The People's Inquiry: One Year On

Evidence presented by Dr Martin Baggaley (MB), Medical Director, South London & Maudsley Foundation Trust.

Present:

John Lister (JL).

JL:
We're doing the follow-up to the report that we wrote from the Inquiry last year, *London's NHS at the Crossroads*. Your evidence in terms of the situation in mental health was particularly important to us. Also the points that Brian Lumsden [SLaM UNISON Branch Secretary] made about the forensics. I do believe that the funding system on the forensic specialist beds has actually been changed?

MB:
Yes. There are still problems with it in the sense that it is still being commissioned essentially by NHS England, and still at the moment they appear to be offering a price that we think is unrealistic.

Essentially every bed we have is costing us more to run than they are paying, and they don't seem to be showing any sign of common sense. What's frustrating is that the costs to the country have gone up, because what we did have previously was quite an innovative, effective service which was moving people through the system fairly quickly, such that they were stepping down to often better care at less price. But they have now just moved on to saying 'no, to do that would cause more intensive treatment, it would cost more', now they are just offering really a very low price: you can't do much with it, so it means people are staying much longer, so it doesn't save money – so that's frustrating.

We are in negotiations. What we are hoping is that the commissioning of these services will perhaps be returned again locally. This makes more sense really because you can be much more innovative if you've got local commissioning rather than centralised national commissioning.

JL: Is that a problem with the London Strategic Health Authority being removed as a tier to administrate?

MB:
It might be, yes. You could do it on a regional basis. The point is it's always very inefficient just to look at one part of pathway separately. A classic example of a similar problem is CAMHS – Child and Adolescent Mental Health Services – in terms of NHS England, again they are commissioning centrally, and so there is a complete disconnect now between tier 4 and tier 3 services, so surprise, surprise you can't find a bed.

JL: Tier 4 is the in-patients?

MB:
Yes, tier 4 is in-patients. Basically what that means is you can't find a bed because there is no incentive to manage patients in the system, so obviously the interests of outpatients services is to refer, so if they can't manage to hold this referral because there aren't any beds that is a huge problem. You get the scandalous situations where the young person is stuck in a place of safety for a very long time, no beds.

In the end you have to admit them to an adult bed, which is better than leaving them in the back of a police van. So that's a bit frustrating. These are the sorts of things where there needs to be some attention to them. If NHS England are going to commission surely they should commission pathways in a particular area where it would make much more sense to link these up rather than disconnect the in-patients. It doesn't make any sense to me at all.

And the forensic side is an issue. We are doing our best to try and provide a service and be as efficient as we can be, but there comes a point where I think we would be forced to say we couldn't provide the service.

JL: You have to pay for quality, aren't you?

MB: Yes, you have to. But we don't want to give up and just allow the Priory [private psychaitric hospital chain] to run it all or something, but it is frustrating.

JL: Presumably there must be an end point at which you say 'people aren't listening, we can't carry on delivering this at a loss'?

MB:
Exactly. We've done our very best. Obviously what we've got to try to do is benchmark it and make sure we are not being ridiculously expensive. We don't want to gold plate the service. But you've got to provide decent quality services, and it is frustrating. It's the lack of flexibility really. I think part of the problem is I don't think NHS England really understand it particularly. There's a big steep learning curve for them: fair enough. But I just don't they understand what they are doing.

JL:
Well it does to be a point where in order to understand the pricing you've got to look at the total performance in other words episodes of care and repeat episodes of care rather than simply one day per day.

MB:
Yes, so that's what we're hoping to do. That remains an issue, CAMHS likewise is an issue. What were the other areas you wanted to talk about?

JL:
Obviously at this time last October you hit the national headlines with these statements about the adult beds. Again I'm not quite sure where we are on that. It doesn't look like there's been much change on that.

MB:
There's been some improvements. What we've been trying to do is our best to reduce our private sector usage. We have managed to achieve that. What we did was we – at our own cost – opened up some overspill beds ourselves. We effectively opened an extra 26 beds I think. Because (a) we could do it more cheaply than the private sector and (b) it is was much more efficient because rather than sending people off to West Sussex where you had to transport people, it was very hard for carers and friends to visit etc., we've done that and got things under control. And we've taken lots of other measures so we now are running more or less at zero. We had one or two last month. Certainly for the last 4 or 5 months we've been pretty much under control.

