The Two doors of mental and physical health: making it one door for both

Innovate Stage

12th September 2017

12:00 – 13:00

Speakers:

- Professor Alistair Burns, National Clinical Director for Dementia and Older People's Mental Health, NHS England, Chair
- Claire Murdoch, National Mental Health Director, NHS England
- Paul French, North Clinical Lead for Early Intervention in Psychosis for the North West, NHS England
- Andy Bell, Deputy Chief Executive, Centre for Mental Health
- Dr Rhiannon England, Chair and Clinical Director, NHS City and Hackney CCG
- Fiona Eastland, Senior Peer Support Worker, Community Mental Health Teams, Central and North West London NHS Foundation Trust

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Alistair:

Well, thank you very much indeed. It is a great pleasure to be here and to have the opportunity to present what I think is one of the key issues for the NHS, as we have heard this morning, yesterday, and we will hear this afternoon, in terms of mental health.

I am an old age psychiatrist and it is a pleasure to be here to hear some of the excitement that there is around general mental health and specifically the interface between physical and mental health. My job as the Chairman is to keep things on time and to keep people occupied. So I am not going to say any words of introduction, because you are here to hear from the experts. To begin with, it is a great pleasure to introduce Claire Murdoch, who is the National Mental Health

Director. You will take us through some of the aspects, Claire.

Claire:

Thank you. Good afternoon everyone, I had to check my watch, I am losing track of time.

Thank you for attending this important session. I just want to set out very briefly, I have got 5 minutes and I know you are just going to pull me off with a shepherd's crook if I go over, so I won't. I want to set out what you already know, what we already know, which is the case for this change, the case for improving integrated physical and mental health care. And give examples of two or three things that we are driving at NHS England with partners. But I do want to say that, in this role as National Director for Mental Health, I go up and down the country, see a great deal of what people are doing and I am so impressed at some of the innovation in this space.

I've visited acute hospitals where they have mental health nurses on their wards but equally I'm visiting mental health services where they are employing registered nurses to help them deliver better physical health care in various settings and a whole range of initiatives across the country, so people are thinking much more broadly than some of the things that we are pushing nationally.

Let's move on to the next slide. I love this 'two doors'. We thought about getting a graphic, I wanted us to picture a patient between two doors and being forced to choose. You can imagine, here I am, the patient or the person in need with a serious mental health problem, a problem with my cardiovascular system, my diabetes, a whole range of potential problems, which door am I going through? Why do I have to choose? When the interrelationship between my physical and mental health is absolute and the evidence-base has been now resoundingly made by researchers. So why do we still have two doors?

Just a few facts and figures and they are depressing. I trained in a Victorian asylum as a mental health nurse, I'm still a mental health nurse, 33 years ago. I look back now at some of the practices of 33 years ago and I think they were really poor. I am

shocked at some of what we thought was cutting edge then, kind care then, and it wasn't. Equally, as a nurse, 33 years ago, I would read patients' notes from 20, 30, 40, 50 years ago and be appalled of what people thought was good care then. I believe that this 15-to-20-year gap in life expectancy for people with SMI is our shame collectively now. I think people 20, 30 years from now, will look at us doing our best, caring for people and think, what were they doing really? That is a shocking figure.

But you know that.

You know that circulatory disease, cancer, is two to three times higher for people with a serious mental illness. Before people die from their cancer or cardiovascular disorders or liver disease or other things, before they die from that 15-20 years earlier, they have been somewhere, living a life.
They have been visiting their GP, they have been in the care of mental health services, they have been in the acute hospitals and on acute wards. I must say, there is superb work being done by the strategy unit led by Peter Spilsbury and team, commissioned by NHS England, where we have sent a report to every STP in the country, detailing where people with serious mental illnesses are in the acute sector and what they are being treated for. If you haven't seen your STP's report, ask for it. See what is happening in your area, it is shocking.

