

Public Accounts Committee

Oral evidence: Mental Health Services for Children and Young People, HC 1593

Wednesday 31 October 2018

Ordered by the House of Commons to be published on 31 October 2018.

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Members present: Meg Hillier (Chair); Chris Davies; Chris Evans; Shabana Mahmood; Layla Moran; Stephen Morgan; Anne Marie Morris; Bridget Phillipson; Lee Rowley.

Sir Amyas Morse, Comptroller and Auditor General; Adrian Jenner, Director of Parliamentary Relations, National Audit Office; Jenny George, Director, National Audit Office; and Marius Gallaher, Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1–244

Witnesses

[I](#): Dame Professor Donna Kinnair, Acting Chief Executive and General Secretary, Royal College of Nursing; Saffron Cordery, Deputy Chief Executive, NHS Providers; Kadra Abdinisir, Strategic Lead, Children and Young People's Mental Health Coalition; and Anne Longfield, Children's Commissioner for England.

[II](#): Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Simon Stevens, Chief Executive, NHS England; Claire Murdoch, National Mental Health Director, NHS England; and Professor Ian Cumming, Chief Executive, Health Education England.

Examination of witnesses

Witnesses: Dame Professor Donna Kinnair, Acting Chief Executive and General Secretary, Royal College of Nursing; Saffron Cordery, Deputy Chief Executive, NHS Providers; Kadra Abdinasir, Strategic Lead, Children and Young People's Mental Health Coalition; and Anne Longfield, Children's Commissioner for England.

Chair: Good afternoon and welcome to the Public Accounts Committee on Wednesday 31 October 2018. We are here today to consider the National Audit Office's Report on children and young people's mental health services, an issue that is absolutely coming up the political agenda. It is particularly important, as most mental ill health starts before the age of 14. So it is really key that we get this matter right.

Of course, we have had the recent announcement that the £20 billion settlement for the NHS includes £2 billion directly for mental health services but not disaggregated for children's services. We want to probe that. We also want to hear from this particular panel about how things are on the ground and what you think could be done to make things better. I will not go into detail, but obviously the parity of esteem ambition is a very big ambition and we are a very long way from it, as the NAO's Report really highlights.

I welcome our first panel; we have two panels today. The first consists of people at the sharp end, on the ground. It is great to see a panel of four women; I am afraid that we do not always manage to achieve that, but it is great to see you all here today. The second panel—there are probably people in the room listening out for them—are people from the Departments and the NHS who are actually responsible for addressing this big challenge.

I am pleased to welcome Saffron Cordery, who is the deputy chief executive of NHS Providers; Kadra Abdinasir, who is the policy officer for the Children and Young People's Mental Health Coalition; Dame Professor Donna Kinnair, who is the acting chief executive and general secretary for the Royal College of Nursing; and Anne Longfield, who is the Children's Commissioner for England. Thank you all for coming.

We have seen your evidence; thank you very much indeed for sending that in advance, as it helps us to focus our questioning. I will hand straight over to Anne Marie Morris. Before Anne Marie asks her first question, however, I will just say that we have about an hour for this part of the session, so if you agree with something that someone else has said you can just say, "I agree." That will save us all time, and you will then have the chance to make another point. As I say, we have your evidence, so you do not need to repeat everything in there. We need to get through quite a lot so we can challenge the Government in the next panel.

Q1 Anne Marie Morris: Ms Longfield, how would you very briefly sum up the



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current state of mental health provision for young people?

Anne Longfield: It has been the biggest issue that children have brought through my door. I have been in post for nearly four years, and from the first day in post, children, their parents and professionals have streamed through that door to tell me about the difficulties that they have been having getting help.

Q2 **Anne Marie Morris:** Typically, if we can sum it up, what are the key issues?

Anne Longfield: The key issues are, first of all, the shortage and lack of help available for so many. We know that only one in four children gets help, and even with plans in place that will be reduced to one in three. There is a real paucity of early help to prevent these crises from happening; there are black holes in the system all over the place.

Those children who do get access to help and treatment have to wait an unacceptable—in my view—length of time to get that; there are often many weeks, if not months, without contact. And then there is the disparity between the amount that is spent on mental health for children and the amount spent on adults. Less than £1 out of £10 goes on children, despite the fact that they are 20%—

Q3 **Anne Marie Morris:** Ms Longfield, that is really helpful in giving us some of the facts, but I guess I am after your opinion. What is it that is wrong that we need to fix? What is causing this problem?

Anne Longfield: What is the cause of poor mental health?

Q4 **Anne Marie Morris:** What is the cause of the mental health problems, as they are currently—

Anne Longfield: I see. For children, a whole range of issues are affecting their mental health. Some of it is about the complexity of life that they are experiencing. Some of it is about pressures within school. Some of it is the fact that stigma has reduced so that more children are identifying this and feel able to talk about it.

Q5 **Anne Marie Morris:** Do you think there is anything that has changed environmentally that has affected this? Might I suggest the internet and the Secretary of State's comments on that?

Anne Longfield: I certainly think that 24/7 communication adds additional pressures for children. It is something that does not go away. There is great pressure around how they look and how popular they are. That all adds to difficulties and anxieties. I am often asked, "Is there a crisis?" Certainly for those children who cannot get help, there is a crisis. Again, children come through my door time and time again to tell me that.

Q6 **Anne Marie Morris:** Ms Abdinasir, what do you think the cause of this is? How would you fix it?

Kadra Abdinasir: Many of our members recently have been shedding light on the wider determinants of poor mental health. We know that

things like poverty, poor housing and lack of access to good-quality education are also having an impact. We need to be taking a more holistic view. It is not just a mental health problem.

- Q7 Anne Marie Morris:** In terms of this £2 billion that the Chair mentioned earlier, how would you like to see that spent?

Kadra Abdinasir: We welcome additional funding and focus on children's mental health. The focus on crisis is important, and the funding for A&E is important, too. We do not want young people presenting themselves at crisis points. We would like to see some of that funding shifted to early interventions in the community.

- Q8 Anne Marie Morris:** What would that look like?

Kadra Abdinasir: Many of our members deliver low-level counselling provision in the community, and they work with the whole family in mind, delivering that holistic view.

- Q9 Anne Marie Morris:** Ms Cordery, with your provider hat on, suppose you were given a chunk of this £2 billion. How would you like to spend it on this problem?

Saffron Cordery: There are a number of issues here. On the £2 billion that has been announced as part of the overall funding settlement, we need to be really clear that it is not new money, but part of the existing settlement. It is welcome to have that focus on mental health spending. We have got a big job to do to continue and intensify the direction of travel. The past couple of years have seen some important and seismic shifts in how we look at mental health care and provision, so I think it is important—

- Q10 Anne Marie Morris:** Can you give an example of that?

Saffron Cordery: If I can give you an example of a trust that is doing some amazing work, it might give you an idea of how this money is being invested. West Yorkshire and Harrogate Health and Care Partnership is doing some amazing work as part of the new care models with CAMHS. Basically, they have taken over the commissioning and provision of the specialist in-patient care for children and young people. Typically that area is under-bedded in terms of in-patient provision. They are aiming to reduce out-of-area placements, which we know is a big and enduring issue that causes a lot of distress and suffering. They are also aiming to improve access to wider services. That is five trusts and local partners working together. They are intensifying their community provision. They have got care navigators, which is something that the CQC said was very important. It is also something that "Future in mind" indicated needed to happen. They are implementing some of what is already out there.

What the partnership has actually delivered is the most important thing. In the six months since April, they have delivered a reduction in occupied bed days from 708 days to 536 days. Some 21 children and young people were not admitted to in-patient care. There has already been a £500,000 saving this year, and there are plans to roll it out further.



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What I am saying is that we need to think about how we invest that money on things that we know work. Investing in these new care models is one thing that we know works. It overcomes fractured commissioning and can help support investment in workforces and help bring different services together. That is the fundamental thing. If, through this more streamlined approach to commissioning, we can support someone in the community, rather than admitting them, we can really make some strides.

- Q11 **Anne Marie Morris:** It would be helpful if you could supply us with information about that case study and any others you have. You have not mentioned the new education hubs. Will they make a big difference to you, as a key component?

Saffron Cordery: As colleagues said earlier, the earlier we identify and start to help people with mental health conditions, the better the outcomes are, however severe or mild their condition is. As the Green Paper for children and young people and "Future in mind" identified, the important thing is cross-public sector working and cross-voluntary and statutory sector working. That means going out into schools and working in youth centres and libraries. Birmingham has got a brilliant drop-in hub that identifies people who are struggling. If we can pick people up now, we stop those enduring problems. We know that 75% of mental health problems start in people under 14. We all know that statistic.

- Q12 **Anne Marie Morris:** You are absolutely right. Ms Abdinasir, what in your experience is the issue with CAMHS? We have not specifically focused on that. We have talked about wonderful things, but what can this money be spent on to sort that out? The waiting times are not only variable but long.

Kadra Abdinasir: Many of our members have done their own analysis of CAMHS over the last few years, and they have found that the lack of joined-up provision often means that young people present really late and face delays in accessing services. Young people are often turned away because they don't meet the criteria for CAMHS. What really worries us is that many of those young people are not signposted to services.

- Q13 **Anne Marie Morris:** Why are they turned away? You say that they don't meet the criteria, and I've heard that before, but what do you actually mean by it?

Kadra Abdinasir: That means that the CAMHS services in their local area are overstretched and unable to keep up with the demand.

- Q14 **Anne Marie Morris:** So you are saying it is rationing?

Kadra Abdinasir: Yes. Recent evidence by the Education Policy Institute has shown that referrals have increased by 26% over the last five years, so there are a significant number of referrals coming into CAMHS. We want to see young people who don't meet that threshold signposted there.

- Q15 **Anne Marie Morris:** Ms Longfield, does it worry you that there are children not being attended to? Presumably, they could commit suicide, whereas if they presented with a broken leg, hopefully they would stay



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alive.

Anne Longfield: It is a huge, obvious concern, which I am sure everyone shares. Again, children have told me about how they have sought help but not been able to meet those thresholds. Children have said that they are very aware of it. I have been really shocked by the fact that children have found it quite normal to say to me, "I know that just feeling suicidal isn't enough to get me help. I have to have actually tried to take my own life." There are a huge number of children who have ended up at the point at which they get referred for specialist help, often by a GP—there is a bit of a black hole there—and then are turned away. They are not turned away to anywhere, systematically. As I said before, even if they do go forward to treatment, there is a gap. We know that, at the moment, three quarters of children will be in that situation. Even in five years, it will be two thirds of children, which obviously is very high.

Q16 **Anne Marie Morris:** Does it worry you that the Government's ambition is to get to only 35% of children from 25%?

Anne Longfield: Absolutely. One the things that I have been talking about very much over the last year is the scale of ambition. The Green Paper put forward really important initiatives and interventions that will make a huge difference. That is what is needed for a certain level of need, but actually it will take us to only about one fifth or one quarter of all schools. I would like to see a trained professional in every school as something we can rely on and know. If we can do that, we can stem the problems that are developing, so you bring down the number of children who need to go for more serious help.

Q17 **Anne Marie Morris:** Okay. The £2 billion that has been identified has mostly been identified for crisis treatment. Do you feel that is the right place? That is not what you have been talking about.

Anne Longfield: I certainly would want there to be spend both on early intervention and on treating more serious problems. In early intervention, we know from the Green Paper that we are looking at £300 million that has been put forward for one fifth of all children. You don't need me to work out how much we will need. It is certainly over £1 billion. If you look at the disparity in spend between 7% going on a population of over 20%, knowing that most of these problems start during this period, you can see the change that is needed. There is also a shortage of access to more specialist treatment, in terms of CAMHS.

So it needs to be ambitious; it needs to be a seismic shift. But it is also very clear that, where there are priorities within the NHS and within systems, change can be achieved; we have seen that with eating disorders. It needs that priority and that scale of ambition, and obviously we have a 10-year plan where that could happen.

Q18 **Anne Marie Morris:** Ms Longfield, I am still not getting a sense of clarity as to exactly how you would like to see this addressed. Clearly, eating disorders have been focused on, but there are many, many other issues. If you were the Secretary of State for Health, what would be the three



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key things you would do?

Anne Longfield: Absolutely, I am very pleased to address that. First, I would want a high-level, high-priority plan that is very ambitious in terms of a seismic change and that sets out to provide the help needed for all children who need it—not one fifth, not one quarter, not one third, but all children who need it—over a period of time. If it has to be 10 years, it has to be 10 years, but 10 years is a long time for children, as is five years. The three components within it would be the increase in help for children from 7% up to 20%, reducing the disparity in spend so that we know funds are flowing through; the fact that targets would be set for all children to be able to get the help—not a portion of children or children with a particular need, but all children, whatever that means; and waiting times reduced to four weeks ASAP.

Q19 **Anne Marie Morris:** Has any collection of data been done as to the impact on those children who get turned away?

Anne Longfield: There is no data, I believe, on that. From the data you will have seen and from the NAO Report, you will know that there are great holes in data. Part of the problem of setting targets and moving on is that data is very poor and inconsistent, but certainly in terms of the number of children who are turned away, there is no data to show either the numbers within that, or what happens to those children. You are talking about a huge number of children who are not getting help and whose problems are being left to develop into more serious crises.

Q20 **Anne Marie Morris:** Ms Cordery, these children are falling out of the system.

Saffron Cordery: Absolutely.

Q21 **Anne Marie Morris:** Are they falling to providers, and are you struggling to deal with those children who are not getting the help they need?

Saffron Cordery: What we have to look at here is how the system is structured, because, essentially, children will be referred to NHS mental health trusts as providers. Typically, they could go into primary care—that is a GP—and then be referred. The point is that, essentially, services need to be commissioned by either clinical commissioning groups or by NHS England, depending on the nature of the service, and trusts are able to deliver those services once they have been commissioned, but we know that demand is way outstripping supply.

It is absolutely right that there is a 26% increase in demand for CAMHS services, and the population of under-18s has only risen 3% over the last five years. That is the level of demand we are seeing. In a system where mental health provision has typically been under-invested in over the last 10 to 15 years, we are trying both to ramp up the investment and then to ramp up the delivery of services. It is very challenging. It is difficult for NHS trusts to fill that gap, because it is about all the wraparound services as well. That is why we believe that, through things such as the example I gave you earlier, with lots of trusts and local partners working together, we can get a more streamlined approach so you have a pathway through



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and some people can receive the low-level intervention and support they need, which would probably stop them needing to be referred in the first place.

- Q23 **Anne Marie Morris:** That is very helpful. The message I am getting—I would be grateful for a yes or no from Ms Longfield and Ms Cordery—is that there is not really a 10-year, three-year or any other plan, as I understand it.

Anne Longfield: There is no coherent plan.

- Q24 **Anne Marie Morris:** There is no current joined-up approach to work out how to deliver the results. I think what you are telling me is that the system is not there to deliver in any event. Am I right? Is that what you are saying?

Saffron Cordery: We have made substantial progress over the last couple of years, with the five year forward view for mental health and the plans that have been put in place. I think it would be wrong—

- Q25 **Anne Marie Morris:** So you think there is a plan, but Ms Longfield is not happy with the plan?

Saffron Cordery: I think it is fair to say that children and young people have not necessarily been prioritised, but I think it would be wrong to say there isn't a plan, because there is a plan. What we need to do now is to work to make sure that is implemented.

- Q26 **Anne Marie Morris:** Ms Longfield, do you agree?

- Q27 **Anne Longfield:** There are elements and aspects of a plan. You can see that in the Green Paper and in various incremental changes to date, but there is not a high-level plan across different Government Departments that sets out how to help all the children who need it within a short timescale and with the resources needed. There is potential within the 10-year plan. That would be my line of questioning—when and how that would be put together.

