HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: Follow-up to the PHSO report "Ignoring the alarms", HC 855

Tuesday 14 May 2019

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Watch the meeting

Members present: Sir Bernard Jenkin (Chair); Ronnie Cowan; Mr Marcus Fysh; Dame Cheryl Gillan; Kelvin Hopkins; Dr Rupa Huq; Mr David Jones; Eleanor Smith.

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Witnesses

I: Andrew Radford, Chief Executive, BEAT Eating Disorders and Dr Dasha Nicholls, Chair, Faculty of Eating Disorders, Royal College of Psychiatrists.

II: Professor Lisa Bayliss-Pratt, Chief Nurse, Health Education England and and Dr Colin Melville, Director of Education and Standards, General Medical Council.

III: Jackie Doyle-Price MP, Minister for Mental Health, DHSC and Professor Tim Kendall, National Clinical Director for Mental Health, NHS England and NHS Improvement.

Written evidence from witnesses:

– BEAT Eating Disorders

- Royal College of Psychiatrists

- General Medical Council

- Department of Health and Social Care

Examination of witnesses

Andrew Radford and Dr Dasha Nicholls.

Q1 **Chair:** Welcome to this session on the Parliamentary and Health Service Ombudsman's report entitled "Ignoring the alarms: How NHS eating disorder services are failing patients". This report was produced a couple of years ago and this is our session to follow up, to draw attention to the report and to review the progress of how its recommendations are being implemented. I welcome our first panel. Could you each identify yourselves for the record, please?

Dr Nicholls: I am Dr Dasha Nicholls. I am a child and adolescent psychiatrist and I am currently Chair of the Faculty of Eating Disorders at the Royal College of Psychiatrists.

Andrew Radford: Andrew Radford. I am the Chief Executive of BEAT, the eating disorder charity.

Q2 **Chair:** Thank you both for being with us today. We have a lot of questions to get through and we have three panels so we will try to ask crisp questions and it would be helpful if you can give short and crisp answers. I will pull you up if you are dragging, I am afraid.

I will start by asking about the information that we have available about the prevalence of eating disorders. What information do we have?

Dr Nicholls: Our prevalence data are not as good as we would like, in part because eating disorders were omitted from the last adult psychiatric morbidity survey, which was undertaken in 2014. It is one of the issues we have tried to address as a result of this report and I am optimistic that will not be the case next time around. However, it does mean that our estimates are based on 2007 data, anecdotal evidence and informal—if I use that in a broader sense—reports about prevalence. They are largely estimates that we have at the moment.

There have also been changes to the diagnostic criteria for eating disorders since the last public survey. Data from 2007 would no longer apply. We have relatively recent incidence data, new cases, but not prevalence at the moment.

Andrew Radford: I agree with Dasha. The absence of the information leads us to attempt estimates, but when we are attempting estimates we are very cautious about overstating the case and almost certainly, therefore, understate the case. BEAT's latest estimate is that there are 1.25 million people with an eating disorder in the UK at the moment but if we look at some of the other estimates that are out there they talk about 4% to 6% of the population, which would be a much greater number, upwards of 2 million or 3 million. We are almost certainly underestimating the number of people affected, which in turn will cause under-resourcing. It means that there is not enough priority given to it in political decision-making and resourcing.

Dr Nicholls: The way that we usually measure these things is through screening tools and they are not the same as diagnostic tools. Usually there is a two-stage process, a screening process and then a more in-depth diagnostic process. That level of data about what is actually happening on diagnoses would require something like—

Q3 **Chair:** What needs to be done to improve the data?

Dr Nicholls: Something like a national clinical audit, the sort of thing that HQIP is commissioned to provide. There is one for anxiety and depression and for psychosis currently. That is the level of detail that you would need if you really want to understand the picture.

Q4 **Chair:** What do coroners tend to record in the case of a death from an eating disorder? Is that useful information?

Dr Nicholls: I do not know. We suspect it is massively under-recorded. We hear about cases where members of the faculty have been asked to attend coroners' cases, but if you attempt to find out actual death rates they are probably under-reported because they will be recorded as secondary to malnutrition, secondary to cardiac collapse or secondary to suicide. Those are the commonest reasons why people die when they have an eating disorder.

Andrew Radford: I believe the rules have changed in Scotland to require eating disorders to appear on a death certificate when it has formed part of the cause, but I otherwise agree with Dasha.

Q5 **Chair:** Is that a recommendation we should consider for England?

Andrew Radford: I would very much like to see that, yes.

Q6 **Dame Cheryl Gillan:** The Parliamentary and Health Service Ombudsman's report into eating disorders highlighted five areas of focus for improvement and also a series of wider recommendations. What impact has that report had on people suffering from eating disorders and those people treating patients with eating disorders?

Dr Nicholls: As yet, I would say relatively little. I know that there has been a lot of work from NHS England and other bodies in addressing the recommendations but much of that has yet to reach the public domain or to impact services at a direct level. All service deliverers are aware of the report and I would say there is heightened vigilance and focus on risk assessment processes and similar, but improving capacity, resource and co-ordination of care, the sorts of recommendations that are in the report, at the coalface are negligible as yet.

Andrew Radford: While there is a lot of momentum, particularly on the policy side, if we look at what is happening in Norfolk where Averil died, I believe that the situation is as bad now, if not worse than it was in 2012 when Averil died, so much so that the trust providing the service there is currently only accepting referrals for individuals who are triaged as

having a severe eating disorder and are in need of priority treatment. I think that is worse than it was in 2012.

Q7 **Dr Rupa Huq:** Evidence to this inquiry has been mixed on the progress that has been made towards implementing those PHSO recommendations. Can you summarise your view of progress to date?

Dr Nicholls: On the five recommendations, I know that there has been a piece of work around convening an expert reference group to develop commissioning guidance for adult eating disorder services. That work is completed and the report is currently with NHS England awaiting release. That will provide commissioning guidance and a template for commissioners to commission services but obviously it will have resource implications and those resources have currently not been identified. I suspect there is understandable reticence about releasing guidance that it is not currently possible to implement.

The NICE quality standard recommendation was included. I was on the NICE quality guidance committee. That is now one of the recommendations that is in the NICE quality standards. What I am not clear about is what the impetus or leverage is to enforce those quality standards and what expectation there is for services to adhere to those quality standards. It is the standard but as to whether there has been an audit against that standard as yet, I have not seen any evidence of that.

We will probably come on to recommendations about training. I have been party to and there have been a number of conversations with the GMC and with other bodies about the level of influence that we can have over training at medical undergraduate and junior doctor level and in speciality training. Each has a different challenge because there are different systems around each. I am sure you will hear more from the speakers later about that, but at every level there are challenges around how to get eating disorders prioritised against and balanced against the other demands on the curricula. I am not aware of any specific recommendations about eating disorders that have been implemented as yet. There are changes generally to the prominence of mental health across training but that is an ongoing area of challenge.

I do not know very much about what is happening from a workforce perspective. I am trying to remember the recommendations off the top of my head, sorry.

Q8 **Dr Rupa Huq:** That is one and a half, it sounds like.

Dr Nicholls: One is a tick but we do not know if it has had an impact in practice, which is the inclusion in the NICE quality standards. I think the rest are all in progress.

Q9 **Dr Rupa Huq:** One, but we do not know if it is being implemented.

Dr Nicholls: We do not know if it is being implemented.

Q10 **Dr Rupa Huq:** What do BEAT say?

Andrew Radford: The point about NICE is a tick, rapid progress well made. I believe NHS England and Health Education England have responded positively to the report and are taking action. BEAT would like them to move faster. They are probably moving at a reasonable pace given all the other constraints that are there.

We are unhappy with the progress made by the General Medical Council. It seems to have taken it a long time to get going and I have not heard any public statement that it is going to take the action the PHSO recommends it takes. There seems to be a certain amount of deflecting of responsibility going on there and I hope that you will scrutinise that point later. Clearly its mandate has its limits but I feel, when we look at some of the other things the GMC has done in the past, it is pulling back on this issue and it could push harder and take more responsibility.

Q11 **Dr Rupa Huq:** Why has progress not been faster?

Andrew Radford: The recommendation said that the General Medical Council should perform a review of junior doctor training. I would assume that the PHSO report means review the training and then make it good enough. What we want are doctors to exit their student training and then their foundation year training competent and fit for practice so that they can recognise and support people suffering from eating disorders. At the moment, curricula are being approved that are failing those doctors, that are leading them into practice unable to identify an eating disorder or to know what to do about it.

Q12 **Dr Rupa Huq:** Dr Nicholls, you said there are resource implications as to why these five have not come into effect quicker.

Dr Nicholls: One of the recommendations is about parity with child and adolescent eating disorder services but child and adolescent eating disorder services received a £150 million uplift in the Five Year Forward View. Unless similar sorts of funding were ringfenced for adult eating disorders it would be challenging to implement some of the findings. I use the word "ringfenced" cautiously because adult eating disorders tend to operate separately from adult community mental health services. Unless it was specified that there is a need for investment in that area, I think they would tend to miss out on generic adult mental health funding without specific guidance and leverage in that direction.

Q13 **Mr David Jones:** We have received written submissions, including from families of people suffering from eating disorders, that point to a geographical disparity in the availability of specialist services. Where would you say that the services are most lacking and why would you say they are?

Andrew Radford: I do not think we can identify the specific geographies where they are lacking but we can absolutely attest to the postcode lottery approach to it. We have a number of pieces of information.

For example, BEAT made a Freedom of Information request earlier this year into the services provided by adult community eating disorder services. After you adjust it for the different population sizes that the different services support, we found a sevenfold difference in caseload, a ninefold difference in staffing levels and a twelvefold difference between the shortest and longest average wait time. There are huge disparities.

The longer waiting times appear to be experienced in those services that have not rationed the services. Some places are dealing with the low resourcing by setting up barriers to access treatment—which is of course terrible if you are trying to access treatment—and those are then getting shorter wait times, but you have this very great difference in services offered by eating disorder services. Those same results, by the way, also found that just a quarter of adults can access treatment within four weeks of seeking it. The equivalent figure for children and adolescents is over 80%.

Q14 **Mr David Jones:** You say you cannot break that down geographically but given you have the data you just referred to, surely these must point to certain areas of the country.

Andrew Radford: We can definitely break it down geographically; I just do not have the data to mind.

Q15 **Mr David Jones:** In that case, would you be able to supply it to the Committee?

Andrew Radford: Yes.

Q16 **Mr David Jones:** Has there been any change since the PHSO report was published?

Andrew Radford: I do not believe so but I do not think we have taken that data back in time. Therefore, we only have a snapshot of what the situation was on 31 March this year.

Q17 **Mr David Jones:** What sort of steps would you say need to be taken to improve the situation and by which organisations in particular?

Andrew Radford: The one central action that would make the greatest difference to a lot of what we are talking about here would be the adoption of an access and waiting times standard for adult services, backed up by appropriate resourcing, training, data collection and target-setting. If we have that, the services provided to adults with eating disorders would start to follow the trajectory that we have experienced with children and adolescent services, which since 2016 have seen a dramatic increase in access and reduction in waiting times.

Q18 **Mr David Jones:** Would that have to be done on a trust-by-trust basis or is that something that you feel central government should take a lead on?

Andrew Radford: Central government have to take a lead on it because it requires funding and target-setting from the centre. Those targets and that resourcing are cascaded down to the trusts, who take action.

Q19 **Dame Cheryl Gillan:** I am aware of a case where someone with an eating disorder, who was normally resident in the south-east of England, was sent to a facility in Scotland to find treatment. I wondered how often this huge geographical difference occurred. Is this a one-off case of going to Scotland or are there better facilities in Scotland that are accessed by English patients?

Dr Nicholls: There is a distinction between the way that eating disorder services are commissioned on a community versus an in-patient basis. In-patient treatment is commissioned nationally and there is a national process of looking for a bed when somebody is in need of care. A person could end up pretty much anywhere in the country depending on where the need is. That is different from the local provision for eating disorders.

One of the things that is being piloted is called New Ways of Working, linking up the community and the in-patient provision, but at the moment that is in only two areas of the country where the community provider is directly commissioning the in-patient care. I think there is a hope that that gets rolled out again. Seeking in-patient care is very much where there is a bed available and that could be Scotland because there happens to be an eating disorder specialist unit in Scotland. The particular unit you are talking about is pretty much full of English patients.

Q20 **Dame Cheryl Gillan:** Is that happening increasingly with a great deal of frequency?

Dr Nicholls: How many people need in-patient care is directly dependent on the investment in community services. Where there is no community service there will be a greater requirement for in-patient treatment because people cannot be held on an out-patient basis and deteriorate quickly. That is exactly what the investment into children's services was about, to improve community care in order to reduce the need for in-patient care.