There is a good economic case as to why we should do something about this and Andy will say more about it later. Medically unexplained symptoms, £3 billion worth of services consumed a year, and what are the outcomes? What is the satisfaction? What is the quality of life of people who have unexplained symptoms, who are going for multiple physical health care assessments and so forth, who may have underlying mental health issues which, if we treated – anxiety, depression - maybe would cut down some of that £3 billion a year? Also, in terms of emergency admissions for people with physical health care problems the financial cost is huge.
I could say so much more, but we've got other experts who will say a lot more.
Some of the things we are driving through the Five Year Forward View for Mental

Health are that we have committed to have 280,000 more people by 2021 who are living with a serious mental illness having the full suite of evidence-based physical health checks. And of course it is not just the checks is it? It is the plan, what do you do once you have made that assessment? What are you doing to key into the GP, into the acute hospitals? What are the plans you are putting in place to help people re-evaluate life and how they live it, and give them some support, whether it is lifestyle or understanding their own illness.

We've got CQUINS which have run, I think, for three years in a row now. We are seeing an increase now, definitely people are getting physical health checks but we are not seeing the increase at the rate we want. I have got Karen Turner, my brilliant colleague in the national team, saying "don't oversell the increase, it is too little, too slow". Your blood pressure can come down Karen. It's true, it's too little, too slow. We are incentivising local areas, we are paying them through the CQUINS, we want to see people having the full suite of checks and then plans to follow.
We've said that no acute hospital will be without an all-age, this is terribly important given how many people in acute hospitals are older people with a complex suite of difficulties - physical and mental health problems often - and our psychiatric liaison services in every acute Trust by the end of the 2021 period can make a huge difference in terms of staff training, making sure patients get the follow up they need after they have left hospital, as well as when they are in hospital. The third thing that we are doing, is IAPT services. Many of you have heard me say at this conference, our talking therapies programmes are the biggest in the world, we think - New York Times, the Gulf, Canada, we are the envy of the world.

This past year, we have pushed pilots out now working in primary care focusing particularly on the use of evidence-based talking therapies for people living with co-morbid long term physical health conditions because, again you will hear from others, the evidence base is clear: if you are suffering from long term physical health problems, you are more likely to be depressed and anxious; if you are depressed and anxious, you don't look after yourself, you don't walk as much, eat as well, you don't concur with your treatment regime for your diabetes, you get iller physically,

you get more depressed and anxious. The evidence is clear that if you have access to evidence-based talking therapies, through the IAPT, you can see a huge improvement in your ability to manage yourself.

So, these are some things we are pushing at NHS England through the Five Year Forward View for Mental Health. I think that working through recovery colleges, patient education programmes, and more peer support, can also make a huge difference. We can't do all of this from the centre, I think it has to be ground up, primary care, led user-led. Thank you, I will sit down.

Alistair:

Thank you, Claire, for getting us off to a great start, explaining the two-door analogy. They are common in mental health, whether it's dementia which is a diagnosis that opens doors, we had the revolving doors and now we have the two doors. The sound bite in terms of some of it is shocking.

Next on my list I have Andy Bell. It may or may not be true. Let's see what the slides say. No, it's Paul French. Now the trick of a chairman is to keep things right. There's a slight danger of over organising things. Paul is a colleague from Manchester. Paul, you're going to tell us about issues to do with mental health from your point of view.

Paul:

Well, firstly it's great that there are so many people here at a session about physical and mental health. It is great to see you here for what is an incredibly important issue. Claire's already given us a heads-up around the real issues around the problem of people with severe mental illness and that fact of people dying 15 to 20 years earlier is a real injustice in terms of our health economy, a massive injustice. But perhaps the real issue is, as well as that health injustice, is that we've known this for a long period of time. This is something that's been on our agenda for a long time. We've known that people die earlier and yet still lots of practices are still continuing.

