HOUSE OF LORDS

Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 1 November 2016

12 noon

Watch the meeting

Members present: Lord Patel (The Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Turnberg, Lord Warner, Lord Willis of Knaresborough.

Evidence Session No. 14 Heard in Public Questions 143 - 149

Witnesses

Claire Murdoch, Director, NHS National Mental Health, NHS England; Professor Sir Simon Wessely, President, Royal College of Psychiatrists; Sophie Corlett, Director of External Relations, MIND.

USE OF THE TRANSCRIPT

1. This is an corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of Witnesses

Claire Murdoch, Professor Sir Simon Wessely and Sophie Corlett.

The Chairman: Good morning. Thank you for coming to give us evidence. Although the last two sessions were related more to the workforce, this session is related more to mental health issues, but within it no doubt we will cover issues related to the workforce in mental health. This session is extremely important to us to get this teased out for long-term sustainability, which is the title of our inquiry, as to how mental health will feature given that we now accept the equal esteem of mental and physical health. If you do wish to make opening statements, please do so. Can I ask you to introduce yourselves, from my left?

Claire Murdoch: I am Claire Murdoch. Since June of this year I am the national director for mental health at NHS England. I am also the chief executive of Central and North West London NHS Foundation Trust and a registered mental health nurse of 33 years.

Professor Sir Simon Wessely: I am Simon Wessely. I am afraid I have got a slight cough at the moment, as you can probably hear. I am a consultant psychiatrist, an academic, the regius chair of psychiatry at King's, and I am currently president of the Royal College of Psychiatrists.

Sophie Corlett: I am Sophie Corlett. I am director of external relations at MIND. MIND runs services across England and Wales, as well as having a central organisation. Our chief executive, Paul Farmer, chaired the Five Year Forward View for Mental Health Task Force.

Q143 **The Chairman:** Thank you very much. Do any of you want to make any opening statements? No. We will kick off with our first question. What are the key issues in the provision and delivery of mental health care services? Do you think they are being addressed appropriately currently?

Professor Sir Simon Wessely: That could go on all day, so I will pick up just two points. One of them is integration of services. Even during my lifetime the provision of mental and physical health services has got more separated, not less, sometimes for good reasons, sometimes for not so good reasons. When we did the Five Year Forward View, the task force, which you will remember, Sophie, and others, the consultation to start with had 25,000 respondents from patients and service users. The thing that was at the top of their agenda, which was a slight surprise, was wanting to have their physical and mental health care together. They did not mind so much where it was, but they did want it at the same time in the same place, and we are very bad at delivering that.

Where I work on Denmark Hill, we have King's College Hospital and I work as a liaison psychiatrist there, but within 20 yards of us we have at the moment the world's top psychiatry institution and research institute, the Institute of Psychiatry—we just beat Harvard, knocked it off its top spot, and we are the largest mental health trust and deliverer in Europe—

yet most of the time I have been there we could be on separate planets. We have not integrated that as well as we could. The same story applies everywhere.

I would say the biggest challenge is, for example, to get CAMHS services so that they are linked in physically with schools, to get our expansion of psychological treatment services, which has been a major success story, except too often it is in the wrong place, it should be in primary care and in secondary care where it is needed, and to get better physical care for the scandal of the poor physical healthcare of people with serious mental illness, with common disorders—heart disease, smoking-related diseases, obesity and so on. Again, we have neglected that by separating out physical and mental. I would say that is our biggest failing.

I have just come back from Sierra Leone, and I would say we should also remember we have very good mental health services. I know very often we do not think we do, but if you go to a lot of other countries you realise that we are up there in probably the top two or three countries for delivering overall mental health services. We need to keep a sense of perspective on that. Although we are now going to talk about all the problems we have, internationally we do very well.

Sophie Corlett: I would like to come in next. I am not sure that our comparator should be Sierra Leone.

Professor Sir Simon Wessely: That is not where I got my cough, just before you all panic.

Sophie Corlett: One of the things we ought to be looking at is that what led the Government to agree to a commitment to parity of esteem is that we are so very far away from that at the moment. We know that we may have some great healthcare here compared to the rest of the world, but compared to our own healthcare in physical health we do extremely poorly. We have got to the heady heights of a third of people with mental health problems getting mental health care at the moment, which means two-thirds of people do not. That has risen from a quarter, but most of that is to do with the big expansion of cognitive behaviour therapy and other talking treatments. That does not apply to all types of mental health care, just to the growth in that area.

We have a huge gap to fill in basic healthcare for people. That is the situation and there is now a commitment to doing something about that. Over the last Parliament, we have seen a more than 8% reduction in mental health funding over the five years 2010 to 2015, at the same time as we are trying to increase services to people with mental health problems. We have seen demand going up. Demand going up is partly due to complex societal issues, but we also have a problem within mental health care where shortage of funds and a feeling of being embattled, not having any way of meeting that demand, has meant that we have seen thresholds rise and people being turned away until the point at which they are most unwell, and that has had knock-on impacts on people's

well-being and demand and cost going up. We have got ourselves into a slightly difficult situation.