Can I add something to the previous question about geographical disparities? I think it addresses both your points to some extent. NHS England did undertake, as part of the work for the PHSO report, a benchmarking exercise for adult eating disorder services. I do not know if you have been made aware of the findings of that but that is not yet in the public domain. That would also tell you where the disparities are.

Q21 **Chair:** That has not been published?

Dr Nicholls: It has not been published. I have seen the draft summary of that and it reflects what Andrew has reported from their FOI request on the disparities, both geographically and in relation to child and

adolescent versus adult. Those data are available, they are just not yet available—

Q22 **Dame Cheryl Gillan:** I presume we have the data available for the number of English patients who are treated in the Scottish unit.

Dr Nicholls: I am sure those data are available.

Andrew Radford: In relation to the in-patient question, part of the problem comes from two particular causes. One is the way that the budgets are allocated. This is being addressed but, again, not quickly enough. At the moment, the budget for in-patient stays is held in a different part from the budget for community work. That creates a financial disincentive for community services to hold people in the community because keeping somebody in an in-patient service means that they will save money. It also creates a disincentive to tackle the importance of early intervention because the sooner somebody receives treatment and the faster that treatment can be provided, the more effective it is likely to be and the more sustainable the recovery is likely to be. It would be good to accelerate the work that is happening at the moment to sort out that budgeting problem.

Q23 **Chair:** That is a very important point for us to understand, isn't it? If people with eating disorders are caught early, it is far more likely they are going to recover and it is far less likely they will develop an ingrained habit of eating disorders.

Andrew Radford: Absolutely, yes. The other piece within that is that there is a form of treatment that is still in the community but it is an intensive day treatment or home-based treatment that has proven to be effective at keeping people out of hospital. It will not keep everybody out of hospital but it gives a very useful step up or step down that can prevent people needing hospital or mean that they can be discharged sooner. It is very effective, at least as effective as in-patient care, and it is enormously cheaper.

PwC did some work for BEAT a few years ago that looked at the cost to the NHS of eating disorders and estimated the total cost at £4.6 billion. Using that data we managed to get the cost of a relatively short in-patient stay and compare it with relatively intensive community treatment provision, and the difference between the two is over £40,000 per patient. The savings available from keeping people out of hospital, even if they are then kept in very intensive community treatment options, are huge. If we can then allocate that saving to helping more people, it seems to be a way of breaking the logjam.

Q24 **Chair:** What is the basis for that figure? Is that based on research?

Andrew Radford: It was research performed by PricewaterhouseCoopers in 2015. I can provide the report.

Chair: Thank you.

Dr Nicholls: The argument for intervention was the basis for investing in child and adolescent eating disorder services but what we now know is that about 50% of new cases onset after the age of 18 and there is no comparable early intervention investment for adults.

Chair: That is exactly what we are coming to next.

Q25 **Eleanor Smith:** Yes, absolutely, because the PHSO described the disparity between the eating disorder services for adults and for children and adolescents and the evidence did suggest that this has not been rectified. What steps do you need to take to ensure that this achieves parity?

Dr Nicholls: I have to reflect on that because it is a big question. The reasons for investing in child and adolescent eating disorders were very clear at the time. We were spending a huge amount of money on in-patient treatment for adolescents at a time when we could and should have been intervening in a home environment with families. The evidence for that was very clear. The evidence in adults was less clear and, therefore, I think there was a strong rationale for investing in child and adolescent services at the time. However, what that has now created is a cliff edge at the age of 18 for people who are trying to access services.

The complexity with adult services is that they include those with new-onset illness—as I have said, there are as many of those as there are in the younger population—but also those who have severe and enduring complex and ongoing needs. Those have a very different sort of burden both financially and on families and patients. Disentangling that in the same sort of way is a much more complex task.

The first step is to recognise those differences across the patient population. The commissioning guidance that you have heard reference to, the expert reference group, does talk about those different needs within it. As Andrew said, there are models for early intervention that have been developed now for adult services and those need active support but not to the detriment of those people who have severe and enduring illness.

Then it is important to recognise that the pressure on adult services is probably about six times that on child and adolescent services. The uplift required in resources is so enormous that it is going to be quite difficult to meet that challenge without significant investment. I am sure you will hear opinions from many people about the best ways of going at that but the very first is raising it to prominence and making people aware of that disparity in care.

Andrew Radford: There might be a case for treating new cases in adults differently from enduring cases because some people have been ill a very long time and obviously adulthood lasts a very long time, but there are nevertheless new cases and I cannot see a reason for treating them differently from the way we treat new cases in children and adolescents.

It also feels like 18 is the wrong time to put in that cliff edge. If we look at what happens with children in care, if you are in care at age 16 you can stay in care, or a version of care, until you are 25. Having a route to avoid the transition out of children and adolescent services and into adult care must be feasible. I understand something is being looked at on that so that you could stay in something that looks a lot like children and adolescent care, if you are already in there before 18, until a certain age. That would avoid the transition problem and that, of course, was one of the major triggers of what happened in Averil Hart's case.

Chair: We should just explain in passing that we are not discussing particularities of the case on which the report is based because the coroner has yet to return a verdict on that and it is technically sub judice. Under our rules, we give precedence to the courts and we do not comment on anything that may be seen to be trying to influence the outcome of a judicial process. That is no disrespect to Averil and her family.

Q26 **Kelvin Hopkins:** The PHSO report identified poor co-ordination of services as "a starkly common issue" and recommended NICE include co-ordination as an element of their new quality standard for eating disorders. Has co-ordination between services in different areas improved as a result of NICE's updated guidance?

Dr Nicholls: As I said earlier to Dr Huq, NICE did include that recommendation in their quality standards. However, to my knowledge there has not been an audit against that standard. Therefore, I do not know the answer to that question directly.

I think there is a particularly ambiguous position about the role of primary care in the care of eating disorder patients and that is a conversation that has taken place as part of the NHS England PHSO delivery group. I am sure that they will update you on that, but I think there are mixed feelings in primary care about the extent to which they can and should be taking responsibility for this patient group and at what point in the patient pathway. That is a fairly major issue that needs to be addressed.

On other aspects of co-ordination of care, there is a document called "MARSIPAN"—I do not know if you have come across that document—which stands for "Management of Really Sick Patients with Anorexia Nervosa", and there is a Junior MARSIPAN version. That is all about co-ordination of care and the need for collaborative partnerships between primary care, acute care, emergency care, psychiatry and other aspects of specialist eating disorder care.

The Faculty of Eating Disorders has just tried to undertake an audit to find out what the implementation of the MARSIPAN recommendations has been across the whole of the UK, not just England. We did not get a fantastic response rate to that but sometimes asking questions raises awareness. At the very least, every medical director in the country will

know about the report now because they have been asked about it, even if they did not respond to the survey. It is a work in progress, I would say. We do not at the moment have good data on how well those recommendations have been implemented. That report is now nearly 10 years old.

Q27 **Kelvin Hopkins:** The enormous disparities in levels of service between different parts of the country that you reported on suggest there is very little communication let alone co-ordination between different areas. Is that fair?

Dr Nicholls: In some areas it is very good. In some areas people have worked really hard to create those sorts of relationships, but it is very much at a personal relationship level, and how much is mandated in a top-down way is still subject to variation.

Q28 **Ronnie Cowan:** We have been told that the majority of doctors receive two hours of training on eating disorders during their 10 to 16 years of training. How does that affect the delivery of NHS eating disorder services in England?

Andrew Radford: I would say it is not the majority of doctors; that is an average. There are a lot of doctors who get nothing. The impact of that is what we have seen in the background to the PHSO report, but it is also GPs failing to identify eating disorders and, therefore, failing to refer people for treatment and those people having delayed access to treatment.

In 2017 BEAT surveyed people who had attempted to get treatment through a GP and half found that their GP did not understand eating disorders and provided poor or very poor care, and a third were not referred for an assessment. NICE says the GP should refer somebody for a specialist assessment and yet they are not being referred for that. All the GP has to do is to turn to the screen on their computer, type "eating disorders" into a particular box and follow the instructions that are on there, yet they are not doing it.

Q29 **Ronnie Cowan:** Why are they not doing that? Are they not seeing eating disorders as an illness?

Andrew Radford: Absolutely. It can only be because they do not recognise eating disorders as an illness or the individual coming into the room is not using the term "eating disorder" and what they are talking about, the symptoms that they are describing, are not being picked up by the GP as something that triggers them to write "eating disorders" into the box on their computer screen.

Q30 **Ronnie Cowan:** What do you think it is?

Andrew Radford: I have no idea. One thing I do know is that we have created a leaflet that we give to people before they go to the GP. They take the leaflet in and there is a tear-off slip that says to the GP, "Why do

you not make a good decision? We know you want to". It instructs them how to follow the instructions on their screen. The GPs are responding really well to it because of course they want to make good decisions but their background and training is preventing them from doing that. They do not have the knowledge and skills to do it.

Dr Nicholls: Part of the problem is that the behaviours that are the hallmark of eating disorders are common and are normalised and in some actually desirable.

Q31 **Ronnie Cowan:** Could you expand on that?

Dr Nicholls: Yes. Dieting and restriction in some populations would be a desired outcome and in others would be a harmful symptom. There is an element of knowing when something is normal and when it is something to be concerned about, and then there is a need to directly ask about specific symptoms because unless they are directly asked about they will not be elicited.

It is quite common, for example, for a GP to notice somebody's weight status and to be concerned if they are underweight but they are very unlikely to ask about eating disorder symptoms in somebody who is normal weight or high weight. If somebody who was high weight reported restricting that might be approved of rather than a concern. You would need to know about eating disorders to know to ask whether that then leads to binge eating behaviour. That is one of the issues, that some of the behaviours border on both normal behaviours and desirable behaviours in certain populations. That is one of the things that needs unpicking.

For me, one of the issues is that eating disorders is a minority speciality even within mental health and mental health is underrepresented relative to physical health across training generally for doctors. It is a minority within a minority. However, there are opportunities for improving education around eating disorders in, for example, training on nutrition, obesity and malnutrition. If you look at the training materials that address those issues, which are a significantly larger proportion of the medical training, you will not find mention of eating disorders even though they are very commonly co-morbid.

If you just look at it from a subspeciality mental health perspective it will be very difficult to argue in a balanced way that it requires a higher profile apart from in the areas where there is none, but if you look at it across the spectrum about places where eating disorders might present and ways that it might present—I think somebody mentioned earlier it is likely to present to other specialities and not to mental health specialities—there are opportunities for improving awareness of eating disorders across the medical curriculum.

Q32 **Chair:** How many diabetics are being treated for diabetes when they really have an eating disorder?

Dr Nicholls: There is a challenge around cause and effect there but I think it is estimated that about 30% of people with diabetes have significant disordered eating behaviour. Whether it meets full diagnostic criteria for an eating disorder is a slightly moot point.

Q33 **Chair:** We keep being told there is an obesity crisis afflicting the National Health Service. Why is there not more being done to encourage GPs to recognise when somebody is overweight because they have a disorder?

Dr Nicholls: About 25% of people with obesity have binge eating disorder. It is not looked for at the moment.

Q34 **Chair:** It is even a taboo issue for a GP to say, "You are overweight", or, "You must do something about your weight". I have talked to GPs in my constituency about this. It does not come naturally to the general practice profession.

Andrew Radford: I would add on binge eating disorder that BEAT runs a helpline. We had about 30,000 people call us last year and very commonly they are calling us because they are suffering from binge eating disorder. Generally speaking, we encourage people to go to their GP and get a referral for specialist assessment, but we know that anyone with binge eating is unlikely to get a referral for an assessment and they will have to fight and fight and fight to get that referral. Then when they get that referral—and sometimes it has taken them two years to get to the point of getting an assessment—what they get is the standard treatment, which is NICE recommended, which is a self-help book and, if they are lucky, some guidance from a professional through using that self-help book. It takes them two years to get prescribed something that they can get on Amazon for about £10.

Q35 **Ronnie Cowan:** We have touched on this earlier but while I have you here in front of me, Dr Nicholls, I want to glean some knowledge from you. We have the Minister in front of us later on and I want to ask her this same question. The Royal College of Psychiatrists developed the MARSIPAN guidelines. The Scottish-specific guidance is that the MARSIPAN guidelines will be incorporated. Is that not happening in NHS England?

Dr Nicholls: It is. It is incorporated into the NICE guidelines now. That is happening. Eating disorder services are all using the MARSIPAN guidance. Where I think it is less clear is whether emergency medicine, acute trusts and primary care are also following that MARSIPAN guidance. It is embedded in all the best practice guidelines. Its reach, penetration and impact outside the speciality is the issue.

Q36 **Ronnie Cowan:** We are always looking for good practice and saying, "It is being done there. That is how you do it", as an example. Has this been taken up well in England?

Dr Nicholls: Yes. For example, our current MARSIPAN lead is based in Leeds. It is one of the areas of New Models of Care so there is a joined-

up community day patient and in-patient service and a good MARSIPAN network. That is one example that I am aware of.

