All Party Parliamentary Group on Mental Health

**APPG on Mental Health**

**Inquiry into Parity of Esteem: Reducing Premature Mortality for People with Mental Health Problems.**

**House of Commons, Committee Room 19**

**Wednesday 29 January 2014, 1 – 3pm.**

**Witnesses:**

| | |
|---|---|
| Norman Lamb MP | Minister of State for Care and Support, Department of Health |
| Matthew Fagg | Deputy Director, Reducing Premature Mortality, NHS England |
| Dr Martin McShane, | Director, Enhancing quality of life for people with long term conditions, NHS England |
| Dr Arokia Samy | Consultant Psychiatrist and Clinical Network Director, Lancashire Care Trust |
| Lynn Burling | Carer |

**TRANSCRIPT OF MEETING**

**James Morris MP (Halesowen & Rowley Regis) (Con)**: I would like to welcome you to the APPG on Mental Health and the launch of our inquiry into parity of esteem. This is the first of three sessions, each focusing on a different theme. Today we are looking at the premature mortality of people with mental health problems.

We're delighted to have had such a strong response to our call for evidence; we have had over 200 responses, so there is a good rich evidence base to inform the inquiry. There are also a range of different organisations here today. I will now hand over to Norman Lamb, Minister for Care Services.

**The Minister of State for Care and Support, Department of Health (Mr Norman Lamb):** Thank you James. I am very pleased you are doing this inquiry as I have a passion for this. Traditionally mental health services get the raw end of the deal. They are not treated on a par with physical health. I am of the view also that failures of parity of esteem need to be challenged and confronted everywhere – wherever they happen – whether that's in the Department of Health, NHS England, or at a local level including in local decision making about finances. I will first give my presentation and then respond to questions.

More than 30,000 people with mental health problems die prematurely every year. The premature mortality death rate is four times higher among people with severe mental illness. It's astonishing that there's a premature mortality gap for men of 20 years, and 15 years for women.

It's a combination of poor lifestyle, higher rates of unnatural deaths, poor physical health, and risks of socio-economic disadvantage that all contribute to this scandal of premature mortality. This contravenes international conventions for rights to health and life.

It's astonishing that in a 21st Century NHS, three quarters of people with mental health problems receive no treatment, and a third of people with psychosis receive no treatment. Why do we even begin to accept this system? It's even more astonishing that people with severe mental illness are three to four times more likely to die from the big killer diseases compared to the population as a whole. They have lower employments rates, their earning power is significantly reduced, and they live in poor housing conditions. All these factors lead to poorer health and wellbeing, and reduce prospects of recovery and leading the kind of life most people take for granted.

These statistics have been well known for two decades. If they related to any other section of the population there would be a national outcry resulting in headlines and immediate action. This stark disparity is attributable to the stigma and discrimination that affects decisions about how services are

designed, developed and delivered. This is what I call the 'institutional bias' against mental health in the NHS. I am very happy to detail that more in the questions and answers.

Lifestyle factors also adversely affect the physical health of people with mental illness. For example, low rates of exercise, high rates of obesity, smoking, and poor diet, leading to hypertension, cholesterol and diabetes.

Many of the premature deaths of people affected by severe mental illness are the result of poor health care and monitoring that fails to monitor risk factors like smoking and obesity effectively. These deaths are avoidable. The National Audit of Schizophrenia, the largest and most systematic collection of information carried out in the UK about the care of people with schizophrenia, showed that the physical health checks recommended by NICE guidelines for the care of adults with schizophrenia are only being carried in 29 per cent of cases. Further, even when health checks are carried out and problems are discovered, this doesn't always result in action. The audit also discovered that only 25 per cent of people with high blood pressure received treatments. There is therefore now compelling evidence that people with mental illness receive worse treatment for their physical health. Evidence also shows that this happens because general healthcare professionals are poorly trained in mental health, or falsely believe that physical health problems are the result of mental illness. This is an issue that goes to the heart of parity.

We must also ensure a person-centred, holistic and preventive approach to the treatment of mental health problems. This in turns leads to an integrated healthcare service, that gives equal account to mental health and physical health.

The costs to the NHS of treatment for people with mental health and physical health runs into billions. The costs of mental illness to society and economy are even higher. By placing lower value on mental health, we get less value from the NHS as a whole.

As a Government, we've committed to improving the nation's health and making sure people live well for longer. In the 'Call to Action', the Secretary of State set a challenging aspiration for England to have the lowest rates of premature mortality among our European peers. Severe mental illness has to be a priority, which is reflected in Public Health and NHS Outcomes Frameworks. Our commitment to parity enshrines in law equally priority for mental and physical health. This is a key priority for NHS England. One of our key objectives is to put mental health on a par with physical health. NHS England is working with national Clinical Directors and others to deliver programmes of work to support this objective.

In 'Closing the Gap', the action plan for mental health services which was launched by the Deputy Prime Minister and myself last Wednesday, I promised an information revolution in mental health. The Mental Health Intelligence Network, jointly led by Public Health England and NHS England, will give us a truer and more up to date picture of health nationally and in each area. There is a very clear gap between the information available and the extent to which it's understood and analysed when you look at mental health and compare it to physical health. We are too often operating in the dark, not really understanding what the evidence tells us about what works and how we can most effectively use the resources available. The information will give us a clearer idea about how we are performing against our promises in the Social Care, NHS and Public Health Outcomes Frameworks. It will also help local Clinical Commissioning Groups, Health and Wellbeing Boards and other partners to determine what types of services are needed in their area and how they can improve the mix of services and support available.

Our Integration Pioneers are already setting the benchmark for services. 14 groundbreaking initiatives are transforming the way health and care is delivered, by bringing services closer together. The pioneers are showcasing innovative ways of providing coordinated care. The aim is to make health and social care services work together to provide better support at home and earlier treatment in the community, to prevent people needing emergency care in hospital or care homes. I will give by way of example Torbay, where they have set the objective of integrating mental health services into primary care. This should be happening everywhere and we know from international evidence that where

mental health is brought right into primary care you can be far more effective at preventing a deterioration of health, but too often it simply doesn't happen.

In its recent review of the causes of high rates of premature death in 2013, Public Health England gave us the information and ammunition to implement change by setting out the extent of the problem for people with mental health problems and also the interventions that we know reduce risk and improve health. Like smoking cessation; smoking rates for people with mental health problems vastly exceed those of the general population. Many areas are now targeting smoking cessation programmes towards people with mental health problems. That's exactly what should be happening. Smoking cessation has a knock on positive effect - smoke free inpatient units are reporting major reductions in the prescribing of antibiotics for respiratory problems, and people stopping smoking can reduce their antipsychotic medication by up to 25 per cent to 50 per cent, reducing the harmful side effects of their medication. Also, with regards to access to screening, Public Health England is working to determine what works to help people with mental health problems to access the screening programmes that are available to everyone but we know are accessed far less by people with mental health problems.

With regards to health checks, we have pledged to improve the uptake of NHS health checks among people with mental health problems with support from Public Health England and a new CQUIN payment framework incentivising Trusts to improve the take-up of health checks.

We also need to improve physical health professionals' knowledge of mental health. For me, this is a critically important area; there is an extraordinary mismatch between the work of GPs and the training they get. We know that the prevalence of mental health means that GPs are the whole time dealing with mental health problems, but they only receive minimal training. This has to be changed as a matter of priority. We've asked Health Education England in their Mandate to improve this and ensure that all staff have an awareness of mental health and the links between mental health and physical health. We are also looking at an extra year of GP training to focus on mental health and learning disabilities.