The ideas and commitments in the Five Year Forward View for Mental Health are helping us move towards earlier intervention, but we have got ourselves to quite a difficult point, with the shortage of funds and the huge gap we have to cover and the difficulties that has created within the culture of people wanting to step back and not let people in.

Claire Murdoch: Just to build on that, the incidence of undetected, untreated diabetes in this country is something like 8%, so we have more work still to do to reach people around detecting and treating their diabetes, and of course now prevention. The incidence of undetected, untreated mental illness or mental ill-health is thought to be closer to 70% in this country. For me, the big issues are an approach to health and the NHS more generally that is an illness-based model of care with a hierarchy that puts big acutes and A&Es at the very top of it. If we are fortunate, most of us will spend a very brief amount of our whole lives in an acute hospital. The entire system needs to be focusing more on prevention, on understanding that human behaviour, emotion and psychology affect hugely how one treats health and lifestyle, and that ultimately tips over into mental illness. I would say in the hierarchy of health we do not pay enough attention to the whole person, how behaviour affects health and, at the extreme end of that, mental illness. We must change the way we think about our NHS as a whole. If we do it will benefit the way we think about and understand care in mental health services.

A second major issue is workforce. We spend so much time in this country talking about an NHS in crisis and a tsunami, a tidal wave; we are all drowning. Certainly it is the busiest I have known it in my 33 years in the NHS and the challenges are real. This country must have a debate about what it spends on health in its broadest sense that involves the public in the difficult choices that must be made. When it comes to mental health one hears so much that it is in meltdown and failing, who would want to come and work in mental health? So the second big issue which needs to be thought about, apart from the hierarchy, is that of workforce. As a mental health nurse of 33 years, working in mental health services is fantastic and your choices across the professions are incredible and your ability to make a contribution is amazing, but somehow we fail to communicate that.

Lastly, the issue of transparency around spend on mental health is pivotal. Have we spent more or less? Last week NHS England published the CCG-by-CCG dashboard, which looks at investment, performance and outcomes. It is an unprecedented level of transparency around mental health in this country, I have to say. What CCGs are reporting is they have spent an extra 8.6% on mental health in the last three years. There it is in black and white: what CCGs are saying they have invested. The reason for getting those CCG dashboards into the public domain is we have to understand if they have spent more, where have they spent

more? Is it in primary care, acute hospitals, with the third sector or the private sector, or with NHS trusts such as my own? This debate, in microcosm almost for mental health, needs to run across the country now: what are we spending; where are we spending it; what value do we get; what outcomes do we get? All the while there is a lack of understanding about whether investment has gone up or down, we are unable to fix or address the issues.

Finally, to be absolutely accurate, this country spends £105 billion a year on mental ill-health one way or another—days of work lost and the NHS—yet we know if we invest in proper evidence-based intervention with your cardiac problem, your cancer problem, your complex comorbidities in A&E departments, as Simon says, we save money and drive better value and outcomes for people.

I would like to end where I started: we need a fundamental shift in mindset around what we spend, where we spend it and how we spend it. Better spending on mental health will drive value and better efficiency into the system.

The Chairman: Do you agree with this figure of 8.6% more spent on mental health from CCGs?

Claire Murdoch: I am telling this Committee that NHS England has been working for the past several months on something called the CCG dashboard on mental health. It was published at 5 pm last Thursday. It is now out there for people to examine. I am saying CCGs have reported to NHS England a cumulative increase in spend on mental health of 8.6%. That varies across the country. If you look at that CCG by CCG you will see big variations. There are those who say they have invested more and others who have not met what was the parity of esteem target: in other words, they have invested less.

That is what has been reported and it is now the job of local health and social care communities to understand how that spend has been allocated locally. That is a really important piece of work to do over the next few weeks.

I should just add that those CCG dashboards will be updated quarterly, so we will keep publishing these every quarter until we are content that they are an accurate reflection of what is being spent.

Q144 **Lord Kakkar:** Perhaps I may pick up on something Sir Simon said. Do you have any evidence that as they are being scrutinised and published the STPs are addressing the kinds of issues that you raised? If not, what pressure is being applied on those developing these STPs, which are at an immediate stage between a few years hence and 2030, to address the kinds of problems you have raised?

Professor Sir Simon Wessely: We have only just got some idea of what CCGs are doing. I think Claire was being quite diplomatic, as she should be, but nevertheless the variation is extraordinary between CCGs. Even more worrying is looking at the indicators of those that are planning

on changing it and the large number that have no plans to increase their spending in line with what they are supposed to do.

The good thing, and it is a really good thing, is it is the first time we have been able to see this and not rely on FoIs as the only way we can find out what is going on. I think there will be changes from that because we are now able to scrutinise it. The picture is not a particularly pretty one at the moment, but the levers of change are hopefully there.