Q37 **Ronnie Cowan:** That is a working model that you approve of, which other trusts could look at and say, "That is how it is done"?

Dr Nicholls: Absolutely.

Q38 **Mr Marcus Fysh:** Dr Nicholls, you mentioned earlier the degree to which different specialities are touched by eating disorders but because they are not the priority within that particular specialty they maybe do not get the attention that they need. In your evidence to the Committee you highlighted the need for cross-college work to ensure better primary care for eating disorders. What outcomes and what practical steps can be taken and would you like to see from such work?

Dr Nicholls: I would very much like to know what the mechanisms are for effective cross-college working. That is what I am currently struggling with. I have only a few months left in my role as chair but it has been one of the things I have been trying to find my way through for the last year. The approach we have taken from the faculty is to write a position paper based on the recommendations of the PHSO report. That needs to be endorsed internally by the college first and that is pretty much done and dusted, but then I am assuming that the best mechanism is for the Academy of Medical Royal Colleges to take that for cross-college dialogue and engagement around the recommendations. If there are other effective mechanisms that people are aware of, we would be very open to that dialogue.

Q39 **Mr David Jones:** Pursuing that, how would you propose to work with other interested parties towards ensuring that all medical practitioners are equipped with the necessary knowledge and skills to be able to deal with people who are suffering with eating disorders?

Dr Nicholls: As I think you have gathered, there are different needs at different levels of specialty. The analogy that Andrew and I often use is that everybody needs to know how to do basic resuscitation but only intensivists need to know how to manage that at the highest speciality level. The faculty has written a document recommending different levels of knowledge across different levels of training but the systems around training are different at different levels of speciality.

I think the very least is to have some expectations around knowledge and care and some understanding about the role of primary care, as I think I referred to. The training needs you have will differ depending on what you understand your role to be. The role of a general practitioner in early identification is going to be quite different from their role in the management of somebody with a severe, enduring illness, for example.

That is the first step, understanding what the need is, and then looking at the opportunities in the curriculum for addressing that. For example, I looked on the Royal College of GPs' curriculum. If you look for eating

disorders you will find it, but if you look at malnutrition there is no mention of anorexia nervosa as a cause of malnutrition, and if you look at obesity there is no mention of binge eating as a cause of and a relationship with obesity, and so on. There are a lot of missed opportunities for bringing eating disorders into the training. That is just one example. I have not had the same conversation with the physicians yet.

Q40 **Mr David Jones:** Who should be taking the lead in bringing this process together?

Dr Nicholls: As I said, to my knowledge the Academy of Medical Royal Colleges is the place where cross-college work happens. I do not know if there are other mechanisms for colleges to collaborate with one another. I know there has recently been a very effective piece of work around physical health and serious mental illness but because anorexia nervosa is not classified as a serious mental illness it was not mentioned in that document. There are precedents for cross-college working. Whether we need one specifically around eating disorders—that would certainly be a way forward. That is the sort of recommendation I would hope might come out of an Academy of Medical Royal Colleges conversation.

Q41 **Mr David Jones:** Mr Radford?

Andrew Radford: I would argue that there should be greater scrutiny of the role of the General Medical Council in the co-ordination of this area. I appreciate that its mandate only goes so far but it has a responsibility for approving curricula and for ensuring that doctors are fit for practice, including on mental health conditions. That means that it is approving curricula and saying that those curricula are good enough to train doctors to recognise and treat mental health conditions. Yet we know that huge numbers of doctors are leaving their training unable to identify eating disorders. That means it is approving curricula that are not doing their jobs properly.

Presumably, if it has the responsibility for approving curricula, it has the opportunity not to approve them. I do not know whether it ever does not approve them—maybe you would like to ask them—but there seems to be an opportunity for the General Medical Council to step up and lead on this. I would love it if it did and I am not hearing that it is going to.

Q42 **Eleanor Smith:** I am going to ask the question: what changes are you making to your specialist curriculum?

Dr Nicholls: As I was saying earlier, eating disorders is a small speciality even within psychiatry. Obviously psychiatry is not the only profession involved in the care of people with eating disorders. That is another, broader issue and you may want to talk to Health Education England about training the wider workforce.

Within psychiatry, there is currently a curriculum review happening, but there are, as ever, a thousand competing demands on that curriculum

and in fact the size of the curriculum is being reduced rather than increased. As somebody from the GMC said earlier, nobody ever wants to take a question out of a curriculum, they only ever want to add another one in. We are struggling to get another one in at the moment because we are a minority voice in that dialogue. We are repeatedly making recommendations about what the need is and what the problem is, referring to the recommendations and so on, but I cannot yet say to you that this has resulted in concrete changes to the curriculum.

Q43 **Eleanor Smith:** The question I was going to ask was: how do you measure the impact of the changes? You cannot do that.

Dr Nicholls: We do not even have changes in yet. The curriculum is still under review. We are lobbying as hard as we can.

Q44 **Eleanor Smith:** Another question I was going to ask was: when these changes are implemented, how do you ensure they are taught properly? But if you are saying you cannot even get them—

Dr Nicholls: I think that is a question for the GMC. Even though medical schools determine their own curricula and there is a degree of serendipity in terms of whether somebody in a medical school happens to have the knowledge and expertise to teach well on a particular topic, particularly given that there are not that many of us, I think the GMC is in a position to answer questions like that.

Chair: Thank you very much indeed. That has been very useful to us. We are most grateful to you.

Examination of witnesses

Professor Lisa Bayliss-Pratt and Dr Colin Melville.

Q45 **Chair:** Can you introduce yourselves for the record, please?

Professor Bayliss-Pratt: Good morning. My name is Lisa Bayliss-Pratt and I am the Chief Nurse at Health Education England and the senior responsible officer for mental health in Health Education England.

Dr Melville: Good morning, everyone. My name is Professor Colin Melville. I am the Medical Director and Director of Education Standards at the GMC. I am a registrant. I was previously a clinician in intensive care medicine until I joined the GMC.

Chair: Thank you for being with us. We are now about five minutes behind so we will rattle on as quickly as possible and, if I can just repeat, we will ask short questions if you can give us crisp answers. We will get to the points that have been raised in the previous panel about the role of the GMC, so do not feel you need to jump in on that point in anticipation.

Q46 **Dame Cheryl Gillan:** A simple question: what was the reaction to the PHSO report in your respective organisations, what steps have you taken in response to the report and how far have you got in implementing its

recommendations?

Dr Melville: It is a very tragic background, as has been alluded to. We are very clear in welcoming the report and it is clearly an important issue. We faced a small dilemma in the drafting of the recommendation that was attached to us, partly because our powers as described in the Medical Act do not quite allow us to do what was required. However, we have taken a number of actions, including meeting NHS England in a meeting chaired by Tim Kendall. He will no doubt update you on that. We have held a parliamentary roundtable with various people, including some of the people who are here today. We have also written to all the medical schools to understand better what their curriculum is, even though we cannot directly tell them what to teach.

Professor Bayliss-Pratt: From Health Education England's perspective, we are very active partners in all that has just been mentioned. We have been part of all of those conversations and discussions. In addition to this work, we are looking at competency frameworks for the wider workforce to understand how we can skill up and ensure many more people are aware of the signs and symptoms of eating disorders and how they can be appropriately educated in training to respond.

Q47 **Dame Cheryl Gillan:** Are you confident that you have the right strategy for implementation following this report or do you think that your strategy needs revisiting and adjusting?

Professor Bayliss-Pratt: No one organisation holds all the levers to change the situation around but we are quite clear that we need to work with partners right from the undergraduate curricula of all the professions through to post-qualifying programmes to ensure that we have a golden thread for eating disorders in everything that we do. That is from trying to ensure that people have exposure to eating disorders as part of undergraduate training, that there are opportunities for credentialing across the professions, and that we are clear that we continue to improve the education and training so that this situation never happens again.

Q48 **Dame Cheryl Gillan:** Has everybody bought into the strategy in a positive fashion or do you have any criticisms?

Professor Bayliss-Pratt: I think everybody has absolutely bought into it. The size of the challenge and the unmet need out there is something that is coming to the fore all the time. We need to continually work and refine our education and training programmes to make sure that people are fit for purpose and fit to care for the communities in which they work.

Q49 **Dame Cheryl Gillan:** Dr Melville, do you share that view?

Dr Melville: Yes. As has been alluded to by the previous panel, the solution does not lie with one organisation and therefore it is about working together. The report has highlighted assumptions that we have in society, and that has shifted, which in itself has altered the profile of

disease. That has not necessarily been reflected in real time in changes to curricula delivery or practice on the ground.

It does occur to me slightly that it is easy to label someone, if I can use that phrase, as having an eating disorder retrospectively. The challenge is in recognising the person who does not present with an eating disorder but has to be recognised as having one. That was something that came out very starkly to me when I met a medical student and a trainee doctor who told me their own stories and their view when they now meet patients and they can see this. The challenge in the curricula delivery is helping to make people aware of the fact that people do not turn up saying, "I think I have this". That does make it quite challenging and it cuts across what I think we would call physical health and mental health. It is not confined into one space or the other. That is where much of our challenge lies.

Q50 **Ronnie Cowan:** Dr Melville, in your opening remarks you said you welcomed this report but you were in the room to hear Mr Radford say that he was unhappy that the GMC was deflecting responsibility from the recommendations. Do you accept that criticism or observation?

Dr Melville: I absolutely accept and recognise that there is a need for change and I think we have acknowledged that, but I have to respectfully disagree with Andrew. I have sought a meeting with him. We have not been successful in arranging that. I would still welcome the opportunity to discuss it with him.

Our challenge lies in the way that the Medical Act is written and where our powers lie. Our powers are to approve the outcomes for graduates as access to the register to practise medicine in the UK, but the regulator for universities, and therefore medical schools, is the Office for Students and they have a different set of powers from us.

In postgraduate, as has been alluded to, we approve curricula, but I think it is fair to say—this is a complicated area and I am going to try to put it succinctly—that we do not have representatives of every medical disease area in approving our curricula. We depend on working through the academy and with the colleges to look at how they have devised their curricula. We then approve curricula, provided they take into account the information they are receiving from various stakeholders. In this context that would include both the public and representative bodies. That is where our difficulty lies.

In March 2017, one of the first pieces that I took to our council was a document called "Adapting for the Future" in which we called on colleges to work more collaboratively to explore where areas of their curricula were in common with other colleges and to develop those curricula in common. That is still a work in progress. All the curricula have to be revised and reapproved by the end of 2021.

Q51 **Ronnie Cowan:** A study in *The BMJ* from 2018 showed that medical

training on eating disorders is less than two hours in medical school and that postgraduate training adds little more, with the exception of child and adolescent psychiatry. We have also heard that GPs felt they did not receive adequate training. What are you doing to remedy these situations?

Dr Melville: That is back to where our powers lie. We absolutely accept, as I summarised at the roundtable we had, that the way in which people teach tends to be siloed to their specialty. If you are an expert in schizophrenia and you have students or trainees, you are more likely to teach that rather than the whole curriculum. There is something about what happens on the ground. We have written to medical schools. Of those who have replied to us, one of the most telling things was that they said that between 25% and 40% of their students would not ever have the opportunity to meet a patient with an eating disorder but that they recognise the need to make sure that students were aware of eating disorders.

Q52 **Ronnie Cowan:** Why?

Dr Melville: It is about marrying up opportunities for students or doctors to meet patients who have a particular disease.

Q53 **Ronnie Cowan:** Surely there is something in the curriculum that says, "We are going to teach people about eating disorders", and you take a month or six months and that is what you focus on during that time. That is a priority. It is about prioritising what is most important.

Dr Melville: As our colleague previously said, one of our challenges is that lots of people want more in the curriculum and no one has offered to take something out. This is about understanding the balance and the shift. The prevalence, as we have heard, of eating disorders is now higher than schizophrenia, so a question for me would have to be that the balance of teaching should reflect that change. Of course it is the case that time allocated does not necessarily equal quality of learning.

It is also the case, bearing in mind the complexity of this and the fact that patients do not only present in a mental health context, that it is about making sure that the signposting of what is being taught exists. We know that for both trainees and medical students, if you do not signpost and say, "I am teaching you this", they do not always recognise it. It is a very complicated picture.

I am not demeaning or diminishing the findings of the report. I think the challenge is how do we change it in a meaningful way so that someone who, for example, is doing surgery and sees a patient who might have an eating disorder, recognises it there and does not assume, "This is surgery so I am learning surgery". That is where some of the challenges lie.

Q54 **Ronnie Cowan:** Do you have any solutions?

Dr Melville: As I said, we have written to medical schools. We can now go back to them, once we have heard from them all, and talk about where we think some of those changes are. We can work in partnership with the Royal College of Psychiatrists and its eating disorders faculty. We have indicated that we would be keen to help it support the development of curricula content across all the colleges. Ultimately, we need the colleges to accept that they are willing to allow that.