That's been partly because we've had to take some quite tough decisions. One of the difficult things about all of this, probably our fault, is that probably that for many years we are the emergency

hostel of last resort. What we've been forced to do really is to take much tougher decisions. People can come into the ward if there is a medical requirement to, but then there are a number of people who perhaps don't strictly have a medical requirement, they have more of a social requirement, and we've now been forced to say 'no'. That's probably the right thing, because I don't think it represents value. The difficulty is, there is a huge gap in some of the social provision.

Case in point. We've got a very good social work team at Lambeth Hospital. What happens is they will say 'well I'm sorry but because you haven't got any particular links to Lambeth, there's nothing Lambeth can offer you in terms of housing, all we can offer you is *No Second Night Out'.* People are given a pack and basically told to go and find somewhere to sleep out, and they are told '9 o'clock the following morning ring this number and they will come and pick you up and take you to a hostel'. If you are a seasoned sleeper-outer maybe that's ok, but you or I wouldn't be particularly keen on that. Let alone you or I if we were anxious and already desperate.

That's the problem, and I think one of the solutions I think is to try to work with the third sector and local authorities to have a greater provision of what I would call some sort of places of safety. You don't necessarily need an all-singing and all-dancing psychiatric ward. But you probably do need something more than just a B&B. You need some sort of support.

If you are sent to these places which are full of people who are dealing in drugs that's no good either really. So that's a problem. But we've done our best to try to manage with what we've got, and I think the system is working reasonably well at the moment. The trouble is all our plans suggest that to make the figures add up, from next April we've got to start taking roughly a ward out every 6 months, about 30 beds a year for about 3 years.

Now what we've done is we've invested in the community team. That's not unreasonable. One of the things that might improve quality is if people get better care outside and they are kept well it will stop them breaking down. Two-thirds of our admissions are people we know. If we can only keep them well, they would be happier outside hospitals. Most people don't particularly want to come in.

That's a positive thing. What I am slightly less confident of is whether we will deliver sufficiently. Theoretically it looks good. It's better than simply cutting it, it's good to actually invest it in better services. There is always this slight worry I have that we still end up with too few beds and people rushing. There is a point where the system is quite delicately balanced, it's quite easy for it to tip into complete chaos. So that's what we're doing.

At the moment, the short answer is by bringing in extra capacity, we've actually improved the situation, we're managing the system much better. So what we are trying to do is try and identify people who are going to have difficulty, if when they are admitted there were problems with their housing, to really concentrate on getting those solutions from day one not day 25.

JL: Presumably you could be doing that while they are actually in hospital?

MB:
Yes. The other interesting thing, because it's always useful to see how other people do it, I've always been somewhat sceptical about the North American experience because you always say well it's private anyway isn't it, and they are Americans and they just chuck people on the street. But we have been doing some work with a couple of organisations.

We went off and looked at a system on the west coast, just below Seattle. What was interesting about that was they had a very impressive quality because actually mental health, what they call

public mental health, is very similar to ours. These are not Hollywood film stars having psychotherapy, they are the sorts of patients we deal with. What they were using a lot, which I was very impressed with, was peer-support workers. People who had had mental health problems, recovered, who were now working for the system, and who seemed to be able to engage with patients in a very effective way. Far more effective than some professionals were. That was quite interesting.

JL: They get paid for doing that?

MB: Yes, they get paid. They are properly employed, they are not just volunteers, they are trained people, which is quite interesting. It's not a cheap form of labour. It's just a sense of some of them are much better.

JL: It's identifying suitable people for the job.

MB:
Yes it is. But also because some of them appear to be much better at working out what the patient really wanted rather than people with mental health experience – community nurses, psychologists, psychiatrists have their particular view – but some of these peer workers seem to engage quite well.

So we have made some progress but overall the system is in chaos. Certainly talking to colleagues in other trusts they seem to be having difficulty finding beds. What we find is that when we do need a private bed it's very difficult because actually everybody else is squabbling over them.