On STPs, we have only seen the ones that you have seen that have been leaked to the press. We know from our own work with some that lots of them originally had no mental health. You should say this because you are doing it, but we are promised that those that do not have a substantial mental health component will be sent to the back of the class and told to redo their homework. I hope that is true.

Lord Kakkar: Can we pursue that question? Is it the case that under the review in NHS England at the moment, if the STPs come forward and do not address these kinds of mental health challenges, which are clearly very important for the longer-term sustainability of the NHS, they will not be approved?

Claire Murdoch: I do not think STPs are approved. There is not a stop-go light. What has been said in more recent times is they are a work in progress and as much about getting a stakeholder community, whether that is local authority care or NHS trust, to work together to come up with the long-term plan. I do not think it is a stop-go. What I can say is that I have an extraordinarily good mental health team at NHS England, which I inherited in June. The people have impressed me enormously with their analytic capabilities and their commitment to this agenda. That team is going through the STP plans with a fine-tooth comb to look at where mental health sits.

I am charged by NHS England with delivering the Five Year Forward View for Mental Health to 2021. That is a growth agenda in terms of money spent on mental health and who we employ in the numbers of staff. Any STP that is submitted that looks as though it is shrinking its mental health agenda will absolutely have the feedback, and my team at NHS England will be working with them and the regions and their local partners on tackling that. You cannot address the plan that I have been charged to deliver by 2021 on an agenda of less. The investment will make savings elsewhere in the system and drive better value, but you cannot see 600,000 more people a year for talking therapies, 30,000 more women by 2021 for perinatal care and 70,000 more children, unless you are investing in your workforce.

The Chairman: I am going to ask for quick questions and quick responses.

Lord Lipsey: There is the question of spending, but the fundamental question is one of effectiveness. Perhaps I could put it this way: 100 years ago doctors were not able to do much for people's health; they

could tell you whether you were going to live or die. That is hugely transformed now. Where are we on the same spectrum with mental health? We hear a lot about talking therapies and new drug therapies, but, taken together, how effective are these new therapies and should we be spending more on them?

Professor Sir Simon Wessely: We definitely should. I remember when I started in psychiatry I worked at Queen's Square, the home of neurology, and all these neurologists used to say, "I can't understand why you're doing psychiatry; none of your patients ever gets better"—which is a bit rich from working at Queen's Square. The evidence for us is extremely good. When we have done the big comparisons of the effectiveness of medical treatments versus psychiatric treatments—it is not a distinction we really hold but you know what I mean—we come out just the same. Most of our treatments, like most treatments in medicine, are modestly effective, but with much better ratios. The figure we use of numbers needed to treat are often much lower in psychiatry than what is taken for granted as being normal in cancer or cardiology.

I use the words "modestly effective" and I absolutely push the point that in the next 30 or 40 years we will see therapeutic advances in psychiatry that we saw in neurology 100 years ago, beginning with disease modification in Alzheimer's, which will happen just about in my lifetime, and then later on in schizophrenia and bipolar. At the moment we have absolutely nothing to be ashamed of. The only thing we have to be ashamed of is the number of people who do not get reasonable treatments. We are not talking about miracle cures but reasonably effective treatments, and our record as a discipline in randomised controlled trials is that only oncology has a better record of patient recruitment.

Lord Lipsey: I wonder if you might give us one side of a piece of paper setting out some examples of effective treatments, as it is a very important issue that you have addressed very well.

Professor Sir Simon Wessely: With pleasure.

Sophie Corlett: Can I add to that? Investing in treatments at an early stage is much more effective than investing in treatments later. That is why it is so concerning that the rationing of services means that people enter later. Regarding early interventions in psychosis—one of you will tell me what the recovery rate is—if you intervene when someone has their first episode of psychosis you can make a phenomenal difference to people's prognoses.

Baroness Redfern: On Sophie's comment that half of all mental health problems are established by the age of 14, and Simon has mentioned CAMHS as well, where is the work to improve that? There is a lot still slipping through that net. To Claire, on STPs, you mentioned some have spent more money and I would like to know whether there are better outcomes for STPs that have spent that money. STPs have their priorities and it would be interesting to know what their priorities are and if they

include mental health issues?

Sophie Corlett: At the moment, about a quarter of young people with mental health problems are seen by child and adolescent mental health services. That means that many people are not getting treatments until their mental health problems have become, to some extent, established.

To remind people—I know it is in the title—the Five Year Forward View for Mental Health is only five years and, with an investment of £1.4 billion, will take us up to the heady heights of a third of people as opposed to a quarter. That means that two-thirds of children who could benefit from treatment still will not be getting it. You cannot just invest money and be there in a minute; it requires training and transformation. That is one of the most urgent things we need to do.

To talk again about the human cost, this is potentially a young person who might have an episode or very difficult period in their childhood or adolescence who is then given support and coping strategies to recover from that so that that does not become their life or they do not become someone with mental health problems.