Q55 **Ronnie Cowan:** We have been doing this since what, 2010?

Dr Melville: Been doing this?

Ronnie Cowan: The GMC has been responsible for professional values, knowledge, skills and behaviour since 2010.

Dr Melville: Yes.

Q56 **Ronnie Cowan:** Are we no further down the road? Have we learned nothing? Have we improved nothing?

Dr Melville: I think we have improved quite a lot of things but this is how things have changed over time. I do not know what the figures were in 2010 but they probably were not as they are now. This has become a much more prominent issue in our understanding and probably in prevalence. That is to my point that because disease changes and the demographics of disease change over time, we need to make sure the educational processes change over time. We do not hold that data. Therefore we cannot directly make that change.

Q57 **Ronnie Cowan:** If not you, then who?

Professor Bayliss-Pratt: From Health Education England's perspective, in partnership with others because, as we have said, nobody holds all the levers to this situation, we are in discussion with the Royal College of General Practitioners to explore how we can create placements within specialist mental health services to expose trainees to a wider range of mental health conditions and patients. We are also looking at integrated training placements whereby GP specialty trainees are based in a GP practice with regular commitment to the psychiatric service within that local community. We are also looking to see where we can align exposure to specialist psychiatric services with other placements providing opportunities within the children's mental health services. We are trying to create placements and pathways for the medical professionals to get exposure to people with eating disorders and learn from those people who are at the front line creating the care pathways, the treatment plans and approaches.

The other important thing to recognise is that it is not just about the medical profession, it is about the wider workforce. For example, we are just piloting an education mental health practitioner role that works between mental health services, primary care services and schools, because we think it is really important to get to children and young

people and to spot people who are identifying these problems early. It is about that wider workforce at the moment and we are currently exploring how we create a more professional competency framework to ensure we get this education and training into everybody who comes into contact with people who require health and care services, including school nurses, health visitors and the whole public health agenda too.

Chair: That was quite a long answer. Sorry to point that out.

Professor Bayliss-Pratt: Sorry.

Q58 **Ronnie Cowan:** It is just my continued frustration, which I hope you understand. We continually seem to be looking at the problems and never coming up with solutions to them. We have bodies, organisations, reports, structures, and letters go back and forth, but at the end of the day there are patients out there reporting to GPs today and those GPs are still none the wiser in identifying a serious illness. Are we getting any better at it? Can you measure that progress?

Professor Bayliss-Pratt: I think at present it is very difficult to measure that progress, but I am sure when you talk to colleagues from NHS England shortly, they will talk about access and waiting times and standards that are being established to help us get to that place.

Chair: We will ask them. Thank you.

Q59 **Mr David Jones:** Dr Melville, in response to Mr Cowan you pointed out that the GMC was unable to implement the PHSO's recommendations because of a lack of appropriate powers. Could you explain what powers you need, because, of course, you are in an important position as a statutory regulator?

Dr Melville: Yes. I think we need to recognise that in undergraduate medical education, because that sits within the universities, it falls under the regulator, the Office for Students, as I alluded to before. It is for Parliament or Government to determine whether it is in the public interest to change where those powers lie, but the risk is that we hive off one part of undergraduate education and then there is nursing, pharmacy, social work and other areas of professional development that also have degree qualifications. We work very closely with the Medical Schools Council and with medical schools. I was very pleased to see the speed with which medical schools responded to our question.

We have some other actions at the moment, including the introduction of the medical licensing assessment, which give us opportunities to influence and change the way medical schools deliver curricula. In our "Outcomes for graduates" that we published last year, we emphasised the need to shift the balance of education so that there is a greater reflection of health promotion, mental health and care in community settings, particularly including general practice. We are driving some of those changes through our requirements for the outcomes, but the regulatory question is not one for us to address.

Q60 **Mr David Jones:** No, but you can express an opinion as to how the position could be improved. You mentioned that you are able to exert influence, but that is somewhat different from actually having powers to exercise. Do you feel that in this particular case you should have such powers, or at least there should be overarching powers that reside in a particular place, which does not appear to be the case at the moment?

Dr Melville: My opinion is that we need to be careful of what the consequences of any shift for medicine would be in terms of in other areas. We have a very constructive relationship with the Medical Schools Council and medical schools. I am very hopeful that the work we have done in this area, and some other changes on the "Outcomes for graduates", which were developed in partnership with them, will help to shift that. In HEE's recent allocation of 1,000 extra medical student places, it prioritised schools that were going to deliver more prominence for mental health and primary care. We have other drivers and other levers we can use to get us where we need to be. It could create quite a complicated position if we were to move the regulation of medical students away from the Office for Students but leave other professional areas there.

Q61 **Dr Rupa Huq:** Dr Melville, the GMC told us in written evidence that it is challenging to get a clear picture of the extent of training in the undergraduate curricula. What steps are you taking to address this, recognise it or whatever?

Dr Melville: Sorry, I have probably partly answered these questions. On the specific issue of eating disorders and mental health, we have written to all the medical schools. I think we have about half of the responses back already. It is, perhaps unsurprisingly, quite a mixed picture, partly because medical schools are proud of what they regard as their unique curricula. What we say is that they must meet a common set of outcomes. Those are necessarily at a very high level. They do not dictate specific disease states but they would be expected to cover in the round the proportion of things that people are seeing. Eating disorders should take a higher priority, and that is what our letter to them has alerted them to, that here is something that is changing in front of us, it is probably under-reported, for the reasons that we have already talked about, and, therefore, should have greater prominence. I am happy, perhaps once we have all that together, to provide a summary of those findings and our actions, if the Committee would like to see that.

Q62 **Dr Rupa Huq:** And the plans to share best practice with other royal colleges—does their pride stop them doing that as well?

Dr Melville: Royal colleges are postgraduate, but in the context of any part of our education QA, it is one of the questions that I have been asking the team to look at. We are currently reviewing our quality assurance process for the whole of medical education. We tend to focus on where failings occur, but it is also important that we identify good practice and share it. We do publish that, but I suspect the only people

who read these reports are the people about whom the report is written. We want to take more positive pro-action in sharing good practice to ensure that it is shared. We have heard of some good practice in this area already.

Professor Bayliss-Pratt: I would like to add that from the undergraduate expansion, which Dr Melville just mentioned, with the additional 1,000 medical trainee posts, Health Education England will invest in a post that will be working very closely with the undergraduate medical schools across the country to make sure they prioritise psychiatry and general practice, but also that sharing of best practice and networking, so that we do get the training in the right place moving forward.

Q63 **Eleanor Smith:** This is about the outcomes, skills and professional knowledge that you expect medical undergraduate students to achieve. How do you assess whether this has been achieved, particularly for eating disorders?

Dr Melville: We have a quality assurance process. We have an annual return questionnaire that we ask medical schools to complete, so that is self-reported. Up until December 2018 we had a cycle of visits and we visited every region. Necessarily, they are only samples when you take into account the number of medical schools, the number of places in which postgraduate training is delivered, and they tend to focus on the document that we call "Promoting Excellence". It is about how is the environment for the delivering of education rather than the extent to which the detail of the curricula is covered. In postgraduate, it tends to fall to colleges to look at the curricula through their college representatives.

Q64 **Chair:** I will press for clarity on this. Do you think medical schools are doing enough to teach about eating disorders?

Dr Melville: Given the evidence of the PHSO report—

Q65 **Chair:** That is a yes?

Dr Melville: Absolutely it is a yes. Yes.

Q66 **Chair:** What have you done to inform medical schools that teaching in this area is insufficient?

Dr Melville: That is why we have sent this questionnaire out to the schools, in order to understand what they are doing now.

Q67 **Chair:** Then you will go to them? How many hours do you think should be taught on eating disorders?

Dr Melville: With respect, Sir Bernard, you know as well as I do that hours does not equate to quality. There is a dilemma here. I suspect that if you ask the question, "What is on eating disorders?" that will be passed

to the mental health team, who will look at their bit, but we do not know where it situates in other parts. It is a much broader question.

Q68 **Chair:** How will you arrive at a consensus that you will be able to authoritatively press upon medical schools?

Dr Melville: In our questionnaire we have asked, "Where across the breadth of your curriculum, not just in psychiatry?" We are looking at, for example, "What are you teaching in the domain of physiology? What are you teaching in the domain of medicine, in psychiatry—which we just covered—and in general practice?" so that it is seen across all the curricula domains and that it is linked together. As we said before, patients do not present with eating disorders. Often you have to discern that that might be the issue.

Q69 **Chair:** Are you doing what PHSO recommended you should do?

Dr Melville: I would say it is what we can do. I suspect the Chief Executive of BEAT might have different views. He has expressed that. We are seeking to establish change. One of the things I have been saying is that I do not think we understand the interaction between physical and mental health. That came out very strongly in the roundtable conversation. That was a moment for me when I realised that I am not confident that we collectively understand how disease profiles change over time. Given that curricula are often signed off at a moment in time and then delivered over a period, it seems to me that it is possible that what has happened is the circumstances of the situation have changed but the education has not kept up with it. They are meeting the curriculum but they are not meeting the patient needs.

That is where we need to shift. The question to colleges and medical schools is to make sure that the way we train doctors aligns with the current and future health needs, not the one that is in the curriculum that we signed off some years ago.

Q70 **Chair:** Without making any judgment about why a meeting with BEAT has not happened, it would seem to be a productive meeting to have.

Dr Melville: I absolutely agree. I found it very helpful to meet the medical student and the doctor. It gave me a completely different, very personal insight that helped connect the fact that this is not just a mental health problem. It needs to be seen as a health problem across the spectrum.

Q71 **Kelvin Hopkins:** What do your respective organisations do to check whether specific areas of medicine get sufficient attention in practitioners' guidance or from training providers?

Dr Melville: In the context of curricula, we ask help from others in saying, "Is what is in the curriculum the right content?" We do not have the professional medical expertise to make those sorts of judgments. Here we have been alerted to a very specific area of practice, and we are

approached from time to time on other areas of practice, and so we can in this case go out and seek specific supplementary information. Could we be more proactive? It would be good if we could. I have not worked out how we would know how to be proactive. What is the problem coming up in three years' time, and could we ask about it now? I am not sure that is easy to do. In this context, we have been active in following through what has happened.

Q72 **Kelvin Hopkins:** You have said it, but practitioners' guidance would be available, I would have thought. The curricula from training providers would be available, wouldn't they?

Dr Melville: We have reviewed that, and I think that comment was made earlier. We had a look at the postgraduate curricula, looking for evidence around eating disorders in the broadest setting, not just specifically in the mental health area. I should highlight that these are curricula that are currently up for review. We can clearly pick it up in the review. Each of the curricula for general medicine, emergency medicine, psychiatry, paediatrics, and general practice has different content when it comes to eating disorders. That does not seem to be a very good solution. I am keen to work with the faculty and the college and the other colleges to say, "We need to make sure that we are all doing the same thing". That is a good starting point. What happens on the ground is more in the domain of the education providers and HEE.

Q73 **Kelvin Hopkins:** In doing such research for both of you, is there a resource constraint on you? Is that a problem?

Dr Melville: We could always do with more resource.

Professor Bayliss-Pratt: I do not think there is specifically a resource-constraint problem, to be quite honest with you. It is about making sure, as we have heard throughout this morning, that we are all completely aligned, that we are maximising all the opportunities that there are, and that we are doing the checks and balances to make sure that our professions are fit for practice at the point of registration and completing of their training.

Q74 **Chair:** I suspect it is about bandwidth rather than resources.

Professor Bayliss-Pratt: Where the focus is.

Chair: This report and this session underlines that PHSO and this Committee thinks it should be a priority.

Q75 **Mr Marcus Fysh:** I want to ask Professor Bayliss-Pratt a question first. You mentioned earlier some of the work that you are doing to expand the awareness and the training on eating disorders into the rest of the community, such as schools and so on. In my area, the schools report regularly that they feel under-resourced in their ability to deal with some of the mental health issues that are coming through the younger population. To what extent is the work that you have been doing with the

National Whole Team Training relevant to that? What plans do you have to expand the way you have been dealing with that younger cohort to dealing in a similar way with adult eating disorders?

Professor Bayliss-Pratt: We are currently undertaking the project that reports in June. However, as I said earlier, without repeating myself, it is looking across all the pathways to see where the touchpoints are with the professionals and what education and training they need. That will report in June, for which we have a more planned approach as to what the next steps are. We are very positive about the educational mental health practitioner programme and this concept of having a mental health worker who works across a system with primary care, schools and the mental health services. That is being tested at the moment and it seems to be a very productive way of reaching out. We are in the foothills of this in understanding what is the medium to long-term plan, but we absolutely know that working across the system and having a flexible and diverse workforce is really important in reaching the number of people that we need to in the mental health agenda, per se.