Having said that, it is difficult to know how well it will be sustained after the next election. The other positive thing is that there does seem to be much greater interest in mental health.

JL: They seem to have switched around from mental health losing more heavily than acute services on the tariff to gaining compared with acute next time around.

MB:
Hopefully yes. What Norman Lamb is saying, which is quite good, is that there should be parity of self-esteem: but one of the ways that you get parity of self-esteem is to have parity of targets. One of the interesting things is that some of the access targets. Although I am not a fan of targets particularly, undoubtedly it focuses the mind. If you've got things like the 4-hour wait it focuses the minds of the commissioners.

So for example they are trying to bring in some of the same sort of targets. If you shouldn't wait more than 18 weeks for a surgery, surely you shouldn't wait more than 18 weeks for therapy. That's quite a positive thing.

JL:
I remember Stuart Bell [previous SLaM chief executive] raising this a long time ago when we were discussing the Darzi plan as I recall. He was saying, let's put us [mental health and physical health] on the same basis, and then it will be the commissioners' task, and they will be measured on it rather than us having to find ways.

What it sounds like from the initiatives you've been taking is that actually the trust is having to dig its own way out of this. On the one hand you've got social care – which is now facing another hit, they are talking about 8.8% off government local spending next year, it is being really squeezed and therefore there is less and less outside support there – and on the other the commissioners, who

certainly at national level, but possibly also some of the local ones, don't seem to be really on the case. Their priorities are elsewhere and they seem to be running around meeting all kinds of other targets.

MB:
Yes, although to be fair to them it is difficult in the sense that everybody has got a particular case. I think you are right, and I think one of the things we have always suffered from is having a different basis of payment because it's always been where we've had Payment By Results [the system of paying per case treated] for the acute side, so places like Guy's can get themselves out of trouble by over-performing.

If there is a shortage of money within the CCG budget we are an easy target to cut. I think we've made some progress on that, and certainly we feel quite robust. Our finance director last year who is now our chief operating officer was quite good at having honest conversations with the CCGs and saying 'look you're getting more out of this contract than you are paying for, it can't go on, actually this is the bill'. That was quite helpful. We were still struggling with Croydon because although they invested more than they had done before, they are still effectively so far behind they are still effectively getting more than they are paying for. That's not really sustainable for the long term,

There are some things we've got to do, I don't think we can simply say 'the commissioners will have to give us more and more money', we have to do the best we can.

JL: Apart from anything else, SLAM and the component parts of SLAM got where they are by actually innovating and developing and being ahead of the curve, so part of this is you doing the same thing in new circumstances.

MB:
Yes, I think that is what we are trying to do. The other thing we are interested in is this concept of really looking at proper systematic quality improvement, and actually measuring things. Again in the past I don't think we've been as sharp as we could be about saying 'yes we know this is what we do, and this is the benefit of doing that'. Then you start to work out what are the things that don't make any difference, we can stop that, etc. That's the sort of thing we are keen on doing. I'm actually fairly positive.

What's worrying is that there is all the shenanigans around the election. It's going to be a very difficult election to call. It seems to me that anything could happen. We could get Farage in or something.

That's a bit of uncertainty but I would hope we get some stability. As you say the big worry is now coming out in local government. What you do with people's basic social care has a big impact on their mental health, and you end up with increased demand on our services and you do get stuck in a difficult situation. I didn't train in medicine imagining that I'd be throwing people out on to the street, but you are left with no alterative, which is frustrating really. It's not cost effective either. Throwing people out who are in a vulnerable position, they often will bounce back in a worse state. We do need to address that and find a way of providing housing. Obviously housing is a problem, some sort of reasonable housing. Especially in London.

JL: If it was only Russian oligarchs who were getting mental illness problems you would be well away wouldn't you?

MB: Yes you would! I think this is poverty related. Having said that, we do see people who are affluent and with mental health problems. It's not just poverty related, but it does make a difference. I think there are some people who without a doubt would not be in our system if they had decent basic housing. Also, some sort of social support and what I call that glue of community, because that sustains people. Whereas I think one of the problems is you've got a lot of people who have migrated into the area, you've got that sort of disruption, that lack of support sometimes. All those things make it worse I think.

