to support children and young people.

Q290 Valerie Vaz: How could we change that? Some of the people who put these things together—the wonderful individuals that we saw; we had powerful testimony from some of the young people who they worked with—did not even have a job by the end of June. How can we move it away from applying to Children in Need? Surely we cannot do that to our young people at this early intervention stage. They should not be applying to charities like that, where you may or may not get the money. How can we change it? Anyone?

Steve Buckerfield: I am not sure I have an answer to that. Where I work, the wiser charities have learned that you cannot rely on the local authority; if they change policy, the charity is in difficulty. The wiser ones will only have 20% of their funding exposed to the local council and will go to other sources so that they can sustain themselves through different changes. It is more difficult if we start to pare back our services; then we are looking for cheaper alternatives. We have to

look to volunteers, the voluntary sector—anybody who can provide a support service—because we have a continuum of need from distress to major difficulties and into mental health, and there is a variety of services that can assist. The voluntary sector can certainly start with early intervention, but of course there comes a point where they need to look for some assistance and more skilled intervention. We are trying to hold on to our resource to make sure it is ready to respond.

Barbara Herts: It is important not to have disjointed resources. That is why, with an integrated commissioning approach, you can pool budgets to be working with the NHS and with GPs; some of the clinical commissioning groups are also running their own separate grants programme. It is important that it is focusing on the needs of that population, the needs of children, pooling budgets towards an integrated approach. That is the way we can hold on to it.

Q291 Valerie Vaz: And presumably through Public Health.

Barbara Herts: Through Public Health as well, and through the leadership of our elected members in the local authorities. We have particular leadership in Essex around early intervention, and we have funded early intervention multi-systemic therapy through a social impact bond as well. It is about looking for creative and innovative ways to protect vulnerable services.

Michael Upsall: If we are looking to fund the pathways—integrated pathways starting in universal services, in communities where needs present—the role of the third sector is clearer. It is harder to ignore the contribution that they can make if you are looking to fund the whole pathway; they are there. We have some examples in Derbyshire where we are able to do that. We are talking about it at our next commissioning group. It is something we would like to take forward, but it is not an easy climate within which to do that.

Q292 Valerie Vaz: What would stop you taking it forward?

Michael Upsall: I think it is about sustainability of funding at a time when the organisations contributing to the pot are having to focus on core business, and it is sometimes difficult to argue that that is core business. You are not inspected on that. You don't fail inspections on that, and that is the harsh reality certainly for local authorities and for health services as well.

Steve Buckerfield: I would like to support Barbara's point about the leadership that Public Health can provide. Locally, we did not have a director of public health. We now have one. A meeting was held, led by

Public Health where, for the first time, the three CCG GP leads turned up, some of their staff came, I was there and colleagues from the local authority were there, and people did not know each other. It was a first for lots of people that have worked in this area of London for a long time. New boundaries were being crossed, and people were quite enthusiastic about where it might go. I think again it was because Public Health thought they had a responsibility to drive this forward. They do not have all the money, but around the table we have some money and that kind of collaborative process—

Q293 Chair: Do you see this as being the best opportunity to bring that money in from the Public Health ring-fence?

Steve Buckerfield: Yes.

Chair: Thank you very much. I am keen to move on because we are slightly overrunning.

Q294 Valerie Vaz: All three of you touched on the role of schools and education. Obviously children are there for a long time during the day, more than at other times. That seems to be a key area that you can look at for intervention. We put a lot of pressure on our young people now; we are asking them to do all sorts of things that I think, in my day, we did not do. A lot of them are growing up with a huge amount of pressure. What do you see, each of you, as the role of the school with young people? Is the school the best setting for counselling, for example, or again are we asking schools to refer them to a service that does not even exist for some of them?

Barbara Herts: Schools are completely vital in identifying early signs of mental health or low-lying issues that might develop into something serious. The role of the school nurse is particularly important in supporting those young people. For instance, in Essex, a lot of counselling is taking place in schools. We have quite a mixture of services that are provided straight away when we identify self-harm or an eating disorder. We are trying to create a rapid response to a GP or to a psychiatrist when things get a little bit more serious. We do not want schools to feel that they are vulnerable and have to deal with some of these very difficult situations all on their own. I think it is about providing support to the school nurse and the teaching staff, and also doing a lot of training with the teaching work force on issues such as self-harm and eating disorders.

We also know from research that the earlier, the better, so again we want to create an atmosphere of collaboration with our Public Health colleagues. They are absolutely vital because, with health visiting

coming into local authorities very soon, we want health visitors to be supporting schools and doing some of that training to support the most vulnerable families where children have mental health disorders.

Q295 Valerie Vaz: Does every school have a school nurse?

Barbara Herts: Not all schools will have school nurses, but certainly where we do have them, we want to be using them to concentrate on mental health as well as physical health. Making sure that there is not that separation is very important.

Q296 Valerie Vaz: In terms of education on well-being, including emotional well-being, is that taking place in schools now? Is that something that should or could be taking place?

Steve Buckerfield: I should explain that school nursing is a very thinly spread resource. A major secondary school like Holland Park has a day, or maybe two days a week; they asked for more and we could not give it. There is a major issue about how you allocate that very thinly spread resource across secondary and primary schools.

Michael Upsall: I would like to answer that question, if I may, with an illustration of the work that we have been trying to nurture and develop in Derbyshire schools. It is predicated on schools recognising and owning the importance of pastoral care and other services, and the link to educational attainment. It is not either/or; they are not separate. For some students, without that help they will not achieve. If and when schools own their responsibilities, if I can put it that way, they are very well placed to engage with other services like school nursing, primary mental health workers and multi-agency teams.