This spring sees the publication of 'Live Well for Longer' – our strategy to reduce premature deaths over the next five years. We will bring together the actions that the national system will take including Government, NHS England and Public Health England coupled with local leadership to reduce avoidable mortality through the five big killers – cancer, cardio-vascular disease, stroke, liver disease and respiratory disease. Mental illness and work to tackle co-morbidities will be central themes that run throughout the strategy. I can assure you that within the Department of Health I have been obsessive that that is the case. These plans in the past too often have ignored mental health. For example, the work that we do on urgent and emergency care, it's critical that it understands the role of mental health. The burden on A and E is absolutely clear for anyone who has visited one, that if you don't address mental health, there are people turning up with mental health problems who get absolutely no access to appropriate care and treatment.

But it's not just directives from central Government that are needed. This can't be just the responsibility of Government alone, albeit the Government plays a critical role. We can only be a part of the solution. We know what works; we know that many of the solutions are neither expensive nor complex. What we need now is the collective will to make change happen. Thanks very much.

**Mr Morris:** I want now to give Parliamentary colleagues the opportunity first to ask questions to the Minister.

**Alison Seabeck MP (Plymouth Moor View) (Lab):** I was at Pembridge House in my Constituency – a secure unit for young people with mental health problems. The message from those young people is clear – there are not enough CAMHS services like the one they are in. For example, one young man was told he had to go to Scotland which was clearly an issue for his family. Their first line of support is education and schools. A lot of them said they had talked to teachers, but in two cases the teachers said they couldn't help anymore and didn't know what to do. The young person then drifted and was not supported. These were young people who had attempted suicide and serious self-harm.

As part of this, please can we look at not just support in the health sector but also at other types of support. Education for young people with mental health problems and early identification is so important.

**Mr Lamb:** Alison you are completely right. I have had a session recently on the gap between the work of schools and CAMHS. The problem has to be very serious before there is eventually a referral to a completely separate service. There must be greater linkage between the work of schools and those support services. I'm also very interested in exploring the work of other countries. For example, in Australia there is a service called 'Headspace' which is a youth service. What attracts me is it's completely de-stigmatised. You can book an appointment online; you don't have to go through a GP. It doesn't just deal with mental health; it deals with physical health issues as well, sexuality, sexual health issues, advice about university or employment. It gives you access into services that so often youngsters simply don't get because they're embarrassed or frightened about going into the formal system. I think we should be exploring these sorts of alternatives.

**Mr Morris:** Let's now take questions from the audience.

Representative from **Greater Manchester Clinical Networks:** The young person question is an important one for us as well. We have looked at the idea of having mental health champions within schools. What's your view with regards to bringing in the role of the voluntary sector in supporting young people with mental health problems in schools?

Representative from **Mental Health Resistance Network:** We submitted evidence to this inquiry. I think one of the things that people who live with mental distress have been saying over a number of years is that we can't understand mental health without recognising the context of society. We must move away from this medical model, towards a social model. I have had numerous admissions to psychiatric wards, and they were full of people who were complying with their psychiatric drug programme. I would like to see a proper inquiry into the use of psychiatric drugs, their efficacy and the devastating side-effects of them.

**Charlotte Wetton, Rethink Mental Illness:** I'm asking this question on behalf on one of our members. She knows in her area very often people don't get physical health checks from their GP. She would like to know if there's a way of checking whether people in her area are getting yearly physical health checks?

**Mr Lamb:** I think absolutely there must be a role for the voluntary sector. There is so much expertise in the voluntary sector. In my own constituency of Norfolk there is collaboration between mental health services and voluntary sector organisations. Another thing that they've introduced which I'm strongly supportive of is the 14-25 service. It just strikes me as completely crazy that we have the cut-off point at 18. I would be interested from views from others. The thought of taking away services or forcing change at that incredibly vulnerable age of 18 when all sorts of things are going on in your head and your life, you may be going off to college or university, it seems to me to be the worst possible age to rip away your support network. I'm very keen on exploring that, and indeed 'Headspace' in Australia has this concept of taking you through into your mid-twenties. But absolutely the role of the voluntary and third sector – we should not assume that the state can do everything. There needs to be good collaboration.

With regards to the second question, the default option is too often drugs. One of the things I am looking at, I don't yet have a solution, is that when NICE approves a drug there is an obligation to provide it, but when NICE approves a therapy there is no obligation to provide it. That is a complete mismatch. It's an unfortunate incentive to go down the medicine route. I am sympathetic to the view that we should be taking the non-medicalised route where possible.

With regards to GPs carrying out physical health checks for people with mental health problems, I think that one of the good things that's happening as a result of the Francis inquiry, the inquiry into the failings of Mid-Staffordshire, is that we've introduced Chief Inspectors of hospitals, Chief Inspectors of social care and Chief Inspectors of primary care. The Care Quality Commission has also recently

appointed a Deputy Chief Inspector of mental health, so for the first time there's a person in the inspection regime whose sole job is to drive up standards in mental health care. They will be looking at whether health professionals are delivering what they should be. If they find that there is a failure of GPs failing to do health checks, it will affect the rating of the service. One of the mechanisms, not the only one, but one of the mechanisms is to be clear about the standards that must be met and if they're not met there will be consequences in terms of the services public rating.

**Jamie Woodward, British Association for Counselling and Psychotherapy:** The Welsh Government has ensured that all schools in Wales have access to a school-based counsellor. I'm wondering the Minister has had a look at that, and if he will consider implementing a similar system?

**Dr Adrian James, Royal College of Psychiatrists:** This is a joint question for the Minister and also Martin McShane. It's about the dialogue between NHS England and Government. We have a bit of a window now where Clinical Commissioning Groups are developing their two year commissioning plans by February, and their five year plans by June. We've had some great documents from the centre, such as 'Closing The Gap', and the 'Crisis Concordat' is about to be published. If we got everything in those plans that would be fantastic, but how are we going to ensure that they are actually in commissioning plans of CCGs and NHS England? Is there a mechanism for cross-referencing, to ensure these things are not just referenced to, but big deliverables like 24/7 liaison psychiatry and 24/7 crisis care services are actually in commissioning plans?

**Paula Peters, Disabled People Against Cuts:** There are three points I'd like to make. The first is about the lack of GP training in mental health. Only ten per cent of GPs in the UK have training, it's not compulsory. We think all GPs should have this training. You go to a GP in crisis and they don't know what to do. People are ending up in crisis in a revolving door situation. Secondly, we haven't talked about poverty. In the current situation, with the welfare reforms, it's impacting heavily on people with mental health. The Work Capability Assessment is placing claimants with mental health problems at a terrible disadvantage. A claimant can't accurately describe their situation. I've had 18 of my friends die due to the outcome of their assessment, who they have taken their own lives. That shouldn't be ignored. Thirdly, the other consideration I have is the cuts to the voluntary sector. In my area it's absolutely appalling. Services are being taken from people who are desperately in need of them. This impacts on their recovery times and that is something that must be addressed.

**Mr Lamb:** Jamie first, I will absolutely look at the schools counselling service in Wales; I'm interested to hear about that. Whatever the mechanism we use, I'm clear we need to do far more in schools on a preventive basis, and linking up CAMHS more effectively rather than having a divorced service. I obsess about integrated care, but we spend buckets loads of public money on fragmented, disparate services, and if you just combine the work of different public sector organisations you could achieve so many more bangs for your bucks. That relates very much to mental health and police, and the work that we're doing on rolling out a national liaison and diversion service is fantastic and potentially transformational. The same also applies to schools and mental health services. We must remove the silos that so often result in poor care.