Q76 **Mr Marcus Fysh:** Will that work, which is essentially on new models, be reported into the PHSO delivery group and that sort of thing? What are the practical ways in which the work that you are saying will report in June will then be acted on?

Professor Bayliss-Pratt: Yes, absolutely. We are working with the system. We have the group established that ensures that the findings do get fed into that work, and then that work is taken forward. It also links with the long-term plan work that we have been undertaking and the priority there now is across the system around improving mental health services for all ages. There is that movement that is occurring and the priority is ramping up all the time. We are building our knowledge, our expertise and the training tools and requirements so that we have the people doing the things they need to do to prevent this awful situation from ever happening again.

Q77 **Mr Marcus Fysh:** On the timescales for that, we hear a lot about the extra £2.3 billion that will be available for mental health services nationally by 2023 or 2024. Is that going to be sufficient to deliver rollout of those new models that you are talking about within the long-term plan that you mentioned, or will more resources be needed in addition?

Professor Bayliss-Pratt: I would not like to say yes or no to that, but we do have increased investment, we have mental health as a priority and we have a national director, Claire Murdoch, who we work with very closely on the whole mental health, long-term plan agenda. We are highly committed to making sure that the investment gets into mental health services so that we can increase the workforce and invest in the existing workforce so that they are appropriately skilled. We are building the expertise, and we are starting to really understand the need and how we can address this need with a diverse, flexible workforce. That is the model that we are working to.

Q78 **Mr David Jones:** BEAT has suggested to us that all junior doctors should undertake a four-month psychiatry placement, which would include, of course, eating disorders. Do you think that is a good idea and, if so, how would it be brought about?

Professor Bayliss-Pratt: It is very difficult to say. Everybody needs a set amount of time in particular training environments. What we are trying to do is optimise the training environments that we have because, as we know, people with eating disorders do not always present within mental health settings. They present in general practice, accident and emergency settings and schools, just to mention a few. It is important that we have a flexible, responsive training circuit for junior doctors so that they can be in a variety of settings, get exposure to these issues and be trained and supported appropriately. The fear is that if we just put everybody into a four-month training pathway would we achieve what we really want to with this agenda? Again, we need to work with our partners to really test that a lot more to see if that is the optimum way forward.

Q79 **Mr David Jones:** Your mind is open to that at the moment?

Professor Bayliss-Pratt: It is absolutely open, but I do not think it is the only way to sort this. That is the work that we need to continue to undertake to better understand how we really do this in a meaningful way.

Q80 **Mr David Jones:** How long do you think that will take?

Professor Bayliss-Pratt: Obviously the agendas are very big now. We have talked about the profile of mental health and the need for parity of esteem, and we are continually working with colleagues on that agenda. I would say that within the next 12 months or so we will have a really good idea of whether we think that is the optimum way to ensure that junior doctors are appropriately trained in this or whether there is a better, more flexible way in which to achieve the same outcome.

Q81 **Mr David Jones:** How would you say it is possible to increase the number of specialist training posts?

Professor Bayliss-Pratt: There is work that we need to do. We are continually reviewing where the specialist posts are and where the resources are in which to support trainees going into these positions. However, that is something we need to do working with colleagues across the system.

Q82 **Mr David Jones:** As Mr Fysh has pointed out, resources are increasing. Presumably they will be available to you.

Professor Bayliss-Pratt: Yes.

Q83 **Mr David Jones:** Do you think that more specialist training posts are needed?

Professor Bayliss-Pratt: I think there is a requirement to explore the specialist training posts but it is important to make sure that we embrace the wider workforce, because this is not just a doctors' issue. It is about ensuring the whole workforce is appropriately equipped to deal with eating disorders, which does not necessarily mean just increasing speciality places for doctors.

Dr Melville: On the foundation training, I used to be a foundation school director once in my past. I think the key bit in this is what the curriculum in foundation says, and the curriculum for foundation helpfully has some very specific comments around eating disorders. Whether or not an individual doctor has a placement in a psychiatry setting should not alter the fact that across the whole of their two-year period they should be able to deliver and achieve all the outcomes set out in the curriculum. Clearly each individual will have a different mix of six different opportunities but they should all meet a common end point. If they do not have mental health as a specific setting, it could come up in general practice, or it might come up in community paediatrics.

There are other ways of delivering the outcome without having to say they must do mental health. HEE and others have increased the number of placement opportunities for foundation doctors, which is a helpful and important part, in the same way as they have for general practice. Those two shifts are really quite welcome.

Q84 **Dr Rupa Huq:** I have a question for Professor Bayliss-Pratt about the Management of Really Sick Patients with Anorexia Nervosa, MARSIPAN. That is the best acronym since Culture Representation and Politics. The Royal College of Psychiatrists has suggested that there is an urgent need to accelerate the uptake of the guidance. What steps is Health Education England taking, in partnership with the royal colleges, NHS England and others, to improve the implementation of the MARSIPAN guidance at acute hospitals?

Professor Bayliss-Pratt: We are very much around that table and we are very much engaged in understanding how you make sure that this guidance gets into practice, that it is used appropriately and that trainers have the right support in utilising this new protocol. Yes, we are very much engaged within that work.

Q85 **Dr Rupa Huq:** Is there a concrete timetable or timescale for the steps?

Professor Bayliss-Pratt: I do not think we have a concrete timetable to say, "By this point every trainee will have done X, Y and Z in relation to this protocol". However, ensuring that they are aware of it, that they are engaged, that it is part of the treatment plan and that the option is there for the junior doctors is something that I would say is happening all the time.

Q86 **Dr Rupa Huq:** Meetings between all the partners?

Professor Bayliss-Pratt: Yes.

Q87 **Eleanor Smith:** I think we touched on it slightly, but this is to you, Professor. The PHSO's report recommended that you look at having future workforce planning that might support an increase in the provision of specialists in this field. What are you doing to implement that?

Professor Bayliss-Pratt: We are scoping. We are still scoping that work around where the services are, where the expansion is and then how we make sure we get trainees into these places so that they are able to be effective and have successful roles within those environments.

Q88 **Eleanor Smith:** Scoping is what you are doing at this moment? You are going out and putting it out there?

Professor Bayliss-Pratt: Yes, and exploring where these speciality posts are, where the provision is and who will deliver that provision to make sure that we have the pipeline of doctors ready to go into these positions as the services develop.

Q89 **Chair:** How old is MARSIPAN?

Professor Bayliss-Pratt: I do not know.

Dr Melville: Crikey, I have no idea.

Q90 **Chair:** I am advised 10 years old. If they are still not being implemented, that does not give us much confidence. What would give us confidence that something is going to change as a result of the MARSIPAN guidelines?

Professor Bayliss-Pratt: I would have to defer that to Professor Tim Kendall, my colleague who you are going to speak to shortly. I am sure he will probably have some answers to that.

Q91 **Chair:** Do you share our frustration?

Professor Bayliss-Pratt: Yes. Absolutely.

Q92 **Chair:** Thank you. You have been very helpful. Thank you very much indeed.

Examination of witnesses

Jackie Doyle-Price MP and Professor Tim Kendall.

Q93 **Chair:** Good morning, and thank you both. We have had two very interesting panels so far. Could you identify yourself for the record, please?

Jackie Doyle-Price: I am Jackie Doyle-Price. I am the Minister for Mental Health, Inequality and Suicide Prevention.

Professor Kendall: My name is Professor Tim Kendall. I am the National Clinical Director for Mental Health, NHS England and NHS Improvement.

Q94 **Mr Marcus Fysh:** There are many young people and older people

throughout the country who are having tremendous issues with their mental health and with eating disorders. We have before us an important report that we think has made some very helpful recommendations. There are constant examples in our constituencies of people finding it difficult to get access to the right services at the right time. Stepping up and stepping down from acute services is a real problem. I want to ask you at the outset: who do you think is responsible? What responsibility do you have for making sure that the recommendations in this report are implemented to address these issues?

Jackie Doyle-Price: The recommendations are sitting with various aspects of the system but ultimately, as the Minister, it is my job to make sure that everyone steps up to the plate. I am happy to take on that challenge. The report goes into some depth about horrifying cases that should never have happened. The areas they highlight really do get to grips with where the weaknesses in the system are. We are now in a very different place from when that investigation first started. We still have a long way to go, I would readily concede, but we are making access to services much easier, although Members will have their constituents' experiences that do not necessarily reflect that, because we see the bad cases.

However, we have come a long way since these incidents took place. There is still more to do and none of us is complacent about it. In fact, we are very ambitious about making sure that people get treated much closer to home and much earlier so that the need for these acute in-patient stays is less necessary.

Q95 **Mr Marcus Fysh:** I accept that your role is as the responsible Minister. Would you two collectively say that you are the key people who we as a Committee should hold responsible for rolling out the effective implementation of these recommendations? I would like to hear more, and I am sure we will as we go through the questions, from the summary point of view about the role of Professor Kendall in the delivery and the chairing of all the other pieces of the picture that need to be drawn together.

Professor Kendall: When the report came out, we spent some time thinking about how we should deal with it, given that it made recommendations across the system. NHS England does have a role as system leader, so we put it to the NHS England board that we should set up a delivery mechanism that I would chair. To that extent, of course, we are responsible for leading the system, but each individual part of this has to play a part and has to be responsible for it.

I would also say that it goes wider than this. Eating disorders are an issue for society at large, as we have already heard. Prevalence rates have probably changed significantly and this is one of the most serious mental health problems. I think it might well be up there as one of the most common mental health problems. I got the expert group to look at all the data and while I absolutely accept that the research is not definitive, we

think it might be up at 6% over a lifetime. Among women, that will be 15%. That is not small.

Q96 **Chair:** I will just pursue this for a moment. Minister, you are accountable to Parliament for the delivery of this report. Who in your mind, given that you cannot direct NHS England, have you made responsible for delivering on your behalf?

Jackie Doyle-Price: Your question goes to the nub of how we can effect change as Ministers. Professor Kendall will confirm that I challenge him regularly. Clearly, when we as Ministers become aware of issues that we think are less than satisfactory, we will engage with whoever is responsible in NHS England. In my case, most of the time I deal with Professor Kendall, but also with Claire Murdoch, if there is a systemic issue, for example an in-house service commission, and so on. The way we work—and Professor Kendall will have his own observations—is that the two of us will talk turkey about what an issue is, what is going wrong, how things are changing and where we think action needs to be taken. We will get people into a room and knock heads together.

In terms of the levers that I can bring, I think that ability to have good, constructive engagement with those responsible for delivery and the ability to challenge other partners and those responsible is where I can really use my influence. That would also inform my ability to be accountable to Parliament for what is happening.

Q97 **Chair:** Is there somebody in your Department who is responsible for this area of policy, responding to this report?

Jackie Doyle-Price: I have a team of officials who advise me across the piece on mental health issues. It is very much advice that comes to policy and they will highlight these things to me.

Q98 **Chair:** We should regard Professor Kendall as operationally responsible?

Jackie Doyle-Price: Operationally responsible.

Professor Kendall: Okay, but it is worth saying that I am very happy to lead the delivery group, to chair the expert reference group and to push as hard as I can to make sure that eating disorders become something that all doctors and nurses know about and that society as a whole starts to take much more seriously. We are in a position where I can work in NHS England and NHS Improvement, but I cannot work in all the other arm's length bodies, who in law are separate bodies, and I cannot instruct the GMC. I cannot tell Lisa Bayliss-Pratt what to do, but I can, as the Minister says, bring people together, which I have done, and we are working as one.

Jackie Doyle-Price: Following on from that, where there are issues that Professor Kendall says, "This is a problem, and I can't fix it", I can bring amplification to the rest of the system. I have regular dialogue with lots of interested parties in the whole area of mental health and I will happily

give my challenge to the system as well. We also need to recognise that when it comes to locally commissioned services, we have local clinical commissioning groups, but increasingly local authorities have an interest in this area through health and wellbeing boards. Of course, I can have a much bigger impact on that interaction than, perhaps, Professor Kendall can at NHS England.

Q99 **Mr Marcus Fysh:** I want to understand within that how often is or will the PHSO delivery group meet to review and co-ordinate the activities of the different people who are involved in delivering?

Professor Kendall: Rather naively, I now feel, I thought that we would have a limited time period, possibly a year, perhaps two, to get this whole thing going and make sure each of the bodies involved knew their responsibilities and had programmes underway. We now, on reflection, think that we need to keep this group going until we are very clearly getting eating disorders established within curricula, within doctors' training, and so on. I do not think we need to meet very frequently but we need to meet at regular intervals. Our next meeting is in June; I think that is correct. We will plan out from there how frequently we think we need to meet, but I would think it is probably quarterly or thereabouts.

Q100 **Ronnie Cowan:** Where do you get your information about the prevalence of eating disorders?