In schools in Derbyshire, we are trying to roll out a model whereby networking of those services within the school provides a platform whereby the school can monitor what is happening, who needs help, who might be in trouble, who might be being bullied and who might be at risk of self-harm. They can respond and they can draw down help from specialist services like CAMHS, rather than exporting the problem and making a referral for somebody else to deal with—they can bring the services into the school and provide the help within the school. We have had examples where there has been a sharp increase in presentations of things like self-harm, and the school, with those services, puts on a series of information events for students and for parents, bringing in people from the safeguarding board and other services to talk about online security, and opening parents' eyes to what is actually going on— the bullying that can take place. They are

providing that information so that the parents are getting help and the young people are getting information and help. That has shown that young people refer themselves for help; it is almost unprecedented within CAMHS, but they will do that in a school where there is a CAMHS presence. It can be done discreetly, in their lunch hour or after school, on their terms, the way they feel comfortable. Clinic-based services that are not integrated cannot deliver that; young people would not buy into it. There is a model of integration at the school level, which sits within a pathway, that begins to redefine the role of those specialist services in terms of help that can be drawn down; help that is accessible and immediate, not stigmatising; help where young people can sit down with staff in the school and say, "Can we do it like this?"

Chair: Thank you.

Q297 Barbara Keeley: That sounds like a good model, but I have concerns. A few months ago a 12-year-old boy in my constituency committed suicide at home 50 minutes after leaving school because he was bullied. What you describe sounds ideal, but there are a lot of situations in schools that teachers are missing. Clearly, in the case of a boy who commits suicide 50 minutes after leaving school, they were missing it all. The self-harm may not always be obvious. Some children internalise, don't they? It may not manifest itself as an eating disorder—it may be internalised.

My other concern relates to young carers, who are a group of young people who get bullied a lot. In my experience, often schools are not aware that a young person is a young carer. Unless a carers project goes in and does positive pastoral work with schools, it seems to me that there is something wrong. I want to draw out the point that seemed to be in the evidence: it is almost as if schools are too busy with other aspects of the curriculum to do this, yet if it results in eating disorders, self-harm or, at the most extreme, suicide, or in young carers being ignored and bullied and having their young lives and education ruined, should we be turning something round and saying that there has to be time for this?

Barbara Herts: Absolutely. We run a number of voluntary organisations that work in our schools. In the light of some very tragic teenage suicides in Essex, we have been running awareness-raising training courses with head teachers to promote learning among teachers about these issues, and about how you separate behavioural problems or self-harming where more sinister things may be going on. It is about raising awareness of the conditions but also, through the schools forum, making sure that children's mental health is on the agenda, and about taking initiatives into schools.

Q298 Barbara Keeley: But your submission seems to suggest that you think it is not being done, and that other aspects of the curriculum are taking over.

Barbara Herts: Sadly, unlike a few years ago, the emphasis on achievement and passing exams and the stresses and strains on young people and schools themselves to achieve high results have deviated and, perhaps, lessened the emphasis on pastoral care and the pastoral care lessons that used to take place. There isn't time in the curriculum now for children to learn themselves about how to be resilient.

Steve Buckerfield: I do not entirely agree with that. We spend a lot of time talking to head teachers. We have also had tragedies in our schools. We are producing guidance on self-harm and the difficult connection between self-harm and some suicides, because it is not straightforward at all. We have considered whether we should set up an advice line so that schools can ask a question rather than having to make a referral, but if they want to make a referral we will make that easier to do. We are keen to make sure that clinicians and head teachers have a conversation, because you can send in somebody who is very experienced and have a conversation quickly that can allay a lot of fears and answer a lot of questions. They cannot treat all the children, but they can make sure there is a connection between the crucial secondary schools and the local clinicians who know what you can do in relation to mental health in a local community.

Chair: It is a tribute to the interest that this topic has raised that we have overrun somewhat. I will bring Charlotte in for one quick final question. We will then have to move on to our next panel.

Q299 Charlotte Leslie: I want to pick up on something that Barbara said. I sit on the Education Select Committee. Do you think there is a danger that you think you cannot do anything in schools unless it is inserted into the curriculum? From observation of schools that I have seen, schools that have tremendous pastoral caring and that bring forth children with resilience do so not because they have a section or a lesson—"Now we're going to be resilient"—but because it is embedded in the culture; it is embedded in the interactions between staff and in the air the children breathe in that school. There can be an overemphasis on putting curriculum time into something where people tick boxes and tell children how to be resilient, but if it is not in the culture of the school you will not get anywhere.

Steve Buckerfield: I do not feel that. You have to talk to heads. If you talk to heads, they find ways to do things that are important to them. Mostly they understand that if children are unhappy they do not learn.

Barbara Herts: I absolutely agree. It has to be part of the culture of the school as well. It is important to make that relationship with head teachers so that they know where to go for help if they spot a child who is struggling.

Steve Buckerfield: Heads are also asking us about how to commission, because there is a mixed economy of provision. They understand that the funding has changed, so how do they buy a counselling team? How do they know whether anybody is any good? We are wondering how to do that.

Q300 Chair: I am very sorry to cut you off. I will give the very last word to Michael, in a few seconds. We will then move on to our next panel.

Michael Upsall: I just wanted to say that, as always, leadership in schools is crucial.

Chair: Yes—leadership everywhere. Thank you so much for coming. We really appreciate your time.

Witnesses: **Jane Lunt**, Head of Quality/Chief Nurse, Liverpool CCG, on behalf of Liverpool CAMHS Partnership, **Catherine Roche**, Chief Executive, Place2Be, and **Anthony Smythe**, Director, The BB Group/BeatBullying, gave evidence.

