



Health Committee

Oral evidence: Children's and adolescent mental health and CAMHS, HC 342

Tuesday 15 July 2014

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Written evidence from witnesses:

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Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Andrew George, Robert Jenrick, Barbara Keeley, Grahame M. Morris, Andrew Percy, Mr Virendra Sharma, David Tredinnick

Questions 336 - 461

Witnesses: **Norman Lamb MP**, Minister of State for Care and Support, Department of Health, **Jon Rouse**, Director General of Social Care, Local Government and Care Partnerships, Department of Health, **Professor Sir Bruce Keogh**, Medical Director, NHS England, and **Kath Murphy**, Assistant Head of Specialised Services, NHS England, gave evidence.

Q336 Chair: Thank you very much for coming to the final session of our CAMHS inquiry. Perhaps the panel could start by introducing yourselves.

Professor Sir Bruce Keogh: My name is Bruce Keogh. I am the lead medical director for NHS England.

Kath Murphy: My name is Kath Murphy. I am assistant head of specialised services.

Norman Lamb: I am Norman Lamb, Minister for care and support.

Jon Rouse: I am Jon Rouse, one of the directors general at DH with responsibility for children and mental health.

Q337 Chair: Thank you very much. Could I kick off by pointing out that the prevalence data that we have is very out of date for children and adolescent mental health

services? As you will know, the CMO has recommended that we review our prevalence data, and that that is done on a regular basis. Perhaps, Minister, you could let us know what you feel about the quality of the prevalence data, which is clearly very important for commissioning of services, and what the Department plan to do about it

Norman Lamb: You are absolutely right; it is horribly out of date. It needs to be updated. We need to have a current understanding of the prevalence of mental health problems. We have now secured the funding to do this, which is really good news. There is a sort of scoping exercise, as I understand it, which goes on over the summer period, before we start the work proper in the autumn. It is terribly important that we complete this exercise so that we understand the scale of the problem.

Q338 Chair: The last dataset was 2004, so we are 10 years out of date.

Norman Lamb: Yes.

Q339 Chair: The scoping exercise is going to be done over the summer. Will the data, however, be in a form that is directly comparable to the former data as well? Even if there is other data collected, will it be in a form in which we can genuinely make comparisons? The evidence we have been hearing is that there seems to be a genuine deterioration.

Jon Rouse: Yes. It will not be an exact read-across, for a number of reasons. Some of the things that we may need to measure are different now from what they were in 2004, particularly around cyber issues and so on. There will be some comparability in terms of a longitudinal approach, but it will not be exact. Nor will we carry out the survey in exactly the same way because again, in terms of methodological techniques, 10 years is a long time ago.

Q340 Chair: Thank you very much. Will there be a plan for that to be repeated on a regular basis?

Jon Rouse: We cannot, obviously, pre-empt the next spending round. The commitment that has been made is to carry out this prevalence survey, which will take us pretty much the whole of 2015-16 to complete. In terms of further commitments, it would be for the next Government to make that decision.

Norman Lamb: But I would give a view that I think we have to avoid a long gap in between; we have to try to maintain a current understanding of the scale of the problem.

Chair: Thank you very much. We are going to move on to tier 4 services.

Q341 Andrew Percy: Over the various sessions we have consistently heard concern around the provision and availability of tier 4 services. It is a problem that has happened in my own area; I represent east Yorkshire and north Lincolnshire. We have had no tier 4 services and there have been some well-reported cases in the local media of people having to travel quite some distance; there have been debates in Parliament about it. Can you tell us

where we are at with tier 4 services? What is the plan in terms of increasing provision? I know there was talk of an extra 50 beds. What will be the criteria upon which we will decide the geographic location of those beds?

Norman Lamb: I will give an introductory comment, but Kath is a real expert on this and has been involved in the review, so I will hand over then. Contrary to, I think, what a lot of people might assume, the actual numbers of beds have gone up quite considerably over the last decade. The figures I have here are 844 in 1999, 1,128 in 2006 and 1,264 in 2014. Actually, what we are ultimately after is not just relying heavily on beds. We want to try to ensure, where possible, that we have good preventive services in places that avoid, if possible, in-patient admissions, but there have to be beds available for those who need them, and they should not be, unless it is a particular specialty, a long way away from home. The analysis that was undertaken by NHS England identified regional variation. I think they found it impossible to judge the overall national picture as to whether the number of beds is too few or too many, but there are clear regional problems; they particularly referred to Yorkshire and the Humber and the south-west. But there are other issues elsewhere as well, which you referred to, so the purpose now is to commission 50 additional beds in order to meet the shortfall that currently exists.

Q342 Andrew Percy: On that, with permission, Chair, one of the things we have heard consistently throughout all our evidence-taking is that everybody wishes to divert and avoid admission to tier 4, but because of the split in commissioning all the way through the system and because of local government reductions—and whether councils spend money well varies from council to council: how they prioritise their reductions—obviously demand is increasing. While it is fine to say, “We wish to divert away from tier 4,” is not the reality that because of the pressure further down the system demand is only going to increase and that is probably not in the best interests of young people?

Norman Lamb: Let me give you another quick view before handing over. I think you are absolutely right. There is a long overdue need for a quite thorough review of CAMHS. The fragmented commissioning, to me, makes no sense. We have commissioning from local authorities, from schools, from CCGs and from NHS England. That, ultimately, cannot make sense. At the same time as the publication of the analysis last week, I announced that we would establish a taskforce, chaired by Jon, together with a senior person from NHS England, probably Dr Martin McShane, but it has not been confirmed yet. We must involve young service users in that process, but we must look at how we can achieve much more rational use of the resources that are available, and avoid the potential perverse incentives that exist at the moment. There is a potential perverse incentive to shunt children into tier 4 because the financial responsibilities transfer to NHS England. NHS England are going to appoint some new case managers so that they can keep much better control to ensure that the criteria that apply when a child accesses tier 4 are right and consistent across the country. But I am looking to find ways in which we can align commissioning—ideally, ultimately, to pool the budget as far as is possible.

Our integrated care pioneers have been a fascinating experiment in allowing local areas to develop their own way of doing things, and I want to identify the exemplars around the country. A great youth service has been developed—12 to 25—in my own area, in Norwich. Let us identify those areas and trial a new way with aligned commissioning, a much more rational relationship between the third sector and the statutory sector, use of

the fantastic online platforms that are now being developed—with very strong evidence to support their role in all this—and a much greater focus on prevention. There is an opportunity now to get a much more rational system, but I agree with your analysis.

Kath Murphy: Do you want me to come to the bed situation? In April 2013 we had 1,343 beds and then, during last year, we increased to 1,386. Since 1 April we have increased by a further 10, and having spoken to our area teams—we have 10 area teams that cover the specialised commissioning of CAMHS in the country—we have written to providers and asked them to estimate what their need would be if they were going to look after their own children within area, obviously taking into account, though, that where there were, for want of a better description, natural flows, where they were going to another area because that was nearer the child's home, that would continue. We have an estimate per area team of what additional beds they need, and we have written to providers to ask them if they would be interested in providing in those areas in a short-term gap in order to try to get the children in the right locality. But even in localities like your own, there will still be long distances for some children to travel.

Q343 Andrew Percy: You mentioned specifically the south-west, but in our area, in Yorkshire, there have been real problems. I do not like to be too parochial, but what particularly is going to be done to address that? Are we going to see more beds created?

Kath Murphy: In South Yorkshire and Bassetlaw they estimate they need an additional 18 beds at this moment in time. That is, of course, assuming that some of the children going into those beds will also be looked after in those areas as well. In total we have asked for 18 there.

Q344 Chair: Could I come to a linked area, which is the section 136 detentions? In the south-west, where, as you will know, there is also a terrific shortfall in tier 4 beds, we are seeing children as young as 12 detained overnight in cells, which I am sure everyone would agree is wholly unacceptable. There are new beds being commissioned in areas where this is happening. Will they have dual use so that we can finally see an end to the assessment of children in cells overnight?

Kath Murphy: At the moment, in terms of the additional beds, we have not got into the detail, because we are waiting for providers to come back to us. Then we can have the discussion with them. But, in reality, with a lot of our services we have asked, “Where is the child best placed to meet their need?”

Q345 Chair: Not in the police cells presumably.

Kath Murphy: Gosh, no.

Q346 Chair: Again, there is a perverse financial incentive because, of course, the police pick up the tab if they are assessed in cells overnight. This has simply got to end. What is your plan with regard to that part of it?

Kath Murphy: I deal with tier 4 commissioning, so I am not the right person to answer for a CCG-commissioned service.

Norman Lamb: We have the crisis care concordat, of which you will be aware, which the south-west has taken a really good lead on implementing locally. It is all about the police and mental health services working much more closely together. There is a very clear objective that during this financial year we halve the number of adults going into police cells and end the use of police cells for children. We have just had the latest statistics, which show quite a significant reduction in the use of police cells for adults, which is really encouraging. The numbers with children are pretty small. There is a reduction, but it is small. So we have to absolutely focus on that. I totally agree with you that it should not happen. Last week, when we met a senior police officer from the Met it was really encouraging that they said that last year around 80 people were put into police cells across the whole of London, which in itself is very good compared with other areas.

Q347 Chair: Can I stop you there, Minister? London does not particularly have a problem with children being detained in cells. It is particularly an issue for rural areas where children have to travel long distances.

Norman Lamb: I agree.

Q348 Chair: Again we see a split in the system, where tier 4 beds are being commissioned by one part of the service but there seems to be no crossover with whether or not those beds could then be used for assessments.

Norman Lamb: It reinforces the point I made earlier about the need for bringing the commissioning together. We are having a completely rigorous focus on every area—the rural and the urban areas—and where there is a significant issue with people going into police cells, whether children or adults, we are addressing it. I am completely determined that we tackle this and crack it. In London they want to get to a point where it becomes a “never” event for anyone to go into a police cell with a mental health problem—child or adult. That is the sort of mindset we need across the country.

Jon Rouse: We are also doing a fundamental review of sections 135 and 136 with the Home Office, which will look at how those sections operate. One of the questions we will be asking is around the treatment of children.

Q349 Barbara Keeley: You have already talked, Minister, about fragmented commissioning. One of our witnesses described a situation where a child from Birmingham was admitted to an in-patient unit in Newcastle at the same time as a child from Newcastle was being admitted to an in-patient unit in Birmingham. Clearly that is lack of co-ordination, and we were told it was completely outrageous. How do you propose to address it?

Norman Lamb: Again, I will hand over to Kath, but the plan from the analysis that has been undertaken by NHS England is for each area to be, in effect, self-contained, so that each area can be confident that they have the beds for children and young people in their area and we end this unacceptable shunting of people around the country.

Kath Murphy: Yes. The west midlands frustration was that they had done an awful lot of work to ensure that they had the right number of beds, but, of course, they are now a net importer—for want of a better description—when the need arises.

Barbara Keeley: That is what they said, yes.

Kath Murphy: So you do get that: when the need arises, where is there a bed? I chair a conference call with each of the area teams together on a Friday and we share information about what is happening, where there are beds, what the need is, who can be transferred back—that sort of information. It is about trying to get each area able to look after its own children.

Q350 Barbara Keeley: How specifically can that be addressed? Birmingham is an importer. How and when can that be stopped?