- Q28 **Anne Marie Morris:** We shall note that when we see the team. From your perspective, Ms Abdinasir, what is happening to the children who fall outside the net? They may even get to CAMHS, but they are then turned away. That is a large number of children. In your experience, what is happening to them?

Kadra Abdinasir: From what we hear from our members, the obvious one is that their needs escalate. Often you find young adults presenting themselves with very serious mental health problems at the more acute end in adult services, and we want to prevent that. We also need to look more holistically and think about local authorities, the police and other services that commission support. It is a matter of having a coherent plan and ensuring that all the various partners play a role and are seen as part of the system. Some young people end up in the criminal justice system, and you will find that the majority have underlying mental health problems that have not been addressed. That is something that we want to see as part of this plan as we move forward.



- Q29 **Shabana Mahmood:** I want to pick up on staffing issues, so perhaps I will direct my questions to you, Professor Kinnair. If we take the ambition to treat 70,000 children and young people by 2021, what do you think needs to happen with staffing capacity to be able to deliver that?

Dame Professor Donna Kinnair: We know there is a shortage of nurses and doctors, but we have a huge shortage of nurses in particular. We have 40,000 vacancies in England alone. We know that there is a gap between the need and our ability to provide the service. It is not just the fact that nobody wants to provide the service; we do not have the ability with the workforce that we have to provide that service. There is a gap, even with the Green Paper. We have created an almost perfect storm, particularly for the nursing professions. We have cut education and we have done numerous things such as taken away continuing professional development, so it is almost impossible to gain the extra skills that you need.

It would be good to get upstream. We have a number of services—the Green Paper, with all the goodness—that start at age five. We know that support for parents is needed way before that to help them work with their children. Look at what we have done with community nursing, which local authorities now commission. You have health visiting and school nursing; school nursing has almost been eradicated. I met someone on the way in who says they have 11 school nurses for the whole of Haringey borough. That is where you put some of your early prevention. You then start to deal with general mental health issues, so that people can support parents in looking after the under-fives so that they do not become the fives and then they do not become the 14-year-olds. There is a huge amount.

I think there is something about focusing on primary prevention. We know that in the next years we are going to have even more cuts for local authorities, which will mean even more cuts in school nursing and health visiting. We would say stop or reverse those cuts. While some trusts are doing brilliant things, others are not. We have a huge problem with access for a number of young people, and we need to reverse the commissioning back into health, so that trusts can deal with the whole pathway instead of taking this piecemeal approach. We need to know what we have for prevention, and for specialist and tertiary services.

- Q30 **Shabana Mahmood:** Thank you, that is helpful. Professor Kinnair, you very clearly outlined the gap. Do you see the gap between the ambition for the service and the capacity to deliver it increasing if we take 2020-21 as our end point for this first phase of prioritising children and mental health? Is anything that is being done at the moment likely to help at least narrow the gap—even if it will still exist due to cuts and changes elsewhere?

Dame Professor Donna Kinnair: One of the things that we have absolutely fought for is mental health education for most or all NHS staff. It has got to be for all nurses, because interventions and small treatments can be done by all of us. In that way you get upstream, and start to do some of the prevention. However, it will still be necessary to invest in the specialist services.



- Q31 Chair:** Can I just stop you there? When you say “everyone”, can you tell us what practically you would do if you were in control of the system? What would you do, and how much would it cost, roughly—or not rough cost numbers, but how much time and energy needs to be put into the amount of mental health training that would make a difference?

Dame Professor Donna Kinnair: We have already fought for mental health training to be part of the general nursing curriculum. Every single nurse should be equipped with the knowledge and theory. The difficulty we have at the moment is the placements; we do not have enough placements for staff to gain physical, actual experience on the ground; but we can provide that in different ways, through simulation activities, role play or working with other services such as homeless services. So that is what I would do. When I worked with children and young people as a health visitor, I worked with parents about how to manage behaviour and how to deal with isolation, loneliness—all of those things. With health visiting services now commissioned elsewhere, they are working to something different, like just safeguarding. Safeguarding, as important as it is, is not holistic care that provides help and support to parents, with an understanding of child development and what to do when things are not going right within families. I think that for me huge investment in early prevention helps us get upstream, and actually some of the commissioning is totally wrong. It is in the wrong place.

- Q32 Shabana Mahmood:** I am trying to understand the specialisms that are necessary in the staff mix that we need to deal with these issues; are you basically saying that if everybody gets that training, if every nurse has it—

Dame Professor Donna Kinnair: We are starting to stop it getting upstream—

Shabana Mahmood: Because in all of their different placements, whether it is within a school or—

Dame Professor Donna Kinnair: Yes, whether you are in a school, or health visiting, whether you are a GP or you are attached to a GP, everybody needs to recognise and understand what can potentially be mental health issues.

- Q33 Shabana Mahmood:** So that is at the general end—general knowledge and a bit of experience, and spotting problems early on. What do you think is the optimal mix of other specialisms in the overall staffing complement to deliver this universal service based on early intervention?

Dame Professor Donna Kinnair: We also need secondary services. These are attached to general practice, or in the community services; because otherwise everybody gravitates to a hospital. So it is nice for a trust to deliver secondary care, but everybody takes the emergency department pathway or gets referred into specialist services. So we need some secondary services, and they need to be in the right place for people to access them. We have had a huge amount of success in schools, but you need not just brief interventions but someone who understands child



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development. So it is a nice thing to think that we can train a psychology student to do a bit of IAPT without understanding where people are in the development of their life. And one of the services that has that is school nursing, because school nurses deal with child development all the way through. Yet we are happy to sacrifice them and start getting others to make brief interventions without the skills that would mean that they could operate right through that child's lifetime.

- Q34 **Shabana Mahmood:** Thank you. That is helpful. Can I just ask Ms Abdinasir a question on data? I saw your written evidence to the Committee. Obviously, a lot of the NAO Report and other comments on what the Government are doing all comes back to data, and data being in a poor place. What do you think are the top one or two things that could be done in order to improve the picture on data collection?

Kadra Abdinasir: As we know, CAMHS in recent years has been operating in a fog. That has real implications for commissioning decisions. The data that we are using is 14 years old, and it is likely that the prevalence of mental ill health among young people has risen over the years. At the same time, there is a lack of focus on outcomes as well. We need to gather more information on what these interventions achieve, and whether they are worth while, or could be delivered by other services.

- Q35 **Shabana Mahmood:** I think you referred in your written evidence to a local audit. Has anything been done to audit how different places measure outcomes, and what the metrics are for these deliverables?

Kadra Abdinasir: No, not to my knowledge. I know that the Care Quality Commission last year undertook a review of practice across the country. There are difficulties in data collection. It is of poor quality, and I know that that is something that NHS England is prioritising. It seems that it will take some time until we can get it right.

- Q36 **Shabana Mahmood:** From your coalface experience, why do you think it is so poor, and why is it so difficult to collect data in this area?

Kadra Abdinasir: I think it comes down to the fragmentation. Many mental health trusts, for example, might be working with voluntary sector providers, but the outcomes are not always reported back. We would like to see a more integrated approach to the gathering of data and outcomes.

- Q37 **Chair:** Can any of you point to other countries where data is gathered well. It is quite challenging to measure outcomes. Do you have any international examples?

Anne Longfield: Others will know much more about the detail, but it seems to me that the data for adults is gathered much better.

- Q38 **Chair:** So you are really saying, "Do for children what you do for adults."

Anne Longfield: Yes. There are clear waiting time targets, a clear accountability framework and clear information on outcomes after intervention—especially around IAPT—so it can be done. That is my point.



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It has not been done for children, and now the focus needs to come for children.

Q39 **Chair:** Professor Kinnair, do you have good examples from elsewhere in the world?

Dame Professor Donna Kinnair: When you have local authorities and health working together, the information is usually much better, because they are usually working for the same outcomes for those children. My experience back in pre-2010, when, as borough and PCTs, we collected that information because it was part of our local needs assessment, was that we knew exactly what we were working with and what the third sector was working with. I can give you the example of the Borough of Southwark where I worked. As a CAMHS commissioner I was very clear about what things I needed to commission because we worked with the local authority and understood what our needs were and where the gaps were.

Q40 **Chair:** So it is not actually rocket science.

Dame Professor Donna Kinnair: No, it wasn't. We knew what the pressure was.

Q41 **Chair:** You seem to be suggesting that coterminous boundaries worked.

Dame Professor Donna Kinnair: Yes.

Anne Longfield: That might be what was happening there, which is great, but certainly from our data gathering, which is one of the things that I can do, we get back huge variation—huge holes and actually the local authority not always talking to their health—

Q42 **Chair:** Also, I think Professor Kinnair is talking about the time when we had coterminous PCTs and boroughs. This is a London perspective, but it is very different now in London and in other parts of the country.

Anne Longfield: Yes, I think that is right.

Q43 **Shabana Mahmood:** This question is for Ms Abdinasir. If you could do one thing to get a quick improvement on the current situation—the best quick win—what would that be? Also to Ms Longfield.

Kadra Abdinasir: We really need to prioritise preventative and early interventions. It is not just about responding to young people who are seriously unwell. We need to do more to promote positive wellbeing and mental health in our communities. We would like some funding to be ring-fenced to deliver those services. On the workforce point, there is an untapped resource in the voluntary and third sector that could be better harnessed and used. Many of our members are equipped and highly trained to deliver therapeutic interventions, but they are not often considered part of the system. That could help to achieve better outcomes more quickly.

Anne Longfield: I would quadruple the Green Paper plans to get to every school and provide that specialist help, so that there are not gaps and



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black holes between the people who see children and the specialist help as well. Obviously, waiting times are within that. A speeding up of that process—it does not mean that other things are not needed—is important.

- Q44 **Shabana Mahmood:** Would you see that as part of the early intervention piece as well?

Anne Longfield: Early intervention, and that move into specialist support as well. It would be both. At different times, different children need different levels of support.

Anne Marie Morris: What is parity of esteem, Ms Longfield?

Anne Longfield: In terms of mental health and physical health?

Anne Marie Morris: Yes.

Anne Longfield: Parity of esteem is the ambition to treat children's mental health as an issue that is as important as physical health. It is unimaginable to think that two thirds of children could turn up at a hospital with a physical condition and be turned away, but it is the case with children's mental health.

- Q45 **Anne Marie Morris:** What would good look like? How would I know that we have reached parity of esteem?

Anne Longfield: We are at the point now where there is a very common understanding from children themselves about the level of support available, and indeed from the wider population. Good, I think, would look like when every child would know where to go to get help. That would mean that, in the first instance, for those at school, they would be able to go to someone in a school, talk to a teacher, go to a wellbeing hub and have people there that they knew, they trusted, they had a relationship with and they felt able to talk to about whatever it was they needed to talk about. With that, they would be able to get specialist help, if needed. There would be specialist teams around that school to be able to provide that coordination and support, and then if more specialist help was needed, you would be able to find access into that at speed and with clarity of purpose.

At the moment, you have a hotch-potch of those in different areas. There are some areas that are able to co-ordinate that. I went to Berkshire; they were co-ordinating it around individual children. They built that service on the back of children having a really tough time and getting lost in the system. They talked to children about how they know the system is accessible, meaningful and determined to help them recover. That, for me, is what it would look like: a clarity of purpose, a clarity of co-ordination and a clarity of outcomes for children, whatever their needs.

- Q46 **Anne Marie Morris:** We have also talked about prevention being better than cure. Ms Abdinasir, what does best practice prevention look like, particularly if you set it against best practice—health and safety, dare I say—for physical health? What does prevention look like?



Kadra Abdinasir: We are working with our members at the moment to respond to the Government's consultation on relationships and health education. We think putting that on a statutory footing is really positive and means that young people will be equipped with the knowledge and skills to be able to identify and self-manage lower-level mental health issues. To add to that, I think we need to further the anti-stigma campaign as well, ensuring that everyone is aware, as Anne said, where to go to seek advice. Those are the things that will help young people, to prevent their needs from escalating.

- Q47 **Anne Marie Morris:** Prevention must be aligned with what you think the cause is. You have all talked more about the parenting issue than what the Secretary of State talked about, which was the internet and social media. Are you both right, or is he wrong and you are right?

Anne Longfield: I think the starting point is that it all plays its part. I don't think the causal nature of social media is established, but it certainly plays its part. It amplifies lots of other things that are going on, it increases pressures and stresses on children at certain times, and certainly there is a real pressure not to go offline, because children think it is socially damaging. Tackling that is important, enabling children to become more resilient and have emotional resilience to deal with it, but also the techniques—to be able to turn off and the like—are really important. It is not the thing that is driving every aspect of this. There is not a quick answer and we must be aware of all the factors that are affecting children's lives and experiences. Certainly, social media often amplifies and deepens it, but it isn't something that I believe is the total and only cause of what is going on here.

- Q48 **Anne Marie Morris:** Ms Cordery, you are in a position where you only get to see the children once they have been authorised, if you like, as needing help. That means that there must be children that you miss, because of the way the system works. How would you change the system to make sure that individual kids who need help get it when they need it, rather than the bureaucracy of having to go through a system to get a tick in the box before they ever get anywhere near you?

Saffron Cordery: That is really the kind of holy grail, isn't it: providing the care that every child needs at the point at which they need it? That is absolutely about increasing capacity. It is about having the right workforce in place, and it is about making sure that all the different organisations work together really effectively. That really is the holy grail. If every trust were in a position where the thresholds were not so high that people could not access services, and were able to offer services with very low waiting times, then we would have cracked it beyond the prevention points that were mentioned earlier. We aren't there yet, but we are on a journey to getting there.

- Q49 **Anne Marie Morris:** Professor Kinnair, as you in a sense see the piece around the schools and within the health system and social care, how do you think we are going to make this work? Take your nursing hat off for a minute and just look across the system. What do we do differently to



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address some of the issues that have been raised?

Dame Professor Donna Kinnair: Where examples have been given, it is really fantastic. Some people have built the services around the needs of their children. They won't meet everybody's need, but they know that children and young people, as well as parents and families, have worked with them about what the needs are. What we have at the moment is a piecemeal approach. If you happen to be in Hackney, you may or may not get access to it. If you happen to be up north in Newcastle, it might be non-existent.

Really, commissioning is about planning what services should be, in the same way that we plan for appendicectomies and other things, and I have long argued that. The conditions are not new. If we knew the answer to the aetiology of mental health, we would have cracked it by now, but there are so many different factors that cause it. What we do know is that there are certain methods that we use that help alleviate some of those symptoms for young people, and that is what we need to get into the system on a comprehensive basis. At this moment, I am not sure who is responsible for that, or who is responsible for the workforce, so there needs to be some comprehensive planning. If there are only five things that we know we can do, we should be doing them everywhere.

Q50 **Anne Marie Morris:** How would you hold this mismatched lot of organisations accountable? What do we put in place, without overdoing the bureaucracy?

Dame Professor Donna Kinnair: If we look at physical health, we know what sort of things you do for an appendicectomy, and it is consistent. What we need to do is have some consistency in mental health—consistency in training and education, and consistency in delivery. Now, we know that it has many different origins, as the specialists might say, but we at least need to have a level of consistency that is available to meet our population need, because then you can start to say, "I've identified the gaps, and also we need to fill this." At this moment, it feels—and it has felt this way for a long time—like a hotch-potch of things available. You know, it is by luck that some people get good services and others do not.

Q51 **Anne Marie Morris:** You are almost putting the case for having the education system, the medical system and the social care system all training in some common way. In a sense, nurses in mental health should be in the classroom along with the teachers and the others to make sure they're all coming out from the same—

Dame Professor Donna Kinnair: Yes, absolutely.

Q52 **Chair:** That brings me neatly to the education hubs that have been proposed. There is slight alarm in this Committee when a Minister announces an initiative and certain numbers of those initiatives, so I want to hear from you who should be in those education hubs, so we can put it to the Department. I will start, perhaps, with Professor Kinnair. You have talked about school nurses being very important, but what would your



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dream hub look like?