Professor Kendall: As Dasha said earlier, there are contradictory research studies. They do not all come out the same. Some studies will look at what the prevalence is now, at this point in time, "How many people could you count with an eating disorder today?" a point prevalence. That will be different from how many people will have an eating disorder over a period of the next year. That will be again different from the prevalence over someone's lifetime. Each one is going to be useful in one way or another, but it does bring it home. When we put all this data in front of the expert reference group—and that includes people who have international reputations in the area of the epidemiology of eating disorders—their view was that probably about the best estimate was that over a lifetime 6% of people will develop an eating disorder.

Q101 **Ronnie Cowan:** Who is in the expert reference group?

Professor Kendall: I do not have a list to hand. Dasha was one of them.

Q102 **Ronnie Cowan:** How large a group are we talking about?

Professor Kendall: Probably 15.

Q103 **Ronnie Cowan:** Do any of these people have lived experience of eating disorders?

Professor Kendall: Indeed. I think it is more than 15, in fact, more like 25. Yes, there are a number of people with eating disorders, and it is jointly co-chaired by me and Jess Griffiths, who has recovered from an eating disorder and is now practising as a therapist in Dorset.

Q104 **Ronnie Cowan:** The Government's written evidence described the PHSO recommendations on quality and availability of services as "implemented". The PHSO and others do not accept this. What is your view?

Jackie Doyle-Price: In the sense that we have set waiting time targets, which are being achieved, and we are working on better transition for services, which is where we found that there was a real problem with transition from childhood to adulthood, and also where people moved around, they have been implemented. We do have plans. I would probably say it is more "in progress" than "implemented" in that sense.

Q105 **Ronnie Cowan:** The Government have written evidence that described it as "implemented".

Jackie Doyle-Price: Which part was implemented?

Ronnie Cowan: The PHSO recommendations for the quality and availability of services.

Jackie Doyle-Price: In the sense that we have set waiting time standards and we are achieving them, yes, they are.

Professor Kendall: For children and young people we now have full coverage for the entire country. We have 70 community-based eating disorder services and they are currently delivering at just above 80% on both waiting time targets.

Q106 **Chair:** Does that include adults?

Professor Kendall: No, that does not.

Q107 **Chair:** The recommendation of the PHSO report did invite you to address adults as well.

Professor Kendall: Yes, absolutely.

Q108 **Chair:** How is that implemented?

Jackie Doyle-Price: We are trialling the same waiting time standards. It is worth the Committee recognising that we are in different places for children and adults in the sense that adults were accessing more services in the community than were available for children at this time. When we approached eating disorders, prioritising the treatment for children was the way to go to improve that access. Now that we have achieved that, we are looking at adults but we are starting from a very different place in that sense, working out what we best achieve, because ultimately we do not want to rely on specialist in-patient services to treat eating disorders. The best success will be if we could treat people earlier in the community. In that sense, we were tackling very different problems at different times. I think a mark of my success will be that we were able to reduce in-patient beds because we have that greater prevalence of services in the community.

Q109 **Ronnie Cowan:** That brings me back to the point I have asked the two previous panels. We want to get it as early as we possibly can, but we now know that medical students, through 10 to 16 years of training, are receiving two hours of training in this. What are you going to do to address that?

Jackie Doyle-Price: This sits with HEE and GMC to challenge the medical colleges which provide the curricula. From my perspective, I am going to put my full support behind the Royal College of Psychiatrists' demands that there is at least four months training for people going through medical school, because when it comes to mental health—again it comes back to the culture we have in our NHS: we will present to our GP with whatever we have got and say, "Fix me". We are expecting our GPs to be gods and know everything about everything and, frankly, that is just not realistic.

Q110 **Ronnie Cowan:** However, they should be signposting people to the right services.

Jackie Doyle-Price: Exactly that. We need to make sure they have sufficient foundation to be able to signpost people to the relevant services.

Professor Kendall: It is worth saying that—and this has been raised by the GMC and Health Education England—one proposal is that all junior doctors go through FY1 and FY2 training, have direct exposure to mental health training and, as far as possible, that should include exposure to working with people with eating disorders. That is a major challenge but it is one that we should step up to. I genuinely think that all doctors should come out understanding mental health by direct experience as well as intellectual training and so on. On top of that, currently undergraduates get probably around about five weeks' exposure to the whole of mental health. I do not think that is enough. When you think that out of all the total burden of disease, 28% approximately is down to mental health, it is not enough to just have four or five weeks' training.

Q111 **Ronnie Cowan:** For my benefit, how do we change that?

Professor Kendall: We are discussing this with all the people in the delivery group, and that involves getting UK universities and medical schools, talking to them about expanding out mental health and making sure that this focuses on eating disorders in particular. That will take time.

Q112 **Ronnie Cowan:** You can probably sense my frustration here—we seem to be taking time. In 2012, when Averil Hart died, the report at the time said that if the MARSIPAN guidance had been followed, her life could have been saved. We are now in 2019 and we are still thinking about how we can improve it.

Professor Kendall: Sure. As the Minister has said, we have introduced the first waiting time ever in mental health for children. We are

absolutely on target for achieving what we set out to achieve, and it is our view that intervening early with children and young people was by far and away the best place for us to start. The long-term plan will include probably the biggest investment in history in community mental health, including for people with eating disorders.

Q113 **Ronnie Cowan:** Is that a financial investment or a time investment?

Professor Kendall: No, the long-term plan for mental health is working with at least £2.3 billion of additional money to be spent on mental health. We have already said that a sizeable part of that will be devoted to community mental health, which has not had this level of investment probably ever in the past. I cannot tell you exactly what that investment will be, because we are still working on the figures and so on, but it will be significant, and that will include all serious mental health problems, including eating disorders.

Jackie Doyle-Price: We set our level of ambition and our plan to deliver it, and that ultimately generates expectations that everything will be done. In order to actually meet all those ambitions and aspirations, we are reliant on a very large and very diverse workforce that are at different places in their professional careers and have different aptitudes for learning. Clearly, we need to do as much as we can to make that training and awareness available at the foundation level when people are entering the profession, but also we need to keep that awareness up and keep reminding the system, a system that is managing many competing demands. This is always one of the challenges in health; it takes time to build up an adequately trained workforce to deliver to the extent to which you want to really be ambitious.

Q114 **Eleanor Smith:** You have mentioned resources. How will promised improvements in access and quality of services be funded and what level of funding will be allocated? You have just said you are going to have so much.

Chair: That is a question for NHS England, isn't it, because you have all the money?

Professor Kendall: Yes, if only.

Q115 **Chair:** You have £20 billion.

Professor Kendall: £20.5 billion. I agree and, I have to say, we are incredibly grateful that we have it. Getting at least £2.3 billion for mental health is the biggest investment in mental health I recall, and probably in the history of the NHS.

Q116 **Chair:** Here we are, nearly two years after this report; how much funding has been allocated to this priority?

Professor Kendall: At this point in time we are identifying what the likely cost is of gradually bringing eating disorders up to the sort of standard that we have seen with children. That is our intention. We have

absolutely said we want to do what the PHSO report says, try to get to that level. The question is how quickly we can we do it and what the costs will be. We have a picture of what it is like out there now for adults with an eating disorder. They are underserved and the services are inadequate. Some are fantastic, but there are a lot that are in a very poor state. We know that there will need to be an investment, but I cannot tell you specifically what that investment would be. I know that it will be a substantial investment, but I cannot tell you how much immediately now.

Q117 **Eleanor Smith:** Can I ask about the workforce as well? How much investment will be in the workforce?

Professor Kendall: Most of mental health is workforce. We do not have operating theatres or a lot of technology outside digital mental health.

Q118 **Chair:** Simon Smith is refusing to spend any of his new money on a workforce strategy because that is going to be very expensive.

Professor Kendall: You need to talk to Health Education England about that, but in terms of what the £2.3 billion will go on, most of that will be on setting up posts.

Q119 **Chair:** That is assuming that there are people to fill those posts.

Professor Kendall: Of course.

Q120 **Chair:** We have already established that more money needs to be spent on creating specialists to fill those posts. What is NHS England going to do about that?

Professor Kendall: To be fair, given that we are not directly responsible for training, that is Health Education England's responsibility. We have, nevertheless, been very inventive across the whole of the mental health programme. We created new posts in the improving access to psychological therapies programme, which is now in primary care, and it should end up at 10,000 therapists within the next year or two. We have created new ones for child wellbeing practitioners, and these are all taking new types of graduates in psychology. We are creating that for new posts. We are doing the same with the Green Paper on children, where we have created and have started now to recruit this year a number of people into the education of mental health practitioner roles.

We are being inventive, knowing that the pipeline for training nurses and training doctors takes time. We cannot suddenly produce those nurses and doctors, but that will happen in the long run. These new posts will make new doctors and new nurses necessary. However, we are mitigating the difficulty of recruiting into these posts straight off. It is a major issue for mental health. We have been underfunded for a long, long time, and to increase year by year, which is what we have committed to doing for a decade, there will be an increased share of the health budget into mental health. We cannot recruit everybody all at

once. It does depend on other parts of the system increasing throughput of training nurses and doctors.

Q121 **Kelvin Hopkins:** I represent a very diverse constituency and one point that comes across to me quite strongly at times is the importance of having cultural sensitivity, particularly in mental health. In other areas, mending a broken leg, it is pretty standard for cultures but mental health cultural sensitivity is important. Is that going to be built into the training of new people?

Professor Kendall: Into the training?

Kelvin Hopkins: Yes, into the training and education of the additional mental health practitioners we are going to have.

Professor Kendall: I cannot tell you about the training done by the Royal College of Psychiatrists—that is not my role—or universities, or whatever. On cultural sensitivity about mental health, we absolutely are aware that the Mental Health Act, for example, is used five to six times more often with males from an African-Caribbean background than it is for equivalent Caucasian whites. Yes, there are major issues about culture and ethnicity in mental health and we are addressing those things. It is not an easy thing to address. I wrote the very first NICE guideline back in 2002, which was on schizophrenia, and we had recommendations in that that were clearly about cultural sensitivity, ethnicity and so on. I am not sure that changed very much. We have to do a lot more than we are doing, but it is an important part of our work.

Jackie Doyle-Price: To follow up on that, because we are investing so much more in services in the community, one of the messages that I am giving loud and clear, following on from Professor Kendall's point about workforce, is that this is not just about relying on clinicians. A lot of this is about the additional wraparound services that can be given by other agencies. The NHS should not be shy about commissioning those. It is looking at other innovative ways of having a workforce to support people who are going through a crisis or need additional mental health support. That plays very clearly to your point, because the relationship between some communities and the medical establishment can be too formal and very intimidating. We do need to have mechanisms of reaching out to people to give them support and comfort to seek help early. I see a big role for third sector organisations to be commissioned to deliver exactly those services.

Q122 **Kelvin Hopkins:** That was something of a digression.

Jackie Doyle-Price: But it is complementary to the whole.

Q123 **Kelvin Hopkins:** I will be fairly brief with my questions, because you have already made reference to the expert reference group and what it is doing. Were you very specific about when it is going to be published?

Professor Kendall: I am not 100% sure when it will be published, but I am pretty sure we will be publishing it over the next few months. The work we have done is basically to get a group of experts of different kinds—research, practice, experts by experience—to take the NICE guidelines, the NICE quality standards, which a number of us were involved in producing, and look at how we can get this into practice at the same time as finding out what the gap was between where we are and where we need to be. That has meant doing quite a lot of work around workforce: what sort of workforce are we going to need and how will we get that workforce in the face of the difficulties that Sir Bernard has already referred to? It is quite a complex piece of work, and we do want to get it right. I anticipate that over the coming months we will publish something from that work that will be helpful to the system. That is the key thing, that it will be helpful to the system, rather like a recipe would be helpful to a cook.

Q124 **Kelvin Hopkins:** Making sure that the commissioning pathway is developed and in practice as soon as possible is important; is that right?

Professor Kendall: Yes. We are moving already on the long-term plan. We are developing proposals around the introduction of waiting times. Steve Powis, the medical director for NHS England, is looking at that across the whole of health, and we want to come up with a solution that does not discriminate against mental health but applies across the board as much as possible, unless there is good reason to be different. We will be trialling waiting times in community mental health, including eating disorders, over the next year to 18 months.

Q125 **Kelvin Hopkins:** Including adults?

Professor Kendall: Including and specifically with adults.

Q126 **Kelvin Hopkins:** NHS England's benchmarking study is also important on the provision of community and in-patient services. When is that going to be published?

Professor Kendall: I am not convinced that we should publish it. This was a study that was basically done to find out where we were in reality. One of the ways NHS Benchmarking do that for us is to say to the trusts involved, "We will not publish about you specifically", so that we get reasonably honest feedback from the trust about what is there and what is not there. We have done this a number of times before; we do not always publish. Sometimes we do if we think it is going to be helpful to the system. We have told each of the trusts, "This is where you sit in the spectrum of all the other trusts in the country". They all know where they sit, and that might be sufficient from our point of view. If we felt that publishing would be worthwhile, we probably would have to do it again, because the data that we have is now two years old, which might not be that helpful. In the future we might repeat this, and if publishing seemed to make sense, we would do.