Q301 Chair: Good afternoon. My apologies for keeping you waiting; we overran with our first panel. Could you start by introducing yourselves?

Catherine Roche: Good afternoon. I am Catherine Roche, chief executive of Place2Be, which is the leading UK provider of school-based mental health provision. I should add that the right hon. Stephen Dorrell is an unpaid trustee of Place2B.

Anthony Smythe: Hello. My name is Anthony Smythe. I am a director at a charity called BeatBullying. My sister charity, which is part of the same group, is called MindFull and deals with mental health. BeatBullying does what it says, and tackles bullying both in schools and online.

Jane Lunt: Hello. My name is Jane Lunt. I am chief nurse/head of quality with the Liverpool clinical commissioning group. I am a member of the governing body with the lead for CAMHS.

Q302 Chair: Thank you. I will direct the first question to you, Jane. According to your submission, you are rather unusual, in that in your area you have managed to reduce referrals to tier 3 and tier 4. Could you set out how you think you have achieved that? What recommendations would you like to pass on to us?

Jane Lunt: A number of points that were brought up in previous witnesses' evidence allude to the strength of how we work in Liverpool. We have tried to intervene as early as we can. We have been very clear about bringing together a range of partners within our CAMHS partnership and having a very clearly outlined pathway that shows the contribution right from early, low-level intervention within universal services, through to more complex interventions from specialist services. We have tried to make sure that locally the work that the CAMHS partnership does is embedded within the children's trust board and is part of wider thinking about the delivery and commissioning of children's services, so that we have a common understanding of what we mean by early help and what the totality of that offer is. In terms of early help around CAMHS, it is about having a range of services that are very clearly accessible early on, through a number of routes that families and children can access.

Q303 Chair: How do you commission voluntary services as part of that? How important is it that they are directly commissioned by you?

Jane Lunt: They are absolutely integral to the work that we do in Liverpool. Without their input and their flexibility in the way they can work with families and children, we would not be in the place we are in. We commission them through the CAMHS partnership. We have been lucky in that, through the changes that have taken place in the reorganisation of the NHS, we managed to keep a lot of continuity within the CAMHS partnership, particularly with some of our CAMHS commissioners. That helped maintain some stability.

We commission through the CAMHS partnership. We are very clear that we want a range of providers to provide a range of services. We try to be very clear about the offer that is the NHS specialist CAMHS offer and how it relates to the rest of the pathway, so that before an offer of specialist CAMHS is needed a range of other services can potentially be accessed. It is about the early help, early intervention model that we use.

Q304 Chair: Are you drawing in funding from the Public Health ring-fenced budget to do that as part of your CAMHS partnership? That is what we heard from our previous panel.

Jane Lunt: We have, historically. Through the changes, with Public Health moving into the local authority, the budget has gone over and has been ring-fenced. We have had a period of stability for the services that were commissioned in primary care trust days; however, things are starting to change. We have strong engagement through our CAMHS partnership; we have the clinical commissioning group, Public Health and other partners around the table as commissioners. But it is clear that in Liverpool, where the local authority has had to make huge reductions in its budget, there will be a huge amount of pressure on the public health budget in future.

Reference was made to the five-year plans—the clinical commissioning group five-year plans and the health and wellbeing five-year plans. We have something called a healthy Liverpool programme, which is the name we have given our five-year clinical commissioning group strategy. Within that we have a very clear children's component. We have maintained very close commissioning links with the local authority so that we are clear about how we move forward, to maintain services that are working well but to commission and develop services for the future that are sustainable. That is a real challenge for us.

Q305 Grahame M. Morris: Just looking at the highlights, it seems to be a real exemplar, Jane: integrated commissioning, early interventions, 90% of those accessing services showing improvements in mental health, 90% high satisfaction and the focus on early identification and prevention. You mentioned that you had seen the evidence from the earlier sessions. You will remember that we had a clinician, Dr Rao, say that one of the problems was that CAMHS is nobody's child. In your submission you use an interesting phrase—that it is "everybody's business." Do you think that is what makes the difference?

Jane Lunt: I think it is. I have been fortunate to work as a children's commissioner for a long time in the NHS. Part of that has been a real joy and a pleasure, but partly it has always felt as though sometimes you are pushing a boulder uphill. In a busy PCT, as was, and in an NHS that is still predominantly focused on acute hospital care, it is difficult to maintain vision and leadership around the needs of children. In Liverpool we have been very lucky. As we set up as a clinical commissioning group, there was a real commitment from the governing body that we would have a clear commissioning team for children and that it would be a priority for the CCG. That was informed by the JSNA.

We have worked with the local authority to re-establish and reinvigorate the children's trust board, which is a subgroup of the health and wellbeing board. It maintains the momentum for commissioning services for children in Liverpool and reports to the health and wellbeing board. Recently we reviewed the memorandum of understanding and the governance arrangements between the health and wellbeing board, the children's trust board and the safeguarding children board to make sure that we have those arrangements right, so that there is challenge from the safeguarding children board, when needed, around what we do with regard to children's commissioning. Children's emotional health and wellbeing is a priority for the safeguarding children board, so we have that challenge as well.

Q306 Grahame M. Morris: Earlier you referred to savings and cuts within the local authority—I mean savings and cuts that the local authority has had from central Government, which it obviously has to apply. You said in your evidence that there is a danger that services "will be mainly commissioned through health again." What sort of particular problems do you envisage? Will there be less resource and emphasis?