Dame Professor Donna Kinnair: My dream hub would start with parents, because the parents who we work with are crying out for education. Whether we do it in a systematic way through health visitors, or in another way, I think parents also need some education and support in helping them to parent.

Q53 **Chair:** Sometimes secondary schools offer courses in how to parent a teenager when your child starts secondary school. Did you mean something as basic as that, or—

Dame Professor Donna Kinnair: As a health visitor, I constantly did toddler taming with parents, because that is where it starts. If you do not get ahead of the behaviour, it does not stop.

Q54 **Chair:** So that would be in primary school—no, that would be nursery.

Dame Professor Donna Kinnair: That would be pre-school, and I think that is one of the most important areas that we could address. There is a range of health professionals and others with whom parents come into contact who could be able to provide some of that generalist support. Then, for me, there is the whole bit about “So, what do you need? What is the next step up to that?”

Q55 **Chair:** It is interesting. I do not think anyone would disagree with what you are saying. I do not think the Government have announced pre-school hubs yet. It is talking about secondary schools at the moment. So, while I hear exactly what you are saying, and we have clocked that, if you had to set up a secondary school hub, Professor Kinnair, and were responsible for designing it in Southwark where you used to work or wherever, how would you shape that?

Dame Professor Donna Kinnair: Where we have done this before, we have worked with teachers and school nurses, and health visitors come into that as well because they do understand—they work with families, so they go back into the family. Certainly when I have worked on it, I have worked with youth theatre—the Young Vic was very much involved in helping us deliver some of these. Community services also can play a huge part. I think it was Turning Point; I can’t remember the names now. Many of them provided services that were wrapped around the school and the children.

Q56 **Chair:** If I had a child in a secondary school and you had been responsible for setting up the hub, and they had anxiety about exams or some situation, how would that practically work for the family and the school, if your ideal hub was in place? What would happen to that individual?

Dame Professor Donna Kinnair: As I have seen it operate, we see members working with the family. There is some counselling provision with families. There is work with the child. That is something about what they need to improve their behaviour. Is it exercise or is it more work or is it individual attention? Are they just bored? Are they isolated? How do we bring them into services to stop anxiety?



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Q57 **Chair:** Who would be doing that—a school nurse?

Dame Professor Donna Kinnair: That would be school nurses and teachers.

Q58 **Chair:** You would then have the networks to escalate it to the providers.

Dame Professor Donna Kinnair: That is important, because that can give you a pathway into specialist services. We will know what work has been undertaken and what work yet needs to be done.

Q59 **Chair:** Does anyone else have anything to add about what their ideal hub would look like?

Saffron Cordery: I would add in one bit, which is the role of primary care here. We mustn't forget that. Community nurses, yes, but GPs as well—that primary care interface is critical in the prevention and I would say it is critical when we are talking about—

Q60 **Chair:** There is a particular issue there, isn't there? Often GPs are very concerned about sharing data. Would there be a barrier to sharing data with a school, if it is not with a health professional, but with the head of year or the mental health lead in the school or something? Would that be a problem?

Saffron Cordery: We have to make sure that the right information governance is in place, but I think if there is an agreement between a hub and a GP—yes, there will be hurdles to overcome on data and I wouldn't want to over-simplify that and say of course it is easy to do, because we know there are data challenges there, but when we are talking about setting up hubs, we are talking about putting in place a system and a structure that is properly governed so that we can manage the data issues that exist. We know data sharing is a problem, but it can be overcome and we have seen that in a lot of the integration work that is taking place up and down the country. It is a barrier, but it is not insurmountable.

Q61 **Chair:** No barrier is insurmountable ultimately, but there is still a barrier there.

Saffron Cordery: Yes, but the important thing is to remember every stage in the pathway. When we are talking particularly about prevention or preventing the escalation of issues, bringing primary care in as well is very important.

Anne Longfield: I think what we are talking about here is making it part of the everyday school life, so it is stitched into what goes on in the school. If you can do that, and you have it in the vast majority of schools, you start to get that universal cover that we are all looking for. You start to be able to anticipate that it is coming up, identify which kids need help and just how people can sort it out as part of the day-to-day running of the school, without it turning into crisis. That is the appeal. With pre-schools, we do have children's centres that do some of this.

Kadra Abdinasir: I echo what others on the panel have said. I would add that the teams would also be playing, in our view, a crucial role helping



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families and children navigate through the system. Often, many of these young people are known to multiple services. We would also echo the recommendation by the Care Quality Commission and the Royal College of Paediatrics and Child Health around having a local offer. These schemes need to be aware of what is available in their area.

- Q62 **Chair:** It is interesting. I can't remember the phrase, but earlier someone said something about a care co-ordinator—

Saffron Cordery: A care navigator.

- Q63 **Chair:** What is a care navigator?

Saffron Cordery: It is someone who understands the individual and can guide that individual through.

- Q64 **Chair:** What are their qualifications? How do you see that role?

Saffron Cordery: The context in which I used it was within a secondary care setting rather than within a setting in the community. It's someone who will be managing the care of—

- Q65 **Chair:** Are they a medical or nursing professional?

Saffron Cordery: Nursing professional. They will be managing the care of an individual—

- Q66 **Chair:** So helping the family through the vortex of bureaucracy, basically.

Saffron Cordery: Yes. It's not just about the vortex, but about receiving the right care and making sure that the links are made so that they have a pathway of care. The context in which I was describing it, the example I described, was actually in-patient care, so this is different from the care that we were talking about here. In that context the care navigator works with the individual, but they also identify where there need to be better links between the in-patient unit and the community, so they overcome those barriers as well. They find a way of negotiating round and then make changes so that the pathway is smoother. It isn't about the kind of care that we have been talking about here. It is in an in-patient setting, which is slightly different, but the principles apply.

- Q67 **Chair:** Professor Kinnair, from what you were saying, the co-ordinator doesn't have to be a nurse if it is a school setting. Would you envisage that being slightly different? Could it be? I am thinking of the cost as well. The £2 billion will not be enough to do everything.

Dame Professor Donna Kinnair: It could be a school nurse, but often a care navigator in the community, in primary care, could be somebody with specialist skills who is able to help the family navigate the system and get the care that is required by their young person.

- Q68 **Chair:** Can I ask about waiting times? We have had quite compelling evidence. In fact, just as we were starting the session, something came in from Michael Gove MP. I won't name the constituent, but an interesting case was raised, and issues have been raised by other MPs about long,



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long delays. We have also seen this in our constituencies. What do you think could be done about that? Do you think the new money will make a difference? We'll start with Ms Abdinasir.

Kadra Abdinasir: Evidence from the Centre for Mental Health shows that on average it takes 10 years for young people to access treatment, which—

Chair: Ten years?

Kadra Abdinasir: Yes. It's very unacceptable.

Q69 **Chair:** When you say "treatment", I thought we were talking about 16 to 18 weeks.

Kadra Abdinasir: Before they come forward and start to self-refer themselves to services, for example.

Q70 **Chair:** I see. I am talking about delays once someone has tried to get treatment.

Kadra Abdinasir: Not following the referral.

Q71 **Chair:** So we are talking about the 18-week delay from the GP saying they need some help.

Kadra Abdinasir: There is a longer-term issue, but, for those cases where there is a referral to the system, we see huge variation and it is described often as a postcode lottery across the country.

Q72 **Chair:** It could also be called local commissioning, but let's not split hairs.

Kadra Abdinasir: It comes back to that point about understanding what's available locally. If specialist services are struggling to keep up with demand, it's important that they are aware of what's available to them in the community and what these services could offer young people in the meantime.

Anne Longfield: There is wide recognition of the long waiting times, but I have been really impressed by what has happened to IAPT and to eating disorder services that have managed to get to the point—this is a generalisation—where there are much shorter waiting times. In my view, we need a clear target for waiting times. It needs to be something that we are impatient about reaching and it needs to be part of the delivery model from the start. I know there are plans to pilot waiting times at four weeks, but, again, I think that needs to be brought forward much quicker.

There is also something about what happens to those children during that waiting time. There is very little communication at the moment. There can be weeks and weeks where there is nothing going on before assessment and referral into the service, and clearly that needs to be part of a new approach.

Q73 **Chair:** Professor Kinnair, we talked a bit about staffing and nursing, but there is a shortage of mental health nurses, which cannot help with



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waiting times. Do you have any thoughts on waiting times and how they could be resolved?

Dame Professor Donna Kinnair: I think they can be resolved because quite a number of nurses will be trained with extra skills. Quite often young people can be managed by mental health nurses with extra skills without even having to go near a psychiatrist. But we do know that there are 5,000 fewer nurses, so we need that investment in the workforce. I would say that that is a huge issue, but I know that in the NHS, when you shine a light on something, the aim would be to get the money to frontline services and make sure it's not snaffled up by all the other problems that the NHS suffers from. There is something about targets and shining the light on it that says, "This has to be delivered." Often, we deliver it once we have a focus on it.

Saffron Cordery: I believe it is really important that we focus on the time that people wait. We need to ensure that we have the right capacity in place at the right level, so that people access the services they need at the right time and in the right place. We do not want to wait for people to reach the threshold in order to be treated.

It is really welcome that we have had initiatives such as the new eating disorders units opening, but we need to focus on prevention as well as expanding capacity—it is not either/or. We need to be able to treat people now and focus on prevention. That is about both the money that we can spend and that is getting through to the frontline, and commissioning the right services. Commissioning is fractured so it goes across local authorities, clinical commissioning groups and nationally. We need the right workforce, and not just the nursing workforce—we have to ensure we have consultant psychiatrists, clinical psychologists and other healthcare workers in place. It is a three-pronged thing.

Fundamentally, we can overcome some of the structural issues with the more integrated approaches that I outlined. Hopefully, the long-term plan that we are all awaiting will help with some of that, but we have to see that happen.

Q74 **Chair:** Are you having the chance to feed into the long-term plan?

Anne Longfield: Yes.

Q75 **Chair:** I should highlight a case that Anne Milton MP raised with us, of a child with Asperger's syndrome suffering from depression—a combination of challenges there—starting in 2016. I will not go through the full litany, but it was a very slow process getting through the system while also going through GCSEs. She said, "It was utterly heartbreaking for his family to watch him disappearing like this. The depression got so bad that he was barely eating. At six foot two, he weighed around nine stone." In this case they highlighted that there was a big difference between the psychiatrist and the psychology support. It sounds like perhaps the referral was not done well. Is that something that you recognise, Anne Longfield?



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Anne Longfield: It is very, very common. Whenever there is any public debate about this I get inundated with letters from professionals and parents. A lot of parents will say that they almost feel they collude through their silence about it, because they are obviously very deeply worried about their child and they do not want to talk about it with others, because they are trying to fix the situation.

Chair: They are investing so much in their situation that they do not have the time.

Anne Longfield: It is very hidden.

- Q76 **Chair:** That brings me to the Michael Gove case. This was a case of someone with autism who had an inadequate service. The parent said, "I don't believe the professional involved has much experience of autism and has refused to refer our son for any psychological therapy." Do you think there is an issue with young people with autism and Asperger's who have an additional mental health condition on top of that?

Dame Professor Donna Kinnair: I think there is. I think we have long known that autism has been one of the most difficult ones to crack when there is an added mental health issue on top of it. That is partly because it manifests in so many different ways for those young people. It could be depression or hyperactivity. It is really difficult. It is about getting to the right person in the system. If you get to the right person you get the support, but from my own experience I know that you often get to the wrong person and get lots of—

- Q77 **Chair:** Is there a solution? Is there something that the plan could help to deliver on for young people with autism and Asperger's?

Dame Professor Donna Kinnair: I think there is. We need a focus on autism because it is very difficult to crack, for the reasons I have said. You do not crack something unless you look at it and some of the solutions to it. It is a possibility that in the long-term plan we could look at that.

Kadra Abdinasir: Absolutely. There are additional challenges that young people with dual diagnoses face. It comes back to the point about integrated planning and partnership working locally. As well as autism, many of our members work with young people who face substance misuse issues. They are bounced around two different services. We need to do more.

Chair: You seem to all say child-centric support. That sounds so great but it is harder to deliver. We will put that to our next panel, but before we finish I know that Chris Evans wanted to ask you a question.

- Q78 **Chris Evans:** I have one question. Obviously eating disorders are now more prevalent; more people are coming forward. But the real criticism that several people have talked about to me is about getting specific psychiatry for eating disorders and also specific places in hospital. How do we overcome that, especially in the present climate, in which eating disorders are on the rise?



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Saffron Cordery: My perspective on this is that we are starting to expand the number of eating disorder units. I am sure that you will ask this of the panel later, because they will be able to give you more detail on that, but I know from our members' perspective that they have really welcomed the investment in eating disorders.

There is a long way to go, of course, and it is absolutely critical that we see the funding for mental health services reaching the frontline, and then the right services being commissioned and delivered. However, I would say that that is an issue that has been recognised and provision is now being rolled out across the system.

Obviously it is tricky when we are talking about individual cases—of course it is very tricky—but I would say that we are on the path to expanding provision there and delivering that. So, certainly from the perspective of NHS mental trusts, I know that there is a lot of positive feedback on that.

Obviously, we are not meeting all need and all demand, and that is, as I said earlier, the holy grail, if you can meet everyone's needs. But right now we are on the pathway to delivery.

Chair: Thank you all very much indeed for your time. We are moving on to our Government witnesses now. You are very welcome to stay. The transcript of this hearing and the next will be up on the website in the next couple of days. It goes up uncorrected, so you need to get on to it quickly if you have got anything that you think is factually wrong or misquoted, but our colleagues at *Hansard* are very good, so that does not really happen. Please take a seat behind if you wish. Our Namibian colleagues have gone, before I had a chance to welcome them, so there are some seats there are the back. Thank you very much indeed.

Examination of witnesses

Witnesses: Sir Chris Wormald, Simon Stevens, Claire Murdoch and Professor Ian Cumming.

Q79 Chair: Welcome back to the Public Accounts Committee on Wednesday 31 October 2018. We are looking at children's mental health services, off the back of a National Audit Office Report on the subject, and of course off the back of promises made by the Government that more money will be poured into mental health services in general. So we will want to probe some of those issues around the Budget and practical issues. It is heartening to note that at least one of our witnesses was able to hear some of the previous panel, who were giving their experience from the frontline.

I am pleased to welcome our panellists—it sounds like a gameshow when I say it that way, doesn't it? Maybe for us. *[Laughter.]* Nervous laughter all round.

I welcome Simon Stevens, the chief executive of the NHS, and Sir Chris Wormald, the permanent secretary at the Department of Health and Social Care; both are regular witnesses at our hearings. I also welcome Professor Ian Cumming, chief executive of Health Education England, and Claire Murdoch, the national mental health director for the NHS. It was good to see, Ms Murdoch, that you were listening to our previous panel.

Before we move on to the main questioning, I want to pick up on the Budget. Obviously the £20 billion promised to the NHS was a significant and welcome addition to NHS funding, and we will be probing the detail of the £2 billion earmarked for mental health, but I am concerned by some of the analysis of the Budget—I direct this to you, Mr Stevens. Anita Charlesworth, director of research and economics at the Health Foundation, has highlighted the fact that "higher than expected inflation means that unless the Chancellor tops up next year's NHS England allocation before his spending review, the NHS England budget will increase by 3.3%".

Let me just rewind. You were promised 3.4% uplift, but it was going to be front-loaded, so you were promised 3.6% this year. The Health Foundation says that you will actually only get 3.3%, and that going up to the 3.6% commitment "would require an additional £260m in cash terms." As I understand it, the £20 billion was in real cash terms. Is she right that you are short of money? What is your take on that?

Simon Stevens: We are developing the NHS long-term plan on the basis of the funding that the Prime Minister announced on 18 June. As you say, that was that the NHS would receive a 3.4% real-terms increase on average over the next five years, and explicitly that there would be a 3.6% real-terms increase in 2019-20 and 2020-21. That is the basis on which we were asked to—and are continuing to—develop the NHS long-term plan.