These are just the facts. These are important to orient ourselves in terms of the facts around this difficulty. The headline is clearly about the fact that people have been dying earlier than their peers, this real health inequality that's there. But also there are lots other issues that perhaps tee into why people are dying early: the factors of obesity and diabetes; the factor around people accessing healthcare in a different way and Claire has orientated us to the fact of this two door analogy in the way people get into services; the fact that people access the services in a different fashion, that lots of people would tend to use more emergency services than a planned way of thinking about care. Yet we have technologies now that we can really start to think about how people can get lots of their screening done in a very different kind of way rather than having to get it done in an emergency kind of way. So, point of care testing, which we know is available for lots of conditions, is absolutely an important thing that we need to promote in terms of people with psychological conditions.

This was an algorithm that we were encouraged to steal from our Australian colleagues. This was a way of starting to categorise why people with severe mental illness were struggling with some of their physical health conditions. What it started to do, and Claire has already given us a heads-up, that it is important to screen people. It is important to get a sense of trajectory of where these problems come from. This algorithm gave us some direction in not only the important things we must screen but what sort of levels we need to look out for if people are starting to struggle. This was termed a Leicester tool. This was based on Helen Leicester, a great colleague who worked in Manchester and Birmingham who sadly passed away a couple of years ago. But she was instrumental in bringing this tool over to the UK and rebadging it for use in the NHS.

One of the things this has done, and done well, it got lots of people screening, and screening really well. When you ask people how they are doing with the screening, they say: "I measured lots of things, Paul." So how are people doing, are people at risk of diabetes? "I'm not sure but I've done the test. I have done the test and we ticked all the boxes to do the test." NHS England have moved further. They have

really started to take the bull by the horns here. They have taken a brave way of managing this through the CQUIN process. What they are incentivising is not just the process, not the fact that people are having all these routine tests done, but they are starting to look at outcomes, looking at how many people are struggling with diabetes, how many people are putting on weight, how many people are starting to put on weight. And some of the latest CQUINS are targeting that early weight gain that we know is prevalent with people with psychosis.

We are moving to getting things right from the start. This was a leaflet that was done locally through Greater Manchester West, as it was. It was done, co-produced, designed and formatted and all of the language was developed with people who use our services. What they were absolutely keen about is that we start to get physical health messages in alongside the psychological messages right from the start. That's what the new CQUINS that NHS England have started to help us deliver. That we're starting to get things right at the start and that we're going to be tackling weight gain right from the beginning. Those are some of the key points I wanted to make. I guess we have the importance of early intervention in psychosis services, which have transformed the way we deliver care for people with early psychosis. We are now seeing people get access to services within a two-week timeframe. We used to measure delay in getting access to services for people with psychosis in terms of months and years. Now we are measuring in terms of days and weeks. This, right from the start, psychologically and physical health, is at the forefront of what we do. Thank you very much.

Alistair:

Thanks very much Paul. So the challenge of the CQUINS we have, changing them from process measures to outcome measures to make a real difference. Very good examples, Paul, about how to capture the imagination and make sure we do that correctly. So, we now welcome for the second time, Andy Bell, Deputy Chief Executive, Centre of Mental Health. You are going to tell us about the economics. We'll have some time for questions and discussion afterwards. Andy, over to you.

Andy:

I want to tell you a little bit about the economic evidence around why we should be supporting mental and physical health across the boundary and all the different boundaries there are between them. Before I do that, I want to emphasise, as we do in all our reports, that the reason for giving economic evidence is not to commodify people and put numbers on people's heads, but so you can demonstrate the importance of doing the right thing for people and the value of money that brings to the NHS. The reason for health intervention is better health, not in order to save money. So that's the preamble.

I'm going to give you the biggest number first. So, we know, from good evidence now, that roughly each year the NHS spends about £14 billion on mental health care. That's money you in your local area spend on supporting people's mental health. What we now know is the NHS spends about the same again on not treating mental health problems, on the consequences of untreated mental health difficulties in terms of people's physical health. So, this is a huge number, a huge amount of money that could be spent better to save lives and improve the quality of people's lives.