The Chairman: I need to request that we keep questions and answers short. We have not moved on from question one. We will run out of time.

Claire Murdoch: The plan is to 2021 for children and we need to get the plan now for what happens post-2021. It says that we will treat 70,000 more children in specialist CAMHS and we will retrain the entire CAMHS workforce in evidence-based intervention. That has begun and is in hand. We are meeting the target of 60%—which is a low one: within two weeks of referral children and young people will be receiving evidence-based treatment. We are meeting that already on the access rate, but the evidence-based treatment needs more work, and early intervention in psychosis.

The final thing that we are doing, and this is an urgent piece of work, is looking at tier 4 beds. The Committee will be aware that we have an immediate problem of children and young people who need admission being admitted far away from home, which breaks continuity, increases distress and so on. We are working very hard now on plans to get local services for children and young people. All of those things combined is good work but we need to focus on what happens in school, downstream, and this needs to be a cross-government strategy, not just an NHS strategy.

Lord Turnberg: Are the talking therapy movement and the clinical psychologists having an impact? A few years ago I was involved with Richard Layard in trying to convince the Government that we need more of that. Is it effective?

Sophie Corlett: Yes. Many people talk about how it has completely changed their life. There is an ambition now to increase it from 15% of people to 25%. It does not work for everybody but it works for many

people. We know that in many areas there is an imbalance towards CBT as opposed to the full range of evidence-based therapies, so that is something that needs to be sorted out. We recognise that it works and the plan from NHS England now is to make sure that a wider range of people will have access to them.

Professor Sir Simon Wessely: The trials show that it certainly works, but people relapse and require different forms of support as well. Our concern is it is not always in the right place. Most people with mental health problems are in primary care and often not seen as part of a primary care team. Much the same happens in diabetes or community mental health services, et cetera. All the time we want psychological treatments to be integrated with the rest of the healthcare delivery team, not as a stand-alone service. It is the right idea but it is not always in the right setting.

Claire Murdoch: In addition to that evidence base, I know that thus far the programme has seen 3.5 million people being treated, with 2.1 million completing their whole treatment and, of those, 100,000 moving off employment benefits and back into work. Many of those people will have been in work anyway and been enabled to stay in work while they were receiving treatment, but 100,000 came off benefits and back to work. So there is a lot of evidence that says this is a relatively good intervention.

Lord Turnberg: We have focused an awful lot of on where we are now and what we need to do, but we have not got to how we sustain it in 30 years' time and what the difference would be. Is it just more money, because clearly it is a starved service?

Professor Sir Simon Wessely: Most of the costs in our world are not on kit: we do not use very expensive kit; we are quite cheap. Most of our costs are in workforce, in recruiting, training and then retaining a well-informed workforce. That is almost all the challenge. It is still difficult. It is curious because it should not be difficult because if you go to schools—and I have been going round all 35 medical schools in the country—there is a remarkable new enthusiasm for mental health among particularly young people that was not present when I was young. What we have not done is really harnessed that to get people into mental health professions. There seems to be a kind of drop-off in my business. Obviously I am a psychiatrist, so a doctor, but it seems to be when they get to medical school they get turned off. They are extremely excited beforehand, but it seems to be something we do to them that turns them off during their medical education. Much of what we are doing is to try and turn that round so that people come into mental health at all levels and stay there. I think that is the biggest challenge we face.

The Chairman: What is it that turns them off?

Professor Sir Simon Wessely: It is often the attitudes of other senior health professionals. I put that rather euphemistically, but I am sure you know what I mean.

The Chairman: There are several around the table, and you know them all.

Professor Sir Simon Wessely: Exactly. Yes, it is that. The people still will end up going into the kind of firefighting glamorous specialties.

The Chairman: In my specialty I encourage youngsters to go into my specialty; you encourage youngsters to go into your specialty.

Professor Sir Simon Wessely: I do.

The Chairman: Why do you feel you do not succeed?

Professor Sir Simon Wessely: Because some people in other specialities do not encourage people to go into my specialty, whereas in my specialty we encourage people to go into other specialties as well. We like them to do that because we like people to have done other things. Most people in psychiatry come in later.

The Chairman: The important question is about the future workforce in mental health care, the totality of the work force, not just doctors.

Professor Sir Simon Wessely: I totally agree with that.

The Chairman: We need to find a long-term solution, as Lord Turnberg has referred to. In the long term, what is the solution to this?

Claire Murdoch: I refer back to where I started in terms of fundamental problems. There is a hierarchy of what is important in medicine or the NHS and it is the wrong way round. It is a pyramid that needs turning on its head. What is really important is where most people live most of their lives and they take steps that keep them well. They receive early intervention if they are struggling from an evidence base to keep them well. We should not separate, as we do currently, the physical and the mental because they are so inextricably linked that we need to train differently. I felt joy yesterday when I had a spinal surgeon telling me—I thought it was time to retire—that he wished he had more mental health support for his spinal patients because pain management is a huge part of his ability to keep them well. Instead, he refers them for a whole raft of investigations that are expensive, and so on and so forth. It is about treating the whole person, changing the health hierarchy, valuing patients' responsibility for their own healthcare, and using more digital enablers as well. I think one can see a sustainable way forward, but the emotional, the behavioural and the psychological aspects to managing a health system need to be much more centre stage.