Kath Murphy: If I come back to the letter that we sent out to providers, having done very brief work with our area teams identifying where we need the additional beds, for example, the west midlands—Birmingham and the Black Country—do not believe they need any extra beds at all. If Leicestershire and Lincolnshire have 17 additional beds, they will not be sending children to the west midlands unless it is nearer their home, so we ignore the natural flows issue. If we get to the point where we have additional beds in the right place and there is not that need to transfer, it should only be when children are going for a more specialty need that they will still travel, and we get to tackle that.

Q351 Robert Jenrick: From your assessment so far, what number of beds are required?

Kath Murphy: We do not know. The reason we do not know is, as you might have seen in the report that was published last week, that we do not have consistent admission and discharge criteria. Until you have consistent admission and discharge criteria you cannot do that assessment nationally. That is what we want to do. One of the things we are planning is, during August, to do some further work on the admission and discharge criteria that the clinical reference group produced, with children, young people and their families, and then work that up and have discussions with providers with a view to introducing those protocols in November.

Q352 Robert Jenrick: By the end of the year you would have an idea on a consistent analysis of how many beds, in an ideal scenario, we would have in the country?

Kath Murphy: The reality is that you would have to allow that to work through. You need to get the protocols working and in place, and then see what issues come up as a result. As you have already pointed out, if you do not have sufficient tier 3, what you do not want is children getting caught in between. I think there will still be some work to be done after that.

Q353 Robert Jenrick: In terms of the 50 beds, where does that figure come from?

Kath Murphy: It was purely that if everybody moved around the system and was able to consume their own smoke, for want of a better description—I know it is not a good one—you get to circa 50 beds. We asked for 81 when we wrote to providers, but if you do the maths it is circa 50.

Q354 Andrew Percy: I may have missed some of the answer from the Minister on the review that I believe you are heading up, Jon. Did you set a time frame for when it is going to report?

Jon Rouse: We envisage analysis through the summer and the bulk of the work being done through the autumn. That is the timetable. We are just putting together terms of reference and membership at the present time. I would make it clear that we did fundamental reviews of CAMHS back in 2008 and 2004. We are not going to go through all the same territory again. There is a lot of analysis and there are innovative solutions, not just in this country—we have named some of the places already—but also abroad. It is very much about working out what actions we can take to allow that local innovation to flourish. We are viewing information and data to make sure that, going forward, we have all the information that we need to allow baselining, comparative analysis and focus on outcomes—all those things. Also I think it is about the visibility of and access to CAMHS, how it is perceived by young people and parents, and how we can change that perception in terms of CAMHS being a set of services that serve young people, not something that you have to navigate your way towards.

Q355 Andrew Percy: But at its core will be that the current commissioning landscape is not working, does not work and must not continue? I think that is what you said, Minister.

Norman Lamb: I agree. We need to get, if we can, some exemplars around the country demonstrating a different way of working, pooling the resource locally and focusing on much more preventive care. I am very attracted by Headspace in Australia, where you have much easier access, with no stigma attached; people can directly access it without having to go through a doctor. It does not just narrowly focus on mental health; it deals with all sorts of teenage angst, whether it is sexual health, education or work. We need to get a service, it seems to me, that is much more imaginative, and modern and properly badged so that youngsters understand what it is.

Q356 Andrew George: Could I come back to the point you were making earlier about the provision of tier 4 beds? You mentioned the south-west where there is no provision and Yorkshire and Humber, and you estimate that the number of beds needs to be increased by 18. In the example of the Newcastle and Birmingham kind of swapping over of cases, presumably during a period of extreme pressure, one can understand how that situation arises. But do you not accept that there are many rural areas around the country—particularly the far west of Cornwall and the Isles of Scilly, which I represent, so you can imagine my concerns, but there are also other rural areas around the country—where it is inevitable that young people will be shunted many hundreds of miles to receive the service they need? If you are looking for rational provision, Minister, what account will be taken in the review of the

particular pressures and challenges in rural areas, or areas far from the centres of population where the majority of this provision is provided?

Norman Lamb: I have a bit of an interest in that myself, representing a very rural area. We need to make sure that we get this right for urban and rural areas. There are inevitably problems in the far-flung rural areas because distances are greater, self-evidently, but we cannot have those situations. We have it with learning disabilities as well. There is a youngster about whom there has been quite a lot of media coverage—a young lad from the west country called Josh who has been in a Birmingham assessment and treatment centre. That sort of thing has to change, it seems to me, and there has to be provision closer to home.

Q357 Andrew George: Part of your review will be looking at geographic spread. Is that right?

Jon Rouse: Yes, but it will be particularly around the interface between tier 3 and 4 services. For example, in a deeply rural area it is perhaps even more important that you have really good home treatment services so that as many crises as possible can be dealt with actually in the community and the home, with in-patient beds for more severe cases available in the locality, or the sub-region where possible and only, as Kath said, for subspecialties—stuff that cannot be provided at sufficient scale within that geography, perhaps requiring the child to move further away.

Q358 Andrew George: If I took you through a certain amount of the casework which I have been dealing with—cases which have ended in tragedy—we would not just be saying that this has been a failure, although one can look at the pathway that resulted in the tragedy and see that there is a serious lack of access to tier 4 capacity in an area like my own. I am not simply making this point about my own area; I am sure it is the same in north Norfolk and many other rural areas. Rather than simply pushing this away and saying, “This is a tier 1, 2 or 3 issue; these things should have been captured at an earlier stage,” do you not accept that there will still be a demand for tier 4 capacity in many areas where there is none whatsoever?

Kath Murphy: To take an example, we know there was a tier 4 unit in Somerset that had 12 beds that closed just as we were coming into NHS England. There have been a lot of discussions with that service. As I understand it, they are out to advert now and there is an attempt to get the service opened by October, but it is obviously reliant on staffing. That was one of the big issues that that unit had. So it is about, yes, trying to put units where we need them, but equally, we have to have them safe and staffed, and able to recruit the staff and have them well trained, in order to have those units.

Q359 Andrew George: We will come to the staffing issues in a moment, but in relation to your earlier point, Minister, about the perhaps perverse incentives that actually direct some young people into tier 4 provision at too early a stage—I think that is what you were saying in your opening remarks—

Norman Lamb: Yes.

Andrew George: It is quite clear that there are many parts of the country where that is simply not an option. What I hope you will understand is that, in terms of geographic provision, it is not just perverse incentives; it is also perverse geographic realities—

Norman Lamb: I totally accept that.

Andrew George: Which push things in another direction. If there were perverse incentives and if you were to establish—I think you used the words—rational methodologies, how would you design a service to avoid these perverse incentives and have a more rational provision of service across the country?

Norman Lamb: I do not want to pre-empt the work of the taskforce, but—

Andrew George: No, but you must have an idea.

Norman Lamb: We have to move away from the sense that there are four different commissioning organisations all doing their thing with a different element of the spectrum. I do not think that that makes sense, ultimately. The perverse incentives may still be operating in the south-west. Even if there is no provision, transferring responsibility to NHS England might result in a youngster being sent too far away from home. It could still be happening. But I accept what you say about the geography as well, and the need to ensure that the service is good in every part of the country and reflects their local geography. The point that Jon made is that if you can have better preventive services, crisis services for when a family, perhaps approaching a weekend, is in a really difficult situation, which at the moment might result in a tier 4 admission—an effective crisis team that can actually provide support to that family—you may be able to keep that child at home; that might well be in the child's best interests. We just have to try to make sure that the system, as you say, behaves rationally to ensure you get the best results for that child.

Q360 Grahame M. Morris: You have covered some of this ground already, but would you agree that one of the problems with the new architecture of the NHS is demonstrated in the consequences of fragmentation of commissioning, and the problems with commissioning incentives, particularly for what are known as tier 3.5 services? The Committee has been told—and in fact you have said this in an earlier reply—that, wherever possible, efforts should be made to avoid young people needing to be admitted to tier 4 in-patient services, and that intensive community CAMH services, which we are referring to as tier 3.5 services, are important in achieving this. NHS England are commissioning in-patient services, but how do we get incentives to invest in the 3.5 services when a different body commissioned them? Is that your thinking in establishing the taskforce, to try to simplify those commissioning arrangements?

Norman Lamb: It is exactly my thinking. I described what I think is a bit of a dysfunctional system at the moment. It has been dysfunctional for a very long time, and there have been, as Jon indicated earlier, attempts over the years to try to improve the way it works. I am not claiming it is easy, but I think we can achieve a much more rational system. What excites me is when I meet people who are running new systems; Big White Wall, for example, is an online platform, which is benefiting enormous numbers of people who in the past might not have got access to any service at all. If you can align that sort of access with the work that some brilliant voluntary organisations are doing with the

statutory sector and get the commissioning much more rational, I think we could end up with a modern service. I do not feel this is a modern service that meets the needs of teenagers in particular. That is why I said I am quite attracted by the Headspace model from Australia.

Jon Rouse: The point about “This has never been got right” is really important, because the system we had before 1 April 2013 had different but equal problems. One of the reasons why we are in the situation we are, in terms of tier 4 beds and disparate geography, is because PCTs took very different approaches to those responsibilities. Some really got their act together, formed regional groupings and worked with their strategic health authority; places like the west midlands and the north-west had really good strategies and adequate beds, part of which are now filled from other parts of the country. Other PCTs did their own thing, did not make proper provision, and in those areas we have insufficient beds. At the very least, by bringing that all together under NHS England, we can see the problem as a whole piece and plan on a national basis, working through the 10 area teams. It may create problems in terms of disincentives for local commissioners around lower-tier provision, but it does at least help us sort out tier 4 beds.

Q361 Grahame M. Morris: With all due respect, Mr Rouse, I accept what you are saying, but the level of in-patient beds is not the only problem; the problem is at a lower level than that, and I hope you will recognise that fragmented commissioning and lack of incentives to provide that lower level provision—if that is a fair way to describe it—is compounding the problem.

Jon Rouse: Totally.

Norman Lamb: I totally agree with you.

Q362 David Tredinnick: Building on what Grahame Morris said to you, Jon Rouse, and listening to you, isn’t the fundamental problem that there was no guidance from the Department to the clinical commissioning groups on how they should deal with this? Is this not a failing of the Department?

Jon Rouse: I really do not think it is, but let me set out—

Q363 David Tredinnick: You have lots of different landscapes that are all completely different, not talking to each other. We have already heard about patients who are crossing over from Birmingham, going to one place, and patients going the other way. There is no co-ordination. I put it to you that the fundamental problem was that there was no guidance in the first place.

Jon Rouse: That was the situation that existed pre-1 April 2013 in terms of the primary care trust responsibilities.

Q364 David Tredinnick: So it goes back to pre-2013.

Jon Rouse: In terms of the geographical issues that we have around the—

Q365 David Tredinnick: There is an inherited problem from before the landscape changed; is that what you are saying?

Jon Rouse: Correct, yes.

Q366 David Tredinnick: You are saying that it was a terrible situation before the change of the landscape and now it is improving. Is that what you are saying?

Jon Rouse: It was certainly an imperfect situation; that is for sure. What NHS England are trying to do—maybe Sir Bruce or Kath can come in on this—is make sense of that inheritance, work out where there is a lack of provision and make sure we have adequate provision in every geography.

Q367 David Tredinnick: I do not know if Sir Bruce was trying to come in there.