This is the reason there's a huge overlap between mental health problems and physical health problems in the population. This is a neat infographic we reproduced from one of our reports and this encompasses all sorts of different relationships. It is people who have diabetes and also depression, people who have psychosis and putting on weight, people who have medically unexplained symptoms. It is a massive group of people, about 4.5 million in this country.

And the costs of that are considerable. For someone who does have a long term physical condition, or two or three, who also has depression or anxiety or another mental health problem, the costs of that healthcare rise by 45% just for that one individual person. It is a massive amount of money the NHS is spending on making very little difference to someone's quality of life.

In terms of hospitals, what this means for your average sized hospital - I know

there's no average hospital but, on average across a reasonably sized hospital - that's £35 million extra money spent on giving people worse care. The good news is if we have liaison psychiatry services, fully functioning, when we get those we reckon each hospital can save about £5 million a year and indeed give people a much, much better experience of that hospital. It does have to be all age and in all departments. This is not an emergency service. It is not just about A&E, it is about the whole hospital, really important. That's where you get the biggest savings.

Most people spend most of their time not in hospital. So, for people with long term conditions, we think there's a real case, and it has yet to emerge, but there's a real case for something called collaborative care approaches, which is integrating mental health support within physical treatment pathways.

That is psychological therapies, but it is much more, it is about case management, it is about accepting the fact that many people who have both mental and physical health problems are also poor, living in difficult circumstances, they need social support, they need economic support, they need help with family and housing and all sorts of other things. There's a big role for the voluntary sector in there.

The economic evidence in this area is emergent. It is small scale at the moment and I hope there are some STPs out there who will be willing to give this a real try and really test this out and see if it works at scale in this country, because that's what we need to do.

Medically unexplained symptoms, they've been talked about already. Again, we know the cost is £3 billion across the country. This is a huge number of people going in and out of A&E having terrible, terrible experiences. And going in for outpatient tests for all sorts of things and it never quite works. We had a look at a fantastic service in Hackney - and we have got a colleague from there so I won't say too much about that – that was really providing proper psychological support and help for GPs in supporting people with complex needs, including medically unexplained symptoms. The results we found were incredibly impressive. We think

this needs to be available everywhere, this kind of approach.

Finally, I can't do this talk without talking about the biggest health inequality of all. I saw some tweets this morning about the inequalities between different areas of the country, where you live three or four years fewer if you are from here rather than from down south. Well this is 15 to 20 years, so it dwarfs those regional inequalities we all go on and on and on about. You provide smoking cessation therapy and it works for someone, you buy seven years of extra life. I don't think it needs any other numbers does it, to explain the benefits of that? We want to help really move this forward and make things happen in this space.

That's all from me. This is a report we produced which has lots of these numbers in it. I have about 10 of these in my bag so come and see me after if you want one. When they've gone, they've gone. And thank you so much for listening.

Alistair:

Thank you, Andy. Fantastic to put some numbers, as well as reminding us it is those improvements that help. Andy, is it true to say they are for sale in the foyer or is it first come, first served? Yes, an economist hadn't thought of something, how much is that? My day is complete! Andy, thank you very much indeed.

Our next speaker is Dr Rhiannon England, GP Clinical Lead for Mental Health and Children. Andy, I couldn't be reminded on your slide, you did say that some of the biggest savings were from older people. We'll come back to that later. Rhiannon, you're going to tell us about your perspective as a GP lead.

Rhiannon:

Hi everybody, I am a GP in City and Hackney and I am going to tell you a little story about medically unexplained symptoms. As Andy said, we developed a service in Hackney and I will tell you why.

MUS, which is medically unexplained symptoms, is a bit of a paradox really. We talk a lot about the inequality of health provision in mental health – so people with severe mental illness, as we've heard, dying earlier than people who don't have severe mental illness. There are a lot of people in the NHS that are getting too much physical intervention and not enough emotional intervention.