Q145 **Lord Warner:** Can we have a change of direction? What role do any of you see for employers in reducing demand on the system, given the volume of work absence from anxiety and depression which is work-related?

Sophie Corlett: We would see a huge role. We do quite a lot of work at MIND with employers. Those whom we work with are able to make quite

a difference to their workforce well-being generally to make it a healthier workplace but also to support people who do develop mental health problems to stay in work. That does not necessarily always work because sometimes their employee cannot get access to the health services that they need in time, but it may be to hold a job open if somebody does have to fall out of work, to support somebody to work more flexibly while they are unwell or come back at a slower pace—all of those are things that an employer can do.

Professor Sir Simon Wessely: We were very pleased to see an acknowledgement just yesterday that now work is regarded as a health outcome for the NHS. That is quite an important step forward. Sophie is absolutely right. We know that where people do develop mental health problems, where you integrate mental health treatment with occupational treatment you get much better outcomes. Where you do one or the other you do not. Things such as IPS, which is a way of delivering what you might call occupational psychiatry, I suppose would be the best way of putting it, or mental health support in an employment context gets very good results, but it is not often used.

Claire Murdoch: Could I add that this year NHS England has tried to incentivise the NHS as an employer, which is what you are saying. For example, a trust such as mine can earn an extra £2 million of CQUIN money if we can show improvements in how we treat staff in three key areas, and this is true nationally. That is around MSK provision—we do not look after people's backs enough in particular—mental health and stress, and the third area is getting people to have their flu jab. If I can get more of my staff to have their flu jab and I can look after their stress levels and reduce their days lost to stress, and look after their well-being better, and if we can look after their backs and MSK issues better, we are being incentivised as an employer to do that.

The only other thing I would add on top is that we must acknowledge we are a society where more employees are in a caring role, not just to young children but to sick or frail older relatives. As an NHS, we have to lead the way in being an employer that supports staff in their caring roles. I do not think we are good enough at that yet, but we really must focus.

Lord Warner: What have you actually done with the CBI and other employer organisations to drive this agenda with the employers?

Sophie Corlett: We have done quite a lot. We work with Business in the Community and with the CBI. We have worked with the City Mental Health Alliance, which includes many of the big banks, law firms and management consultancies in the city. We have done a number of different things through our Time to Change work which we do alongside another charity, Rethink Mental Illness, and as MIND.

The Chairman: How effective has it been?

Sophie Corlett: The organisations come back for more. They find it helps their bottom line enormously.

The Chairman: Is there any evidence of reducing demand?

Sophie Corlett: For the NHS?

The Chairman: Yes.

Sophie Corlett: I do not know that they are necessarily collecting that. They are interested in keeping people in work and productive. Their employees are interested in keeping in work and well. Line managers are interested in support for how they line manage their staff. All three of those levels are coming back extremely happy.

Q146 **Bishop of Carlisle:** Sophie, you mentioned earlier on that there is an increase in the incidence of mental health issues due to complex societal problems of one kind or another. Can we turn that round and think about the way in which mental health problems are affecting people's wider health? This has been alluded to by a number of you. Claire, you were talking about the importance of treating the whole person. From our point of view, looking at the long-term sustainability of the NHS, clearly that kind of link-up is terribly important. Would you like to say a little bit about that?

Sophie Corlett: People with long-term conditions, such as diabetes, respiratory difficulties, any condition that is ongoing and particularly if it includes pain or reduced mobility, increased disability, will have a two to three-times increase in their likelihood of developing depression. That is the first thing. If you have got three or more of those it is a seven-times increased chance of developing depression. So there is an immediate impact.

The more complicated thing is the link that mental health will have on your physical health condition in changing the prognosis. For instance, if you have had a heart attack, your chance of the second heart attack coming sooner and being fatal increase if you have a mental health problem. Likewise with stroke. With diabetes the costs overall are 50%. That is partly presumably to do with your mood and well-being and internal immunity towards that condition—I am no expert on those—and people talk to us about how they find it difficult to manage the condition that they have. They are not able to get their head around their blood sugar levels and the exercise they need to do, or they are struggling to get up in the morning because of depression. Exercise and shopping well to cook well are not top of their agenda, so there are knock-on impacts. So if you can treat somebody's depression and support them with that.

Often people will not think about it as depression. We have not talked about stigma, but there is the impact of stigma. You have already got a long-term condition in diabetes that carries a stigma. You do not want to admit to having a mental health problem as well. Finding ways for people with long-term conditions to get support to cope and to feel better rather

than maybe deal with mental health problems are hugely beneficial and reduce costs on the physical health services as well as on people's lives.