JL: You've mentioned the government's policies and the emphasis on parity of esteem and so on. There was that Closing The Gap report, it had I think about 50 targets. How close do you think we are to getting there?

MB:
It's all hopeless isn't it? One of the quite entertaining programmes we are doing, the Department of Health has decided that many of its civil servants don't know anything about health, which they don't, so we've got a programme where they come and visit us and they spend an attachment with various places and I'm wheeled out amongst others to give them an initial briefing. What I find particularly frustrating is that they run out the right policy documents. If you look at a lot of the public mental health stuff for the last 10 years there is very clear evidence that early life matters, they have done all the economic calculations where one pound invested in parenting classes saves seven pounds later on. What's really frustrating is of course that this the policy but at the same time you know that the CCGs are now cutting funding for cancer, so what is that about?

It's all very well government making policies and recommendations: it's about how you implement them. How you do you drive that? How do you drive that change, which is the problem. I know that some of these policy documents have grappled with it, but it's particularly difficult if the savings aren't actually necessarily from health but they are from improving the justice system or a better economic balance.

This is the trouble, you always get this more interesting agenda about prevention and positive well-being etc., but if at the same time all you are dealing with is influx of illness you are not going to focus on prevention if you are overwhelmed with people who are ill. It's quite hard to get that balance right.

JL:
What strikes me is given where we are from the last 15-20 years and what that's created on the ground, even if you started today a full-scale promotion and preventive thing to minimise the future damage you've still got the damaged population that is going to need healthcare of various sorts, plus the social support, in order to be able to get themselves back into balance.

I would be interested to know what percentage of CCG board members are even aware of the content of that Closing The Gap document, for example. The fact they can even contemplate cutting means they obviously don't connect it with 'we might be responsible for that. Our name might be in the frame'.

MB:
They were quite surprised when actually it was pointed out that they would be responsible for cutting the budget by 20% in the last few years. I heard a fascinating lecture by this German professor, who was very interested in looking at the particular stress of urban living and looking at the impact of firstly being born and brought up in a city environment and then living in a city environment versus being born and brought up in a rural environment or living in a rural

environment. It does seem to me that city living is extraordinarily stressful, and it does whack up your rate of mental illness, which we always knew vaguely. But I was quite surprised at the magnifying effect that sort of thing is. We are living in an area that is quite morbid and has a lot of mental health problems.

JL: On the other hand, colleagues in Norfolk and Suffolk have actually got a predominantly rural area, and they have got a different type of mental health problem. You've got loads of depressed farmers and so on!

MB: Because they are isolated. I think that's right. Obviously they're quite often under-resourced as well so often when things go badly wrong they go badly wrong.

JL: They have been making big cuts in the allocation of service and suddenly the trust comes forward with a whole series of plans.

MB:
I think you are right. One of the things that I am concerned about is the impact of service change and we try to minimise the damage to patients because every time you disrupt the service you tend to cause problems. I have been involved in another trust, whereby they were concerned they had a double suicide; they were concerned – even the Coroner was concerned – that the deaths of those patients were contributed to by the service reorganisation, which it may have done in fact.

If you've got that continuity of seeing a particular care coordinator it's obviously difficult if you suddenly get transferred to somebody else who has different teams. I think in this particular case they looked at it and it was a bit unfair. It was difficult.

JL:
We've talked about your cautious optimism about some of the prospects for SLAM in particular going forward. You've talked a little bit about the national picture. Obviously this is a London inquiry. So we have been asking people this time around, coming up to the election, what steps do you think would be useful, would actually make towards the type of changes you would like to see? Do we need anything at a London-wide level? Would that make a difference? Would that be helpful?

MB:
I think so. There has been something interesting which I think has been some of the things we could focus on a London-wide perspective. Looking at some of the emergency care, some of the 'can we work better together', dealing with 136's – when the police pick people up in a public place with obvious mental health problems – and for some reason if you look at the Mental Health Act figures we are an enormous user of the Mental Health Act, far greater than anywhere else in the country. It's hard to quite understand why.