Professor Sir Bruce Keogh: No. I think Kath has covered it.

Kath Murphy: We did inherit differences, and, as I said earlier, west midlands have done a lot of work. We know that the Oxford model has worked, but their frustration is that they now have children from other areas, where there was not sufficient provision, coming into those beds and then disrupting it.

Q368 David Tredinnick: A related problem is that young people are staying for too long in in-patient units. We have had cases put to us of up to two years. Is it fair to say that NHS England—I think you touched on this earlier—needs to do a lot more to take ownership of admissions, to make sure patients are not kept in any longer than is necessary?

Norman Lamb: Let me say a word on this. We have operated in many respects in mental health in a bit of a fog. We have not had access to the data—the information that other parts of the health system benefit from. We are now making significant steps to improve the data that is available so that we can really scrutinise which areas have excessive lengths of stay. We find that there is enormous variation in lengths of stay. In some cases there may be justification for that because of the case mix, but at least when you get the data you can start to understand what is happening around the country and then seek to address it. On the face of it, the variation does not look as if it can be clinically justified. But at least having access to that information allows us to tackle the problem.

David Tredinnick: Thank you.

Q369 Chair: May I quickly come in to ask Ms Murphy about the co-ordinators that you mentioned? You have recruited two co-ordinators at NHS England for bed management.

Kath Murphy: They are case managers.

Q370 Chair: Certainly one of the responses down in the south-west has been to appoint two case managers, because trying to track down beds, transport and so on takes up such a lot of clinicians' time. Do you feel this is really the best place to put investment? Would it not be better to put the investment into providing the service? Or do you think that it actually makes sense?

Kath Murphy: I believe that if you have active case management you can look at appropriateness of admission, and ensure that children and young people are appropriately placed.

Norman Lamb: And don't stay too long.

Kath Murphy: Exactly. Then you can look at their discharge arrangements. In respect of recruiting additional case managers, at the moment we have come up with a case load of around 55 per case manager, because those case managers are not just looking after the children and young people from their area; we also expect them to look at the quality of services in their area. They will be travelling to meetings about the children wherever they are placed and also, if they have services in their area, looking at those services and their quality.

Q371 Chair: But they will not be making clinical decisions about discharge, just co-ordinating, so that there is some consistency across the country.

Kath Murphy: They can challenge clinical decisions because the majority, if not all of them, are clinicians. Where we have seconded people in, we have been seconding them from trusts that have children's services.

Q372 Chair: Right, so these are clinicians.

Kath Murphy: Yes.

Q373 Chair: But actually they are just managing cases. They are not actually looking after children themselves.

Kath Murphy: But they will be going to case conferences about the children and following up afterwards. I think I mentioned that I have a call with the area teams every Friday lunchtime; the case managers on that will be saying, "I have a child that needs this," or, "I have delays here."

Q374 Chair: If the system was not running so hot, in other words if we had sufficient bed capacity, those individuals would not be necessary.

Kath Murphy: I disagree. The reason I disagree is that over the years we have found that having case managers, particularly in specialised commissioning, is very effective, because it keeps track of individuals. To come back to specialised services, they are usually high cost, small volume, and therefore concentrated in certain units. You need someone from that area keeping track of them.

Q375 Chair: In other words, you feel strongly that there is evidence that it improves care as well as reducing beds—length of stay.

Kath Murphy: Yes. I think it is about having the child or young person in the right place at the right time, and it is the duty of the case managers to ensure that.

Chair: Thank you.

Q376 Andrew George: By their very nature episodes of mental health do not happen in a planned way, and there aren't always long lead times to prepare services for them; nor do those episodes occur between 9 and 5, five days a week. Even in areas where there are adequate in-patient beds, actually having the capacity for an out-of-hours service to respond to those episodes as they occur—when the crisis occurs—is something that we have found from the evidence seems to be woefully inadequate in many areas. To what extent, in your own assessments here and elsewhere—we do not need to have another review on this—have you recognised this and what do you think needs to be done about it? I don't know who I am looking at. Ms Murphy? I will let the Minister off for a moment and come back to him.

Norman Lamb: That is very generous; I am sure you will.

Kath Murphy: I will just come back to the findings in the tier 4 review. Talking to area teams, there are different arrangements in different places. In some areas they have child and adolescent mental health consultants on call, and in other areas the adult psychiatrist will be the first point of contact and they can then admit, in some areas, directly to a tier 4 bed. Then there will be a review shortly afterwards.

Q377 Andrew George: Are these available on a Sunday night? Are they available 24/7?

Kath Murphy: The beds are available in most parts of the country. I cannot say, hand on heart, that every single place will admit at 8 at night, though they should be able to. In terms of a response out of hours, there will probably be an adult psychiatrist as a minimum, if not a child and adolescent mental health psychiatrist, and they will then be able to access the beds. For example, in the north-east I understand that an adult psychiatrist, out of hours, could do the assessment, place the child and then, within 24 hours, they will be followed up by a tier 4 psychiatrist to assess them. It is about responding to the need, but the arrangements will be very local.

Q378 Andrew George: In an area where there are not any in-patient beds—my own area—and in evidence provided to the Select Committee, Cornwall Partnership NHS Foundation Trust, which provides the services there, said: “Currently there is a CAMHS practitioner on call to provide brief telephone contact and information about how to access the service to other professionals. There is no contact or assessment service out-of-hours. There is a direct contact ‘urgent response’ facility for Child Health or the Emergency Department. There is no access to specialist child and adolescent psychiatry, and no inpatient beds, as well as no access to crisis team/home treatment team for those aged under 16.” In

areas like that, without the access to psychiatrists that may be attached to the in-patient beds, how can young people and families get the support that they need? Is it not essential that NHS England actually steps in, in areas where there is evidently totally inadequate provision?

Norman Lamb: The crisis care concordat makes very clear what standards of crisis care should be available everywhere for adults and children. Every area is expected to sign up to their own local declaration by the end of this year about how they will implement those standards. The sort of description you gave of the absence of crisis services in your area, in my view, has to change; it does not meet the standards set out in the crisis care concordat.

Q379 Andrew George: So it is down to them. They are failing and you will point out their failure.

Norman Lamb: It has to be commissioners working together with providers in every local area, collaborating with the police, where appropriate, to ensure that in their local declarations they identify where the gaps are between the standards and the concordat and current provision, and then how they will fill those gaps so that they meet the standards of crisis care that the concordat sets out.

Q380 Andrew George: Where they fail to do that, what will you do? Who will step in when the whole service goes belly-up?

Norman Lamb: The stick, in a way, is the Care Quality Commission, because they have committed, as a signatory to the crisis care concordat, that they will inspect against the standards in the concordat, so that if trusts fail to provide the crisis services that are expected of them—this may be a commissioning issue—that will be identified in the inspection and will count against them in terms of the rating that they get and whether there are other interventions from the Care Quality Commission to ensure safe standards of care in every area. The new robust inspection regime gives us a chance to drive up standards.

Q381 Andrew George: I understand that you have systems to find fault, to wag fingers and have sticks to beat people with; all I am saying is when all that fails, when the whole thing goes belly-up, who can step in and take over a service that has failed?

Norman Lamb: The Care Quality Commission has powers of intervention.

Q382 Andrew George: It does not have the resources to take over services.

Norman Lamb: It can require improvement and it is then up to the—

Q383 Andrew George: Requiring improvement on a failed service that perpetually fails is like hoping the cow will jump over the moon.

Norman Lamb: We cannot necessarily assume that it is simply a resource issue. Performance and quality of service is very variable around the country, and resource is one

aspect. There are other issues as well about how resources are used. When the spotlight is on a particular area, you identify first whether it is a failure of the provider or if it is a failure of the commissioner. I have made it very clear to the Care Quality Commission that if they identify a commissioner problem they should say so, so that the local community can hold that commissioner to account for its failure. But, ultimately, the Care Quality Commission has pretty strong powers to require improvement in standards, and it ought to use those powers as much in mental health as it has done in all the failing hospitals that we have seen. This is about parity. So far, unacceptable practices have been tolerated in mental health which would not have been tolerated in physical health. We now have the chance to bring that to an end and apply the same standards in mental health as in physical health.

Q384 Andrew George: But I have just described—this was the provider themselves describing—the service they are able to supply.

Norman Lamb: It is unacceptable.

Q385 Andrew George: You say that it is unacceptable. At the time the evidence was given, and it was done in the public domain, this should have been a big siren going off throughout the system—to the CQC, to the Department of Health and to NHS England—and you should have been stepping in to deal with the issue because clearly it is unacceptable; you just said it was unacceptable. What has anyone done about it in the last few months?

Norman Lamb: I will personally make sure that the Care Quality Commission is cognisant of that evidence and that they are addressing it when they undertake their inspections.

Chair: Kath wanted to come in.

Kath Murphy: I was just going to say that not every crisis requires an in-patient mental health bed.

Norman Lamb: Exactly.

Q386 Andrew George: I am not saying that either. I am just saying that it needs an adequate response, but there is not an adequate response.

Kath Murphy: I was just trying to clarify that, when I said that it might be an adult psychiatrist or a child and adolescent mental health psychiatrist response, that would be where there is a view that the individual requires detention. But if there is a view that they require some other crisis intervention that is not for an in-patient service, and that in-patient service does not provide that outreach, it would not be specialised commissioning.

Q387 Chair: Isn't part of the problem that there is no new money for this service that everyone accepts is insufficient? Therefore, it would have to come out of another service. How much of this do you feel, Minister, is essentially a funding issue?

Norman Lamb: I think there are funding issues. I have made it pretty clear, I think, in the time I have been Minister, that there is an institutional bias against mental health, and it has not had its fair share of funding. Within mental health there is a big question mark as to whether children's mental health gets its fair share. I think it is 6%.

Jon Rouse: That is right.

Norman Lamb: Is it really rational that 6% of the mental health budget is applied to children and young people when we know that a very significant proportion of mental health problems start in the teenage years? We also know, because there is very strong evidence to support it, that if you intervene early, in psychosis, for example, you can stop the deterioration of the condition, which makes a massive impact on that person's life but also saves the system money further down the track. I think there is overall a funding issue and I will, for as long as I have this job, fight for a better deal for mental health. But these beds will be provided; there is no doubt about that. The other thing is that we have to address the imbalance in levers and incentives in the system that always disadvantage mental health. If you have a very potent 18-week waiting time standard in physical health but nothing in mental health, that will dictate where the money goes from the local CCGs.

Q388 Chair: What about the tariff deflator, which we are due to talk about later on?

Norman Lamb: I will address it. There are two things. First, we now have a commitment in the mandate to start the introduction of access and waiting time standards in mental health from next year. For me, this is potentially transformational. We have never had this in mental health before, but the idea that in mental health you should have no sense of entitlement to access a service within a specified period of time, whereas you do in physical health, cannot be justified. We are ending that imbalance that drives where the money goes.

You asked about the tariff deflator. I have been very clear that you cannot justify the decision that was taken. It was irrational; it was not based on evidence and it must never be repeated, in my view. Having said that, since the decision was taken I have had discussions with NHS England, and a letter has gone out from the previous chief executive to all areas of the country—their area teams—to say, “You should apply the principle of parity in allocation of resources.” We know now that a very significant majority of CCGs have not applied the disadvantage to mental health that the tariff deflator suggested.