Professor Sir Simon Wessely: In a large trial done across the road, our group on diabetes showed that if you bring mental health treatments into a diabetes population you improve their mental health, which is not surprising, but you also improve their diabetic control. That is one of the reasons why diabetes has been used as an example of rolling out into greater physical and mental care—and it saves money.

Claire Murdoch: In addition to the prevention work that needs to happen, if I ruled the world, I think we underestimate the power of patient education programmes, so as soon as anybody is diagnosed with a new long-term condition I would make it an expectation of them that they would attend a training course that would often be peer led. We run one of the most interesting ones in the world in my trust, which I inherited, around HIV, which is peer led but backed by professors. Every newly diagnosed patient with HIV, for example, at UCLH will be referred to our peer-led education programme. It is five sessions that will help them understand the course of their illness, living well with their illness, what to tell an employer, where to link and get self-help, and how to understand the drugs they are on. When you look at what people report before and after that diagnosis, it is extraordinary. I do not think we do enough to give people the information and tools they need at the point of diagnosis to manage themselves through informal networks better. In addition to the prevention agenda, that has to be part of a different, more sustainable NHS. Those programmes are terribly important and effective.

Bishop of Carlisle: Besides the impact on people's well-being, which is obviously the most important thing, there is a very strong financial incentive to get the prevention right at an early stage.

Sophie Corlett: Yes, and we are talking about billions of pounds to the NHS.

Bishop of Carlisle: That is very helpful. Thank you.

Q147 **Baroness Blackstone:** We know that there are big inequalities of outcome between those who are mentally ill and others. Those who have long-term and serious mental illness die 15 to 20 years earlier than other people. One of the issues that has been raised with respect to this is whether there is real parity of esteem between mental health and physical health. I know that the 2012 Act made it a legal requirement to try to promote parity of esteem. How far has that happened? There are things that you have said about hierarchies of status and medical students being put off once they get there in achieving greater parity. What do you see as the barriers and how can they be overcome?

Professor Sir Simon Wessely: Parity of esteem is a kind of slogan that covers a lot of different things, one of them being exactly what it says: the mutual respect that there is. I sometimes say if something is good

enough on one side of the road, thinking of where I work in Denmark Hill, in terms of whatever it is—canteens, car parking, access—it is good enough for the other side of the road, and usually it is not. It would not take you very long if you crossed Denmark Hill to know whether you were in an acute sector hospital or a mental health sector hospital. You would spot it very quickly in all sorts of ways. That would be the first thing.

The second thing is we have to be very clear, and my bit of the profession takes responsibility for this, that we have neglected the physical health of patients with severe mental illness for too long. We have drifted too far away from our medical roots. We have forgotten that we also have a job to do on the simple stuff, such as cholesterol, obesity, exercise and smoking. Fifty per cent of all smoking products are sold to people with mental illness. That is a scandal, but that is the case. The biggest single killer of people with mental health problems is not suicide, it is not violence, it is cancer due to smoking. That is the biggest avoidable death. The next biggest avoidable death is heroin overdose, which we do not even think of as a patient safety avoidable death issue, but it is. The rate of that has doubled in two years. It has gone from 500 to 1,300 in two and a half years. We do not seem to be shouting from the rooftops about this. These are the things that are going on.

There is a lot we are doing. We are doing a lot with NHS England, with our sister colleges, in medical education, in curriculum development, in incentivisation of trusts to deliver better physical healthcare and developing things such as physician associates to help address these problems, but we have got a huge amount of catching up to do. It is partly because we have accepted that it is okay for people with mental health problems to die 15 or 20 years younger. We have known about this for a hell of a long time but have kind of not bothered about it—just like we do with addictions to alcohol and drugs. We are not as fussed about it as we are about other areas.

Baroness Blackstone: Why should that be? Is it because people think it is their own fault?

Professor Sir Simon Wessely: Yes, partly it is that. Sophie has already mentioned stigma. There have been some reductions in stigma due to Time to Change.

Sophie Corlett: A reduction of 8.3%.

Professor Sir Simon Wessely: But anyone who thinks that issue is over or solved is not on this planet.

Lord Mawhinney: Would it be fair to summarise what you have said by saying that while this place here can pass legislation, like parity of esteem, it does not mean a damn thing in the NHS?

Professor Sir Simon Wessely: You are asking for a major change and that takes at least a generation. The answer to your question is what you have said would be fair.

Sophie Corlett: I think it does stand for something as part of the mental health lobby perhaps. Coming from a voluntary organisation, we have found it very useful to remind people that they now have a responsibility to get on and change things, but we have to make sure that those changes happen at a societal level where stigma still persists and people think it is okay for people to have to wait for years to get a service when they would not expect to do that for physical health. Even society's expectations will have to change. Even within the mental health provider sector, there is a tolerance of expecting to not get an equal share of the pot to provide the services that they know they could do, and actually it is all part of the same problem. Shifting people to a belief that we should and can do better, I think, is the first step. NHS England has played its part in coming out with a plan for five years of what needs to be done, but making sure that we stick to that plan will be quite important.