Jane Lunt: There is the potential for less resource. As a CCG, we are quite fortunate in that at the moment we are financially quite stable, so we have been able to re-profile our spend to manage some of the cuts that the local authority has had to make. We have been able to safeguard some services in the interim, to give us breathing space to come together collectively and to review and commission together.

In some respects, it gives an opportunity. The downside of that is that, if health is seen to be the one with the money, other partners can step away. We have a CAMHS partnership where we bring all partners to the table, including our providers. We have a very clear strategy for Liverpool that is linked to the health and wellbeing board and other strategies. We try to provide leadership but also to simplify a lot of the complexity around CAMHS, so that those of us who are working together to commission and deliver CAMH services in Liverpool are very clear about the context of that and how they fit into the wider context of services for children in Liverpool, particularly the early help offer.

Q307 Rosie Cooper: The prospect of it all just going to health is terrifying, but recently we were told about future forecasting where health services will be subject to more top-slicing, in essence, and mental health will get a bigger top-slice removed for funding. How do you see that description of local authorities being impacted and mental health having a fair amount of money removed? Are you planning for that?

Jane Lunt: Yes. On paper, that is the scenario that we are all facing. As part of our five-year commissioning strategy in the CCG, we are doing a lot of work around commissioning for value and alliance commissioning. We are exploring a lot of options that give us greater flexibility and opportunity to commission in different and more creative ways. I do not have all the answers at this point in time, because it is work in progress, but we are part of a very strong core cities commissioning group network. We meet them regularly to test out their thinking, our thinking and their experience of the problems that we are facing, to see whether we can learn from each other. But you are right. Potentially, as we move through the years there is a real danger that health funding will become constrained to the point where it will create a whole range of issues for us.

Q308 Rosie Cooper: How long do you think that will be, on the modelling you are doing now?

Jane Lunt: We have a financial plan for the next five years, which we have done as part of our submission. It gives us assurance at this point in time that, based on current funding projections, things will be okay. However, things can change.

Q309 Rosie Cooper: Does that take care of the future forecast reduction through top-slicing of mental health budgets?

Jane Lunt: As best we can interpret it at this point in time.

Q310 Charlotte Leslie: We touched on this briefly in the last session. We have heard quite a bit that in schools more emphasis should be placed on educating young people about mental health issues. I assume that you think it should, but tell me if you don't. Is that best done by carving out some curriculum time, or is it more effective if it is embedded in some other way in the culture of the school? Are there other ways of best doing it that you can think of? Perhaps you could tell us about some best practice that you may have come across.

Catherine Roche: School-based mental health intervention is absolutely key. At one level, perhaps, it is possible to have some form of emphasis on positive mental health, building resilience; it could be in the curriculum, but it is absolutely vital to have a provision based in the school. Our work demonstrates that that can be a very effective way of addressing the earlier levels of need that we heard described as the tier 1/tier 2 level, but it is equally important to have an integrated pathway and a joined-up service, so that you can refer on when you identify cases where you need more specialist input. We need to see mental health provision in the whole rather than as a statutory specialist issue, with schools being segmented someplace else.

Anthony Smythe: If I look at this from a bullying point of view and look at what schools have done to raise awareness of the issue, the best schools have a whole-school approach. They will embed it in the curriculum and talk about it during assemblies. You will have governors trained in the issue who know how to self-assess and to look at the policies and procedures in place. You will have policies and procedures in place that are open, and parents will have that involvement. You will have education in classes.

One of the things we do at BeatBullying and MindFull is peer mentoring, so you have education all the way from the peer up to the governing board. You cannot do anything without strong leadership and management. That is correct. In terms of the curriculum, there has been a good development in relation to cyber-bullying, which will be embedded in the computer science curriculum from September. On mental health, there is still a lot more work to do. A lot of it is down to PSHE, which is inconsistent. In terms of mental health provision in schools, we would like to see greater representation in the curriculum and for it to be a bit more concrete in terms of where it stands. In my view, what schools do to educate young people around mental health is inconsistent.

Q311 Charlotte Leslie: Everyone always wants to load everything either into the curriculum or into teacher training; I will do the same thing. Do you think that teachers need more information and support in

their teacher training about things such as behaviour management, moving on to mental health issues? Would it be useful for all teachers to have a much more holistic whole-child approach embedded in their training?

Anthony Smythe: Yes is the easy answer. The Department for Education has just released guidance on how schools should deal with mental health. It touched on CPD, but it was disappointing that there was not more in there. We need a lot more investment. The Government is very good at saying what needs to be done, but more needs to be done on the how—the sharing of good practice and the teacher training part of it. If you take an issue like bullying, one of the reasons teachers do not intervene at the earliest opportunity is that they do not know how to, or are a bit nervous of what to do, who to talk to and how to have that discussion with young people. That will be the same across all of these issues. There is a job to do on building the capacity of teachers, so that they can recognise signs and symptoms and intervene at the earliest opportunity.

Q312 Charlotte Leslie: One exciting move coming from the teaching profession itself, and which I have been involved in, is the formation of a royal college of teaching, along the lines of a medical royal college. That is driven by teachers wanting to lead what is best professional practice for themselves, with themselves, on an evidence base, and to form specialisms within that college. That is very much something for the teaching profession rather than for us politicians to do, otherwise it would defeat the point. If it was something that the profession managed to progress, do you think it might be an organisation worth your sector liaising with, to see whether we can join up the idea of health, child behaviour and development and teaching into one unit?