Chair: Thank you. Robert wants to talk about the experience of young people and quality of services.

Q389 Robert Jenrick: You touched on this in some of your previous answers. What is your assessment of the quality of services, setting aside the issue of access to services, which we have heard about? When young people receive services, what quality do you think they are receiving? Some of the evidence that we have received, particularly in the sessions in June before I joined the Committee, showed that services, when they were received, could be pretty patchy. Young people said that there was a lack of respect sometimes—lack of privacy. There was no continuity of carers in many cases, and when they did receive them it was

confused—the access, the pathways. The transition to adult services, which we will come to in more detail later, was particularly abrupt, so they would have one set of care and then it would change very quickly and with difficulty, and there was not generally enough understanding and information available. We had a whole range of concerns from the young people who came to the Committee. What is your assessment of the quality of care that young people are receiving?

Norman Lamb: The truth is that we do not have a full enough picture yet about the variability in quality around the country. In the new robust inspection regime introduced by the Care Quality Commission we now have a deputy chief inspector, Paul Lelliott, responsible for mental health in particular. I think this will help to identify areas of great practice, but also of unacceptable practice.

One of the real success stories of the last four years has been the children and young person's IAPT programme, which has been an investment of £54 million to cover two thirds of the country over this Parliament. This is all about training the work force so that children and young people get access to evidence-based psychological therapies, and measuring results—the outcomes from it. There is going to be a full evaluation of the programme, but the anecdotal evidence so far, and I was talking to the head of the programme yesterday, is that where it has been applied we are seeing much better outcomes, children getting back into school, preventing deterioration of the problem. This is based on good evidence, and we now have a commitment, which I secured in the mandate for NHS England, to cover the whole country by 2017. I think that programme in itself—

Q390 Robert Jenrick: How much of the country is being covered?

Norman Lamb: Two thirds during this Parliament. Obviously there has to be a planned roll-out, but, as far as I am concerned you cannot tolerate a situation where two thirds of the country got access to good evidence-based services but a third was left behind.

Q391 Robert Jenrick: Why does it need to take that long?

Norman Lamb: It takes quite a long time. This is collaboration between academic institutions. I visited a brilliant youth service in Oxford, and heard all about their collaboration with Reading university to train up their work force. It takes time to get through the whole of the work force across the entire country, but at least we now have the commitment to cover the whole country.

Professor Sir Bruce Keogh: The speed at which these things roll out is not a linear trajectory. I am glad to say that actually we are ahead of our predicted trajectory at the moment. We were aiming for about 60% at the end of March. We are now just under 70%, so I anticipate that, if we get this right and enthusiasm grows, we can accelerate that. It might not be quite as slow as one imagines.

Q392 Robert Jenrick: Is that 60% or 70% of the two thirds of the country that is being targeted?

Professor Sir Bruce Keogh: No. That is of the country, so we are 10% ahead.

Q393 Chair: Thank you. I will come on to Virendra now about education.

Kath Murphy: If you don't mind, I want to go back to quality because I think it is really important. We ended up with the tier 4 report as a result of the 10 area teams raising concerns around quality of services in some parts of the country. One of the things that I believe has been a benefit of NHS England commissioning tier 4 is that we have overview of services. Some units will have been spot-purchased; PCTs or previous commissioners would have put young people into those units but nobody would have owned the quality in that unit. We have had instances in the past where it has been a huge issue. When we were coming into NHS England we made it very clear that the 10 area teams were responsible for the units and the services—the tier 4 services—in their area. Very early on, in May, we actually asked a unit to close to admissions. Then, when we looked at another unit that was part of the same company, there were similar themes in different parts of the country, so again we asked them to close to admissions, which obviously exacerbates the capacity issue. That has been one of the benefits: we have been able to take that overview and take action where we needed to for tier 4 services. There is still a long way to go, and a lot of things to do in terms of environments, because a lot of the units were not built for children and young people, but it is one of the benefits that we have had of coming into the one-commissioner system.

Chair: Thank you.

Q394 Mr Sharma: Ofsted reported in November. Many of their inspectors when they were inspecting some places expressed concern about inadequate provision of education within tier 4 units. Young people also told us this. What is your assessment?

Kath Murphy: It is an issue that has been raised, and it is my understanding—I am happy to be corrected—that it is education's responsibility to be providing education in those units, so we expect those units to discuss improving provision with the local education authority.

Q395 Mr Sharma: As I said, Ofsted did a report and inspectors, when they were inspecting the places, and the young people expressed, and we identified, that there is a failure on the local authority's part—or the education authority's part. What are you doing about it?

Kath Murphy: I cannot respond on the local education authority not putting the education in. We can pursue it with that provider, but we need the area teams to pursue it. That is very much a local education authority responsibility.

Norman Lamb: It is something that clearly has to change. You have identified a real problem. Interestingly, there has been the appointment today of a new Secretary of State for Education. Before I came here, I had a brief word with her and she said, "You can tell the Committee that the new Secretary of State has a very keen interest in mental health," which is great news. I have had many discussions with her in the past about mental health

and young people, so I think there is an opportunity perhaps for me to discuss this further with her. Ultimately, we have to ensure that local services co-operate effectively, but some interest from Government in this, I think, would not go amiss.

Chair: Certainly when we met with young people as a Committee, it was a theme that came over very powerfully.

Q396 Andrew Percy: I am a bit concerned about the response and I understand—I am not going to say buck passing because it may not be that. We started off with what I thought was the right approach from you, Minister, in terms of acknowledging that there is an almost asylum mentality; there is this broken landscape in which people are doing different things. Then we have a question about education provision and it is very much thrown back to the local education authorities. That does not quite chime with wanting to take shared ownership of the whole area.

Norman Lamb: This is something the taskforce needs to address. I talked about the four different commissioning bodies: schools themselves, who commission services, local authorities, CCGs and NHS England. We need to get our act together, or the respective acts of those different organisations, to ensure that children in those specialist services get access to proper education. It is intolerable if there is a failure of provision of education.

Q397 Andrew Percy: The question then goes back to what are NHS England doing about that? Rather than just saying, “It is for the local education authorities to be responsible for that,” what are we doing, from an NHS England point of view, to take ownership of it? It is all right talking about what might happen in the future, but what is happening now? We know it is not happening. We heard from the young people that it is not happening. You seem to acknowledge that it is not happening, but all we have had at the moment is, “It is the local education authority.” So what are we doing?

Norman Lamb: Might I suggest in the meantime, before we look at this through the taskforce, that, Kath, it may be appropriate for NHS England, given that we recognise there is a problem, to proactively address this with education?

Kath Murphy: Yes. I will go back and find out from Ofsted which are the units where there are issues and ask what is happening in those localities around that. I was not trying to pass the buck, but what I suppose I cannot do is consume all the issues to do with the units if it is an educational failure. I do not know if that is the case, so I need to find out.

Norman Lamb: I think we should commit to writing to you after we have looked at this. It may be that the Department for Education and the Department of Health together should do this, but before you complete your work—although I do not know what the time scale is—we should try to do that, so that you have some idea of our response to the concern.

Q398 Andrew Percy: For the record, I specifically said that I do not want to say that it is buck passing.

Jon Rouse: The Department for Education have committed to be fully involved with the taskforce and to be members of it, and we will ensure that the issue is addressed as part of the taskforce as well.

Q399 Rosie Cooper: Your comments to Andrew addressed the issue, but for me maybe not quite, and I have listened carefully to your answers. If you are a young person, who has been failed currently—Kath, you said that the local area teams would really pick it up, and I absolutely believe that is what is happening—what powers do health authorities, strategic health remnants, outposts, or whatever you want to call them, have such that you at the centre believe they are going to do it? What powers have they got to actually deliver? If it was my family, my child or me in the system and I was not getting educated, I might want to draw to the attention of an education authority the fact that someone somewhere has not got any power. What has gone on? I appreciate you are looking forward, but how can that be?

Kath Murphy: I suppose that was my response. It is not just NHS England that could do something about education in the tier 4 units. We need to have that conversation and that is why I need to get the detail, to go back and find out what is going on.

Norman Lamb: But the bottom line is that every child, as I understand it—although I am not an expert in education law—has a legal right to an education, so that, ultimately, can be enforced.

Q400 Rosie Cooper: Sadly, Minister, as in this case, it does not have to be a good one; it can be a poor one. The children that we met were cross and angry.

Norman Lamb: They have every right to be.

Rosie Cooper: It is their future and, if they already have medical disadvantages, we ought to be enabling them. I hear you, but a local area team doesn't have power to do squat.

Chair: We are now going to move on to tier 3.

Q401 Barbara Keeley: In many of the submissions we received, we heard of a substantial increase in demand and a change in the mix of referrals. For example, in evidence to us, Cornwall said that referrals “have increased by almost 20% annually over the last 5 years...and now remain at approximately double the commissioned capacity.” They also said—a point that came out in the evidence—that there was “a dramatic increase in the number of young people presenting in crisis,” and that young people are “presenting with self harming behaviour and/or suicidal ideation...a doubling of young people presenting in crisis.” There are some quite serious figures.

The key thing really—apart from what is causing that, because that is a concern—would be the impact on increased waiting times for less urgent cases, the knock-on. Cornwall partnership said to us: “Due to a change in the case mix”—with the greater numbers of crisis referrals, suicide and self-harm—there was a knock-on effect “on the ability to assess and treat non-urgent cases,” such as people with autism and ADHD, and an increase in internal waiting times.

The first question is around waiting times for other children and young people whose condition is seen as less urgent. While they are on the waiting list for assessment and treatment, the mental health of those children and young people may deteriorate further, and their situation at home and at school may become more difficult. Is this a picture that you recognise in a general sense, and do you think that that change in the mix and the knock-on effects on waiting times for CAMHS tier 3 services are acceptable?

Norman Lamb: First of all, it comes back to the case for the prevalence survey, so that we understand more about what is actually happening. Secondly, it is clear to everyone that there appears to be increased prevalence, which is quite alarming. There are particular issues around cyber-bullying, which is a new phenomenon.

Barbara Keeley: I think we have more questions on that later.

Chair: Yes, we will come to that specifically later on.

Norman Lamb: There is a particular issue about the number of youngsters presenting with self-harm and we are taking steps. The action plan has made it clear that everyone who turns up at A and E who has self-harmed ought to be referred for a psychosocial assessment. We know that if that happens the chances of further problems, and indeed the potential taking of their own life, are significantly reduced. We know that interventions like that can work, but it is not uniform, so we have been very clear that this should be happening uniformly across the country. But I recognise the problem and I recognise the problem of waiting times. I am also acutely aware that early intervention has a very strong evidence base to support it. That is why I am very keen to get access and waiting time standards in mental health, although you cannot achieve this overnight. I mentioned early intervention in psychosis, and there is very strong evidence to support that. LSE has done the analysis. In cold economic terms, you make an investment and you get a bigger return on that investment, but it means improved lives for youngsters. So why is it that there is no standard across the country? That is my ambition. Really, this has to be something that is a several-year plan. Just as, under the previous Government, there was a several-year plan to introduce access and waiting time standards in physical health, we have to do this in mental health, in my view.

