HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: PHSO Report: North Essex Partnership University NHS Foundation Trust, HC 31

Tuesday 15 October 2019

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Watch the meeting

Members present: Sir Bernard Jenkin (Chair); Kelvin Hopkins; Mr David Jones; Eleanor Smith.

Questions 1 - 59

Witnesses

I: Nadine Dorries MP, Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care; William Vineall, Director of Acute Care and Quality Policy, Department of Health and Social Care; and Professor Tim Kendall, National Clinical Director for Mental Health, NHS England and NHS Improvement.

Written evidence from witnesses:

– Department of Health and Social Care

Examination of witnesses

Witnesses: Nadine Dorries, William Vineall and Professor Tim Kendall.

Q1 **Chair:** May I welcome our panel of witnesses to this inquiry into the PHSO's report on the North Essex Partnership and the sad cases where it is suspected that two patients took their own lives? Let me say at the outset that the Committee extend our deepest sympathies to the families concerned, and to other families who have been affected by similar instances. However, to clarify, because there are still ongoing investigations, which may lead to criminal charges, we cannot delve too deeply into the individual cases. In any case, this Committee, as a matter of principle, does not look at individual cases; we try to draw on the PHSO's reports to draw general lessons that need to be implemented by Ministers, civil servants, healthcare professionals and the NHS. With that in mind, we will proceed with this evidence session. May I first ask our panel to introduce themselves for the record, please?

Ms Dorries: I am Nadine Dorries, the Minister for Mental Health in the Department of Health and Social Care.

William Vineall: I am William Vineall, the Director of Acute Care and Quality Policy at the Department of Health and Social Care.

Professor Tim Kendall: I am Professor Tim Kendall. I am National Clinical Director for Mental Health at NHS England and NHS Improvement.

Q2 **Chair:** Welcome to you all. May I first thank the Minister representing the Government for the fact that the Health Service Safety Investigations Bill was in the Queen's Speech? As you may know, Minister, this Committee has long championed this reform, from the inception of a report that our predecessor Committee produced at the end of the 2010 to 2015 Parliament. We were delighted when the Government adopted the proposal. I chaired the pre-legislative scrutiny of the draft Bill and, after a long wait, we are delighted that the Bill is going to be published. Has it in fact been published?

Ms Dorries: It will be published tomorrow, Chairman. If I may reciprocate those comments, you were the driving force behind HSSIB. If it had not been for you and your Committee's interest, and your attention to the HSSIB Bill, we may not be in the position we are in today. Thank you very much for that. I joined the Department only at the end of July. There was a lot of work done before that, and I know—I have heard it from officials and from many other people—that your persistence and your consistent attention, not only to the HSSIB Bill and to HSSIB as an organisation in its dry run but to the concept of the NHS becoming a body for learning, have kept this car on the road and got us to the point we are at now, so it is us who should be thanking you and the members of your Committee. You should take the praise for, and pride in, where we are now.

The Bill is to be published tomorrow, when you will see it in all its glory. I am sure that there will be more work to develop the Bill from where it is now, because it is in its first stages, but it is an exciting Bill. I think we are on the brink of change, and I think the Bill is the catalyst that is going to bring about a change in the NHS in terms of how patients are regarded, how we listen to patients' voices, and how we regard learning and safety incidents. Thank you.

Q3 **Chair:** That is all music to my ears. Thank you for that, on behalf of the Committee. We must be cautious about raising too many expectations too soon about the capability of the organisation, but I share great hopes for its effectiveness in the long term.

Ms Dorries: Apart from the organisation, it is about culture change. Something has to bring about that culture change. It may be only something small that does it. HSSIB isn't huge, but I think it is that trigger that is going to bring about the culture change going forward.

William Vineall: One of the key things beyond just doing investigations itself is encouraging the NHS to do better investigations, which is clearly

one of the things that the report we are looking at today raises pretty starkly.

Q4 **Chair:** I thank you, Minister, and Mr Vineall for the attention of your officials to this matter, because as soon as it became Government policy they threw their weight behind it with great enthusiasm. The continuity of policy has been very evident, despite changes of Secretaries of State and other Ministers.

Moving on, can I ask first about the PHSO's report? What was the reaction, and what has been the response, to the report on the North Essex Partnership in your respective organisations?

Ms Dorries: The response has been one of huge concern. The report focused mainly on safety, and that is very current—in both my portfolio and the Department there is a focus at the moment on patient safety. It has brought about a series of actions, not only to investigate what was happening at the trust but in how we handle investigations going forward—we cannot talk about individual cases. There have been a number of recommendations that we have taken on board. We do not know the outcomes of the review and we will know them until it has been completed, but the lessons for the system will be taken forward by the appropriate bodies, including NHS England and NHS Improvement.

What is happening now is a review, and what that finds will determine what the next stages are. If there are any signs of criminal activity, obviously the police will be involved at the next stage. Following on from that, NHS England and NHS Improvement's regional body will go in themselves to conduct another layer of investigation—I think I am correct in saying that. From that, we will take very seriously whatever NHS England and NHS Improvement find during that investigation. Certainly, if there is any interim investigation by the police, we will take very seriously both their recommendations and their findings.

I and the officials—Mr Vineall will agree—are personally distressed at the cases that we have heard. I will certainly make it my responsibility to ensure that any recommendations made are not only honoured in spirit but, where possible, incorporated and enacted going forward.

We are at the stage of discovering what happened. There is a review—I cannot tell you what it will find; there hasn't been an interim report. Those are the stages, and perhaps we should meet at the end of those stages to see what the review did find, whether there was a criminal investigation, and what the regional investigative body found. Perhaps we should discuss it again then, because from that we will have the lessons to learn and, I hope, information as to what did happen.

Q5 **Chair:** Thank you for that comprehensive answer. Do you have anything to add, Mr Vineall?

William Vineall: Obviously the planks of how we approach safety are pretty well set out in the patient safety strategy and the mental health patient safety strategy, and in the wider field there is the forthcoming

activity on reviewing the Mental Health Act legislation. So if there are any key learning points that come out of this particular investigation, there are various things that we can slot them into without necessarily having to generate whole new programmes of activity. I think it is quite timely.

Q6 **Chair:** What about NHS Improvement?

Professor Tim Kendall: We would echo that. Obviously, what has happened is terrible, and you cannot help but feel really quite dreadful for the families involved, who must have gone through hell. But we have to take this as an opportunity to learn about how we should do these things better. I am aware that the trust, now that it has been taken over, is working hard to improve what it does. But we have a series of safety improvement programmes, which thankfully address a number of the issues that these two dreadful deaths bring up. We welcome the reports that are due to come, and we will do everything that we can to put them into effect.

Ms Dorries: I don't know whether it is worth saying it at this point, but the trust has been—I won't use the words "taken over"—merged recently. I think we have now seen improvements in the leadership of the trust. Certainly I think, and Tim knows, that this often comes down to questions of leadership, and how the organisation was run before and who was leading it. There are definite improvements in the way that the trust is being run now. Am I right in saying that?

Professor Tim Kendall: Yes, absolutely. I know that some of the leadership team are now running Essex Partnership Trust. I am absolutely sure that they will see this as a major priority that they will want to fix, and I would think that we would be aiming for this to be completely turned over. I think they will aim for the in-patient unit that has been inadequate to be an outstanding unit.

Q7 **Chair:** I suppose I should declare an interest, because the North Essex Partnership was my local mental health trust, and the merged Essex Partnership University Trust, EPUT, is also my local trust. I knew the leadership of the previous trust, and have dealt frequently with cases—although not these particular cases—including cases leading to the death of patients. I am still concerned, as the constituency MP, that the safety of services is still rated as requiring improvement. I appreciate that there is a review going on, but what is being implemented now to address these safety concerns?

Ms Dorries: We would like to see it reach outstanding, to echo what Tim has just said.

Chair: We all would; the question is how.

Ms Dorries: Measures have been put in place, but we had a review recently by Sir Simon Wessely to prepare for the review of the Mental Health Act 1983. He made 154 recommendations, a number of which have already been taken on board. We have accepted all of them in spirit, and a number of them have been taken on board and are being implemented

across trusts in the UK. They are also being implemented in—the name of the new trust is not north Essex. Is it south?

William Vineall: Essex Partnership University Trust.