Adrian, you are absolutely right in what you say. I hate the idea of empty rhetoric that sounds great but is ultimately completely meaningless. I am determined that when we say in the Mandate that the NHS and the system must make measurable progress towards parity of esteem by 2015 that it means something. That's why I spoke out on the issue of the setting of the tariff, because in my view it's not acceptable. The tariff was set differentially for acute Trusts and the rest of the system in response to Francis and safer staffing levels. Safe staffing is just as important in mental health as it is in acute Trusts. We must be prepared to challenge and confront lack of parity wherever it occurs. There is a legal force to the Mandate – and an obligation on NHS England to seek to deliver it. They do that in part by sending guidance to CCGs and making sure that when they are setting commissioning plans and budgets for mental health and so forth, it is important that they actually act on this legal obligation. Martin McShane may want to add something to that as well.

Paula, you are completely right about GP training. There is mismatch between the prevalence of mental health problems that they deal with and their ability to deal with it. It is completely haphazard

that if you have a mental health problem whether you find a GP who is able to deal with it. That's not acceptable. That's why we've put into the mandate for Health Education England to address staff training and do it as a matter of priority. You also mentioned benefits and mental health. I recognise as mental health Minister, if I see that there are impacts of policies elsewhere that impact mental health I have a responsibility to raise those concerns. I recently met with a Minister in the Department for Work and Pensions to raise concerns. I used a case study in my constituency to highlight these issues and the way someone was dealt with. I am a supporter of reform of welfare system; it too often promotes dependencies and must change. But we must recognise that people with mental health have particular needs and have to be treated sensitively.

Finally you mentioned cuts to voluntary sector. Sometimes in local areas, decisions that are made about how to achieve the savings that have to be achieved are completely wrong. They get it totally wrong. Rather than addressing problems with bureaucracy or duplication in a local authority, they cut the front line, which is the worst possible thing to do. If you go to some of the integrated pioneers, there are great leaders doing precisely the opposite. For example in Greenwich, a Labour authority, they are enhancing the role of voluntary sector. In Barnsley, they are doing the same and building local community capacity as part of their response to the current pressures of public finances, to ensure there are good public services. So we need to think afresh. The very worst thing to do is just to cut services.

**Mr Morris:** Thank you Norman for a very interesting presentation. We'll now move into the main body of the evidence session, focusing on reducing the premature mortality of people with mental health problems.

**Mr Matthew Fagg, NHS England**: I welcome the APPG's focus on looking at parity of esteem and in particular on reducing premature mortality of people with mental health problems. We are very grateful for the opportunity to give evidence here today. I should manage expectations – I am not personally clinical by background, my remit is around reducing premature mortality and that's across the board – I look at things like cancer and coronary heart disease as well. But I do want to set out some of the things that we in NHS England are doing which are specific to reducing premature mortality for people with severe mental illness.

The NHS Outcomes Framework contains a specific measure on reducing premature mortality for adults under 75 with severe mental illness, so a lot of the work we've done, since we were established little over a year ago, has focused on severe mental illness. There is a wider issue there around other mental illness, but I think it's right that we prioritise people with severe mental illness because that's where there is the strongest correlation with premature mortality. We estimate that around two thirds of excess premature mortality is due to the higher burden of physical disease.

What that suggests is that the risk factors for these conditions are not being managed as well as they are in the general population. People with severe mental illness today have the same life expectancy that the average population had in the 1950s.

In terms of our overall strategy for reducing premature mortality, the new system is very much focused on outcomes rather than process measures. Within the new system, CCGs have a much higher level of autonomy to determine what the clinical priorities are locally. It is also a much leaner system than it was prior to the 1st April 2013. During the transition, we lost about 50 per cent of the management capacity across the system. Those two things – the autonomy of CCGs and the extent of the resource available to use - have influenced our strategy. What we are trying to do is implement a broad strategy of seeking to drive quantifiable improvements in outcomes, whilst fostering local ownership over clinical strategies.

'Everyone Counts' 2014/15 is the planning guidance that NHS England issues to CCGs, and it's one of the few things that CCGs are required to have regard for that NHS England publishes. In this, we are asking CCGs to set levels of ambition against all of the domains of the NHS Outcomes Framework. That includes a specific commitment to securing additional years of life for people with treatable mental and physical health conditions. It's up to CCGs to determine how they construct

those ambitions and how ambitious they are. For each CCG, it will give us a clear plan and clear ways of measuring their progress towards delivering improved outcomes.

Also within 'Everyone Counts', we made it very clear that we expect CCGs to have a clear focus on reducing inequalities health promotion and also parity of esteem. These are not things that the CGG has to set a level of ambition on, but they will have to have plans about how they intend to address those issues.

One of the things that NHS England can do is steer CCGs towards where we think the priorities are. There is a resource that we published on the 20th December which aims to do that. The resource sets out a range of different clinical interventions and relevant costs and benefits in terms of the impact they have on reducing premature mortality. There is a section in there on severe mental illness which sets out our view on where we think some of the priorities are. It's still a work in progress at this stage; we have less quantifiable data in relation to some of those benefits for severe mental illness than we have in other areas and that's something we need to address.

In terms of NHS England's view on the priorities for reducing premature mortality, we've worked with the National Clinical Director and a range of partners to draw these up. We had an event a week ago where we focused specifically on what the clinical evidence suggests the priorities should be for reducing premature mortality. Our view on the priorities chimes closely with the Rethink Mental Illness report that was published in November 2013. There are three areas in particular that I think we need to focus on or that the NHS as a whole needs to focus on: the first is on prevention; the second on early diagnosis of co-morbidities; and the third on person-centred care planning.

In terms of prevention, we need to continue the focus that there has been. The Department of Health has made good progress in the past on reducing suicides, particularly in inpatient settings. Less progress was made on reducing suicides in other settings, particularly in primary care and that's something we need to focus on in future. The challenge of reducing suicides in primary care is likely to be greater than the challenge of reducing it in inpatient units where you have a captive audience. Reducing smoking prevalence is also something that will have a significant impact. There is evidence that people with severe mental illness are just as likely to want to give up smoking but they are sometimes less successful and there is clinical evidence around that.

In terms of early diagnoses, we want to promote screening for physical illness in people with severe mental illness. The Rethink Mental Illness report clearly draws out that there are issues around the prescribing of anti-psychotic drugs, particularly in terms of weight gain and the impact on cardio-vascular risk. Over the medium term, it's something we want to look at and work with a range of partners. We also know that people who are detained in institutions are at a higher risk of mental illness and therefore screening in those settings is particularly important.

With regards to person-centred care planning, this doesn't directly contribute to reducing premature mortality. But it's clear that patients who have been through the person-centred care planning process are more likely to be well-engaged in their care. People who are more engaged in their care are more likely to adhere to pharmacological regimes and access a better range of services. So this could contribute to reducing premature mortality.

Those are our priorities across the NHS, but I'm sure one of things you are interested in is what exactly are we doing within NHS England to reduce premature mortality for people with severe mental illness.