Jon Rouse: There is something about service models as well, which the taskforce is going to need to get into, because we know there is variability in terms of waiting times across the country. There are some areas that have very old-fashioned reactive models where there are strict boundaries between the different tiers in terms of accessing tier 3 services; it is a visit to whatever the local CAMHS institution is, which is intimidating for the young person and probably not necessarily the best environment for them to receive treatment. Then you have other areas, of which Liverpool would be a good example, that have a much richer mix of tier 1 and tier 2 services; they even deliver some of their tier 3 services in a different way, with much greater involvement in terms of schools and their interface with the CAMHS service. Then you can provide opportunities, even within quite constrained resources, for earlier intervention.

Q402 Barbara Keeley: If I can just go back to the question of increased demand, the evidence came in from a number of places. The Cornwall example I gave—that demand had

increased by almost 20% annually over five years and now remained at “approximately double the commissioned capacity”—is something that ought to be reacted to, is it not? It is not a kind of one-off blip, or other things that you get where you have to take account of changes. That is steady over a long period of time, five years, and it has to be accounted for. If you end up in a place where your demand is twice your commissioned capacity, it just has to be dealt with.

Jon Rouse: All I would say is that we cannot solve all that nationally. There are questions that need to be asked locally: have you done a full joint strategic needs assessment on child mental health? Do they really understand what is going on?

Norman Lamb: We know that a proportion of areas have not done that.

Jon Rouse: Exactly. About a third have not done that.

Q403 Barbara Keeley: Who is making sure? That is the point. Who is making sure that they do? If they are sitting on that situation and they have not done the needs analysis—

Jon Rouse: But, again, where is the local leadership? Where is the health and wellbeing board asking those hard questions in terms of local democracy? Where is the local scrutiny and overview committee? Where is the local Healthwatch?

Q404 Barbara Keeley: They are variable in quality; that is the problem with localism, isn't it?

Jon Rouse: But you cannot load all this on to a national system. There is also a role for localism, local democracy and actually holding the system to account at the local level.

Q405 Barbara Keeley: In terms of impact, though—my second question—we have heard that, as well as waiting times increasing, CAMHS are now in some instances restricting services to those with higher levels of need. Young people we met described this to us in stark terms, with one young woman seeking help for an eating disorder being told that she would only be given support if her weight was lower. How should that be responded to? That is not an acceptable thing to say to a young woman: “We will wait until your weight has gone down.”

Norman Lamb: That is why we need to look at—Jon talked about this—the different service models that are around. We know that there has been, but it is anecdotal, a decline in access over many years now, so a smaller percentage of children with mental health problems are actually accessing care and treatment. We would not tolerate that with physical health, but that is the situation with mental health. That is why I mentioned Headspace earlier, for example. In Australia they recognised that there was a particular problem of access, that children were just not accessing services. Of course, you have to have the services further down the line where there is an acute need to be addressed. There is a great network of voluntary sector organisations in this country doing similar work, but having a system where youngsters can get access at a very early stage to support mental wellbeing, and if you work much more co-operatively with schools, can prevent deterioration of the condition later on. With this increased prevalence that you have

identified, we have to address a model of service that I think at the moment is inadequate for the level of need.

Chair: I am keen that we should keep going because we are expecting a vote at 5 o'clock and it would be nice to be able to finish. Can I come on to David?

Q406 David Tredinnick: Thank you, Chair. On the eating disorder issue, there is very clear evidence that E additives in orange juice and other additives in food actually cause those problems. What weight do you put generally on looking at dietary issues as a function of those mental problems?

Norman Lamb: I will give a very quick view.

Q407 David Tredinnick: While you are thinking about that, Minister, if I may, might I just say that I worked in HMP Coldingley with prisoners, some years back? We looked at how a variety of treatments, including cranial osteopathy, were helping to deal with mental disorders. It found that with some violent prisoners—this is serious—the plates of their skulls had crossed over when they came down the birth canal when they were born, which is normal, but they had never gone back to the correct position. This made them unbelievably angry about life in general. Cranial osteopaths could release the plates, put them back into position and their behaviour changed completely. They would never have gone to prison—

Chair: Can I stop you there because what we should be doing is asking whether there is any evidence base for that rather than asserting it?

Norman Lamb: I would like to defer to our resident clinician.

Professor Sir Bruce Keogh: I have no idea.

Q408 David Tredinnick: The evidence was at the prison; that is where they had them.

Kath Murphy: Can I speak from personal experience, having a stepson that had ADHD? Yes, there was a definite link with what he consumed and his behaviour.

David Tredinnick: The Chair wants me to move on, but I just draw these points to your attention.

Q409 Chair: Perhaps it would be helpful if the panel could have some evidence base behind that to reflect on.

Professor Sir Bruce Keogh: Are we talking about the additives or the cranial osteopathy?

Chair: Both. Thank you.

Q410 David Tredinnick: It was HMS Coldingley. They were allowed into the prison, so presumably they had some evidence for that.

Moving on, Mr Rouse, you have talked—almost offensively—about the need for local organisations, local people, to use the new tools of Healthwatch to engage in local democracy—health and wellbeing boards. Obviously we are in a new landscape where, as you said, Minister, or your Secretary of State said, patient choice is at the heart of the health service. Do you think there is a real problem with these new tools from the health Act not actually being used properly?

Jon Rouse: No. I hope I was talking more passionately than offensively. I was talking as an ex-local authority chief executive. I was overjoyed when I found out that public health was coming back to local government after a hiatus—back home, as I would put it—having had that responsibility for 100 years from 1874 to 1974. I think that is where it belongs, because local government can take a much more holistic view. Also on top of that are the strategic responsibilities of convening the health and wellbeing boards. I just want them to make the most of that opportunity, to really drive great quality joint strategic needs assessments that really understand the needs of different sub-populations, including children with mental health issues, and that can then drive really great targeted commissioning. It was because I want it to work. I think they have made a pretty good start. They have only been up and running for just over a year. Clearly, there is variability around the country, but most of them now have health and wellbeing strategies for their areas, which are particular to their local circumstances and thoughtful about what they are prioritising. They just need to make sure that that is carried forward into the commissioning plans of each of the local commissioners.

Q411 David Tredinnick: Thank you. NHS England in its submission says that “transition from child centred to adult services is currently poorly planned, poorly executed, and poorly experienced. This can lead to the ‘Cliff edge’ where support falls away,” and the first adult experience is the accident and emergency department. Indeed, when we had a seminar here with young people who had these problems, that was one of the points that came up. They said that there was woefully inadequate transition and, secondly, no appropriate ongoing medication review. Do you recognise that scenario?

Norman Lamb: I feel very strongly about this. I find it hard to understand why a system chooses to withdraw all established services from someone at the age of 18. I am the father of two boys who have gone through their teenage years. When I think of the degree of pressures and angst that an 18-year-old has, I think it the most bizarre stage to suddenly have a complete transition. I am really encouraged by those parts of the country, including my own county of Norfolk, where they have introduced a youth service, from 12 to 25 typically. This seems to be going with the grain of other developments; the combined education and health plan takes you through to, I think, 25.

Jon Rouse: Correct.

Norman Lamb: There is recognition that these years need some continuity. In the pioneers, or whatever we are going to call them—the trail blazers where we are going to try to identify best practice and trial joined-up commissioning of services—I want to develop the concept of moving away from this cliff edge at 18. We set it out as one of the

steps in our action plan “Closing the gap” as something that had to end. I think across the system there is widespread recognition that this has to change.

Chair: Thank you. Robert, you wanted to come in with a quick point on the back of this.

Q412 Robert Jenrick: It was really just an example of where it is not always clear that the age of 18 is applied consistently across the country. Some areas, from my anecdotal experience in my constituency, have used leaving school as an age when the transition is made, artificially really, from child to adult services. Is that an experience you have seen elsewhere in the country? It seems very peculiar for a child to have to stay on at school to receive consistent care rather than perhaps going to a college to do further education. I do not know if that is an experience that you have had elsewhere in the country.

Norman Lamb: It is variable, but whether it is leaving school or 18, either of those is inappropriate, to be honest. Many youngsters are going off to university, and some continuity through that transition is incredibly important. Too often that does not happen at the moment. This is one of the changes that, in my view, have to happen.

Chair: Thank you.

Q413 Rosie Cooper: I want to ask about funding and parity of esteem, but, beforehand, can I ask about joint strategic needs assessments—health and wellbeing boards? Mr Rouse, I hear you say that you are almost passionate, that you want health and wellbeing boards and that you want the joint strategic needs assessment to be—the exact words were—“transferred to the commissioning plans.” How would local government and those health and wellbeing boards actually see it transferred? Already you are talking about various areas that do not have adolescent mental health plans. My understanding is that that would not seem to be legal and yet it is happening. If I lived in an area where it was not there, who would regulate that? Who is making sure about that if I have a poor health and wellbeing board, or one that does not see the priorities that include me? Who would do that?

Jon Rouse: In terms of the health and wellbeing board itself, it is a committee of the local authority, so in the same way that if you were not content with any aspect of local government performance, the answer, on one level, is the ballot box, but also potentially complaints through to the local government ombudsman. But in terms of the translation into commissioning plans, it is a requirement, or I should say it is the ability—it is actually written into the legislation—for any health and wellbeing board that does not believe that a CCG is reflecting the health and wellbeing strategy in its commissioning plan to actually formally notify NHS England that that is the case. NHS England have to respond to that in terms of their assurance of that commissioning plan.

Q414 Rosie Cooper: Has anybody complained to you that child mental health is not being reflected properly? In all the areas where it is not there, has anybody complained to you?

Jon Rouse: I would have to go back and check, is the honest answer, as to whether any complaints have come into the Department or NHS England.

Q415 Rosie Cooper: Thank you for that. So the message from this evidence is, “If your area does not reflect that,” they should contact you ASAP.

Jon Rouse: Or through to NHS England, yes.

Norman Lamb: The first challenge is to the local authority, and indeed local MPs should be doing that as well.

Jon Rouse: Exactly.

Q416 Rosie Cooper: Now to the real question.

Norman Lamb: Yes, go for it.

Q417 Rosie Cooper: I could not let that go because I think we kid ourselves—I will use that word—that it is all joined up when it is very variable.

Given that right through the evidence today we have heard about problems in quality and access to CAMH services, and that when we met the young people they were very clear that they felt let down, do you think that CAMHS is adequately resourced? If not, what can be done to deliver parity of esteem?

Norman Lamb: In my view, it is very variable around the country, and I think this is what was exposed superbly by the YoungMinds survey. It is great that they did it, because we have to identify which areas are doing it well and which are doing it badly. That survey revealed that there are loads of areas around the country that are increasing investment in children’s mental health services, but there are far too many that are reducing funding for an area that, to me, ought to be seen in every area as a priority. That view and the evidence from the survey apply both to CCGs and to local government.

Q418 Rosie Cooper: What do you think about the fact that, while demand for services is increasing almost exponentially, CCGs appear to be freezing or reducing CAMHS budgets? I was just looking at the evidence that people like Essex county council have given, which says it is a vital support but that with local government budgets being frozen and reducing, it is really difficult to sustain anything like keeping it where it is, never mind dealing with the increased demand.

Norman Lamb: As I say, it is a bad decision where local areas have chosen to reduce funding for mental health. I criticised the tariff deflator decision, because there was no evidence to support it at all. Actually there is an accumulation of evidence that, if you invest better in mental health, you get an economic return. Internationally our investment in mental health compares reasonably well, but where we are out of sync is in the proportion of mental health spend on children and young people. That has been a

long-standing issue. We need to rethink that, because I do not think it makes sense in terms of preventive care.