Ms Dorries: They have also been implemented there, I believe—Tim will correct me if I am wrong. A number of these recommendations are to do with issues such as when and how patients are restrained, and giving patients more of a voice in their treatment. I think some of those improvements have been made. I believe—again, Tim will correct me if I am wrong—that ligature points have been removed and the environment has been made safer than it was before, so there is less opportunity for patients who may be vulnerable and considering taking their own life to do so.

Professor Tim Kendall: The CQC has said that it sees further improvements happening, but "requires improvement" means that you have not arrived.

Q8 **Chair:** EPUT is intending to publish an action plan, or to provide PHSO with an action plan arising from one of the cases. PHSO will publish it. When is it going to publish it? When is it going to be available, because a lot of water has gone under the bridge?

Ms Dorries: I am afraid I don't have the answer to that, but I can certainly find out and get back to you, Mr Chairman.

Chair: Thank you.

Q9 **Eleanor Smith:** Chair, if I may, I have one supplementary question. Will any extra staffing be required for any of the changes that you need to put in?

Ms Dorries: We don't know until the review, but what I do know is that all wards are staffed to safe and appropriate levels at this present time. What the review will say, and what recommendations it will make on staffing, we will have to see. As I say, I think it will be really good if we could convene this meeting further down the road when we have put in place the actions that have been recommended and we know the full history of what has happened in terms of the particular cases that we know have happened here that should not have happened. On all wards in in-patient mental health units, safe and appropriate levels of staffing are met. What the review will ask for, or what recommendations it will make, we will have to see.

Q10 **Chair:** As you rightly say, the families have suffered terribly from these tragedies. Part of their suffering is the blindsiding or the lack of involvement that the families have in the subsequent investigation and the lack of confidence they have in the investigation. What is being done to address the families' concerns?

Ms Dorries: That is a particularly important point. Many of us in this room are parents and all you have to do is think, "How would I feel if I was in this position?" You are right; from the perspective of the relatives and

families, it is dreadful. When the NHS England and NHS Improvement regional body moves in to undertake its investigation, we will ask that it discusses all elements of the investigation with family members as a priority, so that their voices will be heard through the process. It will not be us discussing them and being unable to discuss individual cases; they will have input into the review. Their stories will be heard. Their questions will be put and, hopefully, answered. They will have a considerable input into the investigation, when NHS England and NHS Improvement take over.

In terms of the review of the Mental Health Act that we are undertaking, it is a requirement that we are going to put into the Mental Health Act. It is part of the culture change that I was talking about when we were discussing HSSIB. Patients' voices are not heard enough and they should be heard, and so should the voices of families. Going forward with the mental health review, and certainly with this investigation, it is a priority that the voices of families and relatives must be heard and their story must be told.

Q11 **Chair:** This is important because very often the patients or the patients' families have the best knowledge of the cases.

Ms Dorries: Yes, absolutely.

Chair: They find themselves so often correcting what the clinicians thought they had got wrong, in the investigation. Could you explain why the HSSIB safe space is so important in enabling that to happen?

Ms Dorries: Can I answer that question in a second? I can feel William twitching next to me, and I think it might be because I have said something wrong. Have I said something wrong, William?

William Vineall: No, it is not that—I was going to come on to part of that question.

Q12 **Chair:** So, why is the HSSIB safe space so important in helping this to happen?

William Vineall: It is important because we know from investigations in recent years that people, both staff and patients, have not found it easy to be able to speak up and be heard and listened to in a way that maintains the privacy of what they say, and is then taken forward in a serious manner to contribute to the overall quality of the investigation.

The safe space principle that HSSIB will operate basically resolves that and allows for things to be heard in privacy and to then go forward and contribute to the investigation. We are doing that, first, because we think it is effective and, secondly, because we have learned that, as the Minister was saying and as you started your remarks with, the culture that exists in the NHS at the moment—in places, not everywhere—for better or for worse, is not always as open as it should be. In Mrs Leahy's case, as well as there being very bad care for her son, there were then elements of a cover-up and an ineffective investigation afterwards. I watched her

YouTube piece last night. At the end, she said, "Investigations must be done correctly and they're not." That is one of the reasons why we have HSSIB.

The final bit of the answer is that the other plank of HSSIB that is important is that it is there to improve the quality of local investigations as well. It is there to do some safe space investigations itself and it is there to improve the quality of local investigations—in a sense, to professionalise the investigations in a way that the NHS hasn't previously recognised is necessary.

Ms Dorries: For people who may have queries or doubts about the safe space, this is not a new phenomenon that is not tried and tested. It has been working in the airline industry. It has been in operation for two and a half years in the UK in its dry run and its setting up to get to the point where it is on a statutory footing. We know that the quality of information that is divulged and given freely in the safe space is of a much higher quality than it ever was before. When people gave information in the NHS, they feared blame or liability, but both blame and liability are removed in the safe space, so NHS workers who might want to pass on information but are worried that they might be blamed or because it might become libellous can go into that space. I have never met anybody in the NHS who is not there because they want to do their best for patients. But they might feel and carry the guilt of the fact that they might know information, but have felt it would be harmful to them or extremely difficult for them going forward and have not handed over that information. In this safe space they will be able to. That is why it is so important, and we know it works.

We know it has worked in the airline industry. The value of the information then goes on to set standards in the rest of the NHS. It goes on to inform investigations across the UK. It raises expectations of a culture in which it's okay to divulge information and people will not be blamed. It's about learning. It's about the NHS becoming an organisation of learning and improvement rather than fear of blame or liability. That is the change that will happen, and the safe space is what brings all this about.

Q13 **Chair:** While we are on the safe space, how will you convince Mrs Leahy, or people like Mrs Leahy, that the safe space is not an opportunity for the system to cover up what should be made public?

Ms Dorries: Because Mrs Leahy would also be able to provide her information in that safe space. They will take her testimony as well. As we said, the testimony of relatives is always—am I right, William?

William Vineall: Yes.

Ms Dorries: The testimony of relatives is always, I would say, far more informative than that of the NHS professionals, because relatives spend a lot of time with their poorly relative who is in hospital. They spend a lot of time by the bedside talking to that relative, and they get a greater quality of information. The relatives are able to fully divulge what they found,

what they felt, the process that they thought took place and the care of their relative, so they can also access it. I hope that relatives would see that what we are trying to do is the opposite of covering up, which is what happened before when there was nowhere for NHS workers to provide information. It is the opposite of covering up. It is actually opening up. It is about asking NHS workers, nurses, doctors, clinicians to completely divulge all the aspects of the case, including what went wrong, what they thought someone else might have done wrong, or what they did wrong, without blame or retribution, and therefore we have that quality of information coming from that safe space. I think it is the opposite of a cover-up, although people might think it is because it is controlled. It isn't; it's actually the opposite. We see cover-ups now, but we want the safe space to completely stop that happening.

William Vineall: Of course, HSSIB, once established in legislation, will be independent of trusts. At the moment it operates independently, but technically it sits within the bureaucracy, so that is the reason for putting the powers in statute.

Q14 **Chair:** We have mentioned that there might be criminal prosecutions in one or two of these cases. What happens if HSSIB has possession of incriminating evidence—bear in mind the threshold is quite high—that has been given in the safe space? If it withholds that evidence, does that not prevent a prosecution from taking place?

Ms Dorries: HSSIB cannot withhold information of a criminal nature. Apart from anything else, that is both morally and ethically wrong. In the case of a death, a coroner has, in the first instance, the right to be given background information should they so need it. In that background information, if a coroner feels that any criminal activity has taken place, they can apply through a High Court for the information, but on the basis of the fact that criminality has taken place. In that safe space, if anything criminal comes to light, it has to be divulged to a coroner in the case of a death. This is not about covering up criminal activity; it is the opposite of that.

Professor Tim Kendall: The impact that this could have on the culture of the NHS is crucial. You made the point well that we want to give the message that if you are indulging in cover ups and criminal activity, that will be found out. But if you make human mistakes and understandable errors, it is better that we are all open about that and that we can learn from it. Those are distinctly different issues.

William Vineall: As you say, Chair, there is a valve there for in extremis cases. Otherwise, as everybody said, there is an ability to be open and to learn within the NHS.