One of things we are doing is seeking to promote clinical leadership. We have funded a National Clinical Director who comes with a huge amount of energy and enthusiasm. We also support 12 Strategic Clinical Networks which cover mental health. We know that the networks in the North East, North West and London are all prioritising reducing premature mortality.

NHS England also has a role in supporting commissioners. We are effectively a commissioning organisation. We are working with CCGs and Strategic Clinical Networks to assess the evidence in relation to mortality.

In 2013/14, NHS England funded a CCG mental health leadership development programme. This was to ensure that leaders in CCGs understand issues relating to parity, and that they use that to inform commissioning.

We have taken action to improve the intelligence base. We are working with Public Health England to prepare for the launch of the National Mental Health Intelligence network, which is due to be launched in May 2014. That will help address the lack of intelligence in mental health.

We are also introducing a systematic case note review into hospital deaths. In the first instance that will focus on the acute sector, rather than mental health specifically, but because many people with severe mental illness die of physical illnesses we would expect a lot of evidence to come back from that case note review in relation to people who've died of physical causes who also had severe mental illness. We expect relevant learning from 2015 onwards. There is an expectation that that case note review, which is part of our patient safety programme, will be systematically rolled out in future to cover mental health services.

One of the most significant things we're doing is from April 2014 we introduce a National CQUIN. This is a paid performance incentive scheme for providers, who get additional payments if they can prove they have met certain standards. A national CQUIN aimed at mental health providers will seek to encourage them to ensure there is screening for physical illness in people with severe mental illness, particularly psychosis and schizophrenia. We plan to continue to develop that CQUIN. It could be very powerful in leveraging a focus in mental health services on physical illness.

We are also working with a range of partners to develop the Lester Screening Tool. This covers a number of domains of physical health risks, like blood pressure and blood sugars. The domains of the Lester Tool link to the priority things we want people to screen against in the national CQUIN – the two things are really in partnership. Going forward, we'd like to potentially roll that protocol out to physical health services as well, if feasible.

We have a programme of work on parity of esteem, working with a broad range of partners across the system. The aim is to embed cultural change across the NHS and system as whole, to ensure we're as much focused on mental health as on physical health.

We're also working with Public Health England to introduce physical health checks in prisons. Because there is a high prevalence of mental illness among prisoners, this could have a significant impact on reducing mortality. We're also looking at introducing screening for mental illness.

Finally, in terms of integration to support better person-centred care, we have a programme of work on integration. We're taking a collaborative approach to devise a strategy to ensure person-centred care planning is embedded for all people with long-term conditions. We're also working with the Health and Social Care Information Centre to deliver integration between IT systems. That is very important to give us a wealth of data that we haven't had to date, on people with severe mental illness. We've already established a link between hospital episode statistics and the mental health minimum data set. We'll be working in 2014 to 2015 to include a link with GP data as well.

I hope that's been helpful in giving you a flavour of some of the things we're doing. My colleague might want to add something to that.

**Dr Martin McShane:** I would like to add some context around this. If you look at the domain website[1], you'll see that there is a graphic which describes the mission for NHS England, which is 'high quality care for all, now and for future generations'.

Quality is then subdivided into three components: safe care; effective care; and care which provides a positive patient experience. Effective care is then divided into three further sub-components: avoiding premature mortality; enhancing quality of life for people with long terms conditions; and helping people to recover from episodes of acute care and trauma.

[1] http://www.england.nhs.uk/about/imp-our-mission/

Those make up the five domains of the NHS Outcomes Framework. I work closely with Celia Ingham-Clark who is the Director for premature mortality and with Keith Willett who is the Director of emergency care, hospital care and helping people recover from episodes of ill-health, as well as Mike Durkin who is the Director for patient safety and Neil Churchill on patient experience. I think this is really different from the previous system because we work together and have one focus, which is providing high quality care for all. It doesn't define you by condition; it doesn't define you by physical or mental health, but instead focuses on a person. One of the problems is that we've developed monocular vision in the health system; we either look at people through one eye of physical health or one eye of mental health. Actually, we need to restore binocular vision in the NHS, and see people with both eyes. Having been a GP for 14 years, I see how we need to address physical health simultaneously to mental health. I was a GP in the 1990s and I had a Community Psychiatric Nurse in my surgery who I worked with. That was taken away by a central policy that said we had to put all our resources into acute crisis intervention. What we mustn't do is to repeat the mistakes of the past and to design the solutions centrally. We need to design the levers, incentives and frameworks and provide the information that will help people locally to improve care.

As a Doctor, I could get individual diagnostics on any of my patients but we can't get population diagnostics. We now have the wherewithal within the new legislation to link data across NHS and ultimately social care, and actually demonstrate when things are happening, but also demonstrate when nothing is happening because we have invested in prevention. This has bedevilled primary and mental health care for the last 20 to 30 years. We don't actually understand what is happening across the patient care pathway. So our first priority is to develop better mental health intelligence and better analysis of the economic value of what we're doing. We need to train people to commission better, which we've invested in, and we need to change our levers and incentives which we've started doing but need to do more of, to truly show the value of mental health community primary care and physical health. We know from the work we've done on analysing where money gets spent, too much money is ending up by default in the acute sector, due to disinvestment in primary care, and we can't track that disinvestment.

We need to stop thinking about the patient and the professional, and starting thinking about the person, the professionals, that person's carers and the community the live in because until we start taking a much more holistic view, not just about the person but also the environment they live in, we're not going to be able to have high-quality care sustainable now and for the future generations.

**Dr Samy, Lancashire Care NHS Foundation Trust (LCT):**

I'll brief you on the factors that contributed to the success in terms of physical health monitoring in Lancashire Care Foundation Trust. I'm just going to pick up the top key factors.

The first one is about clinical leadership. This was introduced into the organisation a couple of years ago, where Clinical Directors and other clinical leads are appointed to work in partnership with the operational managers. As a Clinical Director myself, I was able to focus on Quality issues from a broader perspective ensuring robust clinical assurance processes are in place, especially when there is a change in service or a reorganisation.

We have also rolled out a mental health training programme for GPs across Lancashire. We care for a population of about 1.5 million people spread across eight CCGs. GPs have welcomed this training initiative, because, for some of the senior GPs, it's years since they last had their training in mental health, and some of the new GPs have never had any training in mental health. We have also introduced a training programme for mental health nurses on physical health. That has been really helpful.

The second key factor is having the board oversight. The accountability and the ownership for physical health of all patients within LCT lies with the Medical Director and the Director of Nursing.

One of the key items on their agenda is physical health. As part of our Trust's Quality strategy, the Quality 'SEEL' – (Safety; Effectiveness; Experience; Leadership) tool has been implemented in every ward and team. This is a dynamic tool, that allows triangulation with other data like serious incidents, complaints, compliments and the SEEL ratings are changed accordingly to reflect this.

The third factor involves the introduction of 'clinical treatment teams' consisting of nurses and recovery workers trained in physical health monitoring. These staff have good relationship with GPs and liaise with them regularly around the physical health of those patients with severe mental illness as they are likely to fail GP appointments. For those with mild to moderate mental health problems, by working closely with primary care we can tackle physical health issues. But for people with severe mental illness, we need physical health trained staff within secondary mental health services.

Another important factor is the linking of physical health aspects on electronic care records with the acute sector path lab. If LCFT patients are admitted to any acute hospitals or received care under them, we will be able to access information on their physical health status through the path lab system.

Recently we have recruited public health consultants in LCFT and this will help to link physical health with healthy lifestyles addressing issues like smoking, alcohol, drugs and obesity.