As a GP, I see a lot of people who present physical symptoms. We all somatise, you know, am I standing here now with a bit of tension headache? I certainly am. Do I have a brain tumour? No, I hope not. Do I get diarrhoea before exams? Yes. Does that mean we have bowel cancer? No, it means we're stressed but we present with diarrhoea. This is a normal thing, but when it gets into people getting massive amounts of over investigation it is shocking really.

I was at a frequent attenders group at A&E a few years ago. We were talking about a 27-year-old man who had presented about 15 times with chest pain in the last 3 weeks. And every time he got an ECG and every time it was normal. Then nothing happened much. He was given a bit of paracetamol and sent home. I said, well, "did anyone think about his mental health? Did anyone ask about anxiety?". "Well no, we're an A&E, we did the necessary."

Anyway, what we did locally was, a good few years ago now, we managed to get some money which was great and we commissioned a service, PCPCS, - it is the worst name ever, Primary Care Psychotherapy Consultation Service. Don't blame me, I'm just the commissioner, they chose the name - to help GP's manage medically unexplained systems.

So it was very tight, we said GP referral only, nobody else could refer apart from us. It had to be delivered in primary care, they had to be able to engage people that traditionally don't want to talk about their mental health, they only want to talk about the next MRI. And often with quite an adversarial relationship with GPs, because I am kind of saying "no, no more MRIs, what about this nice person here?" and they're saying, "no, I want the MRI." I mean, that is a caricature because people don't do that but a bit of translation is needed to get people to accept to see the service.

So, have they been any good? Well the joke - our little sort of local joke in City and Hackney, Hackney is a very deprived area – was that the provider who won it was the Tavistock who, from a Hackney perspective were based in Hampstead. So the

joke was, would they be able to find Hackney, let alone do anything? Yes, they have, they have been a brilliant service.

As Andy said, the Centre for Mental Health have done an evaluation, very beloved of GPs because they provided a service when I had tried hard to get mental health trusts interested in helping GPs with primary care mental health and it was, "well, why are you referring these people, what is the diagnosis?" I am a GP and I said: "I don't know what the diagnosis is, but I don't want to keep referring them for pointless physical tests, perhaps there is something going on?" So, what have they done? They are massively popular with primary care and that is all our 43 practices, some of whom are not very psychologically minded, and they have managed to infiltrate and change the culture. So big cultural change for us locally, big cultural change between primary and secondary care.

The service attends the frequent attenders meeting which is a multisystem meeting so we get frequent LAS callers, 111 callers, crisis line callers, A&E attendances and we try and look at the whole system and they are part of that. A&E no longer say, "I have done the tenth ECG", they say, "ah, let's think about our psychiatric liaison service, or the Tavi service" or "let's ask what's going on." I think it has been a massive cultural change for us locally. We all now talk about physical and mental health better, I mean there is a huge way to go, they are a victim of their own success of course, there is a big waiting list now.
Outcomes, well that's an interesting one. The patients love the service, the GPs love the service. Do patients recover? The bane of my life is recovery as it is measured because no, they don't, and I don't think many MUS services have good recovery rates. The patients show varying improved outcomes but in the strict recovery terms, no. What are we going to do about that? I don't know.

The biggest thing is the cultural change for us. Everybody can talk about MUS now, GP's aren't scared about talking about it. A&E isn't, secondary care providers, primary care providers, and people are getting more appropriate help. There is the economics, as Andy said, but actually what matters is that people get good clinical

care. And just getting a whole load of bits chopped out of you is very poor clinical care. That is all I want to say. Thanks.

Alistair:
Well thank you very much, a fantastic example of a service that really meets a need, raises the profile and changes attitudes and perceptions, and perceptions is something that is so important. We are keeping time which is great. Our last speaker, Fiona Eastmond, is a Senior Support Worker from Central and North West London NHS Foundation Trust, a trust where many good people come from. Over to you.