Of course it often then raises issues of potential racism, because not only do we use it a lot but we seem to use it a lot for patients of ours from BME communities. So I think trying to work together for that, as nationally, to really emphasise the importance we would place on parity of esteem. To say that mental health is as important as physical health, we need to treat them as important as each other to make sure they get balanced resources.

The other thing we ought to be doing more of is looking at that interface between physical and mental health, because when we have started to look at it we've realised that a lot of our patients are using resources at Guy's Hospital and vice versa at St Thomas's. I think a particular problem in London is around housing, I think that's a real problem.

There is a particular problem as well I think around this transient population, so one of the things we get a lot, and for which there's no real provision for, are people who arrive in transit who for one reason or another have no recourse to public funds, but end up in one of my beds. They are really tricky people to deal with, because there is literally no other agency that seems to provide anything for them. I've got a very low opinion of the Borders Agency, because it seems to me that it's the worst of all worlds, to have people who don't have leave to remain here, but do remain here with no recourse to anything. That's unsatisfactory for everybody.

JL: Who pays for them?

MB:
Nobody does. That's the problem. The commissioners pay for their bed. The problem is it's everything else they need. It's things like housing, food, because it means they often get stuck in the system, it's not fair. That is a particular issue I think, the transients. Also it's one of the things that London does have which I don't think is really fully recognised is, it is the centre. So if you are suffering from a mental health problem in Romania, Germany, Spain, Sweden, you will end up in London. It is a magnet. That's an issue.

It's the parity issue, it's really recognising that social care is integral to what we do so, we have got to make sure that we provide adequate social care together with mental health treatment otherwise if you just cut one completely you will end up pushing up the costs. It looks like squeezing something, so you might save money here on your social care budget, but you are going to escalate your costs in the mental health budget. It's probably not an efficient way. I always say to people 'my beds are a very expensive hostel. It's not a sensible place to put people as a hostel'.

JL: Have you seen the Darzi Report, *Better Health for London*?

MB: Yes.

JL: Did you see any sort of things that were helpful in that? It was intended for guidance for the mayor and the GLA to some extent.

MB: I thought it was quite helpful.

JL: Very heavily focused on public health isn't it?

MB:
Yes. One of the things which we are trying to do, again, is the long-term thing. For example, one of the things we are obviously very keen on is things like trying to improve the health of our patients. For example, really focusing on their smoking is one of the things we are trying to do, trying to cut that down. Alcohol is one of the ones we probably need to focus on. I think perhaps this is the right way forward, I think we do have to look at the public health of Londoners perhaps. If we could focus on that, and the public mental health of Londoners. But it may not show immediate effects.

JL: I don't think any of these things can show immediate effects.

MB:
I would be very pleased if in 10 year's time we could demonstrate even the slightest narrowing of the mortality gap in patients with schizophrenia in London – so they only died 15 years sooner rather

than 17 years sooner – well that would be great progress. We'll try and raise that sort of profile to try to make sure people are important.

JL: Yes but you are talking a 10-year time frame when Simon Stevens *5-year Forward View*. He is hoping that health promotion is going to make a significant difference towards his £22 billion of savings within 5 years.

MB:
That is rather fanciful. I don't think it's going to happen is it? The problem is of course with all of this is that to some extent you are never going to win, because I suspect there is going to be an effect so that the more you do that people will start to live longer, so there is going to be a kind of corresponding problem in a way. You are going to end up with an even more ageing population. But I think it is the right way.

JL: Everybody would agree that if it could make people healthier there would be less need for the NHS. I don't think that's a contentious point. Whether or not that is the way to resolve a fairly short-term and immediate financial problem is another point.

MB:
No it's not. I suppose one of the things that he has introduced is to try and encourage people to be looked after at home if they can, to use family support better and support people to be cared for and all the rest of it. It's quite interesting, one of the problems we have is that if you've got a transient population you don't have that, they don't have the extended family there and other people to support them.

You need London-specific things. There are some positive things. I think there is a lot of energy in London. Perhaps the other thing we ought to be doing more as well is harnessing our research expertise to demonstrate, we should be leading in the latest pathways, we should be demonstrating there are new adult mental health models which will bear interesting results.