Q15 **Chair:** Finally, how would you make sure that the lessons that are learned, either through an HSSIB investigation or a PHSO investigation in particular? How would you make sure that those lessons are disseminated across the NHS and not just to one trust?

William Vineall: That is a good question. Obviously, when HSSIB reports, its recommendations will predominantly be for the provider—usually trusts—but there will be a role for NHSENI, effectively to ensure that the trusts take those recommendations on board seriously, so in a sense, there is an enforcement mechanism through the NHS bureaucracy. As and when CQC or others go back and inspect, if you had an HSSIB investigation, one of the things that they could ask is "HSSIB made those recommendations, what have you done?" You get a kind of virtuous circle of enforcing the recommendations made by HSSIB.

Obviously, HSSIB does a limited number of investigations a year, but they are meant to be investigations for which there is also learning for the wider system. In a sense, part of the role of NHSENI is to help with the dissemination of those messages beyond just the trust involved.

Q16 **Chair:** In this particular case, what follow-up is planned to ensure that those improvements are made?

Ms Dorries: In the cases that are being reviewed at the moment?

Chair: Arising from the PHSO report.

Ms Dorries: As I said, if, in the review, it is found that criminal activity may have taken place, there will be a full police investigation. Following that, there is the NHSENI regional investigation—that is what we depend on when HSSIB is not doing its own investigation—but if there is a police investigation, they cannot go in until it is finished. If there is no police investigation, they can go in as soon as this review is completed. It really depends on what happens next and whether it is found that there has been criminal activity. If there has been, of course we have to hand it over to the police, and until the police investigation is finished, we cannot do our own deep investigation. It depends on what happens in the next stage and we are waiting to see what the review will show as to where we go next.

Q17 **Chair:** We would be grateful if you followed up directly with the Committee as soon as you can to report progress.

Ms Dorries: We will.

Q18 **Kelvin Hopkins:** We have already discussed quite a lot about patient safety. My simple question to begin with is whether patient safety remains a core component at the heart of what the mental health services do?

Ms Dorries: Absolutely. I think that the establishment of HSSIB—not just the department but the work that you guys have done as well—and the fact that we have got to the point that we are at today demonstrates this new era of patient safety and how important it is to the Department. I was not exaggerating when I said before that I think we are on the edge of something: a whole new culture change, going from blame and retribution to safety and learning. That has been at the heart of mental health care. It may not always have been there, because there would not be ligature points in wards if true attention was paid to patient safety. We would not have in-patient deaths. It is our objective to have zero in-patient deaths

on mental health in-patient wards. Tim will pick me up on this if I am wrong. That is the objective.

Professor Tim Kendall: It is an aspiration. We have reduced the number of suicides—the actual number of suicides and the suicide rate—among in-patients.

Ms Dorries: They have gone down over 15 years.

Professor Tim Kendall: They have gone down substantially. They have halved, basically, in a seven-year period.

Ms Dorries: Which, I think, answers your question. The fact that the in-patient suicide rate has halved over seven years shows that safety is a huge consideration.

Professor Tim Kendall: But it's also true that, within mental health services, the overall suicide rate has come down by about 50% over the past 10 years. That is partly complicated by changes in the way that it has been reported, but even if you take the last five or six years, it has come down very substantially. I think we are doing the right things within mental health services, but that doesn't make me complacent. I don't think we have arrived. As the Minister says, we want to try to bring in-patient suicides down as close to zero as we can get.

William Vineall: On wider patient safety and mental health patent safety, when we published the patient safety strategy in the summer, there was a specific component on mental health safety improvement. NHS England and NHS Improvement are working with all 54 mental health trusts to look at reducing the use of restraint, sexual safety and suicide prevention. There are bespoke activities for service improvement in safety across the piece.

Professor Tim Kendall: That is probably the largest national quality improvement programme around patient safety that I am aware of. The restrictive interventions programme, for example, includes restraint, seclusion, chemical restraint, segregation and so on. We are looking at all the different ways in which, within an in-patient unit, a person's liberty can be restricted. We now have a programme that is covering two thirds of trusts. Although it is early days—we have been running it for a year—we have had some very substantial reductions in levels of restriction. That includes places like Norfolk and Suffolk, which have been struggling. They are the only mental health trusts that are in special measures. The wards we have incorporated into the quality improvement programme have seen reductions of 80%. I am pleased to say that these programmes are now beginning to bite, and we are going to follow them with ones around sexual safety, which is relevant in these cases. As I say, we have got an even bigger programme around suicide and suicide prevention. In the main areas of patient safety within mental health, we have active programmes already under way.

Q19 **Kelvin Hopkins:** The CQC report "The state of care in mental health

services 2014 to 2017" was relatively recent. They highlighted a safety concern about unsafe staffing levels and poor management of medicines, in particular. Clearly, those two go together. Is that being addressed? My view is that our health service in general is underfunded by comparison with other nations in the developed world, and unsafe staffing levels is crucial in the problems that have been seen.

Professor Tim Kendall: We have had a good settlement for the NHS—3.4%. For mental health, that has translated to, by 2023-24, an increase in expenditure within mental health services of £2.3 billion extra. We have to turn that into people. That is absolutely crucial on in-patient units as well as in the community.

Ms Dorries: Most of that £2.3 billion is for workforce—most of it is for salaries. Actually, that £2.3 billion is over half of the annual prisons budget, which is £4 billion a year. That is just to put in perspective how that looks in real terms. It is actually a fairly huge amount of money, and most of it is going on salaries. Mental health is mainly not about structures and buildings; is about people, so most of that is to go on staff salaries.

Kelvin Hopkins: Another factor in understaffing—staffing shortages—is possible dangers to staff as well as to patients. Has that been addressed as well?

Professor Tim Kendall: The restrictive interventions reduction programme—the easiest way of reducing restriction within an in-patient unit is just banning it. The consequence is that staff will be hurt, and then your sickness rates go up, and so on. This has to be done between the people who use the service and the professionals who are involved in the service. So all of our quality improvement programmes start with the people who use the service and the professionals providing the service sitting down and saying, "Okay, look, we want to reduce the way in which we restrict people. Let's have a look at what you think—the service users—will help us do that." And then they identify what are the four key things. They are often quite simple. They are things like "Don't switch on people's light in their bedroom halfway through the night to check on safety; go in with a small torch", but these are things that patients will tell you. So the whole programme is predicated on a collaboration between the people using the service and the people providing the service, so you are bound to get to the things that really matter.

Q20 **Kelvin Hopkins:** The poor management of medicines is important as well, and that relates, in my view anyway, to unsafe staffing levels. If there aren't enough staff to ensure that medications are being taken appropriately—the right medicines at the right times and so on—if there aren't enough staff to do that and it is left to the patients themselves, perhaps, this has an impact as well. So the poor management of medicines is part of the safety regime, I would have thought.

Professor Tim Kendall: Absolutely, and we are putting additional funding into ensuring that we can get psychologists and occupational therapists into the ward situation, which would free up nurses that are there to do

that kind of work more—to focus on medicines management, and so on—and allow us to make these environments much more therapeutic. So I absolutely accept your point that we have a challenge to ensure that we have got good professional staffing: we are rising to that challenge—but that will allow us not only to make it therapeutic but also deal with some of the issues which nurses are best placed to do.

William Vineall: Overall, the Department published a people plan in the summer, which was trying to draw some of these strands together and saying that we need a workforce where staff can work more flexibly, they can be more responsive to what patients want, which is joined-up care, and you get a better efficiency overall. We recognise there that in some areas—particularly in nursing—there are shortages that need to be addressed; but as well as the numerical issue we need to address how the staff is complemented and utilised and what career structures we are offering.

Q21 **Kelvin Hopkins:** I have a number of private anecdotal stories, which I won't mention in personal terms, obviously—

Ms Dorries: You can tell me later, though, Kelvin.

Kelvin Hopkins: But GPs often are not sufficiently skilled in mental health treatment—medications and so on. That is a fact that I know has caused problems for some people. Is it possible to touch on that?