Fiona:
Hi everyone. It is very big in here isn't it? It really is quite, quite large. My name is Fiona. I am a Senior Peer Support Worker in Hillingdon, one of the Central and North West London places we cover. I work in the community team, I supervise three peer support workers, one in the inpatient, one in the community and one I think the only peer employment specialist that there is.

I use my own lived in experience of recovery to help others. My ex-diagnosis was borderline personality disorder. In order to continue to break down stigma, I would like you to all to know that. I use the clinical system, I have a case load and I work alongside professionals to engage people in their own their recovery. There is a lovely quote here, 'peers employed in support roles are usually further along their road to recovery…' - I am, as you can see, reasonably far along my road – '…so that they are able to offer images of possibility'. So I thought I would bring you images of possibility. There they are.

What do I actually do each day? I often see individual people. Talking of the two doors to mental and physical health I do talk about people's physical health because I have had to look after my own physical health in order to look after my mental health. Some specific things we have done in our community here. Right at the top there, we have got growing vegetables in an inpatient unit. So, it is all in very safe

plastic pots, we couldn't have sticks and things like that, there were all sorts of garden related issues. But our wonderful peer support worker who works there has been growing and now they are eating the vegetables that they have grown. When the patients come out of that unit they are going to come around to the allotment that I have started up in the community and start growing some vegetables. You can see them there against the background of my lovely computer keyboard. That is one of my service users very proudly bringing me some vegetables from their allotment which was just fabulous.

The painting there was done in a craft group that I started. We had several different crafts. It has now carried on in such a way that I am having service users approaching me saying, "when can I start a new craft group?", not, "what are you doing for me, when is this next thing happening?", but, "how can I help you start a new craft group?". That's what I want. I want people to be taking charge of their own recovery, to be taking it into the community and to be starting wonderful things.

Just because you have had mental health difficulty, it doesn't mean that you can only ever be friends with other people who have had mental health difficulties - even though they are the best kind of people.

We have also got here, this was another offshoot from the craft group. This is the railings outside of the Community Mental Health Team where I work, completely covered in crochet that was done by one of my service users. There's some more crochet on the trees and some giant dream catchers and things and it looks a tiny little bit less depressing outside now which is great. That particular service user, when they are mentioned, instead of people saying, "oh", they now say, "oh the crochet", which is just fabulous you know! They are a part of their own recovery. Put their stamp on where they spend a lot of time you know.

What else is up here? This is one of our local cafes because I like to try to situate recovery in the community as much as possible. They're a mental health friendly cafe, a relaxed art group. The art group ran yesterday but I was here. So, my

service users ran it themselves.
That is how I want it to be. I want them to carry on doing what they do in the community. People come along in the park with their dogs and they come along and say hi, they might sit down and pick up the pens. Then we have a community group doing what they need to do in the community. We no longer have a little set of ill people doing special things for ill people. There is some more of what I do standing next to flowers.

Peer support workers add a unique value to teams. It is not a soft job, it is a very, very difficult job. It is not just jobs for ill people and stuff. It demonstrates a full recovery to be able to bring something back and it is almost like magic the way that somebody who has been through something can engage somebody who is just starting on that journey.
It is very, very difficult to recover from mental health difficulties. There is a lot of work, it is an unseen illness, all those unexplained medical symptoms and things. And it is so difficult to be told by a doctor wearing a suit that it is all in your head. Honestly that is never going to go down well is it?
So yeah, we bridge the gap really and I am incredibly proud to be working in Hillingdon. I've got some of the best peer support workers in the country, I believe, and they do some seriously amazing work. I would like to finish by saying that, above all, peer support work should be paid. That is my main point of today. Thank you very much.