Q127 **Chair:** I will just press you on this. Surely, if you need to do another

survey to get more up-to-date information, and if you were to tell trusts that you are going to gather this information and you were going to publish it, that would sharpen them up a bit to get on with implementing what you want them to implement.

Professor Kendall: At this point in time, probably not. I think once we have made an investment and trusts are beginning to step up, as has happened with children with eating disorders, most trusts would be proud to publish. I am not convinced they would be right now.

Q128 **Kelvin Hopkins:** Following the Chair's question, in an earlier session we learnt about the enormous disparities in provision across the country. It is important, is it not, to make trusts aware that they are really way behind where they should be and to draw these contrasts between the best and worst provisions?

Professor Kendall: There are some areas where there has been significant investment and things have changed really very positively, in areas like Dorset, West Yorkshire and so on. You need to bear in mind that alongside the long-term plan there is some other work that we are doing, part of the Five Year Forward View. We are taking anything that is currently being commissioned by NHS England, so these are all the specialist services, of which adult eating disorder beds are one. There are 402 adult eating disorder beds, costing currently £82 million, and we are repatriating those beds to the localities and asking those localities to turn those beds into community-based pathways, which the long-term plan will add to with funding.

That has happened in West Yorkshire. I was up there the week before last. They now have pathways and they have shut beds. They have taken staff from the in-patient units and put them into the localities, and they have recruited other staff. They have some really good community-based pathways that we would like to see people emulate. It is important we bear in mind that there is more than just investment going on. There is also shifting what to my mind is not wasted investment but we could do a lot more with that money than we have currently done with in-patients.

Q129 **Kelvin Hopkins:** When will the planned best practice on adult eating disorders services be published?

Professor Kendall: That is the expert reference group work, which I have referred to before.

Q130 **Kelvin Hopkins:** You mentioned the NHS long-term plan. Will all this work inform the NHS long-term plan?

Professor Kendall: The point of it is to identify what the sorts of workforce resources and outcome measures are that a workforce will need to get in place to be able to reach the level of quality of care that we are now seeing in children and young people. It is essentially a recipe.

Q131 **Chair:** But all you do is work out what your demand for workforce is

going to be. You are not in charge of workforce supply.

Professor Kendall: No, unless we find these new and innovative ways, which we have developed, often with Health Education England.

Q132 **Mr David Jones:** Professor Kendall, I think that you were present when Mr Radford gave his evidence.

Professor Kendall: Yes.

Q133 **Mr David Jones:** You heard him refer to the postcode lottery in terms of access to specialist services. Would you accept that criticism?

Professor Kendall: Yes.

Q134 **Mr David Jones:** What is being done to remedy that?

Professor Kendall: There are two major pieces of work. One is that we are repatriating all the current investment in eating disorder in-patient beds, which cost a huge amount of money. We are asking localities to reinvest that in those community services for eating disorders specifically.

Secondly, we have developed a long-term plan but we are now refining that to develop community-based services covering all the main serious mental illnesses: eating disorder, personality disorder, psychosis, mood disorder, severe depression, and so on. We will come up with relatively soon exactly what figure of investment will be involved in that, and it will involve us piloting over the next year to two years four-week waits for community mental health. Some of that will include eating disorders in adults.

Q135 **Mr David Jones:** That will eliminate the postcode lottery?

Professor Kendall: Not immediately, no. As Sir Bernard has asked, how do we match up? We make this investment; we have to recruit the workforce in it. We have to do this stepwise as there is an increase in training of nurses, doctors and so on supplemented by us bringing in new types of workers. I work with Jess Griffiths on the expert reference group. She is someone who has recovered from an eating disorder. She now works in an eating disorder service. That is what we want to try to help happen.

Jackie Doyle-Price: The postcode lottery is itself an indicator of just how underprioritised mental health has traditionally been. We are partway through a transformative programme to improve mental health provision across the piece, and it will be a postcode lottery because we are essentially relying on what is a locally commissioned service. Frankly, that just depends on how far local commissioners care about mental health. Even now, notwithstanding the emphasis the Government are putting on this and the fact that we are making it such a priority, there are still some local commissioners where there is not quite so much clout on behalf of mental health as we would like. Now we have the machinery

through NHS England to give challenge to that, but again we are partway through what is a transformative programme.

Q136 **Eleanor Smith:** I agree with that, Minister, but the thing is, though, who is responsible? If you are saying commissioners are not doing anything about it because they do not think it is anything that they want to deal with, who is responsible for those commissioners in the first place?

Jackie Doyle-Price: Now we have what we call the mental health investment standard where we have given a clear instruction to local CCGs that we expect them to be increasing their spend on mental health in excess of what they are getting by way of funding. If they are not doing it, we are giving that challenge. We are effectively turning around a juggernaut in terms of delivering this through an existing framework where people have their own expertise and you are having to change that culture.

Professor Kendall: The long-term plan does now ring-fence that money. We are producing our plans. We will put that to all the localities, all the STPs around England. They will be required to come back to us in the autumn and say how they are going to do that on a local basis, including how they are going to spend all the money that we give them.

Q137 **Eleanor Smith:** There is an accountability there?

Professor Kendall: There is an accountability there. It was not my idea but I think that it was quite a smart idea to get the localities to lay out what their plans would be and then say, "What would they cost?" Then we have something much more concrete to monitor them on. All this hinges on being as transparent as we can make it. Things like their spend, their mental health investment standard—we are publishing it all.

Q138 **Dr Rupa Huq:** Minister, I wanted to come back to something you referred to, the disparity between child and adolescent services and adult services. I have a constituent, Rebecca Widdicombe, who is again someone who has come through the other side, experienced it as an adult and now does work with BEAT. Princess Diana, the most famous sufferer of these things, was an adult and we know that there has been investment at child and adolescent level but a lack of investment at adult service level, even following the PHSO report. Why is this?

Jackie Doyle-Price: Coming back to the principle of early intervention first and foremost, we know that people who suffer with eating disorders tend to start to present when they are children, so that is one reason for focusing on children specifically.

The cases highlighted by the PHSO report were very much issues connected with care for children and young people. We focused on tackling those waiting times because treatment in the community was less good for children then than it was for adults. We could tackle eating disorders on the part of adults through adult community services. We really needed to get it right for children.

Now that we have achieved those targets, we are looking at what more we can do for adults. The fact that this is happening at the same time as we are expanding community services for mental health more generally should make it easier to deliver that. I am very confident that we will move forward very quickly. Professor Kendall set out the fact that we are now decommissioning those nationally-commissioned beds that have filled the gap because we have allowed too many people to get into crisis. That will start to deliver more improved services.

It is also worth recognising that what we have also discovered is that because of that historically poor performance, particularly for children's mental health services, the move to a new model of care that sees people treated as young people from nought to 25 means that we can transition into adult services and the whole thing becomes much more seamless. For me, eating disorders tend to be co-morbid with other mental health conditions in any case. I just want to get to a system where anybody of whatever age can get treatment for whatever symptoms they are presenting with. Part of the quality indicator is that we will be seeing far fewer incidents of eating disorders because people will be treated far earlier and their emotional wellbeing will be picked up much earlier.

Q139 **Dr Rupa Huq:** To do things within the school curriculum as well?

Jackie Doyle-Price: That is incredibly important. We are, of course, investing in a completely new workforce to work with schools to improve access to mental health services and embed emotional wellbeing throughout schools. We are still in the process of rolling out mental health first aid training to at least one person in every school. It is amazing some of the things that do go on in schools in encouraging people to look after their emotional health, but I think that prevention is always better than cure. We all need to be equipped with the tools to build our own resilience and look after our own emotional wellbeing.

Q140 **Dr Rupa Huq:** The Government have described steps taken to map the cost and workforce required to ultimately achieve parity. When do you see that day will come?

Jackie Doyle-Price: Obviously, parity of esteem is enshrined in law, but if it was an easy tick-box achievement I could put a date on it. It is actually a cultural and behavioural thing. It is something that basically everyone involved in the system needs to exhibit behaviours where they are treating physical and mental complaints the same. We do come back to training in that because if we are not properly training our medical personnel with sufficient awareness and understanding of mental health, they are not going to be able to deliver parity of esteem for mental and physical health conditions. Until we have a much better understanding throughout the health establishment we cannot say we have delivered it.

Q141 **Dr Rupa Huq:** Is parity of funding going to happen?

Jackie Doyle-Price: We make the funding available to treat what we can, given the multiplicity of demands on the health service and some

things are more expensive to treat than others. The difficulty in measuring is probably less on inputs and more on outputs and outcomes and that is rather more difficult to measure.

Professor Kendall: In terms of when we would get some sort of equality between adults and children with eating disorders, the difficulty is that the adult group are a quite substantially larger group than the under-18s, probably, I would think, at least three times the numbers. As the Minister has said, they are often very co-morbid with lots of other mental health problems like anxiety and depression, some personality disorders, self-harm overlaps and so on. Exactly when we will do this I can't be sure, but I will be much more sure when we have done our pilot of four-week waits for community mental health, including eating disorders. In two years' time we will have a much better idea because that is the point at which the long-term plan really starts to kick in for investing in community mental health services. At that point, I would probably hazard a guess as to when we might reach that level of equality.

Q142 **Chair:** But this report by PHSO was about nothing except what the Royal College of Psychiatrists in an earlier session called the cliff edge of 18, that once you fall off that cliff edge there is what we were told was six times more demand for adult services than there is for children and adolescents. That is what this report is recommending that you address. There does not seem to be—

Professor Kendall: Okay, but if we go back two years, children and young people's eating disorder services were not as good as they are now by a long shot. Only about 50% were reaching a one-week waiting time if they were urgent and four weeks if they were routine. There was not quite such a cliff edge; neither were particularly good. It is true that now we have that we have created a cliff edge, but that is because of the investment in the Five Year Forward View. It is not something that was there before. I entirely accept that the cliff edge is there and that is what the long-term plan for community mental health will address.

Jackie Doyle-Price: The point that you make is crucial because what it highlights is the absolute process failing here, and we have not just seen it in the context of this report. When we look at the performance of individual areas, where they have had that cut-off at 18 there have always been bigger issues with transition, which is why it has informed our approach of going up to 25.

There are also issues there about how, in this particular case, Averil Hart found issues when she went to university and her care was not picked up. That also highlights the need for better care planning, which we are confident we will achieve through managing the service up to 25 rather than 18.

Q143 **Ronnie Cowan:** On a wider issue, we all agree that prevention is best. It is better for society and it is also the cheaper option. If we can catch people earlier it saves money in the health service and so on. Is there a

major problem with the media and the way they portray body image? If there is a major issue with the media and how they portray body image, what are you doing about that?

Jackie Doyle-Price: There is, yes. You will be aware that we have been engaging with the social media companies and internet platforms with regard to content that they manage because increasingly with young people that is where they are getting their images rather than from traditional broadcasts, which is much easier to regulate, although we have seen some poor performance there as well. I am personally in regular contact with ITV about their advertising policies and standards. We are very focused on the whole issue of body image and unrealistic body image. In fact, today I am just starting to roll out some key messages on how we tackle the whole emerging cosmetics industry as well, which again is pushing out images that are really unrealistic in terms of what is attainable.

Q144 **Ronnie Cowan:** This goes on from a very early age.

Jackie Doyle-Price: Indeed, but again it comes back to what we can do in schools and what parents can do with their children in making sure that we are equipping people with the tools to protect themselves. One of the messages that I often give out is that the time was when I was a child we used to go out and play and parents worried about whether we might come to harm with cars on the road and all the rest of it. Now parents think that their children are safe in their bedrooms, but they are on computers and being exposed to all kinds of pressure. We need to encourage everybody throughout society to just think about the harms that content can give.

Professor Kendall: It is worth saying that there is very little research that clearly tells you how to prevent mental health problems in young people, and that includes eating disorders. I do not in any way want to disagree with you about the importance of body image and the way it is portrayed in social media and in the press and so on, I am sure it is an important factor, but we do not have research evidence that tells us how this might lead to prevention. If I was to say, "What will prevent mental health problems in children?", we have clear evidence that dealing with bullying will reduce mental health problems in children. We looked at this for the Green Paper on children's mental health in schools. At the moment, the research suggests getting there very quickly, as early as you can, when a sign of illness starts, but we do not have that much evidence to tell us what to do for prevention.

Q145 **Mr David Jones:** Minister, I think that you were present when Professor Melville gave his evidence and you heard him say that the GMC did not have the statutory powers to oversee the training and education of medical professionals in this area. Is he right? Do you agree with that?