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- Q80 **Chair:** Okay, but these figures look worrying. You are actually going to get less money, according to the analysis of the deflators—in fact the OBR has some similar figures. To repeat, in cash terms, are you getting enough from this £20 billion to do what you set out to do with the 3.6% uplift that you were originally promised?

Simon Stevens: As you say, and as the Health Foundation points out, if the original cash figures were those that actually translated into the ultimate settlement, that would be lower in real terms than the Prime Minister set out on 18 June. But the Treasury made it clear on Monday that the cash figures would be adjusted at the time the long-term plan is published in early December, so our expectation is that that would reflect the proposals that we will be developing in the long-term plan, which are on the basis of the 3.4%, and of the 3.6% for the next two years.

- Q81 **Chair:** So, to be clear, you have had assurance from the Treasury that despite the inflation issues, your budget in real cash terms is protected, and the plans that you are putting in place to spend that money are therefore intact.

Simon Stevens: Well, the basis on which we are developing the plan is the commitments that were made on 18 June. The Treasury has said that the cash figures to reflect those commitments and the content of the long-term plan will be settled by the spending review at the latest, but in practice we are obviously going to need that at the time the long-term plan itself is published in early December.

Sir Chris Wormald: Just to be clear, the Chancellor set this out very clearly on page 74 of the Budget Red Book, at paragraph 5.7: “The NHS will deliver its plan by the end of the year, and the government will confirm the final settlement consistent with that plan, and the £20.5 billion real terms increase by 2023-24, by Spending Review 2019.” He made it clear that the run of cash figures was based on the June commitment, and that is the sentence that is pertinent here. As Simon said, we have not asked Simon to plan on a different basis from the one that we set in June.

- Q82 **Chair:** To be absolutely clear, you are not just getting the £20 billion; you are making sure that in cash terms it is exactly what was promised.

Sir Chris Wormald: It is exactly what the Chancellor says in the Red Book.

Chair: Simon Stevens, you are making a face.

Simon Stevens: No, no. That is a statement of fact that we are proceeding on the basis that the Prime Minister set out on 18 June, which was a real-terms uplift, as I said. I do not think that there is any inconsistency between what I have said and what Chris has said.

- Q83 **Chair:** Just to be picky, Sir Chris, when you talk about consistency with the NHS plan, does that mean that you are not asking NHS England behind the scenes to make a plan that fits with the new figures?



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Sir Chris Wormald: We have not changed the remit that we have given the NHS on the long-term plan at all. Sorry, but I will be very legalistic about this.

Chair: No, it is important to get it on the record.

Sir Chris Wormald: It is not my job to change what the Chancellor said, and he said very specifically in the Red Book what the situation is.

Chair: Let us get into the bit that has already been sliced off for mental health.

Q84 **Anne Marie Morris:** Sir Chris, what is the challenge on parity of esteem going to look like?

Sir Chris Wormald: Actually, I will ask some of my colleagues, who know considerably more about mental health than I do, to define it. In general terms, everybody wants mental health to be taken as seriously, both in the health service and in wider society, as physical health.

Q85 **Anne Marie Morris:** Can I challenge you on that, Sir Chris? That is about perception, but I am after delivery. What will I see in the wards and school rooms that will make me realise that actually we do have parity of esteem?

Sir Chris Wormald: I think Claire is probably in the best position to answer that.

Anne Marie Morris: Ms Murdoch, I think you have been passed the chalice.

Claire Murdoch: I agree with you that it is about delivery. I would say, at a very high level, that we want to close the treatment gap so that children and young people are accessing services at the right level at the right time without undue waits and without having to escalate to a point of real crisis, where they trigger a threshold for specialist care. At the moment, we know that the treatment gaps in mental health are greater than in many physical health disorders and illnesses. Our plan—both the five year forward view plan and the long-term plan—is very much geared towards understanding and addressing that gap, improving access and achieving the outcomes of a speedier and better result for youngsters and their families. That is at a high level, but obviously under that there is a heap of work in our plan to seek to address those big principles.

Q86 **Anne Marie Morris:** How far have you got with that challenge, in terms of parity of esteem?

Claire Murdoch: I was really interested to listen to the evidence of panel members earlier. I think the starting point for better infant, child and adolescent mental health has to be early years, preventive, cross-Government support to parents, including support around perinatal mental health, and the vital role of education, school nurses and so on. I would emphasise that the whole plan to improve health and mental health for youngsters is a cross-Government—either big Government or local



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government—issue. For us in the NHS, we have got a really clear and granular plan—I think it is, anyway—to increase access, in particular to eating disorder services.

- Q87 **Anne Marie Morris:** Can I just stop you there, Ms Murdoch? I am less interested in the plan, although it is great that you've got one, and more interested in what you have delivered.

Claire Murdoch: In the last two years, the NHS has delivered 70 new community eating disorder services, with a waiting time standard of one week for urgent referrals and four weeks for routine. We have said that, by 2021, 95% of all children and young people will be seen within those timescales. Having set up those teams over the last two years and funded them, we are seeing access and waiting time standards of 81% for the four-week routine referrals and 74%—slightly more—for the urgent standard. I would say that that is a huge step forward.

- Q88 **Anne Marie Morris:** That's excellent, and I agree, but I guess people will say, "That's a start." Mr Stevens, there is great progress on eating disorders, but how are you going to deal with the rest? How are you going to categorise it? How are you going to segment it? You talk about the increase of 25% to 30%—in what?

Simon Stevens: Are you talking about children and young people's services particularly?

Anne Marie Morris: I am definitely talking about children and young people.

Simon Stevens: Maybe I can say it like this. It is part of the conversation about the welcome announcements that the Chancellor made on earmarked mental health spending as part of the overall settlement. As Claire is implying, we have got a set of very specific things that we have committed to do by 2020-21—over the next two years—to finish up the initial five years that the Mental Health Taskforce set out. Over and above that, the long-term plan, which will be published at the end of December, will set out a more ambitious set of service expansions and reforms in mental health, as well as in other areas. The Chancellor identified some of them, but that is by no means the comprehensive set. I don't want to pre-empt where we will get to in early December.

- Q89 **Anne Marie Morris:** Does that take us beyond getting from 25% to 35%? Does it get to 100%, or is that not envisaged in that long-term plan?

Simon Stevens: In terms of the access rate to specialist mental health services for children and young people, as you say, the goal is to get to 35% by 2021. We are on track for that, at around 30.5% right now, but two things are going to happen. One is that, as the NAO Report rightly says, we have a new prevalence survey coming out in a few weeks' time. We are expecting to have that prevalence survey before the long-term plan is published, so that we can factor what it is telling us into the service expansions. I think we all expect—I certainly expect—that that will reveal



a much higher rate of mental health pressures among young people than back in 2004. It will be particularly useful if it is able to put more flesh on the bones as to the shape of that mental health stress and disorder, and possibly even enable a better understanding of the fundamental causes of that. In any event, a higher prevalence will of course mean that any given treatment volume represents a lower proportion of the whole.

Set against that, we also have an ambitious programme of expanding services upstream, including school-based support. The hypothesis there—the reason we are testing it in a proportion of schools to start with is that, let's be honest, it is a hypothesis—is that if you intervene to support young people earlier, the flow-through into specialist mental health services will be smaller. There is some evidence that that is the case. What we do not therefore know is the net effect of the higher prevalence data and the ability to get upstream. It is only when we have the net of those two that we will be able to confidently answer the question, "What should be the ambition for the proportion of children who need a specialist NHS mental health service as against other support more broadly?"

Sir Chris Wormald: I don't think anyone has ever argued that it should be 100% of those people who should be receiving specialist services from the NHS.

Chair: No, I don't think Ms Morris or anyone was suggesting that.

- Q90 **Anne Marie Morris:** My question was when we were going to get there. I appreciate that we have set a timeline for 25% to 35%, and I appreciate that you don't yet have the prevalence figures, but even so we all, I think without exception, know they will be increased. There has to be some thinking going on, because even when you get those figures, you will not know how much it will go up in the next X years. You are going to have to make some guesses, aren't you?

Simon Stevens: There is a "no regrets" move that says we will need to expand access to specialist mental health services as rapidly as the purchasing power and the workforce allow. We want to get to a position where ultimately every child who needs a specialist NHS mental health service is able to get it, but that might not be the same as every child with a diagnosable mental health condition, which at the moment is what the 30% or 35% is tracking.

- Q91 **Anne Marie Morris:** Professor Cumming, if that is the objective and the barrier, as has been indicated, is people, what is your prognosis on how fast you can create, and fill the gap with, the professionals we need?

Professor Cumming: It varies from profession to profession. In the short term we know what is coming through the education and training pipelines: if you take a doctor, you would be looking at a training pipeline that is typically up to 13 years from somebody coming into medical school to becoming a consultant psychiatrist. We know where people already are along that pipeline, and therefore we can predict what the demand will be. We have seen an increase in applications to train to be psychiatrists this year, up by about 30% in core training. That is a positive sign that more



people are wanting to train to be psychiatrists in the future. If you take other professions such as nursing, where we can tell you clearly what is going to be the outcome of the output from training over the next three years, that is continuing to show an increase on where we are at the moment. But as well as the output from training, we need to consider what work we are doing to ensure that we keep people in the NHS once we have been able to recruit them. That is just as important as, or arguably more important at the moment than, the numbers of people being trained.

- Q92 **Anne Marie Morris:** That is helpful. We will come on to more of that with Ms Moran, I think. Mr Stevens, we have just looked at one of the barriers, which Professor Cumming believes we can overcome. What are the others?

Simon Stevens: Workforce is front and centre, but so, obviously, is the availability of the funding to pay the staff as we expand services. I agree with the way the NAO describes this: a good start has been made, but nevertheless nobody can be satisfied with where the situation currently is. That is going to be one of the factors that shapes the speed of our service expansion.

Anne Marie Morris: Okay, so money and staff—is there anything else?

Simon Stevens: I am afraid that I did not have the benefit of hearing the earlier panel, but the work—the very welcome work—that the Children's Commissioner has been doing on the kind of broader support structures for young people obviously has an impact on the flow through into specialist mental health services. So that sort of resilient, wider network of support for children in this country is also very significant.

- Q93 **Anne Marie Morris:** So how far have you got in talking to your opposite numbers within Education and with local government to make sure you come up with this consistent approach, because that was the biggest barrier that the previous panel identified?

Simon Stevens: Of course, I will defer to Chris and to the Department of Health and Social Care on that, but in practice the NHS, alongside the Department for Education, schools, local authority directors of social services and others, are engaged in this conversation constantly. Claire can describe in more detail some of the programmatic aspects of the way we kind of track what everybody is doing. But, Chris, this is probably more your baby.

Sir Chris Wormald: Just for once! With Education, the focus is of course on the Green Paper and then on its implementation. I think it is the first time we have ever had a joint Green Paper between Health and Education on this subject. I have to say that it is something that I wanted when I was permanent secretary at the Department for Education and I am very pleased that we have got it now—

- Q94 **Chair:** Nice history lesson, but let's focus on what you are doing now.

Sir Chris Wormald: We see that as a huge step forward in working between our two Departments and then between the NHS and schools—

Q95 **Chair:** But the fact is the Green Paper is not written—

Sir Chris Wormald: It begins to implement from the beginning of 2019, with mental health support teams, trailblazer areas, the waiting time standard and the designated leads in schools training, so there is a plan for implementing what we have set out in the Green Paper, and that is the focus with schools.

With local authorities, the main contact is of course around Public Health England and directors of public health in local authorities, particularly around things like the concordat on good mental health, which PHE has been working with local government on. That is the main vehicle for our discussion with local government.

Q96 **Anne Marie Morris:** Okay. What about budgets, because if money is your problem, sharing budgets surely must also be a problem, across different Departments?

Sir Chris Wormald: In the schools area, we came to agreement with the Department for Education for joint funding of different parts of the programme. So those parts that are school-based—

Q97 **Chair:** Is that school nurses, or would there be—?

Sir Chris Wormald: School nurses are funded by the NHS. The training for designated leads at school level is paid for by the Education budget and then the mental health support teams are funded by clinical commissioning groups. So we came to an agreement about who would fund what. We manage it as a joint programme with Education and we have simply come to an agreement on which budget will meet which—

Q98 **Anne Marie Morris:** So you don't think that sharing budgets will be an issue?

Sir Chris Wormald: As this Committee is well aware, it is always difficult and complicated when you are working across Departments—

Q99 **Chair:** That is a very nice gloss on things, but let us be clear, Sir Chris: you are talking about it like it is just an easy alchemy. We have got local authority budgets slashed; they will be paying, for example, for nurses and some of the educational support. You have got Public Health England sort of in your orbit but presumably more in control of the Green Paper. You have got the acute end. You have got everybody with squeezed budgets and yet this Green Paper has got to try and align it all, and make sure there is enough money for children's mental health services—

Sir Chris Wormald: We all know the position around budgets. Of course, local authorities, as we know, have largely protected their budgets, particularly for vulnerable children, within the pressures that they have got. *[Interruption.]* No, the numbers have gone up; I was looking at them earlier today. But I'm not denying—*[Interruption.]*



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Chair: Sir Chris, we can't let that go. Ms Mahmood.

Q100 **Shabana Mahmood:** To clarify, Sir Chris, you have just said that local authorities have "protected their budgets", but this Committee, in our hearing on local authority funding, heard evidence, from the Department itself and from others, about cuts to children's services and the fact that there is increasing demand that is going unmet. So, with that in mind, would you care to rephrase, or rethink, your current line of answers?

Sir Chris Wormald: I was quite specific in my language—on the most "vulnerable", where they have protected budgets and indeed increased them since 2010.

Q101 **Chair:** Statutory? So can we just be really clear: is the Green Paper going to make it a statutory requirement for local authorities to play ball on this and put their money in, or is it that you are inviting them to do this?

Sir Chris Wormald: No. The Green Paper is very much focused on how schools and the NHS work together, and the funding is for that. We are not putting new requirements on local government as part of the Green Paper. The three big blocks—the designated school lead, the mental health support teams and the new waiting times—are either within the schools budget or within the NHS budget. We of course work incredibly closely with local government and they are involved in other parts of the Green Paper, but those fundamental blocks come out of those two budgets, just to be clear. Do you want to say a bit more about how it works, Claire?

Claire Murdoch: Could I just say one other thing? We are working really closely with the DFE on that. We have got a defined budget. We have identified jointly our pilot sites where we will be rolling out mental health support teams and the four-week waits. We have done that together. Together we are talking about implementation.

One of the criteria for the private sites is that as we put money into the new teams, they are going to need to evidence that they are protecting existing investment. So we would not expect to support the development of mental health support teams at the same time, for example, that local education and health communities are raiding school nurses, who are vital, or, if there is pre-existing pastoral support in schools, this should not replace it.

Q102 **Chair:** We recognise that. This is additionality—additional money. But you talk about taking away school nurses like they are doing a bad thing. We heard very clear evidence from our previous panel, which you heard, about school nursing. There are 11 in the borough of Haringey in London. We have seen a real drop in school nursing because they have to make priority choices and they have chosen to reduce that—although probably not all of it is their choice. There isn't much there anyway.

Claire Murdoch: We see school nurses as a pivotal part of the multidisciplinary team or the multi-agency team around good child health.

Q103 **Chair:** If they are there.



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Claire Murdoch: Where we are rolling out our pilots, we are looking for commitments from all agencies not to take existing resource out.

Q104 **Chair:** Not to take away existing ones, but they are not there in the first place. Are you only looking at pilots in areas where there are existing school nurses?

Claire Murdoch: No.

Q105 **Chair:** So if there are not many or not enough school nurses in the area you are doing a pilot, are you going to be funding that or are you going to be demanding that the local authority does that?