In terms of the successes we have achieved, we are one of the top performing Trusts in physical health monitoring according to the National Audit of Schizophrenia, published in 2013.

However, on a wider scale, there are still some gaps and I share Adrian James' concern about the lack of liaison psychiatry. A recent international study sharing information from 11 countries showed that young people with mental health problems are refusing to seek help for physical health issues due to stigma, discrimination and prejudice. Stigma is still very deep-rooted in the system and that's something we need to tackle simultaneously. Another issue is that people with mental illness use acute hospitals twice as much as the general population. Liaison psychiatry plays a key role here, and I don't think the value of liaison psychiatry is well understood or explored.

**Mrs Lynn Burling:**

My son, Alex, has suffered from paranoid Schizophrenia for the last 20 years.

In 2003 he developed Type 1 diabetes, which I diagnosed, and since then I've worked hard to raise awareness of the need for physical health checks for mentally ill people - including sitting on the steering group for the Rethink Mental Illness physical health check project.

How ironic then that in December 2012, following an MRI scan, he was diagnosed with stage 4 follicular lymphoma and also papillary carcinoma of the thyroid.

This news came out of the blue, his GP practice having failed to recognise the true cause and extent of Alex's continuing physical ill health which had begun about 18 months earlier.

Alex notes were couriered to the brand new Macmillan Cancer Centre, part of UCLH, and a treatment plan was formulated. In the first instance he received intensive chemotherapy and radiotherapy for the lymphoma, and by last July it was in 100% remission. He continues with 2 years of 2-monthly chemotherapy to maintain that remission.

His treatment and care by the Lymphoma Team and his Macmillan nurse have been excellent and he has coped amazingly well.

The situation changed, however, when Alex was admitted to UCH in October for the second part of his treatment plan - a thyroidectomy to remove the tumour. The operation was a success but following surgery and whilst on the Critical Care Ward Alex suffered an acute psychotic episode, when his mental health deteriorated to a state we had not seen for 20 years.

It is relevant to note at this point that a research project carried out at UCH's Critical Care Unit - details of which are currently on the UCH website and were also published in the 'Critical Care Journal', 'Sunday Times' and featured on the BBC in October 2012 - suggests that psychological interventions whilst patients are in critical care could reduce the mental health problems experienced by many patients. The website also states that '. . . a range of methods including relaxation, breathing exercises and therapeutic approaches are used to help patients feel safe and more assured.'

None of these procedures were carried out and, bearing in mind Alex's severe mental illness:

A risk assessment was not done prior to his admission.

A care plan to support his possible mental health needs was not prepared.

The staff appeared to be unaware of the research project findings, and did not carry out the holistic care as specified in the report.

They did not appear to have been trained to deal with mental health problems.

Alex knew he was becoming unwell but the Mental Health Team failed to visit him for 24 hours despite at least two requests from him and a nurse.

As a result Alex became seriously unstable and was detained under Section 5(2) and Section 2 - without our knowledge.

The Mental Health Team failed to provide an AMHP for 24 hours following Section 5(2) and on two nights running I was called to the ward after midnight to sit with him. Fortunately we were staying in a local hotel.

Since Alex's admission we have not received copies of either of the Section papers, nor information relating to our legal rights. When I tried to download Mental Health Act information leaflets from the Camden and Islington website I found them to be out-of-date since 2007.

Other distressing incidents were:

There was no privacy when my husband and I were finally informed: on the ward and in the corridor in full view and hearing of other patients and their visitors.

Alex's bed was directly opposite the ward door - thus exacerbating his paranoia.

The Critical Care Ward staff lost Alex's insulin which led to a delay with his breakfast, anti-psychotic medication and a consequent worsening of his mental state and tachycardia.

The Critical Care Night Sister admitted that she had not read Alex's notes.

A doctor arrived at 4.00 am to remove his drains.

Alex's mental breakdown on a public hospital ward was demeaning in the extreme. He was transferred to Kingsley Green, a secure mental health unit, where he thought he would be 'locked up for the rest of his life'.

The Mental Health Act papers sent by UCH to Kingsley Green were incorrect, and had to be returned, plus the discharge summary gave the wrong date of discharge and did not mention his psychosis or Sections.

His physical health, i.e. his diabetes and tachycardia, were adversely affected and he is understandably anxious about his planned admission next month for radioactive iodine treatment - which means he will be isolated in a room on his own for about seven days.

In short, in the last 18 months my son has nearly lost his life to cancer; in addition, he lost his mind, dignity and freedom as a result of the failure of medical and mental health professionals to work together to provide him with a care package which fully recognised and supported his needs.

The outcome could so easily have been catastrophic and if the Government and NHS England are sincerely committed to achieving parity of esteem for mental health patients they should involve them and carers in developing future improvements to the service**.**

**Mr Morris:** Thank you very much Lynn for that very distressing story. I think it does exemplify some of the challenges we face and indeed why we have set up this APPG inquiry.

The Care Minister has said that he thought there is some degree of institutional resistance within the NHS which acts as barrier to parity of esteem. Do you agree that there is institutional resistance, and if you do agree, how do we overcome it?

**Dr McShane:** I think there is a historical bias. It's this sort of inquiry and the work that's been happening over the past few years that is building a sense of momentum in society and in institutions that this is no longer tolerable. We have tolerated the fact that people with mental health problems have suffered inadequate care.

One of the first programme boards in NHS England is on parity of esteem. We have already set out signals in 'Everyone Counts' this year – the commissioning guidance - that we want to change the levers to combat this. We have also recently had a national event in Manchester on parity. One of the Chairs of our Parity of Esteem Board, Lord Victor Adebowale, one of our Non-Executive Directors, won't allow the NHS England to lose focus on this. So my answer would be yes, but.

**Mr Morris:** Dr Samy, you spoke about the successes in your area. But how can it be that we have such variable levels of commitment to looking at the relationship between physical and mental health that can have catastrophic consequences?

**Dr Samy**: The main thing I've noticed is the little training given on mental health in medical schools, for example for nurses, medical students, social workers and occupational therapists. The problem is that mental health isn't ingrained into other specialities. It is seen as a separate issue. Some action needs to take place at this level.

**Mr Julian Huppert MP (Cambridge) (LD):** I've just had an earlier meeting with the Care Minister on autism. I sympathise with the comment that there is a problem with GP training. GPs don't seem to have enough training in mental health, autism and other conditions. The question I would like to ask is about the interplay between mental and physical health. There is no doubt that mental health has been poorly supported for a long time, but where things are pure mental health only, it seems to me that there is better care than where there are physical and mental health problems. We also have people who are bounced between the two services, with no facilities in mental health hospitals to do physical tests. How do we avoid falling into the trap of saying it's either a physical problem or a mental health problem?

**Mr Fagg**: One of the things I've mentioned is that we're introducing a national CQUIN, to ensure mental health providers undertake physical health checks for people with severe mental illness.

**Mr Huppert:** What do you mean by severe mental illness?

**Dr McShane:** This is actually really interesting because it raises another point. We talk about mental health and we talk about physical health, but when it comes to things like the 'Urgent Care Review', you have respiratory physicians, endocrinologists, trauma surgeons, and then you have one representative from mental health. Whereas actually there is a whole raft of diagnoses within mental health, and its part of the institutional culture that we have that we don't recognise that mental health is a broad spectrum. So severe conditions like psychotic depression, schizophrenia, and bipolar would be three that I would classify as severe mental illness, with great disturbances in thinking, mood and affect.