Q419 Rosie Cooper: That is brilliant, a good response. You have described how you think the deflator is a flawed decision, and you have repeated it two or three times while you have been here today, but what levers can you, as the Minister, pull to make sure that no further strain is put on CAMH services? They are at breaking point, demand is rising and you have the deflator, whether it is flawed or not, with some people using it and some not. What can you do to really help?

Norman Lamb: First of all, this has to be a collaboration between myself, other Ministers and NHS England, and indeed in our engagement with local government, making the case for investment in mental health. The other thing, though, as I described earlier, is that we need to create greater equilibrium in the levers—the incentives—across the system. We have all these levers and incentives, and loads of data, in physical health. We have an absence of data, which we are now addressing, quite dramatically in terms of the improvement of data, but we also need, as I indicated, to introduce access and waiting standards. You do not do it overnight; you have to do it progressively. You have to make sure it is rational, that you do not have unintended consequences. But there has to be that equilibrium; for as long as there is not, mental health will always lose out.

Q420 Rosie Cooper: Young people round this country will be willing you to move on speedily, please.

Norman Lamb: It starts next year.

Chair: Can I come to Robert to take us on to commissioning services?

Q421 Robert Jenrick: We have spoken already about how the commissioning landscape has become quite complicated. In the evidence we heard, many CCGs are finding it quite onerous. In one case we were told in oral evidence that they had a floor of people handling this contracting round; another said it was proving pretty expensive for them to undertake this. What is your view of how complex it is to operate this system, in particular the idea of renewing your annual contract? That seemed to be one of the obvious criticisms that came up: with a relatively onerous system, to go through this once a year was just too much for the resources available.

Jon Rouse: This is the product of annuality, isn't it? It comes all the way up through departmental spending structures, through HMT and up to Parliament. This year, we have actually managed to get the CCGs, through NHS England, to two-year allocations, which will ease the bureaucracy, in terms of contracting, to some extent. But I remember from my time in local government how frustrating this was, although we did not have the same issues in local government and we could enter into much longer contracts. If you are able to do that it gives all sorts of advantages. There are no easy answers. I think it will be a question for the other side of the election, in terms of the next spending round and how much medium-term commitment we are able to build into health budgets. Those decisions

are beyond my pay grade, and even beyond our Department in terms of the Treasury's responsibilities. But I recognise the frustration because I have experienced it at local level.

Q422 Robert Jenrick: How effective do you think the CCGs are in performing their functions?

Jon Rouse: NHS England may want to offer a view on this. The first thing to say is that CCGs are just over a year old. My personal view—I know it was David Nicholson's view as he left NHS England—is they have done remarkably well in their first year. Of course, across 211 or 212, there is a variation in terms of level of performance, but I genuinely believe that having general practitioners driving CCGs, collaborating with local authorities and other partners, has made a real difference in terms of some of the big decisions that needed to be made around changing commissioning patterns within localities. I think that is very exciting and welcome. That is the good news.

There clearly is variation in terms of the extent to which CCGs are prioritising mental health, and, within that, children's mental health. That has to be addressed through the assurance relationship between NHS England and CCGs over a period of time. I do not know if NHS England want to add anything to that.

Professor Sir Bruce Keogh: I have very little to add. Clearly you would expect there to be some variation, because CCGs are, in the grand scheme of things, still relatively immature; they are forming. What gives me cause for enormous optimism with the CCGs is that they have deep knowledge of their local areas, and, most importantly, the input from GPs and other members of the primary care team means that they share the anxieties, fears and aspirations of their patients and of their local communities. If you take that as a recipe, it is a pretty good one. But I think they have some really tricky decisions to make. They have to make difficult resourcing decisions. They do not always have—CAMHS would be a case in point—the data they need to make those in the kind of rational informed way that enables them to justify that decision, and, of course, that is something that we are hoping to rectify. I am pretty optimistic about the future of CCGs, but in this area it is not just data that complicate the issue; it is complicated by the fact, as the Minister has pointed out, that the CCGs have to negotiate a number of difficult areas involving education, local government and so on and so forth, and they will be new and feeling their way in those kind of negotiations.

Q423 Robert Jenrick: Other than data, what else can we do to give CCGs more support?

Norman Lamb: Geraldine Strathdee, the national clinical director for mental health, has been leading brilliant work on improving equality of mental health commissioning from CCGs. That is something that I think is very valuable.

Professor Sir Bruce Keogh: Another thing that you can do is help us raise public awareness. In a sense, this has been a kind of Cinderella area in medicine for too long and what we are seeing now is sudden increased demand because of changing social pressures, social media and so on and so forth. We need the public, parents and professionals to recognise the magnitude of this emerging problem. It is a unique opportunity—a perfect

storm, if you like—for this kind of discussion. If we have all those forces aligned, I think we can elevate the whole of child and adolescent mental health to a level of debate that I think the Minister has sought to do for some time. It is particularly important, because it is actually about the next generation of citizens of this country, and it has a massive economic pay-back if we get it right. At the moment, we are not getting it right and the economic pay-back is not what it could be.

Q424 Mr Sharma: We have heard from both providers and commissioners of CAMH services that a minimum national service specification for CAMHS is needed for commissioners, to ensure that minimum standards are met with CAMHS. Do you agree?

Professor Sir Bruce Keogh: We are in the process of drawing up service specifications for tier 2 and tier 3 CAMHS. We have huge involvement of young people, and by young people I mean people who have experienced the service. Furthermore, with respect to some previous questioning on transition, we are developing a generic specification for transition, again drawn up by a mixture of people, which involves young people, but we are also engaging our clinical reference groups, who are groups of specialist clinicians and users, our strategic clinical networks, the area teams and local authorities. We are in the process. Actually, this is the very first time that there will ever have been a set of national specifications that we can mandate.

Kath Murphy: We already have them for our in-patient tier 4 services. They are on the website, but, as Bruce says, it is now the drafting of the tier 2 and tier 3 services for CCGs to use.

Professor Sir Bruce Keogh: That is one of the ways, of course, that we can help local commissioners with those specifications. It gives them some bite.

Q425 David Tredinnick: I want to ask a question about the Care Quality Commission, if I may. In its written evidence to us, it says: “CQC routinely visits CAMHS services, both as part of its regulation of health services under the Health and Social Care Act, and in the course of its monitoring of the operation of the Mental Health Act.” However, we had young people in front of us, and from other sources we have been told by commissioners that CAMH services receive very little scrutiny from the CQC; one witness told us that they had “never seen a CAMHS team inspected in the same way that they see other parts of the public sector inspected.” Another witness said that in her view the Care Quality Commission do not see CAMHS “as part of their remit.” Do you think that is a fair assessment?

Norman Lamb: It may well have been a fair assessment, but I think it is changing. Now that we have someone with a dedicated responsibility for mental health, Paul Lelliott, who is an extremely able individual, I do not think there is any risk that children’s mental health services will be ignored in the future. They are introducing a much more rigorous inspection regime. They are testing it at the moment; they have done a number of different trusts before it is applied formally from the autumn, with ratings being applied to services. That gives us an opportunity, as I indicated earlier, to put the spotlight on mental health and to really identify good practice, but also unacceptable practices, in a way we have never been able to do before.

Q426 David Tredinnick: Are there any other mechanisms for assuring the safety and quality of CAMH services? If there are, do you think they are working effectively?

Norman Lamb: There are local mechanisms of course. There is the health and wellbeing board; there is the local authority, which is responsible for part of the service at the lower tier end; and, of course, there is also NHS England in their work with clinical commissioning groups. But the regulator is the Care Quality Commission and, as I said, I think we have a real opportunity to improve standards.

Kath Murphy: I am aware of the CQC asking tier 4 units to close to admissions in order to improve their services, so they have done it voluntarily; and just as we have done it as NHS England, we have talked to the CQC about what we have done. So for the tier 4 units we work with the CQC, but I have examples of where admissions have been halted to allow time for improvements to be made.

Q427 Chair: Thank you. We are going to move on now to tier 1 and 2 early intervention services. Before I start, I state for the record that I am a patron of a mental health charity called Cool Recovery. The question I would like to lead with is about the place of the voluntary sector partners in health and the role that they play. We have heard evidence that they are under pressure like never before, but equally their funding streams are shrinking. Could the panel comment on the role of early intervention services and the voluntary sector within them?

Norman Lamb: I have met the head of the network of voluntary sector organisations. I have visited my own in Norwich, a fantastic service called MAP. Interestingly, the Headspace concept in Australia came from voluntary sector organisations in this country, and it was replicated and then rolled out across Australia. Just as they learned from us, we can now in turn learn from them. The smart areas are engaging with voluntary sector organisations in a more significant way, rather than cutting funding. I appreciate that there are some services that have suffered that, but it is a false economy. There is no doubt that, if you can improve access at the very early preventive stage, you can reduce the risk of deterioration.

Q428 Chair: But isn't one of the problems that they come from separate budgets? In other words, the funding for them might predominantly come from local authorities—that background stable funding—but the benefit comes to the health system. It strikes me that one of the protected parts at the moment—the only ring-fenced budget—is public health. Are you going to be looking actively at who is going to pick up the tab? The other issue we heard when we met young people in the voluntary sector was that they are limping from three-month pockets of funding, very short-term funding. It is almost impossible for them to have stable staffing when they are just limping from one crisis budget to the next. Minister, is there anything you can do to provide some system leadership on this as to who should fund it? Who should hold the ring with the voluntary services?

Norman Lamb: The situation you describe is precisely why we need the sort of co-commissioning that I have talked about. There may be legal constraints at present to completing the process, but ultimately pooling the resource that is available for the whole

range of services as much as possible, so that you can then make the most rational use of that resource and—

Q429 Chair: Some coming from each of the budgets. Is that what you are saying?

Norman Lamb: Yes. What I want to see with the pioneers that we develop around the country is a rich collaboration between third sector and statutory sector, and, critically, also including access through online platforms. The smart areas of the country have commissioned online services so that their youngsters can immediately, as soon as they are identified as having a problem, access support online in their own home the same evening as they access the service. That is a crucial element, in my view, of a modern youngster's mental health service.

Jon Rouse: Can I challenge the notion as well that all the benefits are to health? I think a lot of the benefits fall, in one way or another, to the local authority. There is the cost for the local authority of dealing with the fall-out from conduct disorder, for example, of a child not being able to maintain school and then needing to go into a pupil referral unit, or to have alternative education provision. There is an impact in terms of potential antisocial behaviour in some cases; there are all sorts of fall-outs. Again I am being somewhat anecdotal, but when I was a chief executive we had a brilliant relationship with Place2Be—I think you had them as a witness; is that right?—who worked in schools providing sanctuaries and outreach to families. That was a co-commission between us, the PCT and actually Zurich Insurance providing some sponsorship. It worked from the beginning of primary school through to year 9—through the transition to secondary school. I do not accept that this has to fall down in terms of investment in one place and benefits in another.

Q430 Chair: No. But would you accept that there has been a real fall in investment from local authorities to the voluntary sector?

Jon Rouse: It is different from place to place is the truth. Certainly, that is true in some local authorities.