Claire Murdoch: We have looked at a whole range. Every area is different. Every area prioritises spend differently. What we have looked for in the selection of the pilots is a good commitment to advancing child health and building on what is there. We have not gone down to the specifics of “we will only fund if there is a school nurse”.

Q106 **Chair:** That is a very vague phrase.

Claire Murdoch: Having said that, I do want to say that school nurses are a really important part of school life.

Q107 **Chair:** Warm words are fine, but for boroughs like mine in east London, which has a very high percentage of young people, there is no doubt that there is a commitment to child health, but there is not the money to back it up. We have seen lots of challenges in the budget in my area, and we know that is round the country too. They can have the will to do it but if they haven't got the money for those school nurses, that is just a weakness from the day you set the pilot up, unless you fund it.

Claire Murdoch: It absolutely is a concern. I believe that areas that do not have or have reduced school nursing is an area of concern for good child mental health.

Q108 **Chair:** Right. So how are you going to deal with that in the pilots? You are not choosing them because they have got school nurses. You are setting up a pilot area and you are expecting them to make a commitment to it. Are you requiring them to put a certain amount of funding into school nurses in the hubs?

Claire Murdoch: We have not made that a pre-requisite of the Green Paper.

Q109 **Chair:** So if there aren't enough school nurses in an area where you have a pilot hub, how is that going to work?

Claire Murdoch: The Green Paper will still be effective—it is just less effective without school nurses.

Q110 **Chair:** It is quite a big hole, isn't it, if school nurses are at the frontline—the first medical professional that the generality of young people with a low-level mental health issue or an early concern would be seen by?



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Claire Murdoch: Yes, sure. School nurses are an important component of school life. I am concerned where they are disappearing. However, it would be wrong to further exclude areas that do not have them from the Green Paper, where they are committed to work in a multi-agency way to see children with mild to moderate mental health problems, so we have not made having a school nurse a prerequisite to having the team. We have made it a prerequisite to commit—

Q111 **Anne Marie Morris:** I think what the Chair is trying to get to is to try to understand how you are going to make this work. How much money are you going to put in and will it only be health, as opposed to the money that goes into the local government budget? It is local government that will have to bear the cost of the nurses. In a way, the reference to school nurses is a question to try to elicit the extent to which what you are doing and the money you are putting into these pilots is going to be spent in a way that is needed, as opposed to only on health.

Claire Murdoch: As Sir Chris was saying earlier, there are three different components, as you know, to the Green Paper. There is the teacher lead in every school, and Education is paying for that and looking at the curriculum and making sure that teachers are identified and trained. There is the mental health support team, which will see children in a school setting who are experiencing mild to moderate mental health problems. Those teams will work very closely with parents, children, the teaching staff in the school, educational psychologists and school nurses where they exist, and will be heavily part of the local community.

The third component of the Green Paper is to trial, as part of the initial pilot, a four-week waiting time. We are funding each of those individual elements together. Well, Education is funding the first component—we are funding the second two.

Q112 **Chair:** When you say, “Education is funding the teacher lead,” is that the Department for Education centrally?

Claire Murdoch: Yes, I believe DFE is funding that component.

Q113 **Chair:** Sir Chris is nodding.

Sir Chris Wormald: Yes.

Claire Murdoch: It is. I was meeting with Paul Kett last week—

Q114 **Chair:** Just to make sure that we are just talking about school budgets—

Sir Chris Wormald: It is probably helpful to look at figure 19 of the NAO Report on page 50. It sets out our best evidence of what is already happening in schools. As you will see, it is quite varied.

Q115 **Chair:** Yes, but we are keen to push it beyond. We know what is happening; it is what is coming. The hubs are really key.

Sir Chris Wormald: Inevitably, we have to take the world as it is when we get there. The pilots we set out build on whatever the existing provision in the area is. In that sense, it is of course a net benefit



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wherever it is, whatever that baseline. One of the reasons it was done in the way that it was, with local areas coming forward with plans that were flexible to that area, was because what you find is very different in different places. Your original point is, of course, a truism—we are starting from different places, but this is a very serious attempt.

Chair: What we are after is practical answers about what is actually happening.

Q116 **Anne Marie Morris:** Mr Stevens, given that the majority of young people with problems will not get help, because we are only going from 25% to 35%, what will happen to them? Won't that increase your cost at adult level?

Simon Stevens: As well as the human cost for young people and their families there is also a very strong economic rationale for investing in support for young people early.

Q117 **Anne Marie Morris:** Agreed, so I am asking you what will happen to the ones that do not fall within the budget.

Simon Stevens: We are expanding those services as fast as we are able.

Q118 **Anne Marie Morris:** Your premise in, I think, the very first question that we asked you was that you were doing what you could within budget. You have said that you only have a limited budget. You are only going to do stuff to budget—fine. Well, it is not fine, but that is where it is. What is going to happen to the people who fall outside? What will happen to the 65% who are not going to get help?

Simon Stevens: We are talking about specialist services. That is not the same as not getting help in some form, either from primary care services, schools-based services or others.

Q119 **Anne Marie Morris:** But they are strapped for cash. You know that they have not got the extra money.

Simon Stevens: That is why we are embedding mental health therapists alongside GPs. It is why we are expanding other aspects of support, particularly for young people with severe mental health problems.

Q120 **Anne Marie Morris:** So where will you get the money for that from?

Simon Stevens: We are already committing the money for the new waiting times that we have introduced for early intervention in psychosis services. We know that the first time that somebody has a psychotic episode if you can get the right package of support that has a dramatic impact on the rest of their life. About 10% of people are under the age of 18 at the point they have their first onset episode. The EIP services and the waiting time standards that have been laid in there are obviously a very important part of this as well.

Q121 **Anne Marie Morris:** What about the £2 billion for mental health? How much of that will come to children? At the moment the budget is very much in favour of adults over children, so what of that is coming in, and



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what are you going to do with it?

Simon Stevens: We are going to set that out in early December in the long-term plan. Obviously, the Chancellor identified some specific elements of what is going to be in the long-term plan that we have discussed with him, but the comprehensive package will be in early December.

Q122 **Anne Marie Morris:** But do you agree that the balance between adults and children at the moment is not right?

Simon Stevens: I think I would. I do not want to give a glib answer to that, inasmuch as I think unmet need for children's mental health services is greater than unmet need in adults' mental health services, and unmet need in mental health services in the round is definitely greater than in physical health services. In principle, one would want to see mental health growing as a share of a growing NHS, and within the growing mental health spend, you would want to see support for children and young people growing as a share of that. How to actually give practical expression to that, and what the service offer should be on the back of that extra investment, is what we are refining as we get to the final stages of writing the long-term plan.

Q123 **Anne Marie Morris:** I look forward to the long-term plan, but while clearly your strategy is to prevent more people coming into the system, so you have fewer in the pool, there are still going to be some who do not get that help. They are still going to go to CAMHS and they are still going to get turned away. What is going to happen then?

Simon Stevens: In a sense, you are describing the position as it has been for many years: a deeply unsatisfactory position. It is an unsatisfactory position that is beginning to improve, and our collective effort is to improve it as fast as we can, but I do not think anybody is excusing that situation or suggesting that it is acceptable.

Q124 **Anne Marie Morris:** So you are accepting that money will determine how much help we give.

Simon Stevens: No—clearly that is part of the answer, absolutely, but there are some broader questions that are quite fundamental here about "What is it that is driving the increase in mental health problems, self-harm, various other expressions of distress, and lack of psychological wellbeing on the part of young people?" If we want parity of esteem, a phrase that is much used, then we should have parity of focus on prevention and understanding the causes in young people's mental health problems—just as we do for childhood obesity, the other of the twin epidemics affecting our children, and just as we do for conditions affecting adults, be it heart attacks or strokes, where we focus on the underlying causes.

That is part of the reason why I and others have begun speaking about some of the wider potential social impacts on our young people, whether it is body image and body dysmorphia—hence the campaign to get cosmetic surgery ads out of the likes of "Love Island"—or whether it is the impact of



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social media and the impact that bullying has. The Royal College of Paediatrics and Child Health produced an important report on the state of child health within the past several weeks, pointing to bullying as one of the issues. We cannot just medicalise the failure to provide our children with a healthy and nurturing childhood.

Chair: We are coming on to some of that.

Q125 **Anne Marie Morris:** Mr Stevens, you still have not answered my question. What is going to happen to those people who fall outside? You have not caught them on prevention; you have not caught them on your 25% to 35% uplift. What is going to happen to them? Are you not going to be increasing your budget, and are you not having a go at Sir Chris and saying, "Actually, we could do with some more money, because my costs are going up by not dealing with this, not down"?

Simon Stevens: It is no great secret that I did indeed advocate for more funding for the National Health Service.

Sir Chris Wormald: You did not keep that very quiet.

Simon Stevens: That was not a secret.

Sir Chris Wormald: I will add a few things. I would actually like to come back to your original question: what are the barriers here? We have mentioned workforce and funding, which are, of course, two key ones. The other two key ones for me—

Anne Marie Morris: We mentioned money. That was the other one that came up.

Sir Chris Wormald: As I say, workforce and funding. As for the other two key ones, there is clearly a set of data questions, which the NAO picked up. As Simon mentioned earlier, there is also a set of "what works?" questions and evidence-based questions. Those are the four building blocks we need to fix. I think I am right in saying that actually, CCGs have been increasing spending on children and young people's mental health faster than the overall budget on mental health.

Chair: Really? I do not know about that. That brings me neatly on to Ms Moran. We are not going to let that one go, nor are we going to be diverted by your out there statements.

Q126 **Layla Moran:** I am glad you brought up what works, Sir Chris, because chapter 4 of "Future In Mind" makes it clear that tackling very young children's health, and even maternal health, is one way of preventing mental health issues down the line. My question is, why were early years and maternal health not included at all in the Green Paper?

Sir Chris Wormald: The Green Paper focused on how the NHS works with schools. We do a lot in the perinatal—

Layla Moran: Yes, but the Department for Education manages children's centres and that is covered by that budget, so why not—



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Sir Chris Wormald: As I said, the purpose of the Green Paper was to establish much better ways of working between schools and the NHS. That is just what it was about. We do a lot in early years and perinatal—

Q127 **Chair:** Just to be clear about your answer to Ms Moran's question, was it designed only to deal with schools? You are saying that it does not deal with early years because it was never intended to?

Sir Chris Wormald: Yes.

Chair: Ms Moran wants to follow that up.

Q128 **Layla Moran:** Are there plans afoot to include early years strategies?

Claire Murdoch: Certainly one major development of the "Five-Year Forward View for Mental Health" has been a huge increase in specialist perinatal mental health services. In terms of early years and life chances, that will have an incredible effect on the health and well-being of infants, toddlers and children. When we began the five-year forward view two and a half years ago, only about 14% of the country or less had access to specialist perinatal mental health services. As of wave 2 of our pilot, every part of the country will have access to specialist perinatal services. That will materially affect early years infancy and the life chances of those young. That has been a considerable investment that will total about £350 million by the end of the period. The other thing we have invested in—

Q129 **Layla Moran:** But childhood adversity is caused not just by maternal ill mental health; it is due to other factors that surround the child. Are you saying that there is no strategy to deal with the early years issues that young children face that are not to do with their mothers?

Claire Murdoch: In terms of mental health?

Q130 **Layla Moran:** In terms of mental health for under-fives. You keep coming back to the maternal and perinatal health of the mother, but what about the children?

Claire Murdoch: Don't forget that if we treat the mother, we do in fact treat the child and the whole family.

Q131 **Layla Moran:** Not if the child has been removed from the mother.

Claire Murdoch: That is precisely why we have seen every part of the country developing specialist perinatal mental health services, because we have to eat into that.

Q132 **Chair:** Ms Moran is not asking about that. A child could be bereaved at three—that might trigger mental health issues in a child that would not be included by that perinatal health.

Q133 **Layla Moran:** Indeed. Could you just answer my question about the children? Let's say a child has been removed from the mother because there has been abuse in the home. What do you have in place and what are the plans to help such children?



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Claire Murdoch: One of the things we asked as a result of “Future in mind” was that each area develop local transformation plans, led by the health and wellbeing board as the conductor of the multi-agency local inputs to better child and maternal mental health. We know that good child health outcomes are more than the sum of the “Five-Year Forward View for Mental Health.” Through the local transformation plans, whether through school, social services or child centres, what happens is critically important. Our view is that that is where the join-up should sit.

There is not a big national programme. We are working with the Children’s Commissioner and Andrea Leadsom on the first 1,000 days. That will be a really important review of whether we want to do more nationally, but we need some locus in local health and wellbeing boards, local transformation plans, the third sector and local communities.

Q134 **Layla Moran:** I understand that. I think we will come to the efficacy of those local transformation plans later, because—let’s face it—they weren’t in some cases. Ms Murdoch, how will this be delivered in schools? I read through the consultation responses to the Green Paper. There was consternation from the teaching profession that it would place much more stress on their day-to-day lives. What is in place to ensure that that does not happen?

Claire Murdoch: First, we have to note—you all know this better than me—that one of the biggest concerns that schools and headteachers have raised in recent years is poor mental health and a growing need to access mental health services. So I think the first thing to say is it has to, necessarily, be a good thing that Health and the DFE are working together to get more mental health support into schools.

Secondly, when I met with Paul Kett at the DFE last week we were talking about how these new services have to land in the context of a whole-school approach to better mental health, whether that is staff mental health or more general mental health and resilience among the pupil community. The reason these are pilots is that we need to take the learning, as these first pilots learn about how whole-school mental health is strengthened, and then teachers roll it out across the country.

Q135 **Layla Moran:** My question is more specific than that. How are you going to ensure that this does not end up putting extra stress into people who are already in schools? What we see over and over again is schools taking on responsibility for things that used to be done by other agencies. Is this going to be yet another thing that schools have to deliver?

Claire Murdoch: I would strongly say—until recently I was the chair of governors of a major secondary school, a comprehensive school, plus I have been doing visits nationally to schools—that it is absolutely clear to me that they are already working very hard on better mental health. I visited a school in Birmingham recently where, for example, all staff had undertaken training on better mental health, first aid and mental health intervention. Many of the staff were wearing different coloured lanyards to signal to pupils “I am a member of staff you can approach.” I think schools



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across the country are doing things like that already. This intervention, if it is done properly and well—and we will be learning from the pilots, of course—should really assist the head, the chair of governors, the governing body and the school staff to think in a more coherent way about how you build whole-school mental health.

Sir Chris Wormald: There are two very specific things, because of course the issues you raise are a big concern and were raised as a big concern. It was why we wanted to pilot, and people to volunteer for the pilot—

Layla Moran: Let's talk about pilots.

Sir Chris Wormald: Secondly, and very importantly, it was why the mental health support teams sit outside the school. There is a very clear message. Schools are, as Claire says, putting in considerable resources themselves; the question is where do you refer to and get help from outside the school. That was why we structured the mental health support teams as we did, to give schools somewhere to go so that it wasn't all school working.

Q136 **Layla Moran:** That pre-empts where I was going to go next. One of the concerns in the consultation was that the hubs would sit in the school. You are saying they will not.

Sir Chris Wormald: Yes, but they are overseen by the NHS and they are run by CCGs in consultation with schools.

Claire Murdoch: It will be, although in each area that has come forward—part of this, as you have said, is this is a pilot—

Layla Moran: Can I interrupt? When you say they will sit outside the school, will they literally sit outside?

Claire Murdoch: No, not necessarily. The teams will be supervised and overseen by the NHS to make sure they are practising in accordance with a good, strong evidence base, and that we capture the outcome data as well. That is really important. But the local areas will be deciding precisely where these services will sit, and some schools will want a regular counselling presence in the school. It is really important to note here, on the pilot, that we had several more applications to run as a pilot—and they had to be partnership applications—than we have been able to fund at this time; so we are supporting more than we had originally planned. The calibre of the submissions was very high so in fact our coverage in the first year will go wider, but I think in the first instance having schools, CCGs and local areas who are really keen to make this work in their patch is vital.