Claire Murdoch: It is an anecdote, but Chris Smith was the first MP to come out as openly gay in the House in 1983 and people will remember that it caused a big splash nationally. The first MP to come out as openly having mental health problems was in 2012, some 30 years later. For me, that spoke volumes about the ease with which we can talk about having mental health. Everyone in this room has mental health and sometimes our mental health is better than it is at other times. What we do around drinking, exercise, diet and seeking help from a GP is all affected by how we are feeling. I think that the issue of stigma and bringing a new literacy to our young, in particular, about how they talk about and understand the interrelationship between physical and mental health is terribly important, in my opinion.

I have personally stopped using the "parity of esteem" phrase. In the NHS England plan that was published in July of this year, you will not find it. Again, in the planning guidance that has gone to the NHS, you will not find it. It is a controversial step I have taken, but I am saying that actually mental health services and the work that we do is not something just for that mental health trust to worry about but happens in primary care, schools and elsewhere, and there is an evidence base. It is time, in a sense, certainly from an NHS perspective, to stop feeling we have to campaign and we have much more an expectation that we will do what works and what is right for our population. That is a controversial thing to put before the Committee. I will not use it anymore; I have gone beyond it.

The Chairman: It is a pity that you do not use it because the purpose of introducing it was for the very reason of giving a higher profile to mental health care services.

Claire Murdoch: I think it has done its job and we need to push further still now into that thinking.

Lord Willis of Knaresborough: Given, Lord Chairman, that it was your amendment that created it in the Act, I think that is something we should gloss over very quickly, in the realms of diplomacy.

Claire Murdoch: I will go and insert it in the plan immediately.

Q148 **Lord Willis of Knaresborough:** When you actually look at the Five Year Forward View and the impact of the workforce on mental health services, there is not a single area where the actual demand has not gone up for staff, yet the overall workforce is going down. When we talk about this parity of esteem, which I still think is worth discussing, what we actually find is that there is an entrenchment by mental health professionals themselves of actually seeing their empire expanded. In the work of nurses in the shape of caring, and the discussion about the four strands, I have met people who had one morning only of mental health education as part of their three-year degree course, yet there was a protection to say, "We should not expand that to all staff". I just wonder what your take is on the current state of the mental health workforce and what we need to do in talking about a broader workforce who have the skills of mental health. If we do not diagnose it early, how on earth are we going to make any inroads? It is not by employing lots more psychiatrists.

Professor Sir Simon Wessely: We are obviously completely on that agenda, massively, and in two particular areas. We are working hard to increase, not decrease, the amount of mental health coverage in medical school curriculums and it is possible that the proposed expansion of 1,500 extra doctors a year will provide a very good opportunity to realign medicine and bring out a new type of medical school student who actually wants to do the most difficult job in medicine, which is of course general practice—which also carries the bulk of mental health.

The big change we have made and worked very hard for is that, whereas, when we were all qualifying, nobody did a psychiatry house job, they did not exist and it was not possible, we had the foundation year and it still was not possible, this year we have hit the point where 45% of all medical students will do a job in psychiatry. I can tell you the truth, that, when they are told that, they do not go around whooping with joy, but at the end of it they really appreciate it, they have learned a lot and they say that they feel that they can do a better job—actually it is the third most popular job. We are going to keep pushing that until all medical students have done a foundation job in psychiatry. That will have the biggest effect on the delivery of healthcare, I think.

Lord Willis of Knaresborough: It will not if the 2,500 nurses a year, for instance, are being educated in four strands, three of which have virtually no mental health input.

Professor Sir Simon Wessely: I could not agree more. Obviously, I cannot speak for the RCN and nursing, but I can say that we are working with HEE to help it develop new curriculums for nurse training. Clearly, we are—and MIND as well. Why would we not?

Sophie Corlett: We have just today launched part of our primary care campaign exactly about GPs and practice nurses in primary care. Yes, less than half of GPs have any background in mental health, and that is in psychiatry, which is not the extreme end of what they do but the

opposite of what they do, in one sense, because of how mental health works and who ends up in primary and secondary care. Nurses get even less, so the RCN is absolutely backing our campaign to say that nurses need to get more training and more on-the-job training because their access to CPD, once they are in practices, which is not the same as the NHS, can be quite limited and they can often not be released from the practice to do training. So it is not just that people do not get the training before; we have a cohort of people already and getting them trained up is also a real problem. It is a massive problem, particularly in primary care, I would say, but actually it is across the workforce. We have talked about diabetes and respiratory problems, and those people also need to have an understanding of mental health. Otherwise, I think we are going to struggle and continue to struggle to meet the need.

