Public Accounts Committee

OFFICIAL REPORT (Hansard)

Inquiry into Mental Health Services in Northern Ireland: Department of Health; Health and Social Care Board; Northern Health and Social Care Trust

25 April 2024

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Daniel McCrossan (Chairperson)
Ms Cheryl Brownlee (Deputy Chairperson)
Mr Cathal Boylan
Mr Pádraig Delargy
Ms Diane Forsythe
Mr Colm Gildernew
Mr David Honeyford
Mr John Stewart

Witnesses:

Mr Stuart Stevenson	Department of Finance
Mr Peter May	Department of Health
Mr Peter Toogood	Department of Health
Mr Brendan Whittle	Health and Social Care Board
Dr Petra Corr	Northern Health and Social Care Trust
Ms Dorinnia Carville	Northern Ireland Audit Office

The Chairperson (Mr McCrossan): I welcome Mr Peter May, permanent secretary, Department of Health; Mr Peter Toogood, deputy secretary of the social care and public health policy group, Department of Health; Mr Brendan Whittle, director of the community care strategic planning and performance group, Health and Social Care Board; Dr Petra Corr, director of mental health, learning disability and community well-being services, Northern Health and Social Care Trust; Mr Stuart Stevenson, Treasury Officer of Accounts, Department of Finance; and Ms Dorinnia Carville, Comptroller and Auditor General for Northern Ireland. You are all very welcome. All the guests in the Gallery are also very welcome.

We are very keen to hear the evidence from you today on the all-important matter of mental health services in Northern Ireland, which touches the lives of a significant proportion of our population and families. There will be keen public interest in the session today and in the sessions that we will hold in the weeks ahead. We appreciate you taking the time to come and engage with the Committee today and take our questions and your recognition of the severity of this very important issue. I invite you to make a brief opening statement. I say "brief", because the Committee is well versed on the issues and has taken the last number of weeks to consider the Northern Ireland Audit Office's report. That report is very detailed, and we are very appreciative of the work that it has done. We have been discussing the matter at length: we had an evidence session last week with the mental health champion, and we are keen to get to questions to ensure that we have as much time as possible to get to the relevant answers.

Mr Peter May (Department of Health): Good afternoon, Chair, and thank you for the opportunity to come before the Committee. You have introduced my colleagues, but I would like to record that we welcome the return of the Public Accounts Committee (PAC) and recognise the significance of having been called to the first evidence session of the inquiry. I can confidently say that no accounting officer enjoys the experience, but we recognise that the PAC is a key accountability mechanism within government.

It is important to start by saying that I suspect that, on a number of areas that we are going to discuss today, we will end up in violent agreement about the core approach that will be needed to advance mental health. The challenge, however, will be how we deliver that in the current financial circumstances, with a Budget outlook, particularly for 2024-25, that is extremely concerning. Those themes of agreement on direction and challenges of funding will, I suspect, recur throughout this session.

We welcome the Audit Office's report on mental health. It recognised the work that the Department of Health has done, with a renewed focus on mental health, as evidenced by the mental health action plan in 2020 and the 10-year mental health strategy in June 2021. The Audit Office also recognised that the strategy would be the key vehicle for improving the situation, and it acknowledged the work that is being done to develop an outcomes framework to underpin the collection of data.

Despite our funding challenges, we have made funding available over the last two years to take forward priority actions in the strategy, having listened carefully to partners about what those priorities should be. I want to briefly mention a few areas where there has been real progress. First, a community perinatal mental health service now exists across the region, with teams in place in all trusts. That was a service that did not exist previously.

Secondly, we have a three-year early intervention and prevention action plan, with progress made on the rolling-out of an emotional health and well-being teams framework in schools and an initial cohort of schools identified and engaged. There have been 268 referrals of families to the early intervention and prevention service, and 52 families have completed the intervention. Over 70 children and young people with complex needs have been engaged through individual and group sessions.