Alistair:
Thank you very much indeed, Fiona. You have brought things to a fantastic conclusion and you can tell by the expressions in the audience and the smiles that things are going well. One of the things about hosting one of these in a number of areas is that you always listen jealously to the whoops of delight and the applause in other areas. I wonder if you can give me a fantastic laughter and round of applause to all the speakers? So hopefully that will mean the people in the other site will say, "what were they doing in the mental health session? Wow mental health is really fun."

We have got a few minutes. I have got a minder at the back who is going to remind me when we have got a few minutes. So we've got five minutes or so for discussion.

I think we have a couple of mics. If you don't get a chance to ask your question, the speakers will be happy to stay around afterwards.

Andy, could I just ask you a first question? In terms of return, Andy, what kind of rate of return, because the economics are incredibly powerful, can we talk about rates of return as well?

Andy:
We can and the evidence is greater in some areas than others. The one it is clearest on is liaison psychiatry. We know that if that is done well you get back probably about £4 or £5 for every one you put in. It's a huge, huge saving. In many of the other areas, it's about reducing demand on services. In City and Hackney, we found there was a return in fewer people going to outpatient departments, fewer people going to A&E. So, it reduces costs in other areas.

Alistair:
So, if I gave you £5, would you give me £20?

Andy:
If I could get to my wallet, I would.

Question: Hi, my name is Elaine. I work for a pharmaceutical company. We know there's a massive gap for people's mental illness but yet when you look at the treatments that are used there's a very high use still of anti-psychotics that cause significant weight gain. When you speak to service users as well, this is the thing that they always complain about, that they don't feel engaged in their treatment or their treatment is not reviewed regularly. I suppose the question to all of you is: how can you change that when a lot of psychiatrists say we always treat mental health

first and we don't consider physical health?

Alistair:

A very easy question to ask for all the audience. Does anyone want to volunteer a quick response to a very important question?

Rhiannon:

I totally agree with you. I think locally what we are looking at is a much more stringent approach to review. I think mental health needs to move, like physical health, in that we get letters from physical health consultants saying do, this, this and this for three months, then this, then stop. With mental health it was: here's your drug, cheerio. Often, not always. What we are asking for is the same level of detail of review, dropping dose, changing, stopping. I totally agree it is a huge problem.

Alistair:

Thank you, Rhiannon. Now a question here.

Question: Tony Johnston, Health Watch. I would like to know whether you are recommending maintaining separate mental health trusts. I would like to know to what extent the trusts should be accountable to Health Watch and other individuals. Because what I want to know is what the waiting times are, I want to know the teams, the numbers, the numbers discharged, a complete history of what actually is going on. Because there has been resistance in Stockport to providing basic information.

Alistair:

That's very helpful. Claire, do you want to say something very quickly?

Claire:

Firstly, I absolutely don't think that structural reorganisation is the starting point for better and more integrated care. I've certainly worked in acute trusts in my time that ran mental health services and, believe me, they were no more integrated than they

are through separate trusts. I think we have to come right into primary care and the level of the patient and work backwards from there. Partnership working will always be a feature of mental health. We all have to get much better at managing those interfaces, which I believe we do once we start to take the whole person care seriously.

Just on should trusts be accountable to Healthwatch? Yes, they should. Certainly, what we are publishing in the dashboard, CCG by CCG at NHS England, is our attempt to put into your hands, and we're refining it year-on-year, information about waiting times, access standards, outcomes and investment at CCG and STP level. Because accountability to our public, to Healthwatch, to MPs, to user groups, and our commissioners, is paramount, whichever kind of trust you are.

Alistair:
So it will be published and it is there in the public domain.

Question: I'm a mental health activist from Bradford. I created my own not-for-profit organisation. My father has bi polar, diagnosed when I was aged 13. I have my own mental condition, and I manage it by my lifestyle. I'm studying for a masters in psychology of sport and exercise, and there's a connection between the cognitive, behaviour and emotion. We need to look at children's mental health first, primarily. Because, if we look at children's mental health, it stops it escalating in the future. So, my question is: what is going on with the children's mental health services nationally, and especially with young carers?