Claire Murdoch: First responders, who can be teachers and might be the police, a whole tranche of people, need good enough mental health awareness to be able to spot it. The training programme and the awareness programme that you talk about needs to go very wide, bringing it back closer to the professional groups. I completely agree with you that a generic core foundation around physical and mental health is essential. When I trained as a mental health nurse a long time ago, I also did a long stint at the Royal Free on a medical and orthopaedic ward and I had to know the basics of good physical healthcare. That was a real asset and we need to see that across the professional groups.

I do worry about those professional groups, such as school nurses and health visitors, who are fundamental to good child health and are now broadly commissioned by local authorities and outside of the NHS purview. I think we have to think very carefully when we think about the future of the NHS about those elements of provision that have moved firmly outside of the NHS reach into local authority hands. That may be a good thing overall, I do not know and I will not express any more opinions, but, whatever one thinks, it is a vital area of the workforce that we must be sighted on. I think we are less so at the present time and we need to stop that drift going further still.

Professor Sir Simon Wessely: What has massively influenced my viewing of these things over the years is that I am a psychiatric adviser to the Army and there we changed the systems of dealing with soldiers who have trauma, who used to be seen by external professionals, psychologists, counsellors and people like me, and we did the trials that showed that it made them worse. When you support the management and they get the support to do the things they should be doing themselves by people of the same culture, background and uniform, you get good results and you get better mental health. That is the model I have worked my whole career by.

Similarly, with schools, I do not want every child in school to start seeing counsellors and mental health professionals, et cetera, but I want there to be CAMHS people in the school to help teachers do just that, just as

my life is about helping other doctors to deliver better mental health care, rather than us doing it all ourselves, which we cannot do.

The Chairman: Normally, that is done by an institute of higher education developing programmes of education which they can target towards teachers and other employers. We are not doing that, are we?

Professor Sir Simon Wessely: We are doing that, but, even more important is what I said about IAPT earlier about working in a team where there is a psychologist as a part of the team on the same rounds and having coffee with you to whom you can then say, "I have this really difficult problem. What should I do?" You should have the people with the mental health skills and training as part of the group, not in another hospital 20 miles away, and not in another system with its own IT system that does not talk to you when you need to refer. That is where you get a cultural change and the normalisation of mental health as part of the wider team. We have done quite well with the Armed Forces, and we are already hearing tremendous enthusiasm for putting CAMHS people into schools.

Sophie Corlett: You are right, it is also about people in other front-line jobs, such as teachers, youth workers, police, employers and line managers knowing how to spot and support people in a general way and then how to signpost people on.

The Chairman: That is exactly what I was trying to get at. We run all kinds of courses in the institutions of higher education, including universities, where departments of psychiatry might run such courses. Why do they not?

Professor Sir Simon Wessely: We do run these courses. One of the few ways we make money is by running these courses, so we do. But that is not in itself enough.

Sophie Corlett: I do not think it is always psychiatry. You do not necessarily want a teacher trained in psychiatry; you want them to understand mental health, so it is the sort of thing that we deliver, and there are other training courses specific to teachers or to different groups.

Q149 **Baroness Blackstone:** What is your single key suggestion for change that the Committee might recommend to make the NHS more sustainable?

Professor Sir Simon Wessely: I will end where I started, which is integration of the mental and physical. You can call it parity or whatever you want, but it is the integration, not separation, of the mental and physical at all levels, from training right through to service delivery.

Sophie Corlett: I would go back to the money.

Professor Sir Simon Wessely: Yes, and the money.

Sophie Corlett: I am sure the money is a given in all that we are saying. We need to see the money that has been committed get through to the front line and we need to see a promise of further money after these five years because we need to see a trajectory where we are actually moving from the current position to something that resembles parity. However many years that takes, we need to see that it is a constant commitment that people are absolutely determined to reach. It is about the forward commitment to the money, the money at the moment getting through to the system and it is the people who work in the system having the confidence then to say, "Okay, we will deliver what's being asked of us". At the moment people are still in that position where they are not quite sure that the money will get through. There is a lack of confidence and, therefore, potentially, the jury is out for some people as to whether they are going to make the changes that are required.

The Chairman: What is yours?

Claire Murdoch: Probably transparency. I agree with what both of my colleagues have said, but I think too little is known or understood about mental health, the spend against it or the value that it adds. We need education and transparency so that we do understand the evidence base more, the outcomes and what value a pound spent here might bring to a patient journey where you might save £4 there. Last Thursday at 5 pm when we published the CCG dashboards, it was not just the money that was published, the investment, it was also performance and outcomes, which will enable us to look in a more sophisticated way at which health systems are deriving greatest value. It is transparency and education that will bring the biggest benefit, I think, not just to mental health services but to health, the NHS, as a whole.

The Chairman: Thank you, all three of you, for coming today to give evidence; it has been most useful. I think you have promised to send us some treatment data that Lord Lipsey asked about, and we will welcome any other evidence that any of you may wish to send. Thank you for coming today.