Ms Dorries: This is a really important issue—who suffers from mental health illness, when does intervention happen, who intervenes, how do they intervene? What we have at the moment is patients walking into GP practices probably fairly along the way—advanced—in their mental health illness. In mental health illnesses, let us talk about eating disorders. I think it is one of the worst mental health illnesses because it is probably the only mental health illness where the patient actually fears recovering more than they do getting worse. They actually fear getting better, and it is deadly. One in four people with eating disorders dies, so I think it is one of the worst mental health illnesses, and they will present in a GP's practice quite often at a very advanced stage.

So one of the aspirations and objectives of the £2.3 billion is that we will have, by 2023, 25% of schools and colleges covered, with mental health support teams. I went to actually see one of the trailblazer sites in Hounslow last week. That is where mental health illness in young people quite often presents—quite often at the change from primary school into senior school; getting ready for exams; leaving school and going on to college; when there are things happening at home. But these mental health support teams will be able to intervene early, and it is that early intervention that is so key.

So you are right that GPs do not have—and it depends on the GP, Kelvin, because some GPs have actually specialised clinically in mental health before they become GPs and have gone on to do the GP training. Others train in dermatology. So, across GP practices, you have a broad range of

clinical expertise, and you are right that not all of them will be trained in mental health. What we want to do is for GPs to treat people who have physical illness and to minimise the number of patients with mental health issues that you get walking into a GP practice at an advanced stage and put layers in before, so that we have early intervention when these mental health illnesses present.

However, we also want to have community mental health teams, in the structure, really, in the way that we used to have—we used to have community mental health teams—so that they actually deal with patients with mental health issues, not only in crisis but ongoing, and deal with those patients in the community.

That is because there is a line that Tim said a while ago that I have never forgotten, and I repeat it constantly, and it is that no mental health service was ever better provided in a hospital than it is in a community. Well, I don't think it is any better provided in a GP practice actually than it is with community nurses and clinicians and those who really understand and specialise in mental health services.

So there is going to be almost a transformation in the way that mental health services are delivered and that will be at a community level. I think that with eating disorders, we want people who are in crisis to be seen within a week, and not have to wait to go for a GP referral to be referred to a clinician. We want people to be seen immediately when they present.

So we do have these objectives, to ensure that these mental health illnesses are treated appropriately by the right people in the right setting, close to patients' homes and families, so that we are not dependent on a GP both diagnosing them and then making the decision as to whether or not to refer them on to where they are referred on to.

I think I am right in saying that quite often the GP will have to refer to the community health services. But the fact is that, going forward with this £2.3 billion to fund this workforce, those people will be in place, so that people will be seen quicker, intervention will be earlier and treatment will be more effective. That is the plan, I think, going forward, to ensure that the responsibility is not all laid at the GP's door, as it is now, because GPs will tell you that they are overburdened with the number of people they see.

One GP just told me recently that he thinks probably a quarter of the patients who go into his practice have mental health issues, and he only has 10 minutes with each patient, which is not long enough with a mental health diagnosis or complaint. People need longer, and they need the right intervention and the right therapies, and quite often it is not drugs. Quite often it is talking therapies, or having the right mentors or the right people to help them to develop strategies to deal with what they are going through at that particular time.

With drug treatment, there is an overuse of anti-depressants and other drugs to treat mental health illnesses, and very often it is not the

appropriate treatment. So I hope that in the future we will see a shift away from GPs, in-patients and clinicians, who, of course, will always be there for the most serious of mental health illnesses, which will always present. But I hope that a large number of people will be dealt with in the community and in the right way.

Tim, in case I have said something wrong, do you want to add anything?

Professor Tim Kendall: It was absolutely fine. I head up NHS England's response to the PHSO report and to Averil Hart, which was a tragic case of someone who died from an eating disorder—from anorexia nervosa. Part of that is to make sure—I mean, the report says very specifically that many GPs, junior doctors, general nurses and so on do not really understand eating disorders at all, and we are now charged with how we are going to up everyone's game, so that all GPs should be able to deal with mental health and eating disorders.

I have met with the Royal College of General Practitioners and the GMC; they are part of the group overseeing this. It is pretty clear that GPs who have been trained in the last 10 to 15 years are actually very good on mental health; it is built into their postgraduate training that they do a lot on mental health.

It is probably more of a problem for those who were trained earlier, so we have got a job of work to do in getting them more up to speed. There are ways of doing this, but we have got to do this across the board so that junior doctors—I mean, we have discussed this before at this Committee. Junior doctors in the main do not understand mental health as well as they should. Currently, only 20% of them have direct experiential training in mental health in their FY1 and FY2 years—their first two years. We would like to see that increase; we would like to see them all do it, to be honest.

Ms Dorries: We also now have community-based units for eating disorders. I actually spoke to someone who works in one only yesterday morning, who told me that they just had somebody brought in in a wheelchair, too far advanced to even walk. We were discussing it, and she was saying to me, "If only there had been mental health nurses in the school that could have picked this up", because quite often the family do not deal with these situations desperately well at home. If somebody at school had been able to intervene—a mental health support team at school—to work with the family and help the family through, she may never have got to that position.

We have put the units in place in the community to deal with eating disorders, but now it is like we are working backwards; now we need the mental health support teams in school. The first trailblazer teams have already rolled out, and by 2023 we hope to have 25% of all schools and colleges covered.

Q22 **Kelvin Hopkins:** Just before I ask my last question, Chair, may I say that it is a pleasure to see the new Minister before us, my geographical neighbour? I also know that you have health service professional

experience, which is very significant and obvious from the way you are speaking.

My last question is really about resource, and residential resource as well, because I know from personal experience that sometimes, patients have been discharged when they should not have been discharged because of pressure on resources. While we want as many patients as possible to be in the community, living with their families, medication or whatever, there are others who do need to be in a mental health unit, and we need sufficient of them to cope with demand. Is that something that the Government have at the forefront of their thinking, as well?

Ms Dorries: Upgrading the existing estate is a priority now. I don't know if anybody remembers Friern Barnet, or when I trained as a nurse it was Winwick Hospital in Warrington, and there was Rainhill in Liverpool. When you look at some of those old buildings, they have actually been the poor relatives of the NHS, and I say that without any fear myself. They really have; they got the raw end of the deal. They were the last to be upgraded, the last to be enhanced, and there is now a project moving forward to bring the mental health estate buildings up to be fit for purpose in 2019, to be at the same standard as all NHS estate.

I think the first part of that issue is having somewhere that is a reasonable environment—a good environment—for in-patients to be kept in, which actually aids their improvement, not makes them feel worse and is not fit for purpose for treating patients. A fair amount of the mental health estate was just not fit for purpose, and I do not think I am being too strong in saying that.

Professor Tim Kendall: No, no.

Ms Dorries: For a lot of mental health patients, it just was not a good environment to keep them in, and I think we are working towards improving that now, aren't we?

Professor Tim Kendall: There is absolutely no doubt—the CQC has said this, too—that the physical environment of a number of mental health wards and so on is a limit to patient safety. That suggests it is pretty bad, but it is also worth saying that in terms of the use of that resource, it is a very expensive resource. An in-patient stay will cost anything between £100,000 and £200,000 per year per patient, and the more secure it is, the more expensive it gets.

If you go to areas where they have really good community services and they are backed up by an in-patient unit, the in-patient unit do not have all its beds filled all the time; they are not sending people out of area. If you have really good community services, that precious resource can be kept just as that: a precious resource.

Ms Dorries: For the very worst cases, you need it.

Professor Tim Kendall: For all these things, you have to monitor use and things such as readmission rates, so that you know that if you are

discharging people relatively quickly, they are not being readmitted, which is obviously evidence of a failed discharge. But I cannot stress enough that I don't think that this precious resource is too small; it needs to have really good community services before you get to that. That is the big focus of the extra £2.3 billion, roughly half of which will go into ordinary, routine community mental health care and crisis care in the community.

William Vineall: Going back to the physical fabric that the Minister was talking about, obviously there was the large announcement about capital funding a couple of weeks ago. Within that, we said we would bring forward a health infrastructure programme that will include more schemes across community and mental health services. In August there were some other announcements, and there was £70-odd million for the Manchester Mental Health Foundation Trust to develop a new in-patient unit. There was about half that sum of money for Mersey Care for a low secure unit for people with learning disabilities. There is some physical fabric improvement resource going into mental health services, and we all agree that there is more to do.