We have also published an independent mental health workforce review, with work under way to begin its implementation. Furthermore, there has been over £2 million of additional investment in the child and adolescent mental health service (CAMHS) to enhance existing provision and to alleviate pressures. That allowed us to increase the CAMHS workforce by 38 whole-time equivalents.

We have completed a review on how to engage the community and voluntary sector, and we are working collaboratively, with colleagues in the Republic of Ireland and across Departments such as Education and Communities as well as with the PSNI, on programmes and initiatives. That recognises that solving the mental health problem is not just the responsibility of the Department of Health.

Finally, we have made significant progress on data. We have finalised the regional outcomes framework, which includes measures that will help us to track how much we did, how well we did it, and whether anyone is better off as a result. Those measures are being embedded in the new Encompass system, which will support the collection and analysis of data as it is rolled out across Northern Ireland.

We have also taken forward the recommendations from a report by the Office for Statistics Regulation (OSR). Following a recent review exercise that was undertaken by OSR, it has asked us to write a guest blog to highlight and make public the good work that it considers we are doing in Northern Ireland, particularly around Encompass and the regional mental health outcomes framework.

I hope that that summary is helpful. We are happy to take questions from the Committee.

The Chairperson (Mr McCrossan): Thank you very much, permanent secretary, for those brief opening remarks. You touched on a number of areas that will be of interest to members. I am going to begin by addressing a number of points. First, you touched on Encompass. Diane Forsythe will ask about that later, but I will ask about it now because you mentioned it. There is another system called Epic. Why are two systems being designed? What is the benefit of that? What is the cost of that to the public purse?

Mr May: There is only one system. Encompass is the system that is being introduced. Epic is the name of the firm that is supporting the introduction of Encompass. Epic delivers systems along the same lines in the US, GB and across other parts of the world.

The Chairperson (Mr McCrossan): Epic is —.

Mr May: The name Epic is sometimes used interchangeably with Encompass, which can be confusing. Encompass is what we call the system that is being introduced. Epic supports its implementation and functionality.

The Chairperson (Mr McCrossan): Can they interlink?

Mr May: Epic is the firm that supports the functionality.

The Chairperson (Mr McCrossan): That was not clear, so I appreciate that.

Mr May: Apologies for that.

The Chairperson (Mr McCrossan): There are 17,500 people on waiting lists in Northern Ireland because of poor mental health, but, given the poor data collection and the system's failure to prioritise mental health needs and demands, I argue that the real figure is much larger. Many of our constituents say that they just cannot access services, that services do not exist or that, if they get access to services, they are being failed by them. Is that acceptable? What action is the Department taking on those issues?

Mr May: Thanks for the question. Waiting lists are one of a number of important areas. You quoted, I think, the total number of people who are on a waiting list. For me, the key is the number of people who are not being seen within the time limits that have been set. There are nine-week and 13-week time frames. The nine-week one is for adult mental health, and the 13-week one is for psychotherapies.

It is a reality that numbers overall have grown over recent years. We face a demand and capacity gap in mental health, and there is no doubt that the COVID pandemic made that substantially worse. We are now seeing presentations with much greater acuity than was the case before. The consequence of that is that all those individuals need even more treatment, which takes longer and means that we do not have the same turnover of cases that would otherwise be possible.

Substantial efforts are being made to maximise the delivery of activity within the resources that we have, and we have seen increases this year. Activity in adult mental health is 15% above levels in the baseline year of 2019-2020 — before COVID — and in psychotherapies, there has been a 16% increase in the level of activity. Activity is one measure; it is also important to have high-quality services. In a moment, I will ask Petra to say a bit about how quality is measured in each trust. There are robust quality measures as well.

Even after focusing on productivity and increasing the level of activity, we still have waiting lists that are too long. We all recognise that. I am afraid that mental health is not the only area. You all know that that is a problem. The reality is that we will need additional investment to address the problem. For the last two years, we have faced substantial funding challenges, and it looks as though the funding will be incredibly constrained this year too. Therefore, it will be very difficult to make the investment that is needed in order to deliver the enhancement that will help to address waiting lists.