Q137 **Layla Moran:** How many pilots have you got?

Claire Murdoch: In response to the Green Paper we said we were aiming to have 15 pilot sites for the mental health support teams, leading to 40 mental health support teams. We thought that would give us 4% cover—

Q138 **Chair:** Sorry, to be clear: what have you got in place or are about to start



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now?

Claire Murdoch: We thought we would have 15 sites, with 40 mental health support teams.

Q139 **Chair:** Sorry, I am puzzled by this: 15 sites, with 40. I do not understand the maths.

Claire Murdoch: The initial plan was to have 14 sites that would come forward, but often those areas would be bigger than one school, so often you would need more than one team in an area to get the population coverage. So we thought we would select 15 sites; there would be 40 mental health support teams; and that would give us 4% coverage.

Q140 **Chair:** Is that one mental health support team in one school or attached to one school?

Claire Murdoch: One team can cover more than one school, but—

Q141 **Chair:** How many schools?

Claire Murdoch: There will be 25 sites and 62 mental health support teams.

Q142 **Layla Moran:** No, no, no. How many schools?

Claire Murdoch: I am not sure how many schools that is. I will let you know.

Q143 **Chair:** I am absolutely confused here. We've got 14 sites, 15 sites, 40 hubs. If you can't clarify now, can you write to us?

Claire Murdoch: We've got boroughs or half a borough. We try to work coterminously with boroughs, so within any given borough obviously there are multiple schools, and we have worked out how many teams you need to provide support.

Q144 **Chair:** Will you write to us and clarify that?

Claire Murdoch: We will tell you how many schools. In fact, because we have had so many applications, we have increased the sites and the number of support teams.

Q145 **Layla Moran:** Where are the 15 sites? Are they spread geographically?

Claire Murdoch: Yes, they are. We have spread them geographically and in terms of deprivation and other characteristics, so there is a very good spread nationally. We hope to announce the selected sites very soon.

Q146 **Layla Moran:** How soon? This month? Next month?

Claire Murdoch: Within a month.

Q147 **Layla Moran:** November?

Claire Murdoch: Within a month.

Q148 **Layla Moran:** November. Okay. And what's the spread between



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secondary and primary?

Claire Murdoch: I'll have to get back to you. But there is a spread.

Q149 **Layla Moran:** Turning now to early intervention and prevention and in particular the impact. I understand the pre-panel heard about surrounding services. Mr Stevens, have you been able to quantify cuts in Sure Start or youth services and the effect that that has had on rising mental health issues in young people? Have you been able to quantify that link?

Simon Stevens: We have not, but we have been in discussion with the Office of the Children's Commissioner as to whether some of the data available to her in a more comprehensive fashion, and would be available to the NHS, might provide insight on that question. As we shape the long-term plan, one of the elements of that will be a strong focus on early years and child support in the round: not just the mental health aspects that we have been talking about. We have been working with the Children's Commissioner and also the Children's Society, the Royal College of Paediatrics and Child Health and various other stakeholders on this very question.

Q150 **Layla Moran:** On early intervention, a lot of this has been criticised for not being ambitious enough.

Simon Stevens: This being what?

Q151 **Layla Moran:** The Green Paper and the rolling out of mental health services and prevention, particularly in children, knowing that a child with mental health issues is likely to cost the NHS much more down the line. Why has it taken this long to get to this point, Mr Stevens?

Simon Stevens: Two reasons, to be blunt. First, as we've discussed earlier, there is an empirical question as to what the right model of support is and what impact that has downstream. That is what we are testing. Secondly, there are costs associated with rolling out the model, and before that money is spent we really want to make sure it works. Hence the approach that has been taken through the Green Paper.

Q152 **Layla Moran:** How much would it cost to actually fund everything that has been suggested in "Future in mind"?

Sir Chris Wormald: I don't think—I need the NAO Report on this—that has been costed.

Q153 **Layla Moran:** Do you plan to?

Sir Chris Wormald: No. As the NAO has set out, we and our many partners have basically taken the pragmatic approach of how fast we can do things, given the resources available.

Q154 **Layla Moran:** That's fair enough. You might not be able to do it all in one go, but surely there is some value in recognising how far you have got to go and how much money to ask for.



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Sir Chris Wormald: As Simon says, as part of the long-term plan process we will be charting the future of these services. I don't think there will be much merit in going back to "Future in mind", which was mainly a call to action. It was never designed as a set of programmes.

Q155 **Layla Moran:** So you have no intention of fulfilling the recommendations?

Sir Chris Wormald: "Future in mind" was a completely revolutionary document at the time. As I say, it was set out as a call to action to the system as a whole, which has been picked up through the five-year forward view on mental health and then beyond the long-term plan. Those are the things that we and our partners project manage to conclusion. As the NAO correctly said, we haven't tried to project manage "Future in mind" as a programme as such. We do those underpinning bits.

Q156 **Layla Moran:** As you develop the long-term plan, what lessons have you learned and would like to take forward from the roll-out of the local transformation plans, in particular? Who wants to take that one?

Simon Stevens: I'll take a punt.

Layla Moran: Particularly on the criticism that the money wasn't spent where it was meant to have been spent.

Simon Stevens: We are sure that we are seeing increases in children and young people's mental health services, as well as overall mental health services.

Q157 **Layla Moran:** But do you accept that it could have been more effective had the level of funding been used more stridently than it was, for example?

Simon Stevens: More stridently?

Layla Moran: Indeed.

Simon Stevens: How do you use funding stridently?

Layla Moran: The money was just given out in year two to the local partnership funds, wasn't it? It wasn't on the condition that they fulfilled what they set out to do with the plans. Why wasn't the funding withheld unless they could show they had done it?

Simon Stevens: Those are two separate, but related, questions. On your first question, which was about whether the development of those plans is a good role model, I think there were 122 of them—is that right, Claire?

Claire Murdoch: Yes.

Simon Stevens: They were the natural local decisions, based on the partners they needed to get round the table. That was partly driven by the health and wellbeing boards, and what their locus was. Frankly, I think there would be great benefit in having the same planning footprints for these services as for everything else that we are advancing in the future.



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As part of the process of implementing the long-term plan, we will set out our national stall for the improvements that we want to see on childhood and early years, and health in the round, including young people's mental health services. There will then be a process of engagement locally, whereby people refresh what they have got to get done in order to do that, and shape that in the context of their local circumstances. Then we will have an accountability mechanism to ensure improvement occurs.

If the question is whether we are about to double down on 122 local process of the sort that were originally set out to drive the next phase, the answer, I suspect, is no. Claire, is that right?

Claire Murdoch: I think that's right. There is a question for this Committee and others about the role of health and wellbeing boards as a local system conductor or integrator, and about the new NHS architecture and how we drive better integration.

I wanted to say that we put a good percentage of the health money for children and young people into CCG baselines. That is true. We did withhold some of that money for specific transformation projects, programmes and pilots. It was a mixture. I would say that, of the money that went into the CCG baselines, we have become increasingly expert in measuring the activity. We need to do more on outcomes—perhaps we will come back to that. We are increasingly sighted on where the money is going and whether the CCGs, with the money we have given them in their baseline, have indeed spent it on children and young people's mental health.

Q158 **Layla Moran:** Because currently you can't tell, can you?

Claire Murdoch: We can tell—we absolutely can. We can't always tell at the level of detail that we would like. I am told by finance colleagues at NHS England that we now, over the past two years or so, measure CYP mental health spend in a more granular way than probably any other area of health spend nationally. In addition to what my finance colleagues are doing nationally, regionally, through STPs and in CCGs—

Q159 **Chair:** You talk about not being able to measure outcomes, and you heard some of the examples I cited—we were talking about Asperger's and autism, in particular—where there were lots of interventions, but they were ineffective. When will you be able to measure outcomes? Measuring activities does not really show very much. It shows that people are busy, but they might not be doing the right thing.

Claire Murdoch: That is a fair question. We do measure a lot, and I am happy to come back to that.

Q160 **Chair:** When will you know about outcomes?

Claire Murdoch: In terms of outcomes, we have been doing a great deal of work with our clinical networks, academic colleagues and also NHS Digital, to make sure that the MHSDS—the data repository or the data flow for NHS information—is geared up to collect paired outcome measures electronically or digitally. We are having a huge push on that in

the coming year and I expect to have the internal planning guidance that we will give to the system well in advance of next year.

Q161 **Chair:** When?

Claire Murdoch: We will start to really implement them across the country—

Q162 **Chair:** When?

Claire Murdoch: We are already measuring through the newly assembled—or built—system what we are doing now on paired outcome measures. We know that there are some areas—too small a number of areas—that are doing really well. For example, in Essex, the trust there has 100% achievement of paired scored outcome measures. However, that is in too few places, so we are ramping up hugely in 2019-20, having built the infrastructure.

Q163 **Chair:** Do you take any qualitative evidence? We have had some quite extraordinary evidence from colleague MPs around the House, with really heart-breaking cases—obviously they all send us their more difficult cases. Do you look at that qualitative evidence about what it feels like for the parent or for the young person as they go through the system and whether they feel that they are getting the right support?

Claire Murdoch: On outcome measures, we have built a clinical and a digital system to start really driving that very hard in the year ahead.

Q164 **Chair:** What about the qualitative?

Claire Murdoch: We have a huge programme, for which we are very grateful to YoungMinds and other organisations.

Q165 **Chair:** Just to be clear: are you getting any qualitative information?

Claire Murdoch: We get lots. We hold several events, we co-produce a lot of our work and we take feedback from parents.

Q166 **Chair:** So you are getting it, but how is it helping you to shape the service?

Claire Murdoch: We do an awful lot of engagement activity, for example, and we were disappointed that more of that was not pulled out in the Report, because I think it is impressive, and thanks to our partner organisations—

Chair: The Report was not really looking at that.

Claire Murdoch: No, but that is something that has been really useful in driving—

Q167 **Chair:** We are asking the questions. Please answer the question about how you incorporate that information.

Claire Murdoch: We have taken much of what we have learnt from that huge engagement and fed it into things like a bespoke training



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programme, which we have set up for 111 commissioners across the country, about how you commission good-quality services. We have run that programme nationally. We are feeding some must-do elements of high-quality services into our service specifications or our transformation moneys. We have also fed it into early intervention and the access and waiting times standards for eating disorder services. We have done a huge amount of work on CYP IAPT, which is a formal training for staff enabling them to practise more in accordance with the evidence base, because, as you say, you might get through to a member of staff, but unless they are adequately trained and able to identify your needs, to some extent what you get is not a quality intervention. There is a very significant programme aimed at driving quality improvement.

Chair: There is a lot of activity—we are just trying to grasp how it makes a difference.

Sir Chris Wormald: Can I just come in on your data question because I am not sure we have answered it?

Chair: I think Ms Mahmood is going to come to that now.

Q168 **Shabana Mahmood:** With specific reference to figure 21 of the NAO Report and the difficulties in the tracking of progress, I was going to ask you, Ms Murdoch, what you would say is the main achievement of all of the strategising and prioritising to date, but in your earlier answers you made specific reference to the progress on eating disorders, which I note is one of the only ones that has got a green rating—one of only two. Is that the only main achievement of this programme to date?

Claire Murdoch: No, definitely not.

Q169 **Shabana Mahmood:** What else could you confidently say is another?

Claire Murdoch: We have opened a very significant number of tier 4 specialist child and adolescent beds across the country.

Q170 **Shabana Mahmood:** That was the only other one that got a green rating. Apart from the two that got a green rating, is there anything else that you would point to as a significant achievement using the metrics laid out in figure 21?

Claire Murdoch: I do not have the metrics in front of me but I can certainly tell you what the other achievements are—

Simon Stevens: It was not intended to, and I apologise for suggesting it, but that almost sounded slightly dismissive. Actually, if you think back three or four years, there was huge pressure—there still is in some parts of the country—around acutely ill young people needing specialist mental health beds and having to travel hundreds of miles across the country. The fact that we have begun the journey of explicitly expanding—

Chair: Mr Stevens, we know, and the Report highlights—

Simon Stevens: Sorry, but I would not want to gloss over that, because—

Chair: Mr Stevens, the Committee has looked at that. Unfortunately for all of you, this Committee has to probe where there are still challenges. We cannot just have you sitting here talking about all your successes.

Simon Stevens: That would take too long, I assure you.

Chair: We acknowledge that, and the Report acknowledges that. We take that as read, but we need to move on to where we want to push for improvement. Given that you have an injection of cash and a big challenge, Ms Mahmood is going to continue to push you on how you are going to improve.

Q171 **Shabana Mahmood:** The reason why I brought up the treatment of eating disorders, particularly in the community, was to ask about the two areas that have a green rating, which you have said that you have seen lots of movement on. What are the features of those areas that need to be replicated in order to move things along in other areas that are currently not rated or are rated amber or red?

Claire Murdoch: We do not fully agree with the NAO's RAG rating. We think its assessment of some of our other achievements has been harsh.

Shabana Mahmood: You may not agree with it, but the main achievement that you yourselves pointed to was in the treatment of eating disorders. That was your own answer.

Q172 **Chair:** May I bring in Jenny George as a director of the NAO? This is an agreed Report, Ms George. Would you like to comment on this apparent disagreement, which we were not expecting?

Jenny George: We agreed the factual accuracy of the Report with all bodies. We were clear throughout figure 21 that this is the NAO's assessment—it is our RAG rating.

Amyas Morse: It is just our assessment. To be fair—I know Simon Stevens is very keen on being fair—we put these RAG ratings together based on our judgment and the evidence we saw. They are our RAG ratings, not the NHS's.

Simon Stevens: That is right. We factually agreed the Report, but we may have a different view on the judgments that the NAO has reached in the light of it.

Chair: Let us be clear. You agree that the green ones are going well. Will you agree with that bit at least, which will give Ms Mahmood a platform to repeat her question?

Q173 **Shabana Mahmood:** For the third time, you all agree, and we have established, that the treatment of eating disorders has rightly received lots of attention and that we have seen progress on it. You agree with that, and the NAO agrees with it and has given it a green rating. What have you done there that you need to replicate in some of the other areas in which the NAO rates you less highly, in order to get the same kind of progress?



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Simon Stevens: My starter for 10 on that would be that in relation to the CYP talking therapies expansion, there has been a requirement for a much larger number of new people to get trained in order to be in place. The complexity of the training task and pipeline is much greater in that area than it has been in some of these other areas. That is why that is yellow rather than green right now, and frankly I think that that is not an unfair assessment—I know that Jenny is flabbergasted to hear that.

Claire Murdoch: There are other things. Understandably, you took issue with whether we had a clear baseline in 2015 from which to build. We pointed out in “Future in mind” that actually we didn’t. We cannot retrofit a baseline, but we believe that the single collection we have done, which demonstrates the increase in access, the monitoring that we do through regional and local quarterly deep dives, and the evidence of increased spend all show that in the absence of that 2015 baseline, which we recognise, there are lots of other areas in which we think the rating should be green, because we are very much on top of growth in that area.

Amyas Morse: On top of it?

Claire Murdoch: We understand it and we can chart it.

Q174 **Shabana Mahmood:** Another way of looking at it, though, would be to say that on the treatment of eating disorders there was great political pressure because there was much more public consciousness about it. A time standard also applied to the service that a young person suffering from an eating disorder could expect. Have you thought about that as something that works and that you should apply to all these other areas to ramp up and meet your very laudable ambition, which we all agree with?

Claire Murdoch: For sure. The clinical pathways, the clinical evidence base, clarity about access and waiting time standards—things like that are part of our longer term ambition against a whole range of needs. There are other things that we are doing in patient care. You rightly said that there was not a ratified set of definitions around things like out-of-area placements. We have subsequently ratified the set of different definitions that we have been using for the last two years, but it was a very fair point that it had not been through proper governance and been ratified. There are things such as that where we could get tighter, and we should.