Q23 **Chair:** Can I just pick up on one thing? Maybe you should write to us about this, rather than answer now. The Department hands over money to NHS England. How do you guarantee that NHS England and CCGs actually expend the extra £2.3 billion that you refer to on what you intend them to spend it on? They are autonomous.

Ms Dorries: Tim is NHS England, so maybe he could answer.

Professor Tim Kendall: We have got the mental health investment standard, which is that every CCG has to increase its spend on mental health. We now have agreement that, over the next 10 years, their investment in mental health will exceed their spend, proportionally, on physical health. Even more so is that, as a percentage, children's mental health will exceed everything else. We are tracking that—every quarter, we publish data on what the CCGs spend.

Q24 **Chair:** So we can expect the annual accounts for NHS England to show this increase, and for the National Audit Office to confirm that the increase is actually being spent on mental health services. We can expect that, can we?

Professor Tim Kendall: Yes. Over the next five years, for the first time in the history of the NHS, we have ring-fenced the money that is going into mental health. That additional money is to be handed on to the providers to invest in mental health.

Ms Dorries: And Chair, I can assure you that I will be watching every penny.

Q25 **Chair:** Does that require Simon Stevens's consent and agreement, or is it something the Government can instruct Simon Stevens to do?

Professor Tim Kendall: I think it was Simon Stevens's idea to ring-fence it, actually. He has been a great supporter of mental health, as you are probably aware. I feel that we are in the best possible position for the next

five years to ensure that the money promised by Government to go into mental health will in fact go into mental health.

Q26 **Mr Jones:** Professor Kendall, you mentioned the downward trend in the number of people taking their own life while in the care of mental health services. I think you said the decline was about half over the last seven years.

Professor Tim Kendall: As a rate, yes.

Q27 **Mr Jones:** What does that translate to in numerical terms?

Professor Tim Kendall: If you look at the absolute number of people who die by suicide within mental health services, which amounts to about 28% of all suicides in England, it has come down. There are some periods where it has gone up, but they are brief. It has gone up when the national picture has gone up, but overall the absolute number has come down. During that time, the number of people using mental health services has gone up significantly; it has virtually doubled in the last 10 years. If you then look at what the rate is—out of the number of people who are actually using mental health services, what proportion have died by suicide? The rate has come down by about 50%. It is quite a substantial drop, given that we have many more people using mental health services.

Q28 **Mr Jones:** What does that equate to in numerical terms for the last period that you have available?

Professor Tim Kendall: It is about 1,250 per year. Out of a total of approximately 5,000 people, there will be 1,200 who have killed themselves. That is significantly lower than it was in the past.

William Vineall: If you look at the figures for in-patient suicides alone, between 2006 to 2016, they reduced from 142 to 89.

Professor Tim Kendall: That is absolute numbers.

Q29 **Mr Jones:** What steps are you taking to reduce the number of deaths still further?

Professor Tim Kendall: We have a national suicide reduction and prevention programme. Public Health England has got every locality—every local authority—a suicide prevention programme and plan that is all in the public domain. NHS England and NHS Improvement have set up a programme of work that we are about 18 months into, which is funded by £25 million—£5 million in the first year, £10 million in the second, £10 million in the third—which is focused on three major groups of people who are at particularly high risk of dying by suicide.

People who use mental health services are at high risk. People who self-harm are at high risk. If you self-harm, in the year after you have self-harmed, your risk of dying by suicide is about fiftyfold to seventyfold—not per cent—higher than if you had never self-harmed. It is the biggest single risk factor we know about. The third group, really sadly, is men, in the main in their middle years, who are not in touch with mental health

services. Generally speaking, they do not see the value of talking. They are in touch with their GPs, usually in the couple of months beforehand. We have a programme of work that addresses all those three groups, with the challenge that we reduce it by 10%.

Ms Dorries: It is not only in mental health settings that patients take their own lives on the NHS estate. We have recently provided £2 million of funding to an organisation called Zero Suicide Alliance. One of the objectives of the organisation is that it is training NHS staff in recognising—

Q30 **Mr Jones:** Can I interrupt you, Minister? I will come to that later in the session.

Ms Dorries: Okay.

Professor Tim Kendall: For those three groups, we have recruited nearly 50%—not quite—of STPs around the country. We have given them a sizeable amount of money, between £300,000 and £700,000 each per year. They have given us plans about how they will deal with those three groups—people who self-harm, people who are in mental health services and men who are isolated and do not talk.

They have their own local way of doing it. We have started with areas that have high suicide rates. My own area of South Yorkshire has a pretty high suicide rate, but there are others. They are coming back with plans about how to reach each of those groups.

We are working with the National Confidential Inquiry into Suicide and the National Collaborating Centre for Mental Health at the Royal College of Psychiatrists. They are bringing together expertise on suicide and self-harm, and quality improvement. They are basically working at the local level to address those three groups.

I am pleased to say that there are some very innovative things going on. In Leicester, they have a group called It Takes Balls to Talk around the football club. Sorry for the pun, but the point is that they are getting into things like football clubs and rugby clubs. We are at the early stages of working with the Professional Footballers Association, which is helping the programme to get in touch with local football clubs. It is early days. We are evaluating this as we go along—well, not us, but Niche, which is an organisation we brought in to do so. This is all in the five-year forward view. The long-term plan is now agreed and will fund us to extend that to the whole of England, so by 2023-24 we will have covered every STP in the country. We hope that that will go some way towards bringing the suicide rate down.

Mr Jones: Thank you.

Chair: We are covering a lot of ground and you have given very comprehensive answers. Perhaps we could move a little more quickly, or perhaps we don’t need to ask all the remaining questions.

Q31 **Eleanor Smith:** That is fine because we have already covered steps around improving the care and treatment of patients in a mental health setting. What mechanism is there for spreading best practice for patients with mental health problems throughout the NHS?

Nadine Dorries: I am a bit HSSIB-focused at the moment. Best practice for me—well, we have already seen it happening. Reports have come forward from HSIB, and there are deep investigations. We are disseminating that information across the NHS to set new standards of care delivery, and new processes for the treatment of patients. I see HSSIB being very much involved in that in future, as the organisation that can, from the purpose of incidents, gather and garner the most qualitative information and disseminate it, driving forward those standards of care and safety. Although HSSIB is the safety organisation, because it moves in when there has been an incident, standards will be set as a result of information that HSSIB will learn and processes will be developed.

This example is not from mental health, but one patient had a nerve block placed in a left ankle, but the right ankle was operated on. Via its investigation and information gathering, HSIB developed a new process regarding patient positioning, and together with the Royal College of Anaesthetists, it developed a new procedure to ensure that such a thing never happens again. That is not a mental health example—perhaps William will dive in with one of those—but that is how I see standards developing in future.

William Vineall: As the Minister says, there are quite a lot of standards out there already, and often the challenge is to get people to implement them if they haven't done so—people often complain that there are too many standards. The letter that Tim and Aidan Fowler, the patient safety director, sent out at the start of last month in response to this report, stated, first, that we will do an investigation in the fullness of time once the police and HSE have finished their work. Secondly, it listed a number of areas, including NICE guidance on the use of risk assessment, evidence of best practice, normal patient safety alerts, and the mental health implementation plan that Tim has already commented on. We said to people, "There is plenty you can do now based on the resources and advice you have to improve services. You do not need to wait for a further report to make improvement happen."

I suppose the spirit of NHS improvement is that there is a large amount that trusts can do at the time, and then there are specific things that you sometimes need to do with further resources or support. The idea that improvement is not a day-to-day activity that trusts are undergoing anyway would be wrong. The spirit of the letter was to say, "There is plenty you can do now. Don't wait for a further investigation to improve where you need to."

Nadine Dorries: That is particularly important in the suicide risk assessment tools used in A and E. We had a situation where someone came into A and E and was discharged, and they then took their own life after discharge. That is because their assessment in A and E did not follow

the NICE guidelines on how to assess somebody who presents at A and E and may be suicidal. The guidelines basically ask the clinician to make a judgment and take a holistic approach to how the patient presents, rather than having a tick-box exercise where if someone ticks two boxes they therefore cannot be suicidal. I think you included that in the letter—we should use the NICE guidelines, because they are already there. It is just that not every NHS worker across the NHS or every A&E is actually adhering to those guidelines. That was to remind everybody: "We can minimise the risk of suicide if you just follow the already established NICE guidelines and use the risk assessment tools properly." That is part of that. It is not the standard setting—the standards are already there—but the standard reminding. It is reminding the trusts that the standards are there, reminding them to follow them and reminding chief executives—"If you feel your staff need professional development in the guidelines that are already in place, make sure that professional development is there for staff to undertake that."