I'm all for seeing this in 2015 provided we don't get a completely paralysed government. If we had a weak minority government that couldn't make any decisions at all, that would be very worrying. Although I suppose if it stopped them bringing in another Health & Social Care Act then we might be happy!

JL: I suppose so but on the other hand you might find that a weak government is looking to maybe get re-elected or something a little but further down the line in another election, and might be less likely to push the austerity cuts that are turning the screw on a lot of the funding across the country.

MB:
In the longer term, regardless of the politics, what you really want is a stable, balanced economy. You want a sustainable economy that's balanced and equitable, or as equitable as it can be, because that will drive the tax revenues that fund the service. You have to get that balance right. That's difficult. I'm not an economist but it seems to me that there are lots of different arguments.

The other point is the difference between rhetoric and reality. On the one hand people are saying that the government is cutting too much, there has been too much austerity, and the other people who are saying well no actually he hasn't been cutting enough.

JL: From where I see it is, there is no doubt they seem to have created some more jobs in the private sector. But there is also very little doubt that most of these jobs are very low paid, and people don't feel much better off having got them then they were before.

MB:
And they don't seem to generate much tax. What you want is generating better and proper jobs, don't you, and contribute.

JL;
It's useful for some of these students with these new degrees coming through to actually get the earning power that they are supposed to have in order to do that. At the moment a lot of them are coming out in jobs that they can't repay their fees because they are not earning enough to do so. It's all a bit contradictory I think.

MB:
It is. It can't be that easy. It's easy to moan and groan but I can imagine when you are in charge it must be slightly tricky, mustn't it? You must think 'What am I going to do?' I agree with you, we don't want to create e a whole load of part-time jobs in Starbucks. That's not really the way forward, whereas if you have innovation – it's interesting, there are parts of London that are becoming really innovative, I think some of these software centres in Spitalfields are quite interesting. Whether that employs vast numbers of people I don't know.

Also it's making sure we have the right skills. The trouble is, for example, ironically we find it very hard to recruit high-quality staff. Really what is more shocking is that we only think about a third of the output of our main nurse training partners are up to it. I don't know what's going on there. That really is a worry.

JL:
I was going to raise that. That was going to be my final question. These figures I think today or yesterday in the *Health Service Journal*, talking about the problems, one of their headlines today talking about problems of recruiting psychiatric nurses. That's the problem we're in. Then if you can't recruit them you are paying agency enhanced rates.

MB:
Yes, exactly. But the problem again is that it comes down to affordable housing. We visited various regional universities. We went to see Leeds and Southampton and said would you come down to work in South London. They just laughed at the thought of coming down to London. They all said it was far too expensive, they couldn't possibly come down to London. Which I think is a bit silly but that is a real issue.

It is about thinking about how would you sensibly help attract and retain people. Could we find some schemes of providing housing and providing some sort of affordable housing to keep people at it. We find it very difficult to employ people, particularly at the Bethlem, because there they only get outer London weighting. It's easier slightly in the Maudsley and Lambeth but it is difficult.

Of course the quality of the staff is such a key factor in providing quality care. No matter how good your training and how good your policies and procedures, if fundamentally your staff are weak you are always going to provide or potentially provide a poor service, so that is an issue. Training is an issue. It's OK at the moment for psychiatrists but I can't guarantee it will be like that forever. One of the things the NHS has always consistently done badly is workforce planning, you can always guarantee that.

JL: Yes, they seem to make a decision that maybe they are training too many, it seems to be the opposite is the case.

MB: Obviously you don't want to waste public money on training unnecessary numbers, fair enough. Nor do you really want to run a system that asset strips other countries, which is the other model.

JL: Which is what we are doing at the moment. It's 6000 in the last year.

MB:
That's scandalous as well, so I think it is trying got get that balance right, we are trying to get to our young people and train them and employ them in a constructive and worthwhile job. But we do struggle. That's one of the things that London might need to do. London should be self-sufficient in these things. It should actually be a net exporter of trained professionals. Quite why we don't get it right for mental health I don't know.

JL: Well, I think that pretty much covers it, thank you very much.