**Dr Samy:** Whether its schizophrenia, bipolar or schizoaffective disorder, it's not the diagnosis that gives the severity, but it's the way that the conditions affect the person. Even if you take people with schizophrenia, there will be some patients who have just mild symptoms with little impact on day to day life, who have all the potential to work, have a family and lead normal lives. Someone with mild symptoms can be managed very well, with low medication and a combination of psychological therapies. So it's not the diagnosis of a condition that makes it severe, but instead where they lie of the spectrum which depends on symptoms, duration, prognosis, and co-morbid factors like alcohol and drugs, which all add to the severity of the illness.

**Mr Huppert:** So we've established there isn't a clear definition of severe mental illness. And so there's payment for mental health? I'm not quite clear on this.

**Dr McShane:** This takes us back to the point about intensive care. I've been talking to Simon Wessely about this and I've written to James Palmer and the leads in specialised commissioning in NHS England to say that whenever specifications are drawn up, they should take into account what mental health needs might be required, alongside the physical support that's required for people. We have 24 National Clinical Directors. One of them focuses on mental health in their title, but the Directors of children and transitions, dementia, and learning disabilities all have an interest in mental health. Talking to Bob Winter who is Director for Emergency Preparedness and critical care, he says that on his intensive care unit at any one time, 30 per cent of the people will be there primarily because of mental health problems having led to the necessary for critical care. And on this ward, we would specify all the physical support needed, but we don't tend to specify what psychological support is required. I was with the Royal London Blind Society last night, and 60 per cent of children who are blind will group up with chronic depression and anxiety. What are we doing to support the mental health of people with long term conditions because physical conditions can bring their own mental health problems? That's why we need to have person-centred care rather than condition-centred care.

**Mr Huppert:** Do all hospitals have a Consultant Psychiatrist present, available if assistance is needed?

**Dr Samy**: Usually they do. Speaking for LCT, there are ward-based Consultant Psychiatrists available between 9 to 5pm, but out of hours and during the weekend you always have a residential junior doctor and in some organisations there are middle-tier doctors who have some training in psychiatry, but there is access to an on-call consultant psychiatrist.

**Mr Mike Thornton MP (Eastleigh) (LD):** One of the things that concerns me is we talk about GPs not having mental health training, but A and E departments don't have mental health professionals. There are people who have gone into A and E with some physical health problem, but they have a mental health problem as well, and there is no-one in the A and E department that can help. I have had two occasions now where the police were better with the patient when they were asked to come and remove them from A and E because they were causing trouble, and the police understood the person better than the nurses. I'm from a family of nurses and doctors, so I'm not prejudiced against health professionals, but it's absolutely shocking that that should happen.

Why do we have this idea of having mental health trusts and other health trusts? As long as we continue separating these things, we're going to say if you're ill physically then you're ill, if you're ill mentally then you're a problem. What happened with Lynn with just litany of incompetence, which is frightening. Should we have separate mental health trusts, is this a good idea? Should we make sure we have psychiatric or psychological trained nurses in A and E? My wife is a nurse and she did a few weeks of mental health training and that was it.

**Dr McShane:** I think the answer is yes, but first we need to raise awareness of this disparity and that this is no longer tenable. We then need to help and support professionals to develop skills in the way for example that has been done in Lancashire. That's a perfect example of the specialist sector reaching out to support generalists. There's a subliminal message here that somehow it's the GPs

fault that they haven't been trained. We need to reframe that, and make it clear that the system needs to look at the functions which are required, and support professionals to get the right functions in the right place. Some of that's about this kind of inquiry, and de-stigmatising the issue, some of it's about information, sharing information, a lot of it's about training, and then it's about people and taking feedback, their outcomes and their experiences to continually improve the system.

**Mr Thornton:** The people I've been talking to don't tend to have severe mental illnesses, and tend to have depression, stress and difficulty with coping. Surely those people must be included in these physical checks. We must make sure these people aren't overlooked with the focus on severe mental illness. Sometimes mild conditions are a trigger for developing more severe illnesses, so we should be right at the beginning and not waiting until they develop psychiatric illnesses before we intervene.

**Dr Samy**: That's really important, because a recent study that was published this year showed that if people are able to tackle their physical health problems at the beginning, the prognosis is much better. People with severe mental illness are not the only ones with co-existing physical health problems.

**Mr Charles Walker MP (Broxbourne) (Con):** Just to go back to GPs, I would like to cover a number of things. Firstly, of course it's not GPs fault they haven't been trained, but surely intellectual and professional curiosity means that if you are a professional you would ask for and demand that training. So the BMA and GMC should be hammering on the door of the NHS demanding that their members receive training in mental health. It seems extraordinary to me that if you're running a practice where you're seeing many of your patients presenting with mental health problems that you wouldn't want to, as that Practice Manager or lead GP, go and get the necessary skill sets within your organisation to meet that demand.

Secondly, the QCQ report – the annual review of mental health services - launched yesterday, showed that record numbers of people are having their liberties removed and being locked up. That to me does now show a progressive agenda; we're going backwards not forwards. We've had two fantastic Minsters for health under this Coalition – not from my Party - who have showed great passion, but I think there is a great disconnect between what they want to see happening and what is actually happening.

Finally, we're still embarrassed by mental health; we don't like people to make a spectacle and a scene. We tend to treat the symptoms rather than the person. We provide medicine that hasn't been updated since 1985, making the patient feel miserable, they want to smoke cigarettes, they weigh 20 stone. I have so many friends and acquaintances that have children with a severe mental illness, and the one thing they all have in common is they smoke and weigh over 20 stone. We have a long way to go and we have to get over this embarrassment.

**Mr Fagg**: On the first of those issues, GP training, there was talk earlier about Health Education England improving training. It's the GMC that has responsibility for setting professional standards, and accrediting training providers, and I think the regulators, like GMC and NMC, here have a key role. I think there's an opportunity in terms of re-validation which has just been introduced for doctors. Certainly if someone is working in General Practice, there should be an expectation through good medical practice that they have understanding of the needs of their patients and that they're able to deal with them. We haven't yet seen the results of revalidation, but it's the biggest change in medical regulation that we've had in 10 years. It's a good lever to ensure practitioners take professional responsibility and they are up to date in all aspects of patient care.

**Mr Walker:** What's extraordinary is that if I was a GP and I couldn't tell if a patient had cancer or another chronic disease, I would lose my license and probably be struck off. But I can know nothing about mental health, and that's not a problem.

**Mr Fagg:** It's a very similar issue with cancer actually. The average GP sees 10 cancers a year, of which five are common ones. It's actually not that easy for GPs to spot the symptoms of cancer. We have to work out how NHS England can support GPs to understand the symptoms, but there is a role

for regulators here to look at training and the education providers to ensure that there is proper training in mental health from the outset.

**Mr Walker:** That's the point, you nailed it. A GP only sees 10 cancers a year, but a GP will see hundreds of people with mental health problems and yet no-one is really that bothered that they don't know much about it.

**Dr McShane:** Having worked as GP, I can say my colleagues were bothered about it and are committed to continuous professional development. One of our problems was that the support we had when we identified people with mental health problems was asset-stripped in the 1990s from General Practice. I met a Community Psychiatric Nurse on a daily basis, and then suddenly they were removed. Now we are reintroducing that support through the IAPT programme – Improving Access to Psychological Therapies. Over the last three to four years we've increased the number of people who have access to psychological therapies. We can always find quite a lot to criticise with all the consultations and surveys every year, but there is a lot of good work being done as well, and a lot of people undergoing training. But there is a lot of variation between areas – from extremely good and outstanding to very poor - that we need to address.