Professor Tim Kendall: The Minister is absolutely right. If you look at those people within mental health services who die by suicide, 84% of them in the months before were in a risk assessment rated as being at low risk. The NICE guidance says, "For God's sake, don't do that!" If you rate people at high risk, medium risk or low risk, all the mental health workers will say, "High risk—we stay in touch with them. Low risk—we don't have to worry too much." The moment you say, "We don't have to worry too much," you have just introduced an unnecessary risk.

I think the Minister is right: you create a safety plan that fits the individual, and you stay in touch until they are out of the woods. You don't decide on the basis of a risk assessment who should or shouldn't get a treatment.

Having said that, I am aware that me writing a letter is not going to suddenly change everybody and to make them do stuff. It is terribly important that this is backed up by national quality improvement programmes; that the CQC is able to come in to say to trusts, "Look, you are"—or are not—"doing this well"; and that we have national audits, NHS benchmarking and so on.

The key thing for the NHS is that we have the potential for a system that is really transparent—which is unlike almost any other national service health service worldwide—and that we can start building on that to get safety into everything that we do. I think we are doing that, but we have a way to go.

Q32 **Mr Jones:** The PHSO believes that the evidence from the cases outlined in its report should have prompted immediate action, with leadership from the top of the trust and senior accountability for delivering and evidencing improvement. It is a question of leadership. What steps are you taking to improve leadership throughout the NHS?

Ms Dorries: In terms of this trust, as we discussed earlier, there has been a merger, the leadership has changed and therefore standards have been raised. It is very much about leadership in the NHS.

In terms of what we are doing to change leadership, I think there is no excuse for poor leadership. Raising standards within the NHS I think weeds out poor leadership. As we have discussed, lots of standards are set already that we know are not necessarily being followed everywhere, and we are trying to encourage trusts to follow them, but I think the emphasis on learning, cultural change, patient safety, setting safety standards and having ambitions such as zero suicides—almost zero suicides—and having those ambitions, direct poor leadership to become better leadership.

In terms of the workforce, the £2.3 billion that we have injected into mental health services is to increase the workforce, because the pool has been quite narrow. We are seeing more people coming through training to work in mental health. We never had that before. It was never an area that people really wanted to work in or chose to work in. That has changed now, and we are seeing people coming through wanting to work. As a result of that, I think that we will see better leaders coming through too. I don't know if William wants to say something?

William Vineall: I mentioned the people plan before, which came out in the summer. One of the chapters is about leadership—and another document is enthused about leadership—and there are some things that we have committed to do now, during 2019-20, which include: first, as the Minister said, establishing effectively what we mean by leadership, as fully understood across the NHS; secondly, ensuring that the CQC reviews its "well-led" framework to ensure a greater emphasis on leadership, which in a sense is a theme of this report and others; and also having more talent boards across the NHS, as well as some very straightforward things—or seemingly straightforward—such as having a central database of directors, so that we know where the leadership comes from.

As well as the significant sums of money going into the health service, we are also saying that we need to improve the HR and leadership functions, and that is a piece of work that is being taken forward by NHS Improvement and NHS England, particularly led by Dido Harding, who is the chair of NHS Improvement. That is significant action, which we want to take.

Q33 **Mr Jones:** If a trust shows a pattern of serious underperformance, what proactive steps does the NHS take to improve that?

William Vineall: There are two planks. First, NHS England and NHS Improvement can step in and, secondly, the CQC can take action that includes, in extremis, closing down elements of a service, if they are inappropriate.

Q34 **Mr Jones:** Can you clarify that point? You could step in. What action would you take?

William Vineall: For NHS England and NHS Improvement?

Mr Jones: No. If there was an underperforming trust. You said that you could step in.

William Vineall: Well, NHS England and NHS Improvement would look at why it is underperforming, and it could potentially be put into special measures for finance or quality via the CQC, which then means that you are at the bottom of the class and there has to be a targeted programme of action, which is overseen by NHS England and NHS Improvement, to ensure that improvement takes place, so that you don't let the thing drift.

Professor Tim Kendall: We have a much closer relationship with the output of the CQC than we have had in the past. Having said that, as William says, there are mechanisms in place where if the CQC puts a trust in special measures for financial or quality reasons, we have a conversation with it immediately. Say it is a children's unit, the question is then whether we shut beds or units because we regard them to be unsafe.

Nadine Dorries: And we have suspended staff. That is an important point. When a unit has been found to be failing, staff have been suspended and reallocated to other units, and the unit has been closed. The CQC move in very quickly, because that is a patient safety issue. If a mental health unit is found to be failing, it becomes an issue of patient safety. There is an immediate closure, patients are reallocated and staff, if it is appropriate, are suspended during that time.

Professor Tim Kendall: If a trust is put into special measures, a whole army of improvement directors and associate improvement directors, and so on, are put into the trust to help it, and it gets access to special funds from NHS Improvement. For that group we have a fairly consistent response. The next group up are challenge providers and there is another programme of work that NHS Improvement puts in to help those providers.

I should say, as we move towards integrated care organisations on the basis of a population of 1 million to 2 million, that they will also have a part to play in trusts or services that are not doing so well. These would not be ones at the bottom end, but ones which consistently require improvement. One of the things I know from talking to the CQC is that it is aware of trusts which just bump along, and require improvement after improvement, and you think that there must be some problem in the leadership for it not to have clocked that. We aware that leadership is a big issue. CQC has the "well-led" framework as a key part of its inspections.

There are things that we are doing. Only last week, the Royal College and NHS England started a leaders' programme, where we are inviting in chief executives, medical directors and so on. They get direct exposure to people such as Simon Stevens. Lots of things are available, but we need to be quicker about getting in to help trusts that are just bumping along. We are clearly doing things about those which fall into a more difficult place, but for those that are bumping along, we need to do more.

Q35 **Mr Jones:** You mentioned already the issue of training for doctors. What are you doing to improve the level of training generally for staff working in mental health settings?

Professor Tim Kendall: Do you mean mental health staff?

Mr Jones: Yes.

Professor Tim Kendall: In the main, I am pretty pleased with how mental health nursing has changed over the last few years. They have integrated physical health and mental health; it is the same in the first year. That is great news from our point of view, because if there was one gap among mental health nurses that I was aware of, it was that they were a bit deskilled when it came to physical health, and that is not good. We know that people with mental health problems, particularly those in in-patient settings, will commonly have some physical health problems. I am aware that these things are changing and, as I say, we are looking at the stuff around doctors.

We are also looking at evidence-based training around new types of workers. As Nadine said, we have the mental health programme for schools. We are training brand-new workers—education and mental health practitioners. They are trained over a year to be skilled up to do basic evidence-based interventions for mild and moderate problems for children in schools. These new types of workers—we have them in primary care in the IAPT programme—are trained specifically to do interventions for which we have NICE-concordant evidence that they work. I am reasonably confident about that.

The bit that I am less confident about is the mental health training of people who are not in mental health—within acute trusts. Some 30% to 70% of people going into an acute trust out-patient appointment turn out to not have a physical health problem, after all the investigations—70% in some parts. We need to get to the point where they understand the basic mental health of people coming into their departments. We are not there.

Q36 **Chair:** That is something that I think came out in our eating disorders report, which was based on a PHSO report.

William Vineall: One of the things in the health workforce plan that already exists is looking at how we can have improved recruitment and retention of existing staff. As Tim said, that focus is across acute and community trusts as well as mental health trusts, recognising that there needs to be a greater awareness in those settings as well.

We are also doing various things to try to increase the number of posts—there are 21,000 new posts—and, as Tim said, to have different kinds of advanced clinical practice, such as the nursing associates, in order to have, as the people plan says, a more flexible workforce that recognises mental health needs.