Q175 **Shabana Mahmood:** Ms Murdoch and Mr Stevens, which of all these areas would you say you are most worried about in terms of delivery? Of these 15 areas, which is the one that you personally worry most about not being able to deliver?

Chair: Ms Murdoch?

Simon Stevens: I am sure Ian will want to come in on this as well—

Chair: I did actually say Ms Murdoch, so Ms Murdoch first.

Simon Stevens: Sorry.



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Claire Murdoch: I think the biggest rate-limiting factor is getting the workforce right. I am relatively confident that we will deliver what we said we would deliver by 2020-21, but I would like to be really confident. I think workforce is the single biggest defining factor for our ability to deliver.

Simon Stevens: I was going to say the exact same thing.

Shabana Mahmood: Don't feel the need to say any more then.

Simon Stevens: Full stop.

Q176 **Shabana Mahmood:** That is helpful. Why is the position, the status—call it what you will—of the data in this area so poor?

Simon Stevens: Firstly, probably because children and young people's mental health services have been relatively neglected even within mental health services, which have themselves been relatively neglected. That is just the starting point for the overall service offer. I would say, by the way, that that is unfortunately not unique to England. The international benchmarking study looking at 13 countries showed that England now has better data on the measures for CYP services than just about any of the other countries being compared. We have come an awful long way over the last two years, but the fact is we knew that was the starting point back in 2015.

Q177 **Chair:** We know that. Can you just talk about the situation with the data?

Simon Stevens: We said in "Future in mind", "Although there is locally collected data, there is a general lack of clarity about what is provided by whom, for what problem, for which child." That is why, rather than simply cursing the darkness around the data, we chose to light a candle in terms of service expansions, which is what we have been doing over the last several years, at the same time as putting in place the data collections to give us increasing line of sight to what is happening locally.

Q178 **Shabana Mahmood:** What you are saying is that you inherited a bad picture before this strategy came along—

Simon Stevens: Yes, definitely, as we said at the start.

Shabana Mahmood: As you said at the start, indeed. The start is marked 2015; I think that is when we had "Future in mind". I forget all the names of these things, but in 2016—

Chair: It was another five-year plan. It sounds very Stalinist, doesn't it?

Q179 **Shabana Mahmood:** Yet another five-year plan. It is now October 2018—it is not November yet—so three and a half years from the start of this process. Why did it not occur to anyone on this panel that getting the data right and setting that process in place in 2015 was the first thing you needed to do so that you could understand this really difficult picture for provision?

Simon Stevens: We did do that, but it was not the first thing we needed to do. The first thing we needed to do was to begin expanding services; it



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was apparent in 2015, of course, that there were these big service deficits, and therefore—as the NAO judiciously remarks—we took a pragmatic approach to expanding services despite the fact that there were data gaps, and have built the data intelligence alongside the service expansions. We make no apology for that. We think it would have been ludicrous to wait two years or three years to get baseline data and then track just how deficient the services were before actually beginning the service expansions.

Q180 Shabana Mahmood: You have obviously made some progress on service expansion, particularly for eating disorders. We can understand why—

Simon Stevens: Not just eating disorders, but psychological support for children more broadly.

Q181 Shabana Mahmood: I know it is not just that, but that is where you have made the most demonstrable progress. In order for the rest of this service to catch up you need good data; maybe you did not need to start with that in 2015, but why not get that properly rolling in 2016?

Simon Stevens: We now have much, much better data—

Q182 Shabana Mahmood: It is still a pretty poor picture, I think you would have to admit.

Sir Chris Wormald: I was going to come back on your original point. Our data will now improve every year. We have a mental health data set and we have also done—

Q183 Shabana Mahmood: How much will it improve by every year?

Sir Chris Wormald: We think we now have both our workforce data, which Ian might want to say a bit more about, and our mental health data set in the right place. What of course we do not have, which you are pointing to—

Q184 Shabana Mahmood: You think that, or you know that?

Sir Chris Wormald: It will be proved in practice and audited along the way.

Sir Chris Wormald: It will be proved in practice and audited along the way. What we do not have and what we cannot do is create trimmed data of the type we would want, going historically, which the NAO has pointed out. We have a series of estimates and we have surveys, but we cannot show progress right now—the NAO is absolutely right about that—because we do not have the historical data. We believe we have made a lot of progress in a lot of areas and we have evidence we can piece together, but there is no single dataset to show year-on-year progress at the moment. Now, because of what was done in 2015—

Simon Stevens: I certainly think that was true in 2015 but I don't think it is true today.



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Sir Chris Wormald: Exactly. From now going forward we ought to be able to do that. That is because of the actions people took in 2015 to put the data into a better place. You are describing exactly the right situation right now, but it is not because people did not take action. We are only where we are because people took action. Do you want to say a bit about that?

Professor Cumming: Well, if I may add—

Chair: It is for us to decide who to bring in. We are going to come back to workforce in a moment, but does Ms Mahmood want to come in?

Shabana Mahmood: In our pre-panel, which I think only Ms Murdoch was in, we discussed with practitioners and people with coalface experience of issues about data. They seemed to think and clearly indicate to us that all the data is in place. They agreed that it is not rocket science. I am trying to understand why we have still found it so difficult to get an accurate picture on data, which means we cannot plan properly where the pressure points are if we are going to meet all of the—

Chair: Just to be clear for those who were not here, they were saying that for adults the data is there and there is a well-worn route, but for children it is not.

Simon Stevens: The Committee is right in saying that the legacy for 2015-16 and to some degree 2016-17 was such that it was hard at that point with the look-back to describe the position then prevailing. Subsequently, for 2017-18 and indeed 2018-19 we are now in a much better position. We did a belt and braces exercise with the minimum dataset, which was incomplete, so we supplemented that with the annual survey. I think in all likelihood we will choose to do that again on a belt and braces basis for 2018-19 so that we have methodological comparability between the two years. What that will continue to show is the expansions in the number of children getting access to specialist mental health services, not just on eating disorders but across the board.

I might add, by the way, that we have taken a very conservative approach to the definitions we use as to whether or not somebody is getting a specialist children's mental health service. In every other walk of life in the NHS, one contact with the specialist service constitutes as a treatment volume, whereas we have said that you have to have two or more to count towards the 30.5% volumes that we have expressed. If we had just used one treatment as the measure then we would already be showing 35% on the current prevalence rate. We are being really hard-nosed and conservative about the way we are approaching this.

Q185 **Shabana Mahmood:** When will we have usable data that uses the correct definitions and that is methodologically comparable—all of that? When we will have a full dataset from which we can measure progress and work out where deficiencies are? What timeline will you apply, Mr Stevens?



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Simon Stevens: The key things we needed to track in terms of the number of people getting care—

Q186 **Shabana Mahmood:** I am not looking at the key things but a date. When?

Simon Stevens: We have already had it, is the answer. We were able to produce those data for 2017-18 and we will produce them again for 2018 at the end of this year.

Q187 **Shabana Mahmood:** You are saying that all the data that is required to assess this fully is in place?

Simon Stevens: We have those data. Can we continue to expand the range of indicators that are being tracked? Of course we can. We must do that and we are working with NHS Digital on the comprehensive coverage of the minimum mental health data set that they are compiling.

Shabana Mahmood: For example, the access estimate by mental health services data puts access at 22%, I think, and the NHS stats survey shows that at 30%.

Simon Stevens: 30.5%.

Shabana Mahmood: Yes. That is a big difference. We are still looking at different types of data and there are still big gaps between them.

Simon Stevens: Yes, precisely because the NHS Digital mental health data set was not comprehensive at the conclusion of 2017-18. We undertook the national data collection in order to be able to get that estimate. As I said a moment ago, we will do the same again for this coming year so as to have methodological comparability between the two estimates. We hope to supplement that with the more accurate and comprehensive mental health dataset that NHS Digital is compiling for us, but on a like-for-like basis, we want to be able to make that comparison.

Q188 **Shabana Mahmood:** I want to return to an earlier point about funding for services given to CCGs, which has not necessarily been spent as was initially intended. We had a bit of a discussion with other members of the Committee on that before. Can you tell us how much of the additional funding for children's mental health services that was given to CCGs wasn't spent as intended?

Simon Stevens: We are on track by 2021 to spend the full allocation that was made in 2015-16.

Q189 **Shabana Mahmood:** I am trying to establish how much. We know from the report and from evidence that we have heard that not all of the funding that was supposed to be spent on children's mental health services was in fact spent on those services by CCGs. I am trying to establish how much.

Claire Murdoch: Firstly, we are largely on track.

Q190 **Shabana Mahmood:** No. I just want an amount.

Claire Murdoch: There are some individual CCG exceptions.

Q191 **Shabana Mahmood:** Which ones? Which are the exceptions?

Claire Murdoch: I couldn't tell you the list off the top of my head.

Q192 **Chair:** Could you write to us?

Claire Murdoch: We have that list. Our dashboard publishes which ones are below. We are doing intensive work with each of those CCGs to talk about their recovery plan for investment to the 2020-21 period. We are confident that, by the end of the period, we will have spent, and CCGs will have invested, the right amount. We are publishing on the dashboard. We follow up through regions. Where necessary, we go to individual CCGs, both operationally and with finance colleagues, to understand what has happened, and we track and work with those CCGs who need to catch up any underinvestment.

Q193 **Shabana Mahmood:** Are you able to give me an amount of that additional funding that was made available for children's mental health services that wasn't spent as intended?

Claire Murdoch: We are tracking to the 2020-21 period. My view is that we will ensure that the £1.4 billion is appropriately invested over the lifetime of this programme.

Q194 **Shabana Mahmood:** Why were some CCGs allowed to miss meeting the mental health investment standard before 2018-19? Why do we even allow that to happen?

Simon Stevens: Because we framed the mental health investment standard as a goal for England and in aggregate that has been met in each year for which the mental health investment standard has been set. In 2016-17, which was the first year the mental health investment standard applied, 85% of CCGs met it. Last year, it was 90% of CCGs, and in both years, overall the NHS exceeded the mental health investment standard. In the current year, we have asked every CCG to meet it and we have required their external auditors to certify the accuracy of the attestations that they make to that effect.

Q195 **Chair:** Can I move on to workforce issues? We have had evidence from individuals and from MPs, and the Royal College of Psychiatrists also put in some strong evidence, about the real concern that there has not been the right increase, or a notable increase, in mental health staff numbers. Ian Cumming, it took you a year after the publication of the forward view to publish the workforce strategy, "Stepping forward". Why did it take that long and why has there been no notable increase in mental health staff numbers?

Professor Cumming: It took as long as it did because, as we have already heard on many of the other questions today, this is an extraordinarily complex area in which there was no robust data, so we undertook a bespoke data collection exercise. Bear in mind that 20% of the workforce that we are talking about here are not employed by the



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NHS—they are in organisations for which we do not automatically have a data flow on the number of people employed and what their jobs are.

Q196 Chair: I will just stop you there. There is no doubt that to get it perfect, you have to have absolute data, but where you have glaring vacancies—there is a recruitment crisis in mental health nursing, for example, or you know you are going to need a bigger pipeline of psychiatrists who take 13 years to train—could you not have started earlier?

Professor Cumming: We did.

Q197 Chair: Okay. What did you do?

Professor Cumming: We have been growing the intake into the registered nurse training programmes for mental health year on year. The intake in 2017-18 was up by 13.2%, for example, on the intake in 2013-14, into mental health nursing. We have also launched the trainee nursing associate programme, of which we are seeing 14% of all trainee nursing associates being employed within mental health. I can't break that down into children and young people—that is in all mental health services. That is a significantly higher percentage than you would expect if we had an even distribution across the areas.

Q198 Chair: Earlier you talked about people leaving the NHS, so why is the overall number of mental health nurses going down? What are the factors in that, given that you are also trying to recruit in at the bottom, as you have just highlighted? Why is the number going down?

Professor Cumming: The number has been falling until last year—we saw a small increase in the whole-time equivalent of mental health nurses employed in the NHS last year of somewhere in the region of 250, so it's very small. We are hoping that that signals the bottom of the decrease that we are seeing and as we are now seeing larger numbers of nurses coming out of training, coupled with some work that is being led by colleagues in NHS Improvement on how we make the NHS a more attractive place for people to work, how do we respond—

Q199 Chair: But they are more general things—

Professor Cumming: But they are critically important to how we retain the staff that we train.

Q200 Chair: Right. But 250 is a very low number and you are hopeful that it is the bottom. What evidence have you got of that? And have you got evidence—or even a hunch, if you haven't got the evidence—of what stopped people applying in the first place? I mean, we are thinking of the bursary, for example. Has that had an impact?

Professor Cumming: We have seen a broadly flat level of people applying for mental health nursing training places over the last two or three years, which coincides with the introduction of the bursary. But we have seen a shift—the average age of people entering undergraduate nurse training has gone down. It certainly looks as if the introduction of



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the move towards student loan funding has definitely had an impact on the more mature entrants.

Within mental health nursing historically, we have attracted more mature entrants as a percentage than we have in other branches of nursing, which is why routes such as the training nursing associate through to nursing associate through to registered nurse, which allow people to train while working, is an important part of the future pipeline.

Q201 Chair: But you didn't even spend all the money you had for training in the first two years of the forward view programme. Why was that?

Professor Cumming: That wasn't for nursing; that was training for IAPT in particular, and it was purely a phasing issue, associated with our budget years, higher education institutes' budget years and being able to commence these programmes when we could actually recruit people on to them and when we were able to pay for them. We remain confident that, with the 1,700 new children and young people IAPT therapists and the 3,400 existing ones who are receiving additional training, we will meet those targets by the 2021 deadline.

Q202 Chair: Jenny George, is it your opinion that a phasing issue is the reason why the money was not spent?

Jenny George: I think a delay in the first year could well be that. I would question why there would also be an underspend in the second year if it was a phasing issue of the first year, and maybe point to the revised targets that were set out—

Professor Cumming: To respond to that, yes, there was a slight delay, but the phasing issue is associated with when we pay the universities for the students. If we have a delay in the first cohort starting, that then means that we end up with that delay being knocked on into future years.

Q203 Chair: That seems okay, but on the slow progress in recruiting, let me put it this way: what are your priorities—I am asking Claire Murdoch too—in terms of the different types of personnel that you need to recruit and in what time frame? If it takes 13 years to get a psychiatrist, that is a very long haul but you have to start now. What about in the immediate future? What can you do with the money you have got now and all the money that has been promised, and how quickly can you do it?

Professor Cumming: If we are looking at a professionally qualified workforce in the next three to four years, training will not have an impact, because new additions to training are going to take longer than three to four years in the nursing and the other allied health professions and the medical training groups.

The factor that has an impact here and now is retention of the workforce. Just to give you a figure, which I think I have used with this Committee before, if we had kept the retention of the nursing workforce in the NHS between the period of 2012 and 2017 at the level that it was in 2012, 50% of nursing vacancies would not exist in the NHS today. So we have to focus on retention.



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We have to continue to focus on attracting people back into the professions: people who have already been trained, who may have left for a variety of reasons—

Q204 **Chair:** So what are you doing on that?

Professor Cumming: We are running a return-to-practice programme that so far has recruited 5,000 nurses back into training to return to active nursing.

Q205 **Chair:** How many of those are mental health nurses?

Professor Cumming: I can write to the Committee with that—

Q206 **Chair:** That would be helpful because what worries us is that there is a slow spend, and then it will take three to four years. This is for Simon Stevens or Claire Murdoch. Does that rather screw the plans if you can't actually get the people in place to deliver everything that you are planning for?