**Mrs Burling:** With our local mental health Trust, Herts partnership, 11 years ago when my son developed diabetes, I diagnosed it and there is a whole litany of problems stemming from that. I took my complaint to the Healthcare Commission, because I'm quite sure that if I hadn't diagnosed it my son would have died from diabetes then. I complained on 13 counts, and the Healthcare Commission found in my favour on 12. It took me a year to discover that the Trust hadn't implemented any of the recommendations that were made. They had clozapine protocols, but I telephoned every single clozapine clinic in our area and nobody knew about the clozapine protocol. I took it to Rethink Mental Illness in the end and they helped me raise awareness. I spoke to the APPG eight years ago on this very issue. I've been Chair of the Carer council locally for some years, and just being a member of Carers in Herts and Rethink Mental Illness, I'm raising awareness of this issue with carers who can then take it to their loved ones. I've been banned from Trust meetings because I upset one of the local Trust Managers. Even now the Trust is not getting it right; a recent QCQ report showed it failed spectacularly in one important area. They have a long way to go.

**Mr Walker:** Mike Thornton made a point about separating mental health trusts, and separating mental health trusts from hospitals trust is sensible as it does allow us to see where money is being siphoned away. Acute trusts are at the front end, doing all the hospital work, the glamorous work that we see on television. It's very emotive to cut their budgets, so typically when there has been a financial squeeze, money has been taken away from mental health. That still did happen in the 2000s, but at least we can see when money is being taken from mental health budgets, and we can make a noise about it happening.

**Dr Samy:** I think that's important and also mental health trusts are built specifically for their purpose, with a calming and therapeutic environment.

**Mr Morris:** I will open up questions from the general audience now.

**Audience member:** I would like to raise the issue of domestic violence, both for the perpetrator and the victim, because they both I think have psychological problems.

Representative from **Mental Health Resistance Network:** I was sorry to hear Lynn's story and I am pleased that she is here to speak. I'm from the Mental Health Resistance Network and we're people who have experience of mental distress and we don't always have to have other people speak for us. We have to move away from this idea of 'does he take sugar?' I'm a bit disappointed that there wasn't a mental health service user or survivor on the panel. We gave you some evidence and we are capable of talking for ourselves, so please start listening to us.

**Mr Morris:** Yes I think that's a fair point. It's also fair to say that in the past the APPG has had a considerable number of service users on the panel who have given evidence, and we intend to do that again.

**Mr Nick Bosanquet, Imperial College**: The NHS is not the only provider of services; in fact 30 per cent of patients who are under section are being treated in the private sector. What are the plans for NHS England and others for ensuring that private and voluntary providers, like St Andrews, play a significant role in this? They want to do more but I'm not sure that their record is that much better than anyone else, partly because they are not allowed to do more of the long-term rehabilitation work. What is your approach to building more partnerships with the private sector?

**Dr Samy:** Domestic violence is high on the public health agenda, and there is specific work going on in this area. I also think it's very important that we involve service users. For example, in our trust we have an experts by experience group, and now involve service users in customer care training. With regards to the private sector, my personal experience of using them is that, if we compare performance, the private sector isn't as good as the NHS sector. Their lengths of stay are definitely longer and readmission rates are higher, but there are good examples of holistic approaches that are done well in the private sector.

**Dr McShane:** The question about the private sector actually speaks to the question about skilled commissioning. That's why we've invested. Geraldine Strathdee, the National Clinical Director, had led a commissioning development process across London before she came to NHS England. This led to a transformation in the way that services were being commissioned across London because we up-skilled commissioners. I'd like to point out that I've been deeply involved in commissioning since 2004, and this is now my fourth organisation. The longest team I worked with was for just over five years, which was fantastic. We were able to build real skill and local knowledge, experience and engagement with the public. We need parity between providers and commissioners on re-organisation as well. I worked in one GP practice for 14 years and we were able to achieve some real quality and improvements and changes there. I'd really like there to be an opportunity to do the sort of commissioning which draws on the public, private and voluntary sectors to intelligently commissioning and deliver great outcomes for people in England. A little bit of stability would be really nice.

**Dr David Osborn, University College London:** I've worked with people with mental health problems just researching this area, I'm afraid for about 15 years now. So one of my cautions is that it's great we're here today, but it's also very sad we're here today because this had been on the agenda for a long time. QOF came about in 2004, so it's the 10th anniversary of GPs screening and physical health checks. I think it's a bit of an own goal that having cholesterol as part of that QOF has been retired this year, because cardio-vascular disease is one of the biggest problems for people with mental health problems. So I want to be optimistic but I think it's really important that we think about solutions that are sustainable. With respect Ministers come and go, and MPs come and go, but what we need is something where we are really measuring outcomes over the next decade to make sure we are really delivering what we all believe in her today.

**Ms Matilda MacAttram, Black Mental Health UK:** I just want to echo how much I believe in what the lady over there said about wanting service users to speak for themselves, even though I'm not a service user, and her call for a national inquiry into the side-effects of antipsychotics. The reason that I raise this point is because the stakeholder group that the organisation I run represents are people from the UK's Afro-Caribbean communities, who are often given very high doses of anti-psychotics and the side-effects affect their physical health. So I think that's a really important factor.

**Liaison psychiatrist:** I'd like to add to the question about liaison psychiatry across the country. The answer to whether acute hospitals have access to a psychiatrist is no, and beyond that, we don't know. There is no way of knowing what services are provided across country. This is something that Geraldine Strathdee is trying to figure out, and find out what the state of liaison psychiatry is and what a liaison psychiatry service looks like, because there is no standard service. I should probably point out that I'm a liaison psychiatrist. As a liaison psychiatrist, approximately 30 per cent of the people we see in the emergency department having harmed themselves more than twice in six months don't have a diagnosable mental health problem. The combination of physical health problems and mental health problems is toxic. So my question is how we can make sure we address the needs of people with these co-morbidities, when actually many people with mental distress don't have a diagnosable mental health problem?

**Dr McShane:** It's a really interesting question about QOF as it goes back to the information and diagnostics we need to improve care. We have, according to the Commonwealth Fund, the best primary care IT system in the world. General Practice has invested heavily in electronic medical records. They also have clinical registers. I do recommend reading the QOF guidance that's coming out. Patients with co-morbidities will be included in all the registers where they meet the relevant criteria. For example, a patient could be on the asthma register and also the COPD register if they have both conditions. This means that they would be eligible for the care outlined in both disease areas. So we have a severe mental illness register for General Practice and you have the cardio-vascular disease register. The principles of QOF actually state that we shouldn't be collecting data twice. We can interrogate these systems, and we need to give people confidence that we want to use the information from GPs systems to improve the quality of care. If we can use this information more intelligently, more frequently, and cross-cut it to get the sort of information that professionals are looking for, I think we can drive quality improvement far more rapidly. There needs to be feedback to GP Practices and Trusts on a regular basis on the quality of care that's being delivered and the outcomes that are being delivered, they get frustrated when they are lambasted for not providing quality of care when they are only measured once a year or once every three years.

**Dr Samy:** I do agree with you that Liaison Psychiatry is not very well explored, but has a huge role to play in the acute sector. I think it is less-explored because it is poorly funded.