Ms Dorries: We have turned a corner with the workforce. The numbers have increased by 3,400 in the last year. We have turned a corner in that

mental health is a desirable area to work. Previously, it was difficult to get people to move into that arena. Now, universities and colleges are willingly wanting to offer courses where they weren't so much before, and we have the money for the workforce when they come through. It is not huge numbers, but I think we saw 300 people qualify on the new course last year and the uptake has been 340 this autumn, on a new course in mental health. We are definitely going in the right direction in terms of the workforce.

Q37 **Chair:** I am encouraged and impressed by the detail of knowledge you go into about the workforce strategy for mental health. I very much welcome the NHS workforce plan or whatever it is called. It is a good start, but it really is only a start. There are no pages of spreadsheets showing what specialities are going to be required or what training is going to be required for nurses in those specialities; identifying the shortfalls in the year ahead, how the pipeline is going to be supplied and the training places that need to be created; or creating a budget or financial requirement for a workforce development strategy for the whole NHS. It is a very thin document.

Ms Dorries: Are you talking about the people plan?

Q38 **Chair:** Yes, the people plan. I thought it was rather indicative that it did not have the usual faces of Ministers and officials prominently in the document. It was an almost anonymous document. I think it is a start, but would you agree that we need a much more comprehensive people plan for the NHS?

Ms Dorries: We do. As the mental health Minister, I would very much. Actually, it is also the interim plan. It is work in progress; we are not actually there yet in the full plan.

Chair: No, I appreciate that.

Ms Dorries: But as the mental health Minister, I would like to see exactly what you have just identified. I would like to know exactly what our aims and objectives are in terms of the workforce and mental health.

Q39 **Chair:** And what it is going to cost, and where the money is going to come from.

Ms Dorries: Exactly, but we actually know where the money is going to come from now. We do have that box ticked; we know where the money is coming from to pay the workforce. We have the £2.3 billion.

Q40 **Chair:** How much of the £2.3 billion is being spent—

Ms Dorries: Most of the £2.3 billion is going on workforce, but what I would like to know is—and I have had a discussion—

Q41 **Chair:** Is the workforce you are seeking to employ there to employ?

Ms Dorries: This is the discussion. This is the big issue. I have had this with—

Q42 **Chair:** How much are you going to spend on training places?

Ms Dorries: Yes, and where those people are going to come from; how we are going to attract those people into working in mental health. I think it was described to me as, "We're all fishing in the same pool." NHS trusts and the Prison Service—lots of people are fishing in that pool for those kinds of people who want to work in those caring professions. How are we going to attract people to work in mental health, how many are we going to get, where are we going to train them, and where are we going to deploy them once they have been trained?

As it is an interim plan, it is just work in progress. Feedback like yours, Mr Chairman, can be—I don't know when there is going to be a consultation process, but when there is a consultation process, perhaps you and your Committee would like to feed into that, because that is a very astute observation.

Q43 **Chair:** The people plan is not directly within the remit of this Committee, except as it overlaps with patient safety and the PHSO.

Ms Dorries: That is a shame. Well, I am sure Mr Vineall will take away your comments and feed them in.

Q44 **Chair:** But I am personally giving it a lot of my attention and working with the colleges and the professional organisations. They are all very concerned about this.

William Vineall: The spirit of your input is very welcome, because part of the reason why it is an interim plan is because NHSI wants to go out and consult in a sensible way, talk to the NHS and make sure the set of solutions is going to work, rather than just putting a blueprint down.

Q45 **Eleanor Smith:** What are you doing to embed the effective learning culture in the NHS trusts?

Ms Dorries: As we're talking about the mental health trusts, perhaps I should hand that over to you, Tim.

Professor Tim Kendall: I have alluded to it before. We are very keen that we help the leadership in trusts develop a learning culture within their trust, and that means on the shop floor, so to speak—the clinical-patient interface. That is where quality improvement input is so important. I will not say too much more about it, but the point is that you are engaging people on the coalface, so to speak—the patients who they are dealing with—and you are getting them to find what the next steps are to achieve an improved experience of care, more effective care or safer care.

We want to see that process spread across the NHS. If you go to Northumberland, Tyne and Wear, where the vast majority of their services get "outstanding" with the CQC, that is exactly what they have done across their entire trust. East London Foundation Trust, another outstanding trust overall, has done pretty much the same thing. Northampton is the most recent outstanding mental health trust; there are now three, and all of them are doing this kind of work.

I would add into the Darzi model on quality—effective, safe care that has a great experience from the service user's point of view—a fourth leg, which is quality improvement, and it is continuous. There is not a point at which you finish. Every year, you are working out ways to make it more safe, make it more effective and improve the experience. That would be the key thing that I would want to stress.

Ms Dorries: We know that learning flourishes in environments where there is an openness to challenge, and at the risk of sounding like an HSSIB bore here and sounding slightly obsessed with HSSIB, I see the answer to your question in some part being the continuous use of HSSIB going forward—that openness, that challenge. I just want to point out that there used to be a difference—you will know this, Eleanor—between a district general hospital and a university teaching hospital. I moved from one to the other. I moved from a district general hospital, where long-term practices that may have been bad became embedded in the culture of the hospital, to a university hospital, where it was exciting because there was a refreshing openness to learning and discovering. We want all areas to become like university hospitals used to be across the board. We know that where there is that openness and that excitement about learning, professional development and challenge, employees respond really well. I see HSSIB as being a real part of that by setting standards, embedding learning and bringing learning into the NHS—as a matter of course, not just in the pockets with the title "university" above the hospital name, as used to be the case; and across every area in the NHS, not just in mental health.

William Vineall: HSIB has done two investigations so far into mental health services, where it has made recommendations not dissimilar to the things we have been discussing. They have made a start there, and obviously we want them to do more. It will be up to them to determine the cases that they think are most important in mental health services or others, once established.

Q46 **Mr Jones:** Minister, I interrupted rudely when you were telling me about the Zero Suicide Alliance.

Ms Dorries: I am very excited about that too.

Mr Jones: Could you tell us about it? What has been its overall impact so far?

Ms Dorries: The Zero Suicide Alliance, which I take no credit for—it was in place when I arrived at the Department—has received £2 million of funding to establish an online exercise. I do not know whether you have undertaken it, but people can go online and go through the process of how to identify someone who may be presenting with suicidal tendencies, how to intervene and how to signpost someone to receive help. NHS staff across the estate are also receiving this training with the Zero Suicide Alliance. As we have discussed, in a general hospital setting, people may be in with just physical illnesses but may also have mental health issues, so we are training NHS staff to identify suicidal tendencies in patients. I

have asked for an update, as I have just arrived, on how much has been spent so far and what has been achieved: how many people have been reached online and how many people have been trained in the NHS. I am waiting to get that data back. I believe I have received the spend figure, which I think is at the £250,000 stage at the moment. We advertised this during Suicide Awareness Week.

I would just emphasise on that point—this is something that I personally feel very strongly about—that we must not silo responsibility for suicide awareness to any one organisation. We must not say that the Zero Suicide Alliance, as an organisation, because it is being funded by the NHS, should take responsibility for all the training and all the information available about suicide. Every member of the public—every one of us—has a responsibility to prevent people from taking their own life. Every one of us has a responsibility to intervene.

There is this stigma: "We mustn't mention the word 'suicide', because, if we do, someone is more likely to take their own life." That is nonsense. That is not true. We must all remove the stigma and the fear of intervening when we feel somebody may be at risk. Every single member of the public can go online, look at the tools and go through practice conversations to learn how to approach someone they think may be suicidal, how to intervene, how to signpost help and how to get help, but we must all take responsibility. Suicide should not be siloed with any one organisation—not the NHS or the Zero Suicide Alliance. We, the public, have the responsibility to identify and intervene.

The Zero Suicide Alliance is running. It is training people, and as many people as possible should undertake that training—the more, the better. We also launched Every Mind Matters last week. Again, that is trying to remove the stigma from mental health. I don't know if you saw this, but the royals voiced over a film written by Richard Curtis and featuring celebrities such as Davina McCall, Nadiya Hussain and lots of others to destigmatise. It was people saying, "Look, we are celebrities, and we are really successful people, but we have suffered from mental health issues. We have had suicidal tendencies." The more of this we do, the better. It is not just the job of Zero Suicide Alliance. We have to destigmatise mental health and suicidal tendencies, too. That is a job for all of us—every member of the public—because that culture change has got to come about. Sorry, Mr Chairman, I was too long in my answer.