Alistair:
I think it is an important question, one that we might have to take offline afterwards. If you stay, we'll make sure that we get someone to speak to you and give you some information about that. A question right over there and then we're just in the dying moments.

Question: I'm from the Race Equality Foundation. So, several years back the

Bradley review found that black minority ethnic people are 40% more likely to access mental health via criminal justice than primary care. What do you feel are the major steps that need to happen in order to address that?

Andy:

We have produced a recent report looking at what's happening to young black men, particularly during their teenage years. From age 11 black boys have as good mental health as white the boys, but by the time you get to your late teenage years you have very much poorer mental health and very much poorer experiences of services. We said we need national co-ordinated action on this. We need something like the concordat we've had for crisis care.

And we now have Prevention for Race Equality in Mental Health. We want to see real leadership from Government on this. But it has to support local actions and the solutions have to be co-produced, working with communities and community groups, in schools, in youth work. And youth work has been completely devastated in recent years. That's incredibly important for mental health. There's an enormous amount to do in that space and we need to get on with it.

Alistair:

Thank you Andy. A very good question and a very good answer.

Question: Anne Greiner from the Patient-Centred Primary Care Collaborative in the States. I agree that we need to integrate mental health into primary care. Collaborative care is a great model. In our system, we don't pay for that and that is a real problem. What do you do here and how are you making progress?

Alistair:

We're in the dying moments and I wonder if this might be an iterative conversation to have over a cup of coffee afterwards. But great to learn from experience abroad. A question there.

Question: Hello, Judy Abel, Policy Connect. Just wondering, in a more esoteric

way, is it time we stopped talking about ‘mental health’? If people have diabetes, they don't say, "I have a physical health problem", they say, "I have diabetes." But we constantly use this umbrella of saying people have got ‘mental health issues’, ‘illness’ and it could be a bit depersonalising. Is it time to talk about emotional well-being, particularly as psychologists say a lot of mental health illness is caused by childhood trauma and other things like that. So, we need to change the terminology to set people free from the stigma.

Alistair:

That's a challenge for us all. That's a point well made. There's someone who said she was going to come and get me at 12:50. She hasn't appeared yet. Let's keep talking.

Question: Very keen to hear a bit more, a sentence or two, from Paul on why it is so difficult to do the tests that are in the CQUIN. Why is it so difficult in our inpatient mental health wards to get really good support to give up smoking, and diabetes? The CQUIN results are shocking on inpatient wards if you think we are in year three now. We are trying to hold on to it, but they need to be going up and up and up. They are not going up and up and up fast enough on wards. Why?

Alistair:

So a sentence, Paul, really on why. And then we’re going to have to draw to a close.

Paul:

I agree, it is absolutely shocking, but the CQUIN is absolutely going in the right way, it challenges more and more. I think we need the CQUIN to continue to challenge us. The difficulty is that inpatients are not structured in a way that does prioritise people's physical health conditions. Because of the nature of the way our inpatient units are now, the people on there are incredibly poorly psychologically. I think that what happens is our services focus on getting people psychologically well, rather than really thinking about their physical healthcare.

I'm not so sure inpatient wards are necessarily the focus. Most people are in community care. Most of the people who we work with, with psychosis and schizophrenia are in communities and that's where we should focus.

Alistair:

Thank you very much. We'll end with perception because we all agreed that perception is an issue. Perception is an individual thing. Mine were challenged recently.

I was on holiday in Scotland and I was driving around the road and suddenly, round the corner a car came fast on me, driven by a young woman in an open top car, swerving from side-to-side. As we passed, I nearly went off the road. As we passed, our wing mirrors clipped. She looked at me and shouted "pig." I thought, oh that's not very nice. I drove around the corner, and drove into a pig!

So my perception was challenged. Thank you very much to the speakers for a great session and thank you very much for taking part. They will be here if there are any final questions. Thank you very much.