Catherine Roche: Definitely. We need to train teachers and to build the understanding of school staff generally—teaching and non-teaching—around children's behaviour and what lies behind that behaviour, which is often just a manifestation of a child's mental health issue. Helping teachers understand and work with that is absolutely key. We have made numerous attempts to get something in there, but one of the challenges with teacher training is how packed the curriculum is. We have been doing some great work for newly qualified teachers, so that when a teacher has done their initial teacher training they can have some applied experience. They are in the classroom, beginning to experience some of those behaviours.

Q313 Charlotte Leslie: So it does not stop when they get QTS; there is a continued professional journey.

Catherine Roche: That is absolutely key. Especially in the primary school, they are the ones who see the children for the whole day.

Q314 Charlotte Leslie: Do you see much interplay between learning difficulties, or specific learning difficulties, and mental health issues? I am thinking of a child who may be dyslexic, does not understand why they cannot do stuff in the class and feels inadequate. Their self-esteem plummets and then, along with other factors, you have a mental health issue as well as a specific learning difficulty.

Anthony Smythe: You also have the bullying issue. In addition to the bullying that the majority of children now seem to experience around transition ages, children with SEN tend to be bullied for longer and the bullying tends to be more severe. That has an impact on their health and wellbeing and their attainment. A great deal of work needs to be done to support those children.

Q315 Grahame M. Morris: Do you think improvements need to be made to the quality and availability of counselling services in schools? Do you think that, by and large, support for younger children is adequate at the moment?

Catherine Roche: It is really important to have high-quality services available, and that there is accountability—that the service providers are accountable for the outcomes. Earlier we heard some talk about focus on outcomes. The providers should be accountable for those and schools should understand what to commission. There is a need to build their understanding of how to identify a quality mental health provision in the school.

Anthony Smythe: Schools should not be expected to do this on their own. The risks that young people face today do not start at 9 am and finish at 3.30. A good example of such a risk is cyber-bullying. Cyber-bullying and bullying are not two separate things for young people. They are bullied in the playground. They are bullied on their way home. They can be cyber-bullied by somebody who is standing next to them and then they go home, turn on their computer and are cyber-bullied by the same people, so it is 24/7. It is the persistent nature of bullying that impacts on their mental health. When I was young, you could at least go home at half-past 3 and get away from it. Young people today can’t.

I work with these young people, but I can only imagine the anxiety and stress they must go through. It is all well and good to have a counselling service that is available at school, and of course it needs to

be there, but we find that the greatest pressure on the counselling service that we provide is between the hours of 8 pm and 12 am; the children who are suicidal tend to contact us from 12 am to 2 am. We need services that focus on the needs of children and the modern-day risks that they face, not just to look at school or college infrastructure. Children's and young people's lives jump between their real life and the online world, and we need provision that accommodates that. That means using our approach, which is about having text-based counselling, working with CAMHS, working with schools and everyone working together so that there is support available at all hours of the day. That is what they need.

Jane Lunt: I absolutely endorse that. In the last few months since our submission, we have undertaken to work more closely with schools and, through their representative organisations, make sure that they are represented in our CAMHS partnership. We have a very strong school fraternity in Liverpool. Initially, they were almost going off at a tangent in their role as commissioners and thinking about how they could commission services within schools. We have put a lot of time into working with them to support them in understanding that they need to commission a more comprehensive service, and that by working with and through the partnership they will get much more effective use of their funding. More importantly, children, young people and families will get more holistic services, available at times when they need them and not just within the school day.

Q316 Barbara Keeley: We are almost on to the next question, which is about how significant an impact bullying has on children's and young people's mental health—I think we know it is substantial—and the way in which cyber-bullying amplifies that. Anthony Smythe has just touched on that. We have a minute or two before we are expecting a vote, so what are the best strategies for tackling that? What should be happening? You have touched on it, but do you want to say more about it?

Anthony Smythe: A lot needs to happen, to be honest. It starts with education and awareness. That is about getting the curriculum right. It is about getting awareness out there for young people and getting the investment in. One of the programmes that both MindFull and BeatBullying promote is peer mentoring. If you are to solve an issue like bullying, you need to get the bystander to support the victim, not the bully. Training bystanders in schools and creating a safe environment is the best way to do that. There needs to be a great deal of investment in both education and awareness.

That alone will not solve all of life's problems, unfortunately. It will deal with the majority, if we get it right, so what do we do next? We

intervene early. The problem with a modern-day problem like cyber-bullying is that teachers, social workers and internet providers have no framework to work to; they do not clearly understand their roles and responsibilities and how to share information. For example, if a child is cyber-bullied during a summer holiday, what is the role for a teacher to intervene, if there is a role? Guidance has been produced by the Department for Education, but there is still a great deal of uncertainty. There is a great deal that needs to be done.

We as a charity have called on the UK Government to produce an anti-bullying strategy that is child centred. It is very similar to the reforms that we have seen for child protection, where they have looked at child protection through the eyes of a child. With bullying, there is still an old-fashioned approach of looking at the issue sector by sector. As I said earlier, that is not how children look at it. They do not see cyber-bullying and bullying— they are often cyber-bullied by people standing next to them. If we get it right, we can intervene early, make sure children are safe and address the behaviour before it escalates for the bully.

There is one final thing, which is a review of the law. Bullying is not a criminal offence in this country. It is not defined in legislation. There is often a great deal of confusion when people talk about bullying. We desperately need a refresh of the law. Most of the legislation that deals with bullying predates the development of social networking sites. In our view, current law is not fit for purpose. This is not about criminalising young children. Far from it; it is about having a smarter criminal justice system that intervenes earlier. The current approach is that school head teachers have powers to deal with bullying. If it is missed, there tends to be an escalation into criminality, with persistent bullying, which is why we see so many children self-harming and committing suicide. The perpetrators of those acts end up being prosecuted for crimes that we could have prevented if we had intervened earlier. *[Interruption.]*

Chair: Thank you. We will have to break now because we have a vote downstairs, but we will reconvene. In the meantime, perhaps you could have a think about what recommendations we should include—what is missing from the current legislation.