Q47 **Mr Jones:** What would you say are the key barriers to progress towards the zero suicide ambition that your Department has announced?

Ms Dorries: Stigma is the key barrier. In achieving zero suicide, stigma is the hurdle we are yet to get over. The reason why men do not talk or see value in talking is because mental health is stigmatised. They see it as a failing, or they see reputational damage to themselves, if they open up about the fact that they have mental health problems or suicidal thoughts.

William Vineall: If you look at the breakdown by gender of suicide in different countries, the best situation you see is where there are two times

as many men as women who kill themselves—it can be up to nine times as many. This is an international problem. As is the case in England, many are not in touch with mental health services. The Minister is right that as the stigma falls away, we need to be in there saying, "Look, if you're in a difficult place"—if, say, your finances are difficult, you are in debt and your gambling has got out of hand, which are the kinds of things that we know are relevant to why people might kill themselves—"there needs to be an opportunity to talk." The less stigmatised this is, the better.

Ms Dorries: That is our big objective: to de-stigmatise. If someone breaks their leg, they will go into an A&E and get a plaster cast put on it. When someone has a mental health illness, it is the same: they need to get help and have the treatment. They are the same, but people see being physically ill as okay and being mentally ill as just not okay. We need to break down those barriers.

Q48 **Chair:** Some people might say that by putting so much emphasis on the role of the general public, you are taking the responsibility away from health service professionals, who cannot be responsible for how the public deal with mental health.

Ms Dorries: No, I am not saying "The general public instead of"; I am saying "as well as". We take our responsibilities very seriously. The Zero Suicide Alliance, Every Mind Matters and all these campaigns are about de-stigmatising and helping to prevent suicide, but the NHS cannot do it alone; everybody needs to be aware.

Q49 **Chair:** I appreciate that. The other point I would make is that in some instances it is disputed whether a death can be classed as suicide and whether, in fact, there is culpable responsibility on behalf of the NHS for the loss of life. Is it unreasonable of me to caution you not to be seen to be seeking to shed that responsibility for those two issues?

Ms Dorries: I don't think I am shedding responsibility; I am trying to break down stigma and elevate awareness to make everybody play their role. We are never going to be in a position where everybody who is contemplating taking their own life, for whatever reason, is receiving NHS treatment. It tends to happen at periods of huge change. If someone has had a divorce, lost their home, lost their children, lost their business and they suddenly find themselves facing bankruptcy, they are not going to go to the NHS for help with that. We need to ensure that everybody around that person is aware and understands that it is okay to intervene. That is what we need to do. That is the only way to prevent and bring down dramatically the numbers of people who are taking their own lives.

Q50 **Chair:** The two cases involved here were already subject to a lot of intervention. It was not lack of intervention—

Ms Dorries: Those people were on the NHS estate, so that is completely different. I am talking about suicide in general across the UK, and men in particular, who, as Tim has highlighted, tend to be much more vulnerable to taking their own lives without seeking intervention or help from the NHS, having had no medical intervention at all.

William Vineall: In the two cases that we are talking about, there were safety failures. People were aware but there wasn't the follow-through.

Chair: That is an important emphasis to add.

Professor Tim Kendall: People come into mental health services with the expectation—certainly, it is the expectation of their relatives—that they will be safer, not less safe.

Q51 **Chair:** Exactly. There have been demands for a public inquiry into NEP. The Government have responded by saying that they are introducing the mental health safety improvement programme to address the safety challenges. Can you clarify when that programme will be introduced and what the timings will be?

Professor Tim Kendall: It has already started.

Nadine Dorries: It is in place already.

Q52 **Chair:** When was it implemented?

Professor Tim Kendall: It was launched by Jeremy Hunt, the then Secretary of State, in October 2017.

Q53 **Chair:** And when is it going to be completed?

Professor Tim Kendall: It will never be completed; it will continue. As with all good quality improvement programmes, it should be continuous. Part of it is the suicide work that we are doing, and part of it is the restrictive interventions reduction programme that we are doing. Next year we will be starting with the central safety on in-patient units; that will be a part of it.

I think mental health may be the only ones doing this proactively, but every time the CQC delivers a report on a trust we sit down with the trust and the CQC. We are there to make suggestions about how we might help direct them or provide input in terms of improving quality and safety. It is becoming more like a virtuous circle.

Nadine Dorries: Also, one of the functions of HSSIB is the role of medical examiners. It puts a duty on all trusts to have medical examiners in place who will review death certificates at the time of death of a patient, to review that patient's treatment, where a coroner isn't involved. It is just another step.

Q54 **Chair:** Is this the statutory medical examiner we have had running in Sheffield for some time?

William Vineall: Yes, they have been running in shadow for some time. The fourth element of the Bill is to change the funding arrangements, so that it goes from being a local authority funding purpose to an NHS funding purpose. Therefore, it requires the NHS to appoint medical examiners across all the trusts. It works by having an 100% geographic coverage; there isn't a medical examiner in every single trust because they work to geographic communities.

For all the non-coronial deaths, it means there will be the ability for those cases to be reviewed and examined independently and, pertinently to this case, for an explanation to be given to the family. People will be able to understand the cause of death at the time. In a sense, it is complementary, which is why it is in the HSSIB Bill.

Chair: In fact, it was one of the recommendations of our original report.

William Vineall: Exactly. If we get all that right, hopefully in the fullness of time there will be fewer historical cases coming forward, because you catch things at the moment.

Q55 **Chair:** I am very pleased to hear all that. In response to the petition, the Government have said that they are considering advice and representations on whether there should be a public inquiry. When will you make a decision?

Nadine Dorries: As I said earlier, we have the review that is taking place now. We have had the PHSO report and the review that is taking place. We need to wait to see whether the police will be involved and whether there has been criminal activity. Then there is NHS England and NHS Improvement.

I too have asked this question, and the answer is that public inquiries do not happen for individual cases; they tend to happen when there is a systemic problem or there are multiple cases. In this case, a public inquiry is not an appropriate response because we are talking about two cases. That is the answer I have been given. But we do have, still, without a public inquiry—

Q56 **Chair:** So even though you are taking advice on whether to have a public inquiry, you have, in fact, decided not to have one.

Ms Dorries: I have asked the question already. Mrs Leahy has asked the question. That has been her campaign—for a public inquiry. I looked into it and asked why there was no public inquiry into the case. I have been told that it is because it does not happen with single numbers; it happens with multiple numbers. It tends to happen where there is a more systemic problem.

Here we have these layers to go through, which is the review now and the police inquiry, and then, for the families, the NHS England and NHS Improvement regional investigation will take place. I am not sure what else a public inquiry would actually be able to find out as a result, because the families of the deceased will have their chance, in the regional investigation, to give all their information. There is nothing else that a public inquiry could achieve that is not going to be achieved by going through this process.

Q57 **Chair:** How will you involve the families in that so that they have an opportunity, at least, to be convinced of that case?

Ms Dorries: That will come when NHS England and NHS Improvement conduct their regional investigation. How the police conduct their

investigation, if they are brought in, we have no say over. That will happen, or not, as a result of the review that is taking place now.

NHS England and NHS Improvement's regional investigation cannot take place while a criminal investigation is happening. If it does not happen, they will move straight in when the review reports. If the police are involved, they cannot move in until the police finish their criminal investigation. I would imagine that the police will involve the family. If they are not involved and we go straight to the regional investigation, NHS England and NHS Improvement will involve the families. The families will have their voices heard in that investigation, in the same way that they would do with HSSIB.

Q58 **Chair:** I think this has been an extremely important evidence session. I do not imagine that we can do much to assuage the grief, anger and anxiety of the families—I suspect that this will be painful listening for them—but you, Minister, have demonstrated great passion for improving mental health services in the NHS, and we are very grateful for that. We will hold you to account for the way you implement the findings of the PHSO's report and the subsequent commitments that you have made. If you can report to this Committee on progress over time, we would be very grateful.

Ms Dorries: It would be our pleasure to.

Q59 **Chair:** Are there any other questions? This has been your first Select Committee appearance.

Ms Dorries: This has been my first ever Select Committee appearance, yes.

Chair: Well, your answers have been very full, and the sincerity of your commitment to your work is evident, which is refreshing. I thank both officials as well.