Jackie Doyle-Price: To an extent I do. The curriculum is obviously something for the medical colleges, but we can give some expectations collectively as partners in the system that we want this to change.

Q146 **Mr David Jones:** Do you believe that there should be a single body that should take leadership in this area?

Jackie Doyle-Price: To an extent the Royal College of Psychiatrists does, but if we collectively are making this a priority for the system, clearly there is power in acting collectively to give a signal.

Q147 **Mr David Jones:** What are you doing to ensure that there is a framework in place that ensures that the necessary leadership is provided?

Jackie Doyle-Price: As I say, I stand four square behind the Royal College of Psychiatrists with its demand to properly embed this through the curriculum. What I will do following this session is go away and talk more collectively to the other royal colleges so that we can all stand in partnership to say the entire medical establishment will benefit from this.

Q148 **Mr David Jones:** That is something that you will be doing as a consequence of this session?

Jackie Doyle-Price: I will do that following this, yes.

Q149 **Chair:** A few moments ago, Minister, you endorsed the idea that every clinician should have four months of training in psychiatric issues. How is that going to be implemented?

Jackie Doyle-Price: That is the demand of the Royal College of Psychiatrists. That is something that I absolutely support and will encourage that policy to be adopted by the other royal colleges. That can then be used as a signal to the rest of the establishment.

Q150 **Chair:** Yes, but the General Medical Council said that it cannot make it happen.

Professor Kendall: I think that Health Education England is the body that would be in a position to be able to reallocate training posts for FY1 and FY2 doctors so that instead of—

Q151 **Chair:** This is not about the specialists. I am talking about the generality. This is about changing the nature of courses for GPs, for example.

Professor Kendall: That is right. Every doctor has to go through FY1s and FY2s.

Q152 **Chair:** At the moment they get only 1.8 hours of training on average.

Professor Kendall: Well, 40% currently will have a four-month period in that two-year period of doing a mental health job. We would like to see that go up to 100%.

Q153 **Chair:** Who in the system is responsible for making that happen?

Professor Kendall: I think that it is Health Education England.

Jackie Doyle-Price: Yes, Health Education England. The delivery is the—

Q154 **Chair:** You cannot regulate the medical schools?

Jackie Doyle-Price: No.

Professor Kendall: No, that is a different issue. That is for the undergraduates. That would depend on UK universities' medical schools, who we are talking to with the GMC. We have had some very fruitful discussions about looking at the curriculum and increasing the amount of mental health, and specifically eating disorders, in the curriculum.

Q155 **Chair:** Would it be helpful to send us a note about this because I am very confused?

Jackie Doyle-Price: I can see exactly where you are coming from, Chairman. Yes, I think it will. I will give the Committee a note about who owns what in the system and where the buck is going to stop to make sure that clinicians get more training.

Q156 **Chair:** Particularly tackling that question that the GMC says it cannot quite tackle because it is not the body that can direct individual medical schools to change their courses in particular areas.

Jackie Doyle-Price: They are correct to say that.

Professor Kendall: I think that is true. It is UK universities' medical schools that could do this.

Q157 **Eleanor Smith:** The wounded healer concept is now well known. How does the NHS support and learn from doctors who have experienced an eating disorder themselves?

Professor Kendall: It is incredibly important in terms of the workforce from my point of view. We used to have the view that if someone has had a mental health problem you should not let them go anywhere near mental health. Almost all the trusts I know of in the country are now recruiting what they call peer support workers. I think that is a relatively ill-defined role and I think that we could do much more in the way of Jess Griffiths, who co-chairs the expert reference group with me. She recovered from quite a severe eating disorder. She has now trained in therapy of eating disorders and does a really good job in probably an outstanding service in Dorset. I think that we have people who can do this. It is an underutilised resource.

Q158 **Ronnie Cowan:** Since the PHSO report, here today what lessons have been learned from serious incidents?

Jackie Doyle-Price: We have moved quite a long way forward. You will be aware that the previous Secretary of State's entire priority was patient safety and learning from things that should never happen. Again, there is a cultural change abroad here in the sense that we are embedding

throughout the NHS complete transparency when things go wrong, not to foster a blame culture but for a culture of learning. There is going to be much more by way of independent investigation when incidents happen. We are establishing the HSIB to undertake those investigations. Generally, I approach all this from the principle that sunlight is the best disinfectant.

Professor Kendall: As far as NHS England and NHS Improvement are concerned, NHS Improvement started a piece of work sometime last year to develop a new framework for serious incident reporting. As the Minister has said, our thinking about serious incident reporting has changed because of our approach to safety. It makes a lot more sense that we look at anticipating problems rather than just analysing ones that have happened and trying to learn from them. The framework that will be published probably in July will be more about safety and promoting safety within the NHS and it will also incorporate another piece of work that is being done by our national director for patient safety at NHS England, who is developing a strategy around patient safety. These will be two pretty live documents because the research around safety is changing sufficiently within health services that they have to be ready to change.

With particular reference to the PHSO report, because the NHS is changing its structures—we are moving to working more in primary care and place-based delivery of care and so on—that does mean that we have to account for that in reporting processes and co-ordinating investigations that involve more than one organisation. This will specifically address some of the issues that the PHSO report looked at. I don't know if you remember but it clearly said there were real shortcomings in organisations saying, "No, that was not to do with us, that was their problem". This will ensure that we have a much more integrated approach to the investigation of incidents and problems.

Q159 **Ronnie Cowan:** I have heard in this Committee and in other committees that when the medical profession is challenged on serious incidents, which may have resulted in someone's death, the first thing they do is round the wagons and become very protective. What can you do to make sure that does not happen and that we get the truth?

Professor Kendall: I think that what the Minister said about creating a culture of transparency and not blaming people is quite an important step.

Ronnie Cowan: Certainly not a blame culture, which I agree with, but allowing people to speak up honestly and truthfully if they think that there is a problem there. The medical profession does not have a good reputation of doing that.

Q160 **Dame Cheryl Gillan:** The PHSO report quite rightly remarked upon the confusion between NHS England and NHS Improvement. I think that what you are saying is that because the operating models have been merged recently that has brought greater clarity, I presume.

Professor Kendall: I think that it will do. NHS England and NHS Improvement are two very key bodies in running the NHS. One works with providers and the other one works with commissioners. I think that bringing the two together is going to simplify this considerably. I also think that the framework that is due to be published about serious incident reporting and safety will make the problems that this report throws up more accessible to us and will prevent organisations at a local level from shunning their responsibilities.

Q161 **Dame Cheryl Gillan:** Do you think that HSIB and its role in investigations will make a difference?

Professor Kendall: Yes.

Q162 **Dame Cheryl Gillan:** You do. Do you think that it will be independent enough to protect against this culture of pushing the wagons round?

Professor Kendall: One of the things that the previous Secretary of State did, I thought very well—I used to go around with him to visit mental health trusts and it was all about patient safety and mental health—was he began a whole programme of patient safety in mental health. One of the things that he did was that he got us senior doctors, including from the Royal College of Physicians and others, to stand up and talk about their experiences of making a mess of things. We have to create a culture in which we are all a lot more honest and that does include senior doctors at the top being honest about where we have made mistakes.

Q163 **Dame Cheryl Gillan:** Minister, I have been sitting here for two hours and we have heard a lot of evidence. It is two years on from this PHSO report and I still get the feeling that we do not have that clarity of knowing where we are going to end up on this road. It seems to me that there are so many organisations involved in this, that it is so complex, that you really are going to have to take a hot knife to cut through this butter to try to get there. It still appears to me that we do not have end dates, we do not have outcomes, we do not have the surety that we are going to have all those changes that are going to make a difference in the end to the patient. I still am marked by a constituent who had to receive in-patient treatment at the other end of the country, and I am not sure that that would not happen again. What is your view on that? If you really did have all the tools in your bag, what would you do right now to try to cut through all this?

Jackie Doyle-Price: I am rather more confident than you are and I understand the problem completely. I genuinely feel that we have moved a long way and I am much more confident. When people bring these stories of what has happened to their constituents, I am much more confident that they will not happen.

A lot of what will improve people's confidence in this is if we can be a lot more outcome focused in our measurements. It is infuriating because constantly our debate about the NHS performance is about inputs and

structures, and then when we find something that goes wrong everyone goes and hides behind those things and all of us who are here to give scrutiny are thinking, "What a mess. Nobody owns this person in the system". I am not going to rest on my laurels ever. I am constantly giving challenge to the system and Professor Kendall will confirm that. Whenever I get a case like that, it is, "What exactly has happened here?" I think that we are getting much clearer systems of accountability, clearer ownership, but we still have to be much better at it.

If I can point to one outcome measure that I think will prove that we are doing better here, it will be that reduction in in-patient beds. When things get so bad that we are relying on NHS England to commission specialist services because people are being failed so badly—they really are at that stage—they end up probably being treated more harmfully because they are then taken away from their family. The tendency is that they are there for a lengthy period of time and they are stuck. The system is doing those people harm.

One of the outcome measures that we can hold our performance to is the ability to reduce the number of beds because we are picking people up sooner and in the community. I appreciate that you are hearing numbers again: "by this year" and all the rest of it, but please don't underestimate how far we have come. The death of Averil Hart was in 2012. The investigation started and was completed in 2017. We had already made a lot of progress in dealing with some of the issues highlighted here, and I think that we are on the way to delivering the others. None the less, we are still tackling decades of underinvestment in mental health against a pattern of what is increasing demand. This is a job that is never going to be finished, I think.

Q164 **Dame Cheryl Gillan:** But would it be fair if we wrote in our report that the current structures and the changing of the structures are, in fact, at the moment defeating the objectives to a certain degree and it is those structures that we need to improve to produce better outcomes?

Jackie Doyle-Price: Which aspects of the structures?

Q165 **Chair:** On the question of the note I have asked you for, it is not clear in our minds—

Jackie Doyle-Price: That is in terms of the curriculum.

Chair: —how you are going to deliver the change in the culture of clinicians that is required by changing the education that they are given.

Professor Kendall: I am aware that the structures—that Health Education England is a separate body from NHS Improvement, from NHS England—create a lot of problems. There is no doubt about that. The only thing I would say is that if you look at our track record in what we have done with children's eating disorders and with getting the implementation of the Green Paper for mental health in schools, it is the same team that is doing this. It is the mental health team in NHS England and we will

achieve with adults what we have achieved with children, but in how long I can't say right now.

Jackie Doyle-Price: When it comes to operational delivery, though, the challenge there is that we have an overall structure through NHS England, which sets very clear expectations and very clear priorities. We are relying on services that are commissioned locally, so in that sense there is complexity in the system. We will increasingly use the levers of accountability from the centre to try to get more consistency, but it is absolutely right that this is a locally commissioned service against a nationally commissioned set of objectives.

Q166 **Chair:** Can I be clear on one thing about HSIB? HSIB at the moment is part of NHS Improvement, and NHS Improvement and NHS England without any legislation remain legally separate. HSIB remains under NHS Improvement; is that correct?

Professor Kendall: NHS England and NHS Improvement are functionally merging.

Q167 **Chair:** Yes, this does not bring clarity, it confuses. We conceived HSIB as the Healthcare Safety Investigation Branch of the Department of Health. It is not a regulator. How do you see HSIB?

Jackie Doyle-Price: There will be legislation to put HSIB on a statutory footing. Again, it would be helpful, Chairman, if we could write to the Committee on that.

Q168 **Chair:** Okay, thank you. That would be very helpful because obviously we are concerned about its independence.

Finally, I think that you touched on getting the correct balance between making people accountable for what has gone wrong and learning for the future. Can you say a bit more about how you are going to achieve that? Obviously, PHSO plays one role and HSIB plays another role. How do they complement each other in your mind?

Professor Kendall: They complement each other in the sense that there are a number of regulatory bodies whose job it is to have a look and see when things are done wrong or right. Within that context, so within the NHS, we need to create a culture in which people can own up to when things have gone wrong. That does not mean that if somebody acts maliciously or whatever that that should not be treated as I think the GMC or the equivalent for nursing would do, which would be to undertake disciplinary action, and that should happen. When we are talking about human error we have to have a culture in which people can say, "I made a mistake". I think that that is down to all of us, the GMC included. It is down to the NHS, NHS Improvement and bodies like HSIB and CQC getting this right. We cannot afford for bodies to come in and create an atmosphere where people are frightened to speak.

Jackie Doyle-Price: We rely on local leadership for that as well. The chief executives of trusts really need to be setting out and leading from the front with that sort of culture. Increasingly, we are looking to CQC to consider that as part of their well-led judgments regarding institutions.

Q169 **Chair:** Thank you both very much. Is there anything that you want to add, Minister?

Jackie Doyle-Price: No, thank you. Thank you very much.

Professor Kendall: Thank you.

Chair: We are very grateful to you both.

Jackie Doyle-Price: I look forward to reading your report.

Chair: Thank you very much.