Barbara Keeley: Are there controls on the internet to do with anorexia and self-harm that we should be thinking about, alongside the things you have just mentioned?

Chair: We will reconvene shortly. I am sorry about the break.

Sitting suspended for a Division in the House.

On resuming—

Q317 Chair: I am sorry to have broken the flow. A number of members of the Committee have had to go on to other commitments, so we will kick off now that we are quorate, with three of us. We were halfway through Barbara's questioning. You were also going to give us some reflections about what is missing from the legislation.

Anthony Smythe: In terms of what we can do to address bullying, and cyber-bullying in particular, I mentioned greater investment in education and awareness. The types of services that organisations in the VCS—the voluntary and community sector—provide are crucial. I mentioned the need for a strategy. You can have all the hard levers and investment, but if we are not clear about roles and responsibilities a lot of that work will go to waste. In terms of legislation, I mentioned the need to review and refresh the current law that addresses bullying, and cyber-bullying in particular, which in my view will only increase. If we are to stand a chance of dealing with cyber-bullying and the impact it has on children and young people, we will have to regulate the internet at some point. It is unregulated. Because of its lack of rules and lack of policing, it poses risks to children and young people. That is why more and more we are starting to see cases of self-harm and suicide, which puts more and more pressure on local services. If we are to stand a chance of dealing with this issue, we will have to regulate the internet.

My fear with a number of the new social networking sites that are coming up nearly every day is that they realise there is now a market in cyber-bullying and are offering the cyber-bully something to get their attention and the attention of their audience, the main one being anonymity. We heard last year the stories about Ask.fm. That trend is continuing, and there is a race to the bottom. If the Government do not intervene, that race will get faster and it will get meaner, and during that time, more and more children will be put at risk. More and more children will suffer depression and self-harm and, unfortunately, as we have seen, commit suicide as a result of this new risk in their life.

Q318 Chair: One of the challenges has been that Ask.fm is not based in the UK and is therefore not subject to UK legislation.

Anthony Smythe: I would like that to be challenged. There are examples across the world of countries that have regulated the internet, for various reasons. China and the middle east regulate, for

different reasons, but they do regulate and they do not get that push back from industry. Australia is looking to regulate social networking sites so that there are basic standards networking sites have to adhere to. The response from social networking sites is, "You can't regulate us. Our server is based in California." It has been more around freedom of speech. When there has been that challenge, I have seen industry back off. I would like the crime to be more about the child and their computer, not where the server is based. That is a legal challenge; as far as I know, nobody has made that challenge. That said, there is possibly a need for European regulation as well, so that we have some consistency across countries, because cyber-bullying has no border.

Catherine Roche: Moving back to service provision and what we can do for children and young people, it is really important to build children's resilience and their ability to self-refer. Whether bullying is online or offline, they should be able to go and talk to a trusted adult or to share whatever is going on with somebody they trust, so that you can start to address the issue and deal with it. That is absolutely key.

Q319 Chair: You would take the view that you cannot regulate these things and that it is better to intervene to reduce the harm that can be caused.

Catherine Roche: Perhaps you need to explore and have a means to do both. I come back to the importance of the environment the child is in on a day-to-day basis—whether they can talk with their parents, so you build parents' understanding; or talk with somebody trusted in school—and the importance of having an integrated pathway so that where issues are more severe, you can identify and refer on to services that are more specialist, if need be.

Q320 Barbara Keeley: Are there any positives? Earlier I mentioned young carers. I am very concerned that young carers get bullied in school because they are different. They do not have the same leisure life, people do not understand, or it may just be a proxy; they may get bullied because their parents are drug taking or alcoholic. As we conclude the questions, could there be internet services—forums and chat groups—that are supportive? I know that some of the young carers projects run things. Some young people are stuck at home and cannot necessarily go to services. At least the internet is there, isn't it?

Anthony Smythe: Visit beatbullying.org. You will get that chat room, the online mentors and the online counsellors.

Barbara Keeley: It's a chance for an advert.

Anthony Smythe: I completely agree that the internet is a wonderful thing and provides many opportunities, but we need to face up to the fact that if we do not do something about it soon—about its lack of regulation and controls and about the lack of criminal sanctions to prevent crimes from being committed peer on peer—the trolls and the cyber-bullies will take over and the wonderful opportunity that the internet provides will be wasted. We are already seeing more and more people leave social networking sites—including adults, not just children and young people—because of the amount of abuse they receive.

Why is that being tolerated online and not offline? If you bring a child to any activity, such as a playground or an amusement park, you expect the highest health and safety standards and regulations. If they go swimming, you expect a lifeguard. You can oversee all of that, yet if they go online there are no rules or regulations and we are all okay with that as a country; we are all standing back. It is simply not good enough now. It is not unreasonable to say to internet providers, "If you want to work with young children and you want young children from this country on your site, we expect standards from you. If you can't deliver those standards, please don't work with our young people."

Q321 Valerie Vaz: I want to go back to some of the other areas we touched on, to do with the voluntary sector and the provision of school-based counselling. Catherine, it is really a question for you. I do not know whether you were talking about this Government or previous Governments, but you made the observation that many of the Government's funding initiatives were targeted at early intervention and that has now ceased. Could you say what they were? Did they have a specific name? How much was it?

Catherine Roche: An example was the targeted mental health in schools programme, which was exactly that—putting service into the schools. It ran for a period of years and has come to an end.