Claire Murdoch: One thing I would add as a registered mental health nurse is that we know that retention is really key, but one of the things that appears to be driving some nurses out now is this mental health officer status, which means that your pension is fully cooked by the time you are 55. Tax penalties on that are causing a whole tranche—

Chair: We found that a lot in the public sector.

Claire Murdoch: Not just in nursing but elsewhere, so I think this is something we need to think about.

Q207 **Chair:** So even in nursing the pension limit is—

Claire Murdoch: It is. Now, because the pension thresholds have problems for a million—

Chair: We know the issue. We have covered it a lot.

Claire Murdoch: For example, a matron, and your other allied health professionals—it is not just a doctor/consultant issue. It was when the threshold was higher, but a matron, a nurse who has been in the NHS for 35 years—

Q208 **Chair:** What would a matron earn at that point?

Claire Murdoch: A matron will be earning £45,000 to £50,000 a year. If they have worked for 35 years, their pension pot will be of a size that triggers the issues—

Chair: We know the issues. Thank you for highlighting that, but—

Claire Murdoch: I just wanted to make that point, because it is not helping us across the piece in mental health.

Q209 **Chair:** That is a very important point. I hadn't realised it would be matrons at this point. But can you deliver without—



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Claire Murdoch: I saw some information yesterday, which I have not had the opportunity to analyse but which I think we will share with you as soon as we can, from the benchmarking club, because we know that in 2016 HEE did a survey of CYP health workers and found that there were approximately 7,700 in the field. Yesterday I had sight of the benchmarking data from 2017-18, which suggests that the workforce has in fact risen to 8,650.

Q210 **Chair:** I think these are unverified figures. Could you send us the data?

Claire Murdoch: We will send it to you, because we think it is a very reliable source. What that really means is this. To get to the five-year forward view level of workforce, which was 10,500 working in the sector, to deliver our plans, we need to deliver a further 1,850 staff. I think that is doable in the timeframe. The other thing—

Q211 **Chair:** So you think this slow recruitment and training and everything will not affect delivery?

Claire Murdoch: We have a recovery plan, and we are seeing progress, but we need to share that data with you because it is very new. It remains—

Chair: Okay. We don't like new data being thrown at us in the middle of—

Claire Murdoch: I'm sorry, but I have only just had sight of this. Your other point—

Q212 **Chair:** Sorry, can we just be clear? Even if that data is correct, and I do not doubt what you are saying at headline level, we do not know without seeing all the data what professions they are, or whether you are recruiting doctors from overseas because they are already trained—that sort of thing. It does not really tell us a great deal.

Claire Murdoch: It needs a much more granular analysis.

Chair: Yes, it does.

Claire Murdoch: The work that we have been doing with HEE and the sector on where we get the workforce at scale suggests—you heard some of this earlier—for example, psychology graduates, other graduates, and mature people who perhaps do not have a professional training but want to come in through the nursing associate workforce. We have been working with the Royal College of Psychiatrists, which is really keen on exploring the role of physician associates in mental health—

Q213 **Chair:** Okay, but these are all ideas. We have been doing this for a few years now and there is still a shortfall in mental health staff.

Professor Cumming: If I could just give an example of what Claire is saying, in the Green Paper are the new education mental health practitioners. In Manchester they advertised for 30 posts. They had almost 400 applicants. There is no shortage of people—

Q214 **Chair:** For what posts?



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Professor Cumming: These were the education mental health practitioners. It was the entry to training that we have launched. We have 210 people starting in January on that—

Q215 **Chair:** Just to be clear, they are not nurses.

Professor Cumming: They are not nurses. These are the people that are coming in on the back of the Green Paper to work in schools.

Layla Moran: To work in the hubs?

Q216 **Chair:** So they are not teachers or nurses.

Professor Cumming: No. We are seeing huge interest in that.

Q217 **Chair:** How long does it take them to train?

Professor Cumming: It is a 12-month training programme. A large number of psychology graduates in this country are looking to work in health. One of the things that we are looking to do is to work with the British Psychological Society and others to see how we could get more psychology graduates into the area.

Effectively, the answer is not to target one single professional group. We need more nurses, more doctors, more psychologists and more AHPs. The answer to get the workforce that we need is to increase the supply of all of those, but to make sure that we are a good employer that actually keeps people once we have recruited them.

Q218 **Chair:** What about the non-NHS workforce, because they are harder for you to measure?

Professor Cumming: They are hard to measure. We have said that before the end of this financial year we will repeat the census that we did in 2016 to give us a much clearer independent assessment of what has happened across the whole sector.

Q219 **Chair:** How do you measure the quality? Obviously people have their professional qualifications.

Professor Cumming: Although HEE is an NHS body, we train the majority of the workforce for health and, in fact, some of the care workforce. We do not just train people who are going to be employed by the NHS. The doctors we train, the nurses we train and the psychologists we train work across the whole public and private sector. We need to make sure that we do not see different levels of vacancies from one part to the other as a result of pay, terms and conditions, or opportunities that people see they have.

Q220 **Chair:** Is there any geographical difficulty in recruitment?

Professor Cumming: Certainly, we are finding it much easier to fill nursing training places at universities in the north of England than we are in the south of England.

Q221 **Chair:** I can guess the reason, but can you—?



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Professor Cumming: We are working with the Department of Health at the moment to do a deep dive into the specific reasons for that. We are also seeing that where there is a good, close working relationship between the university and the local NHS, it is easier to fill training courses than where perhaps there is not that same relationship. It is multi-factorial, but I think there are factors simply associated with the cost of living, to be honest. That is one of those. It is much more expensive to go to university in London than in Manchester, Leeds, Sheffield or Newcastle.

Q222 **Layla Moran:** To that point, in Oxfordshire, we have a dire situation with this, and with the cost of housing in particular. Is the Department considering things like housing allowances and key worker housing? How are you working across Government to deliver those kinds of things?

Professor Cumming: That is not my area, so I will pass that.

Layla Moran: So, cross-Government working. How are you going to ensure that the right houses, of the right price, are in the right place so that nurses can live in them?

Sir Chris Wormald: Sorry, but this is not an area I have briefed myself on, so can I write to you with the answer?

Q223 **Layla Moran:** Absolutely. I wanted to finish on cross-Government working in general. What we have in the Green Paper is a very specific initiative between two Departments, which has a governance structure. However, to deliver the longer-term plan, how many Departments have you identified that you will need to work with?

Sir Chris Wormald: Off the top of my head, I have not added it up, but the key ones are ourselves, Education, MHCLG, MOJ, the Home Office and the DWP. Those are probably the key ones that we work with.

Q224 **Layla Moran:** This is going to be big.

Sir Chris Wormald: Yes.

Chair: It has success written all over it.

Q225 **Layla Moran:** So my question then is, are you already thinking about what kinds of governance structures are actually going to deliver this?

Sir Chris Wormald: We have an inter-ministerial group, which is our key governance. We do not attempt, as I said before, to programme manage this as a single thing, so most of what we do is bilateral between Departments. Where it comes together is the inter-ministerial group and the officials' group that sits beneath that. But, just to be absolutely clear—and the NAO said this as well—we are not attempting to create a programme structure that covers what the NHS does and what those other—

Q226 **Layla Moran:** Would you see your Department as taking the lead in that, though, given that it is your plan?



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Sir Chris Wormald: Oh, yes. And where we have specific actions—I think you said this in your question—such as the schools programme, then we have a formal governance thing for that, which is joint with another Department. What we have not tried to do, because it is so big and so complicated, is create a giant programme structure that would cut across a lot of the NHS accountabilities and other programmes. That was an active choice. We do it bilaterally, with an information exchange and strategy function that goes across Government, but not a programme management function.

Q227 **Layla Moran:** When will the longer-term plan be ready? I am dying to see it.

Simon Stevens: Early December.

Q228 **Layla Moran:** Early December this year? Will it include these kinds of governance structures, or is it more the vision?

Simon Stevens: No, we have been asked to produce an NHS long-term plan. Obviously, a lot of the work you are describing cuts across the whole of Government, so that would be for Government to respond to, or to set that up with the NHS.

Q229 **Layla Moran:** And then the Government will respond, so would we then be looking at a consultation on that? Take me through the process. I want to know when the frontline is going to start to see the effects.

Simon Stevens: Sorry, of the—?

Q230 **Layla Moran:** The process of the longer-term plan. It is going to be produced by the NHS in December 2018.

Chair: That is NHS England.

Simon Stevens: There are two slightly separate things. When the NHS long-term plan is produced, then that is the NHS long-term plan.

Q231 **Chair:** But then all the other Government Departments have to step up. Sir Chris?

Sir Chris Wormald: Sorry. As Simon says, keep the two things separate.

Q232 **Chair:** I know Simon Stevens would like to rule the world, but he is only running the NHS at the moment, so the Whitehall connections kind of come down to you. How are you going to make sure that the other Departments—?

Sir Chris Wormald: That was a bit pointed.

Chair: He possibly thinks he already does. The other bits of Whitehall are down to you to co-ordinate. You have just listed a long number of Departments, and the thought that it is ever going to work with that number of Departments makes our blood go cold, so how are you going to do that, and what's the timetable?



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Sir Chris Wormald: As Simon says, we have to keep the two things separate. We have asked the NHS to produce a plan for how investment in the NHS will be spent in line with the assumptions that we gave it. That will be managed as a separate thing. On the specific question about mental health, we will continue to do it in the way that we have done it. We will continue to do it bilaterally with individual Departments. In the NHS plan, we should see what the NHS will be doing on mental health. We will continue to do the rest in the way that we have done.

Q233 **Layla Moran:** Are you going to have your own plan, driven by the Department? Taking the example of key worker housing, how are you going to make sure we have the right number of houses in the right places for nurses?

Sir Chris Wormald: I have not come briefed on that specific one, so I will come back to you on it. Our way of operating—as I say, our work with education is the best example—is that, where the Government have agreed to deliver a specific thing, we have a programme management structure to deliver that specific thing. Whether we do specific things in other areas, beyond what we are currently doing, is obviously a choice for the Government. That is entirely separate from the long-term plan process.

Q234 **Layla Moran:** Coming back to a question that I mentioned earlier, but is pertinent now, is your Department measuring the value-for-money link between services in the wider community and the mental health and wellbeing of young children? How do you intend to make sure it happens?

Sir Chris Wormald: My Department is not specifically doing that.

Q235 **Layla Moran:** Is anybody?

Sir Chris Wormald: There is work across the What Works centres, which I know you have looked at before, and things like the Early Intervention Foundation. We work across Government to look at those sorts of questions, but I could not say that DHSC is specifically doing that.

Q236 **Layla Moran:** Do you not think you should, if you are going to be driving a cross-departmental plan?

Sir Chris Wormald: Well, the National Audit Office Report describes our approach exactly. We have been doing these things on a case-by-case, pragmatic basis, based on what we can do now. We have not been doing the wider things.

Q237 **Layla Moran:** So you will be taking the strategic lead across Government in all these areas.

Sir Chris Wormald: We take the lead on mental health policy. Where the individual thing is a responsibility of a different Department, it is for that Department and their statutory responsibilities, as you know. The overall lead on mental health is with the Department, and it is then overseen by the inter-ministerial group that I described.

Q238 **Layla Moran:** Do you think there will be more of these Green Papers and



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co-working between Departments?

Sir Chris Wormald: It is a model that we have been developing. As I say, the education one that we have been talking about is a first. The Work and Health Unit, which we have jointly with DWP, is also a first. The Office for Life Sciences, which we do jointly with BEIS, is another example. This is a way of working that we are trying to develop. We take a specific thing that crosses two Departments and create some joint machinery to crack that problem. My personal view is that those sorts of bilateral things, where you have clear focus, are very frequently more effective than saying, "Here's the cross-Government programme board trying to do everything." We have seen those examples in health and work, in children and young people's mental health and in life sciences. That is actually a very effective way—

Chair: Fortunately, we are a Committee that looks at lots of Departments, so we have other opportunities to probe those other Departments and help you in your task, Sir Chris, of making sure services are delivered more effectively.

We have had a lot of evidence from other MPs. It is fair to quote Helen Whately MP, who is the Member for Faversham and Mid Kent. She praises some of the improvements she has seen as a result of the five-year forward view in her area, like the eight-bed mother and baby unit, which means that mothers with mental health problems are not separated from their children, but she also highlights the fact that nearly 1,500 children and young people in Kent have been waiting over 18 weeks to start treatment, and 144 have waited more than a year. I know that Shabana Mahmood wants to raise something, but that underlines why, as you and we all know, this challenge needs to be resolved. That is clearly not acceptable.

Q239 **Shabana Mahmood:** As the Chair said, lots of MPs have written to us about their difficulties in breaking through the barriers when constituents come to them in absolute crisis. One wrote to us saying, "I've been very concerned about the lack of response when I have raised my constituents' cases with Surrey CAMHS. In the past, my office could phone the head of the service in the knowledge that they would look into the case. This is not happening since a change in the head of service." That is from the right hon. Jeremy Hunt MP, the former Secretary of State for Health and current Foreign Secretary. If he can't break through the barriers in the system, what do you think that says about the system that you are overseeing?

Simon Stevens: Who had Jeremy Hunt been trying to contact?

Chair: The head of his local service.

Shabana Mahmood: He is not getting any answers.

Simon Stevens: Like any Member of Parliament, the Foreign Secretary has the opportunity to raise that directly with us. We will see what we can do, but I do not make any false promises—we know there are significant



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service deficits across the country, which are unacceptable. They are being tackled, but the situation that you describe is real and very heartfelt.

Chair: We have heard much evidence about the glue of getting through the system; it is one of the real themes of what MPs have sent us.

Q240 **Anne Marie Morris:** Mr Stevens, I am sure that you are not going to tell me how much your 10-year plan is going to cost—

Simon Stevens: It will cost £20.5 billion by the end of '23-24. That is an answer I do know.

Q241 **Anne Marie Morris:** There is a very significant workforce recruitment exercise that needs to be undertaken. How much do you think that will cost?

Simon Stevens: We have been asked, as part of the development of the long-term plan, to set out the workforce requirements and consequential that go with that. Some of that relates to the workforce training budgets as well as other, wider contributions that are needed to the NHS long-term plan. We will have that discussion with the Department of Health and Health Education England. Ultimately, I think those questions will be settled by the time of the next spending review.

Q242 **Anne Marie Morris:** The Royal College of Psychiatrists reckoned it would be £3.7 billion. Does that feel vaguely right?

Simon Stevens: £3.7 billion to do what exactly?

Anne Marie Morris: To deliver the necessary investments in people to get what you have promised by 2023-24.

Simon Stevens: We have not made any commitments yet for '23-24, so that's jumping the gun. That is probably a description of what the Royal College of Psychiatrists would like to see. We work very closely with them and think they have much to bring to the discussions that we will have over the coming weeks in order to conclude the long-term plan.

Chair: We all know that it is going to cost more than £2 billion, which is what Ms Morris is driving at.

Simon Stevens: There will be many competing demands on the good things that the health service should be doing more of. Clearly, mental health will be right at the front of the queue alongside a small number of other, very high-priority areas, but there will be many competing considerations. We will have to be realistic while ambitious, and we are going to have to be judicious in the phasing of the improvements that we can bring about.

Q243 **Chair:** We recognise that it cannot all be done at once, but we have heard evidence about the urgent need out there. Just to be clear, of the £2 billion that has been taken out of the £20.5 billion for mental health services, how much of it will go on children's services?



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Simon Stevens: We will have to determine that as part of the long-term plan.

Q244 **Chair:** So that will be announced in December?

Simon Stevens: Yes. I have a couple of clarifications. As the Chancellor rightly said, it is at least £2 billion in real terms. That has not been taken out. That was the discussion we had with him about the priority that we would attach to mental health. It was fantastic that he was able to announce that in the Budget.

Chair: Thank you very much for your time. The uncorrected transcript, as ever, will be up on the website in the next couple of days, and our report will be out before Christmas.