Norman Lamb: I would also draw attention to the Torbay and South Devon pioneer where they are making a conscious effort to bring mental wellbeing into schools, working collaboratively with schools, as part of the bid that they made to become a pioneer, as well as integrating mental health much more into primary care. That is the sort of model, in my view, that we need to be pursuing.

Chair: Thank you.

Q431 Mr Sharma: In 2013 the Children and Young People's Mental Health Coalition conducted a review of joint strategic needs assessments and joint health and wellbeing strategies, and found that two thirds of JSNAs did not measure children and young people's mental health and one third of the JHWSs did not prioritise children and young people's mental health. What is your response to this?

Norman Lamb: I think it goes back to what Jon said earlier. It is not acceptable. These are organisations in their infancy. Some are doing it really well, but any local area, and the health and wellbeing board for that area, needs to recognise that, if they are not addressing children's mental health in that area, they are not getting a full picture of the strategic needs in that community, that locality. It is a missing piece of the jigsaw in some areas and that has to change.

Jon Rouse: You have to be a little bit careful about what a JSNA is. You would not expect an area to do a deep dive on children's mental health every year. You would expect some sort of coverage in a summary document, and then each year the director of public health would lead a deep dive into two or three areas. What you would expect is that within a three or four-year period children's mental health definitely would be covered in detail. I would have real concerns if there had been no coverage within, say, the last three to four years.

Q432 Mr Sharma: The next question is on GP services. We have been told that many GPs are ill-equipped to deal with children and young people presenting with mental health difficulties, and that they require better training in this area. Do you agree that this is a major gap?

Norman Lamb: I totally agree. I think your Chair will have a very clear view of this, but, to me, there is a complete mismatch between the training of GPs and their daily workload in terms of mental health. A significant proportion of their daily workload will relate to mental health, yet it is not a core part of the training. We are addressing that. We have got it in the mandate to Health Education England and we are working also with the Royal College of GPs. There is an examination of whether there could be a fourth year of training for GPs, and whether a significant proportion of that could relate to mental health. Irrespective of that, the training needs to change to reflect more accurately the actual workload that they have. I do not know whether Bruce has a contrary view.

Professor Sir Bruce Keogh: I do not. I agree with that entirely.

Q433 Mr Sharma: That is good for future training, for future doctors coming in who can take part in that education system, but existing GPs are dealing with patients on a day-to-day basis. How best can they be given some sort of training or extra knowledge in this field?

Norman Lamb: There is continuing professional development. I have to say I am not an expert on this and it may be that we can come back to you with a written note, but you are absolutely right to address that fact; of course we need to get it right for the future but we also need to address the shortfall of expertise within the current work force.

Q434 Chair: Can I move to another aspect of early intervention—perinatal mental health? Could the panel comment on how important you feel perinatal mental health services are to CAMHS? We have received some written submissions telling us that this is also an

area which is inadequate. Perhaps you could tell us about any variation in perinatal services that exists around the country, and how you are planning to address that too.

Norman Lamb: We had a brilliant round-table last week with experts from around the country on perinatal mental health. They showed us a map of the country, and there were some areas which had sort of turned green in that they were now providing good access to specialist services, so women—mothers—got access to the support that they needed, but it is very variable around the country. There is a clear objective to get this uniform across the country, I think by 2017.

Jon Rouse: Yes, 2017.

Norman Lamb: In terms of answering your question about the importance of this, there is nothing more important. It has been, I think, badly neglected in the past, but there is such an accumulation of evidence about getting it right at the start of life, and the impact of what a mother might be going through in the immediate aftermath of birth and the impact that that has on a child's development, that there is nothing more important than this. You can alter the life course completely and have a massive impact on individuals, but also of course save money for the system down the track. Prevention is better than cure.

Chair: Thank you. Sir Bruce, do you want to come in on this?

Professor Sir Bruce Keogh: No.

Q435 Andrew Percy: I declare an interest, as a teacher, as I suppose we should in all these things. I know this is not really your department, but the provision of training for teachers in mental health is pretty poor. I do not remember doing any during my PGCE. There is a lot of emphasis in schools on physical disabilities, as you would expect. I know new guidance has been issued; I think it was in response to the *Daily Express* or the *Daily Mail* campaign—one of the two. What is your assessment of how equipped teachers are to identify early, when it is most important, underlying mental health problems? Secondly, do you think the provision of ongoing professional training and development is sufficient at present? Thirdly, is there—this is all part of one question—a case for significant changes to teacher training programmes involving mental health? Fourthly, Chair, perhaps we ought to invite the new Secretary of State, who has such an interest in mental health, here to talk about mental health in general and the cross-over with schools.

Norman Lamb: Your experience demonstrates the problem. You have gone through the training, and you made the point that there was not a focus on mental health as part of that training. Clearly, there is a shortfall, which, in my view, needs to be addressed. One of the initiatives we have taken, which I think is incredibly positive, is something called MindEd, which is an online resource. This is an extraordinarily rich resource with access to the best possible guidance. The purpose of it is that the whole work force—it might be teachers, but it could be youth workers or anyone working with children—can access a whole course of training on the internet through the MindEd platform. There has been quite an investment in this and I think it is a very positive thing. It is being used quite heavily already; I think a thousand people went through the modules in the last month. That is part of it. Clearly the curriculum for teachers, I suspect, is something else that needs to be addressed, but I look forward to a good collaboration with the new Secretary of State on this.

Professor Sir Bruce Keogh: With respect to your previous question, MindEd is also aimed at GPs, so there is an opportunity there that we could exploit.

Jon Rouse: In terms of schools, it has to be a team approach. There is a role for the school nurse, for the SENCO and for CAMHS, in terms of doing outreach to schools. A lot of this is about building up the confidence of teachers, in terms of identification and knowing how to refer, how to utilise basic knowledge. My two adopted daughters had a very positive experience of this, of the school working very closely with CAMHS in the school environment. It works much better for the young people themselves as well, I think, in many examples. Of course MindEd can support that in terms of giving access to training online. But I think it is a team approach, actually using all the resources that are available within a school and CAMHS coming in.

Q436 Andrew Percy: Just to run with that, I know that even if you are a SENCO adviser you would not be fully trained, obviously, but it is more to do with identification for front-line classroom teachers, many of whom are relatively inexperienced, as I was when I started, in actually knowing what it is they are looking for.

Norman Lamb: Absolutely. MindEd is really good at identification and, of course, if you can identify early and provide support at that stage, you have a chance of capturing it.

Q437 Andrew Percy: Sure, but the push on MindEd obviously has to come from the school or the individual themselves, I guess, which will mean that there will be a lot of practitioners who simply will not access it at all.

Norman Lamb: I accept that.

Q438 Andrew Percy: Who has responsibility for that?

Norman Lamb: I think it is something that we need to talk about further with the Department for Education. Raising the capacity of professionals to understand and to intervene early is an incredibly important issue.

Jon Rouse: I think it is about changing our mindsets as to what CAMHS is. CAMHS is not just an institution or a segregated service. It is about how CAMHS reaches out, infiltrates and supports children's centres, and works with health visitors and in schools.

Norman Lamb: That is what they are doing in Torbay.

Jon Rouse: Exactly, on a proactive basis. Then why can it not be CAMHS that actually comes to a school and says, "Don't you know about MindEd? Wouldn't it be great if four or five of your teachers did some of the modular training?"

Chair: Thank you. We are going to move on to digital culture.

Q439 David Tredinnick: Yes—it is really cyber-bullying. We have had witnesses who said that this was a great worry to them. I know a lot of action has been taken about

pornography, but one of the witnesses said to us that there is a lot of evidence that there is cyber-bullying but, “I have not seen a filter or a block that deals with peer-on-peer abuse. That is an ongoing conversation.” I know you have been meeting internet security companies, charities and other Government Departments, according to our briefing, and social media companies, but how are you dealing with the specific issue of bullying and the fact that it goes beyond the classroom and does not just end at 3.30 but goes on for 24 hours a day sometimes?

Jon Rouse: This is very much a partnership with the Department for Education and, to a certain degree, the Home Office. The Department for Education actually has three or four programmes aimed at reducing cyber-bullying. That is partly about working with the software providers, but it is also about specific grant-aided initiatives, often working through third-sector organisations, to ensure that there is support going to the young people themselves, and that there is access to helplines and also to peer mechanisms and peer networks that can be built up within the school. Quite a lot of it is supporting young people themselves to become anti-bullying champions and anti-bullying mentors, so that with any given school there are people other young people know they can go to and get support and help from when they are facing those issues. I do not think there is just one solution to this; there are a variety of different ways.

Q440 David Tredinnick: Do you think that the solution is only partly to do with hi-tech and that it is more basic than that—sort of getting a lot of samaritans out there, or Esther Rantzen helpline people? It is really more a one-on-one solution that we need, is it?

Jon Rouse: I think you need to do both, but there is a very important role for one-on-one support.

Q441 Robert Jenrick: Can I ask a follow-up question? From the submissions that we had there was concern that, because this cut across a number of different areas, ultimately no one was responsible for it. Is that a concern to you? Do you think it would be helpful if responsibility lay with one group or Department?

Jon Rouse: I think the responsibility primarily lies with the Department for Education. If they were here I think they would acknowledge that, because it starts with addressing bullying, of which this is a form, and that is their responsibility. There is now legislation that underpins that responsibility, and indeed in local schools as well. Clearly, though, the Department for Education cannot do this by themselves. They need support and help from the Home Office. They also need support and help from us and from NHS England in terms of addressing the consequence of bullying and ensuring that victims receive the support they require, including from mental health services. But the lead is with the Department for Education.

Q442 Chair: When you are scoping for your prevalence study, will you be very specifically looking at all the various types of cyber-bullying that affect young people, and actively seeking prevalence data related to that and the impact it is having on young people’s lives?

Jon Rouse: We are still scoping, so we will take that into account. I am very aware that in the past there have also been the Tellus surveys. My understanding is that they are now completed on a voluntary basis, so they probably do not create a complete dataset. Can I take that away and have a look at it in terms of the scope of the survey?

Q443 Chair: Yes. Certainly, the other concern, I think particularly for girls, is the new impact of, for example, the sharing of indecent images of them; the impact is not only on girls but also on the attitudes to young women that it engenders in young men, normalising attitudes to women that are unacceptable. How much do you feel that is impacting on mental health at the moment?

Jon Rouse: It must be impacting, but I am not going to extend beyond that because I do not have sufficient expertise to give you an informed view.

Q444 Chair: Your view is that this is being held by the Home Office. Who is actually taking responsibility for dealing with that area?

Jon Rouse: In terms of bullying, it is the Department for Education. If we are getting into the territory—it does not quite fall within sexual abuse—within the framework of that sort of attitudinal approach to women, it would be the Home Office.

Chair: I meant to ask you that rather than state that you had said it, so thank you.

Q445 Andrew Percy: I have a general question. This afternoon, we have heard a lot of things that I think we would all agree with, about improvements and wanting to head in the right direction. Everybody seems to understand that things have not been working as they should have been and that the services need to change, and change pretty swiftly. It seems to be very much warm words almost; I do not mean that in an offensive way. But the basis for our inquiry was that we had heard some fairly shocking examples of really poor care and provision of services, which, as I said, in my own area, started with this awful lack of tier 4 beds and people having to travel a very long way. What we have heard this afternoon has kind of been reassuring, with lots of good examples, but I want to be clear, from both the Minister and NHS England, that the starting point is that the provision of services at the moment is pretty poor in many places; the service is not where it should be, things are not integrated properly and that there is a real lead, both at the top of NHS England and in the Department, that things need to change and change pretty quickly. Otherwise, I think we could end this session feeling that everything is in hand and okay, but nothing concrete has actually been put before us on how things are going to improve. This is a comment and I know we should not really make comments, but I just got to the end of it and thought that we have heard a lot of really warm things, but actually the start of all this was that the service has been under massive pressure and has been providing some pretty poor provision to people.