Q322 Valerie Vaz: Has it made a big difference?

Catherine Roche: It built some awareness. Our experience is that it has not made a huge difference. A service was there, was provided for a brief period and then it disappeared.

Q323 Valerie Vaz: Was that directly to you as a voluntary sector organisation—Place2Be? Was it straight from the Government to the voluntary sector, as opposed to being through a local authority or anyone else?

Catherine Roche: TAMHS ran through local authorities; it was co-ordinated and run through local authorities. One of the challenges that we experienced in the programme was that sometimes there is a sense that there has to be equality, with the same service provided everywhere. That can sometimes result in a very thin spreading of service—an attempt to have something universal—across all schools, whereas actually there are some communities in some areas with more significant levels of need.

Q324 Valerie Vaz: Where does that information come from? Would it come from the CCGs?

Catherine Roche: Which information?

Valerie Vaz: The information about targeting certain areas.

Catherine Roche: We highlighted in our submission the gap in up-to-date information about the level of need in communities, and gaps in terms of the JSNAs, particularly around children's mental health. I think we heard that earlier as well.

Q325 Valerie Vaz: Some of the evidence that we heard was that children and young people were getting, for example, eight sessions of counselling with four different counsellors, and that was it. How can we change that?

Anthony Smythe: Both MindFull, the charity, and BeatBullying provide a service that allows young people to choose their counsellor—they can view three and pick the one who is suitable for them, and we will do everything we can to ensure that that counsellor stays with them. We will work with them—stages, not ages, if you like. On average, children and young people tend to get eight sessions, but if we need to do 16 we will. It is delivered in a way that is suitable for them—online counselling. Children love tech. They love texting; they prefer it to speaking and are more comfortable doing it. For a lot of children who tend to be shy of these services, it provides a great opportunity to get support and to build a long-term relationship. More importantly, with the squeeze on budgets, technology allows you to get out there and do more for less. That is why we keep pushing it as the next approach for children and young people. It is relevant to them and it may deal with an issue that you as policy makers have in terms of your budgets.

Q326 Valerie Vaz: Is your funding guaranteed?

Anthony Smythe: BeatBullying is funded by the Department for Education up to March 2015, we hope. Without that funding, BeatBullying closes down. MindFull will work with local commissioners; it will sell units of counselling, act as a wraparound service and work with local commissioners best to meet their needs. There are different approaches from both charities, but BeatBullying is definitely one that is working in partnership with the Department for Education. To be fair to that Department, they provide good funding. Obviously they need to provide more—I would say that, wouldn't I?—but they have stepped up and we are helping quite a lot of children, but there are a lot more out there to help.

Q327 Valerie Vaz: I am not sure who is the best person to answer this question. Some of the evidence that came up was that a number of young people were on medication for a long time—longer than they needed to be—and did not know what to do about it. They wanted a review, but they were not getting one. I am looking at you, Jane, because I think it should come through GPs; well, they said their GP and the CCGs. What framework can you provide so that they have somewhere to go?

Jane Lunt: There is a lot of tension around something called shared care models; you will probably recognise this. Sometimes a consultant will initiate medication and the expectation is that the GP will go on prescribing it within some sort of framework. However, some of the drugs used for children are not particularly licensed for children, so that creates some tensions. It does not always mean that the drugs are unsafe; my understanding is that it is just a technicality around the pharmaceutical industry and how it licenses some drugs and not others. In order to get that review, often you have to go back to the consultant. Obviously that means that you are very much dependent on very specialist input.

We locally, and colleagues nationally, are thinking about how we can manage that in a way that is safe and supportive, not just for the child or young person but also for the clinicians involved in that shared responsibility around prescribing. It might be something as simple as that—just the issue around the medication. We have examples where that working between specialists and GPs works incredibly well, but it can be very variable. We are trying to take what we know works well and make that the norm. Shared care models around prescribing for children have been an issue.

Q328 Chair: Mr Smythe, I know your preference would be to see regulation of the internet. Given how difficult that would be, could you

talk to us about how you feel we can best harness the internet to develop further your ideas about harnessing it to good effect to help people and to mitigate the harms? What would be your recommendations?

Anthony Smythe: Continue to invest in the education programmes that exist out there. I mentioned earlier that the new curriculum for 2014 will have safety from key stage 1 upwards, which is a good development. We will be looking with interest at how schools implement that. We do not want education around safety to be about how you secure your bank details—or not about that alone. It needs to be peer on peer.

A lot of work that has gone into safety has been looking at the child protection side of it—child pornography images and so on—which is understandable. The Government have invested a lot in filter systems and parent filters, which is good—we support anything that makes children safer—but there is a danger that it provides a false sense of security. There is a danger that filters can filter out useful information, especially around the issues we are discussing today. There is a lot of evidence that that happens. I have not seen a filter or a block that deals with peer-on-peer abuse. That is an ongoing conversation. The technology does not allow for that, unless you come to sites like ours that are heavily moderated. The big social networking sites and the new apps that are popping up do not provide that type of moderation.

If we do not get regulation, we will look to industry to regulate themselves. That is what they said they would do. I have been working on this since 2008, both in Government and doing my job in the charitable sector. My view is that industry has failed miserably. What they pass off as self-regulation is by and large self-assessment. Occasionally they will get in a peer to do some peer review. That peer tends to be pretty friendly. I say to industry, "If you want to self-regulate, you are only going to be as strong as your weakest member." There are some very weak members in that sector, and that is not being addressed.