As for side effects of anti-psychotics, I think that's a very valid point. When we treat people with anti-psychotics, it's very important to get a shared understanding with the patient of what they would like to achieve. For some patients, you can give them a lower dose of anti-psychotics, and bring the auditory hallucinations down to a degree that they can tolerate. But if you want to completely get rid of auditory hallucinations you give a higher dose, but many patients won't comply with the medication because for them they want to lead a good quality of life as well as have some improvement in symptoms. The other thing about anti-psychotics we need to be aware of, and I think Norman Lamb touched on it, is for people who smoke, the level of anti-psychotic in the blood reduces so they need to be on a higher dose of anti-psychotic to get the response for their symptoms. Once they quit smoking, the level of anti-psychotic required will be much less, which means less side-effects.

**Mr Fagg:** To come back to our colleague from UCL and the point about mental health having been on the agenda for years, I think part of the issue as I see it is that there were people who dealt with mental health as part of their job, and those who always thought that it was someone else's responsibility. I think one of the ways this is different in the way that NHS England is set-up is that mental health is now part of everyone's jobs, and hopefully by starting from that we can start to embed the idea of parity throughout the structures.

**Mr Morris:** Let's take some more questions.

**Audience member:** I have found this discussion slightly backward and I think I want to refer to some of the points made earlier. It's about having people who are experts by experience up there on the panel and discussing it with you. For this to be a new issue I find odd; it's been on the table for a long time. I suggest that you consider getting service users involved in training and commissioning services in every layer.

**Mr Simon Tan, Therapist:** I've been a therapist for 14 years. We are all here because we care about mental health. For all of us who are feeling a bit frustrated that there is so much to do, and not enough time and resources to do it, actually there is something each one of us can do. We can all take care of our health, and that of our family, friends and colleagues and any strangers, if safe, who are feeling low. There was an article in the Evening Standard and Telegraph that a young man was about to jump off a bridge and a total stranger approached him and asked him to go for a coffee and have a chat, and saved that man's life.

**Mr Charles Fraser, St Mungo's:** I'm from St Mungo's, we're a homeless charity. I realise that homeless and rough sleeping is a relatively niche part of mental health, but in general principle would like to see more services delivered in community centres. As far as mental health is concerned, our

clients complain about the carousel of assess and refer, assess and refer. When does treatment start? Every time there is a referral, there is a gap in services for someone to fall into. The final point that I want to make is that the emphasis on IAPT is something that we find concerning. It seems to be a service for the worried-well. We would like to see more resource go into intensive counselling.

**Mr Fagg:** With regards to service user involvement being important, I think that's absolutely the case. We had a workshop a week ago and we had two patient representatives there and their stories really reinforced the things we were talking about. One lady brought pictures of herself through her life course and she could demonstrate the amount of weight she'd put on as a result of anti-psychotics.

**Dr McShane:** I'd like to put a challenge back. I spoke at an internal parity of esteem event we had at NHS England. We had 60 clinicians and managers there. I asked the room if there was anyone here who has not been personally affected by mental health or someone they know affected by mental health, to please put their hand up. Not a single hand went up in the room. In a sense we are all users. In my family and in my job, I've had personal experience. It is critical that we bring that challenge of bringing in service users into everything we do.

With regards to IAPT, this is the beginning and not the end. I would challenge the assertion that it's for the 'worried-well', because it's the first thing we've implemented that carries a measurement at the beginning of therapy, through therapy and then at the end of therapy and tracks outcomes on a recognised scale of distress and we can see what the reliable recovery rates are. We need to continue the work to bring up the level of investment and focus on mental health in the NHS and in society.

**Dr Samy:** With regards to IAPT, a lot of work has gone into it, but we just need to be careful because there are some people who need a higher level of psychological interventions and they shouldn't be placed in IAPT just to tick a box.

**Mr Morris:** I'd like to thank everyone for coming along today. I think we've had a very wide ranging and productive discussion on a range of issues. I'd like to express our gratitude to the panel for their wisdom.

MEETING ADJOURNED

All Party Parliamentary Group on Mental Health

**Attendance list**

**Members of Parliament:**

| | |
|---|---|
| Russell Brown | MP for Dumfries and Galloway |
| Gloria de Piero | MP for Ashfield |
| Julian Huppert | MP for Cambridge |
| James Morris | MP for Halesowen and Rowley Regis |
| Alison Seabeck | MP for Plymouth Moor View |
| Mike Thornton | MP for Eastleigh |
| Charles Walker | MP for Broxbourne |

**Observers:**

| | |
|---|---|
| Laura Able | |
| Maqsood Ahmad | NHS England, Greater Manchester |
| Mick Atkinson | Place2Be |
| Helen Atwood | Kids Company |
| Andy Bell | Centre for Mental Health |
| Jonathan Bellini | |
| Jazz Bhogal | Department of Health |
| Nick Bosanquet | Imperial College |
| Lara Carmona | Rethink Mental Illness |
| Denise Cope | NHS England, Wessex |
| Stephanie Creighton | British Medical Association |
| Felicity Dormon | Department of Health |
| Steven Duckworth | NHS England |
| Margaret Edwards | SANE |
| Charles Fraser | St Mungo's |
| Helen Gilburt | King's Fund |
| Matthew Goldin | South London and Maudsley NHS Foundation Trust |
| Lily Harthill | |
| Stephanie de la Haye | Survivors of Depression in Transition |
| Michelle Hayward | |
| Lucy Hill | |
| Heather Hurford | Care Quality Commission |
| Poppy Jaman | Mental Health First Aid England |
| Adrian James | Royal College Psychiatrists |
| Gordon Joly | East London NHS Foundation Trust |
| Pippa Jones | |
| Tim Kendall | |
| Catherine Kinane | |
| Eleanor Levy | NHS England London Clinical Senate |
| Matilda MacAttram | Black Mental Health UK |
| Brynley Mansell | |
| Denise McKenna | Mental Health Resistance Network |
| David Morris | |
| Dominic O'Brien | Samaritans |
| David Osborn | UCL Mental Health Sciences Unit |

| | |
|---|---|
| Paula Peters | Disabled People Against Cuts |
| Jenifer Phillips | Young Minds |
| Jonathan Preston | NHS England, Northern Clinical Network |
| Kathy Roberts | Mental Health Providers Forum |
| Matthew Rowett | Tees, ESK and Wear Valleys NHS Foundation Trust |
| Nancy Rowland | British Association for Counselling & Psycotherapy |
| Alexander Rushton | NHS Confederation |
| Anthony Sella | Race on the Agenda |
| Tanja Siggs | British Psychological Society |
| Fiona Smith | Royal College of Nursing |
| Matthew Smith-Lilley | British Psychological Society |
| Ian Smyth | Janssen |
| Genevieve Smyth | College of Occupational Therapists |
| Tim Swain | UK Council for Psychotherapy |
| Suzanne Thompson | NHS England (Northern England) |
| Stuart Thompson | Happy Soul Festival |
| Nicola Vick | Care Quality Commission |
| Marjorie Wallace | SANE |
| Seamus Watson | Public Health England |
| Emily Wright | Care Quality Commission |
| Sarah Yiannoullou | National Survivor User Network |
| Simon Yu Tan | Therapist |

**Secretariat organisations:**

| | |
|---|---|
| Lizzie Blow | Rethink Mental Illness |
| Andy Kempster | Mind |
| Paul Spencer | Mind |