Norman Lamb: Sometimes I think there is a view that Ministers, in a way, are immune from being shocked by unacceptable practice. I have the same view as you. I cannot begin to justify failures of care that result in a youngster being sent off somewhere else around the country, or not getting access to early intervention in psychosis, or whatever the issue might be, so I have impatience about this, just as all of you do. It is complex. The problem

has been made worse, in my view, by some fairly irrational decisions around the country about disinvestment in children's mental health, and indeed mental health more generally in some areas—not across the entire country, because there are areas that are doing, in my view, exactly the right thing. I think there needs to be a sense of a national imperative that this changes.

I would accept all the propositions that you put to me, that the system, to me, looks rather dysfunctional with all this different commissioning, that there have been poor decisions about funding in localities and that there needs to be a complete recognition across the whole system that mental health really must be treated equally—that parity of esteem is not just a bit of rhetoric but has to be delivered in practice. You cannot do that just by exhortation. You have to make sure that the levers deliver it. That is why I think it is so important that you get access to the data. Information drives change. If you have an understanding of what is actually happening across the system, rather than the fog we have worked in up until now in mental health, you can start to put pressure on the system to change. That has to be combined with standards of access and waiting times that exist in physical health but do not exist in mental health. That has to change, and it is starting next year.

Q446 Chair: Minister, who do we hold to account for this? You have described the existing poor services, but what we are not clear about is who can be held to account for failure to deliver that parity of esteem in practice.

Norman Lamb: We have established quite a devolved system; this is not just the health reforms in the Health and Social Care Act but an evolution over many years. You could say, “Let's go back to the system where everything is driven by the Minister in Whitehall.” I think we tested that to destruction—

Q447 Chair: Minister, will you be holding people to account? In other words—

Norman Lamb: Absolutely. I spend my life fighting for mental health, I can tell you. I am probably regarded as quite an irritant, as a result.

Q448 Chair: What are the penalties? What will be the consequences for people who fail to implement it? The point I am trying to get across is that we are all describing a very poor service, but what we would like to know is who is going to be held to account and what will be the penalties for failure to deliver it? Otherwise, we will be having the same conversation in five years' time.

Norman Lamb: I think you will recognise from your work in the NHS that you cannot rely on any single lever to deliver change. This is a very complex system and you need a whole set of levers. One lever is regulation, so having a much tougher inspection regime—with ratings and putting the spotlight on mental health in a way that has never happened in the past—on the part of the Care Quality Commission is part of the solution to holding the system to account. Along with that, I have a job to do in holding NHS England to account through the mandate. I take the mandate very seriously. The mandate, in a sense, for me is the democratic legitimacy of the system. The Government set out their priorities.

Q449 Chair: Yes, but what will be the penalty for failure to put that into place?

Norman Lamb: As I indicated, it will be first of all through regulation. If people fail to deliver good standards of service, at one level they get a poor rating, but the Care Quality Commission has intervention powers that can ultimately put a service into special measures and remove the leadership of that service. There is also the power—

Q450 Chair: Somebody would lose their job, in other words.

Norman Lamb: Yes, absolutely. In a way that has not been possible, incidentally, in the past.

Q451 Chair: I suggested, for example, that the new chief inspector of mental health might like to go and spend a night in a police cell to look at what it is like to be a child in a police cell with a mental health crisis, because if that were a physical health issue the service would be shut down immediately.

Norman Lamb: I agree.

Q452 Chair: Then there would have to be alternative provision, but the fact is that it does not happen because it is a mental health crisis.

Norman Lamb: A fortnight ago I went out and visited a 17-year-old girl with learning difficulties in an assessment and treatment centre because I was so horrified by what was happening. Next week I am meeting commissioners from the south-west because of a youngster with learning disabilities who has been sent hundreds of miles away from home. I will intervene where I can, but the Minister cannot do everything. There are lots of different levers and incentives that all have to be aligned to work in the same direction. It is complex, but at the moment, and in the past, mental health has lost out, and that is what I am determined to change.

Q453 Chair: Minister, would you spend a night in a police cell? I should ask that carefully.

Norman Lamb: What a generous invitation.

Q454 Andrew Percy: The basis of my question was when are we going to see something tangible, and when are we going to be able to look constituents in the face and say, “This is not going to continue any longer”? We have heard from the Minister, whose commitment to this I genuinely understand, believe and appreciate; I know you are passionate about it. I wonder if we could hear from NHS England as well.

Professor Sir Bruce Keogh: Certainly, it would be a pleasure. I cannot beat the Chair’s suggestion.

Chair: The invitation extends to you as well.

Professor Sir Bruce Keogh: One of the striking things is that I think we are all on the same page; we all recognise it as being really tricky, but what I will do is show that we mean what we say. We have done a number of things since April 2013, when we came into existence. With respect to our area teams, we have diverted staff to case management. We have pursued some quality concerns against the mainstream of opinion. Kath Murphy runs a weekly Friday morning sit-rep, which discusses bed availability and discharge delays, and follows that with a conference call to pursue things. We requested an increase in capacity last December, and a letter was sent out in July, and you heard about that with respect to tiers 2 and 3. We are in the process of developing service specifications, and young people are involved. We have developed a youth forum. In fact they had a meeting last Saturday to tell us what they need. We have drawn up, in conjunction with service users—the youth who have experienced this—nine participation priorities which we will be happy to share with you.

With respect to tier 4, we are reviewing the whole of our specialised commissioning endeavour, but in particular, we are reviewing it with respect to CAMHS. We have put in, as you heard, additional beds in priority areas. We have increased the number of case managers. We have developed the very first ever national mandatory specification for tier 4 services. We are going to have admission and discharge protocols by November, following work in August.

We are going to look at co-commissioning, which I have to say means different things to different people—we could explore that. We have done quite a lot of work, and are now in the fourth year of the children and young person's IAPT. We have started to address the skills deficit. We have trained a lot of people, over 770 of them to postgraduate and diploma level. We have improved leadership. We have started to address the IT and data deficit, because for the children and young person's IAPT, we now have very good clinical and outcome data on 28,000 people. This is starting to provoke cultural change within the whole service arena. It is the first time that we have had really structured monitoring of outcomes, and those outcomes have shown improved user satisfaction. They have shown reduced symptoms, and shown that people who were part of the IAPT programme felt that they were increasingly meeting their personal goals. We have seen that it has led to good practice dissemination, particularly through an improved staff survey. We used this to benchmark CAMHS as a whole, as a surrogate, if you like, for the progress around the country.

We have started to accredit therapy courses for CBT, parental training, systemic family practice and interpersonal psychotherapy, and we are working with statutory partners in third sector providers.

Q455 Andrew Percy: Can I stop you there? It all sounds very impressive, but what happens when X-shire council disinvests at the bottom and the whole thing collapses there? What does any of what you have outlined do to address that or take responsibility for that? This is the whole problem, isn't it? While a lot of it relates to tier 4, which is great to hear, the fact is if you—

Professor Sir Bruce Keogh: Actually, most of it related to tiers 1, 2, and 3.

Q456 Andrew Percy: But you cannot stop X-shire council disinvesting in those basic services.

Norman Lamb: There is an issue about ring-fencing here. I have not reached any conclusion, but I think ring-fencing was withdrawn in 2008.

Jon Rouse: Yes, exactly.

Professor Sir Bruce Keogh: We have used some of our experts, particularly Peter Fonagy, who has been here, and Mick Cooper to give help and advice to the Department for Education, with particular reference to some of your questions on guidance on mental health and behaviour in schools. Clearly schools can use their own budget to buy in support from CAMHS. With respect to the CCGs, it is more tricky because, in a sense, we cannot tell CCGs what to do in the world in which we work at the moment, but we have an assurance system which invites CCGs to consider mental health across the whole lifespan, and NHS England is now revisiting the financial levers that we have at our disposal. That is kind of what we have done in the last, whatever it is, 12 or 15 months.

Q457 Rosie Cooper: I am encouraged by the words, and I am reflecting what has been said so far. I am really encouraged by the session, but the Chair asked the question about who is accountable and I feel compelled to put on the record that we talk increasingly about integration—everywhere we talk about, “Let’s get the services joined up. Integrate it”—yet when it comes to accountability or responsibility, you could not find a more fragmented system if you tried. I was just making notes; you have all the regulators—CQC, TDA, Monitor, NHS England, LATs and CCGs. Everybody has a bit of everything and no one is responsible and, when it comes to it, no one is really held accountable for any of it. When I can ask the Prime Minister a question, which I did a few months ago about another trust entirely, and find that he thinks that the CQC could do it, when they do not have the powers, the reality is that we talk a good game, but in terms of accountability it is so fragmented that trying to make anybody absolutely responsible is like nailing blancmange to a wall. Do you agree?

Jon Rouse: I hear what you say. I will come back, but can I just say first that previously we had a much more top-down system? I actually brought along the diagram of what it used to be. It had seven levels of governance that went from the Minister all the way down to a local sort of CAMHS board. That did not work either; it was so bureaucratic, and nobody quite knew who was doing what.

Q458 Rosie Cooper: I tell you what, the strategic health authority and the Minister could remove a board that was absolutely rubbish. That needs to be done today and it is not being done because no one has the responsibility. I have evidence of that. So who is CAMHS—

Jon Rouse: NHS England have the ability, in very serious circumstances, to de-authorise a clinical commissioning group. Those powers exist, but, at the end of the day, that has to be balanced by the commitment that exists to a localist system, and to local partners working together to the health and wellbeing board, which is part of the local democratic framework.

Q459 Rosie Cooper: Do you think that matters to a kid who is locked up for no good reason?

Jon Rouse: No, and it is unacceptable, whether you have a top-down or a localist system; the key is to try to make either of those options work.

Q460 Rosie Cooper: The point I am trying to make is integration versus the actuality of fragmentation: how do you join it together?

Norman Lamb: I have described why I think the fragmentation of commissioning needs to change; it leads to disparate accountability, in a way that is very unhelpful. We now have the ability for the Care Quality Commission to take decisive action against providers and to put organisations, ultimately, into special measures where they are failing on quality—not just on finance but on quality as well. I think there are much more effective levers now than there used to be. But there also needs to be a sense of the direct personal accountability of the clinician within the system. The Secretary of State has started to develop the case for reintroducing clinical accountability for individuals, and I think that is important as well.

Q461 Rosie Cooper: Let me say, Minister—a final word from me—I understand and clearly hear what you are saying. In the real world, I am told that in the north of England, for example, it may be that somebody missed being in special measures by a whisker but really it was because the system was so stretched that it could not deal with another trust in the north being in special measures. That is about resourcing, not reality. I know it is off the subject, but it is all part of the same thing. Unless you resource it, that is fragmentation.

Norman Lamb: I have tried to address my views on that as well.

Chair: On that note, thank you very much for coming. We really appreciate your time.