We need a mixture of soft and hard levers. It is the totality of that that will change things. BeatBullying has the largest peer-to-peer mentoring programme in the country. We provide more counselling on bullying than most organisations, so of course I endorse all of that. We need more investment. But we see the failures in the system and we need to get to the source of the problem. We need to review how we go about dealing with cyber-bullying. So far I feel that there is a lack of leadership. That is why we are seeing the problem escalate.

Q329 Chair: Catherine, do you want to add to that?

Catherine Roche: There is a role to build parents' understanding as well. Parents should recognise that the internet is there and that children of five or six are accessing it. Parents should not be afraid of that; they should embrace it and understand what it is about, so that as parents we can also help to direct and provide support for our children. Again I emphasise that, both offline and online, a child should be able to go and talk with a trusted adult, so that they can take responsibility for themselves, with help within families to provide that supporting network.

Q330 Chair: Do you think there is a lack of responsibility from some parents, given the evidence that has been presented to us about the link between the number of hours that children spend online and the impact on their mental health? Is it just that parents are not aware of that? What do you think is the reason that parents do not look at that evidence and respond by themselves directly affecting how much time their children spend online?

Anthony Smythe: There is definitely a need to do more work with parents so that they recognise the signs and symptoms of bullying, whether it be online or offline, as has already been mentioned. By and large, parents are scared of cyber-bullying because their children often know more about technology than they do. That is a barrier to conversation. It does not need to be the case. What you want from a parent is to have a conversation about safety; it is about empathy with other users. You do not need to know the latest craze online; some of my youth workers do not know that, because it changes every day. It is about having discussions about risks that they face online, in the same way that you would have those discussions about offline risks, such as violence that you may come across or bullying at school—whatever the risk may be.

To do that, parents need to be supplied with greater information. In saying that, I do not think we can say this is for parents to deal with alone; the issue is too big. It needs everyone rallying around the child; it needs a child-centred approach. There is an old line that came out of Government many years ago but is still true: tackling bullying is everyone's responsibility. The problem with that in terms of cyber-bullying is that it is fast becoming nobody's responsibility—everyone is pointing at one another. As I mentioned earlier, somebody somewhere needs to pick this up and lead.

Q331 Chair: Jane, do you want to come in on that?

Jane Lunt: As the discussion was unfolding, it occurred to me that unless something more definite is done through the legislative route

and management of the companies, we are not going to turn that tap off. We can work locally and nationally to support children and families, but it will always be an ongoing problem. There is just that huge dilemma.

Q332 Chair: In closing, is there anything that any of you feel you would like to have said this afternoon that you have not had the chance to say and that you think should be in our report?

Catherine Roche: I emphasise again the role that schools can play and the importance of community-based mental health services and CAMHS in a broad context, through all of the traditional tiers. It is important to have a quality service that does not work just with the child; we have talked about school staff and the role that they can play, as well as the support of parents and the role that they can play, and having an integrated service. Integration seems to me to be a key word in the whole thing.

Anthony Smythe: The one thing I have not touched on yet that I would like to mention is the need for better data on bullying, cyber-bullying and mental health in general. The Public Health Outcomes Framework does not include any indicators on bullying or cyber-bullying. The EO policy adviser in me would suggest that that is because there are no data to measure it. The Government stopped measuring bullying in 2010, so there is a lack of data out there.

There is a lot of academic research. The problem with that is that, as you know, academics tend to look back over a long period of time, but bullying, especially cyber-bullying, changes practically on a weekly basis. We need ongoing data to measure the improvements we are all making, whether it be as a Government, as a Parliament, or as the voluntary and community sector. How effective are our policies and procedures? If we have that data, we might see greater representation in Public Health frameworks and the investment that comes from having that representation. Lack of data—a lack of definition—is causing a great deal of confusion. It creates great debate but no clarity.

Jane Lunt: I endorse everything my colleagues have said, but I would add that in order to have that integrated pathway some of the commissioning issues we spoke about in the first session need to be addressed. Unless the commissioning pathways, particularly the commissioning of tier 4, are clarified, it will lead to confusion and make it more difficult for local commissioners such as the local authority—whether that be Public Health or children's services—and the CCGs to discharge their responsibilities for commissioning quality services and ensuring that those services maintain high quality standards.

Q333 Chair: I have one final point. Other panel members talked about having only year-long cycles for commissioning. You have managed to do it with five-year cycles. Why is it that you can do that and they cannot?

Jane Lunt: I may be wrong, but there may have been a bit of confusion between strategy and ambition and the contractual processes that we use. We use annual contracting processes, but that does not mean that you cannot have a specification that is for two, three or five years. You just renew your annual contracting process and refresh your key performance indicators, outcomes, quality schedule and so on. Within that, the key specification could be for three years.

Q334 Chair: They talked about having contractors rather than commissioners, because all their time was taken up by contracting.

Jane Lunt: Yes.

Chair: Is that your experience in your area, or do you get round it by having the longer-term strategy and an automatic refresh?

Jane Lunt: Yes, we do. We try not to allow the contractual process to become the commissioning process. The commissioning process is a cycle that includes the contractual process, but that is just a nuts-and-bolts function. Your commissioning process is understanding your local needs assessment, looking at what services you have—where your gaps and strengths are—and then commissioning and determining what you need as services to meet the needs of your population.

Q335 Chair: Do you ever feel under threat from people challenging that under competition rules? Has that ever arisen in your area?

Jane Lunt: Yes, it does present challenges we have to work through, but the whole of the new NHS is wrestling with and understanding that. We are making sure that we do not fall foul of the competition processes and law but also that, where we can, we support local providers of a good, high-quality service. There are tensions within that.

Chair: Thank you very much.