The Chairperson (Mr McCrossan): Before Dr Corr comes in, I have a number of points to make. You mentioned the nine-week and 13-week waiting periods: What are the numbers in relation to those targets?

Mr May: Give me one moment to get the figures. There are 2,622 cases that have not met the nine-week target for adult mental health; for dementia, which also has a nine-week target, there are 1,665 people; and the number for CAMHS is 1,104. The number for the 13-week psychotherapy breach is 4,845. In total, we are looking at 8,000 or 9,000 cases in which there has been a breach of the timescales that were set.

The Chairperson (Mr McCrossan): Again, Diane will raise this matter, but, if there have been issues with collating data for a number of years, how accurate are those figures?

Mr May: We have confidence that those figures are accurate. There are some challenges when it comes to data, and I am happy to talk in more detail about what we are doing on data if that would be useful, but we have high levels of confidence in the range of the data that includes that set of statistics. As I said, we have the service delivery plan that the Department's strategic performance and policy group oversees. It reports monthly to me and has detailed interactions with trusts on performance across a raft of key measures of which mental health is one. We have confidence in that data.

The Chairperson (Mr McCrossan): Do you want to come in on that, Dr Corr?

Dr Petra Corr (Northern Health and Social Care Trust): Yes.

Mr May: It is about the quality aspects of casework.

Dr Corr: Across the five trusts in Northern Ireland, there is a range of mental health and psychological services, and we have been working to develop, as part of the regional mental health strategy, a framework of outcomes that will allow us to measure more than just the quality and volume of the sessions that are offered, because, while those measures are important, as are waiting times, it is really important that the intervention that is offered is evidence-based and makes a difference. That is based on work that I am very familiar with that has been ongoing in the Northern Trust since 2016, so there is a strong framework for evaluating the outcomes of all the sessions of interventions. For example, in psychological services, we measure the outcomes of each individual who comes through the services by whether they are any better off — whether they have been impacted — by virtue of the intervention that they have received. So, we are able to answer the question, "How many people are better off?".

In our evaluation of last year's activity in psychological services in the Northern Trust, we identified 72% of the population as having achieved a reliable clinical improvement. That is a better outcome than that for improving access to psychological therapies (IAPT) services in England, which are benchmarked and achieved reliable clinical improvement in 69·5% of the individuals who used the them. We are able to look at standardised measures of, for example, depression, anxiety and stress, and to evaluate whether the person is better off after intervention. The framework that we have used in the Northern Trust, has, with input from many others across the region, including service users, families and carers, been developed as part of the regional mental health strategy to enable us to bring forward a consistent approach to that data. Other trusts have similar approaches, obviously, but it is clear that Northern Ireland should have one clear and consistent set of data that enables us to answer the question, "Are people better off as a result of the intervention they've received?".

The Chairperson (Mr McCrossan): OK. Thank you. My colleague Diane Forsythe will pick up on that shortly, but I appreciate that answer.

Over the past number of weeks, I am sure that you have been following the business of the Assembly. Much has been discussed and indicated as a priority for various Departments and, indeed, Members. Everything is a priority if you look at it in a certain way, but what is being done to ensure that mental health services are prioritised in the interests of people across Northern Ireland?

Mr May: We have used the mental health strategy as our North Star: the guiding light. It was a 10-year strategy, agreed in 2021. It was not only put in place by the then Minister of Health; it was agreed by the Executive as a whole. Indeed, at that time, the Executive committed to providing the funding that was needed for the mental health strategy, and we still hope that that will be possible. That strategy sets out 35 actions. Delivery has started on 20 of those. As I mentioned in my opening remarks, a number of key areas have been advanced, including the community perinatal mental health service, under which 75 individuals each month benefit from the experience that is possible compared with what was there before. I might ask Peter to say more about the plan for the establishment of a regional mental health service. The establishment of a digital mental health board and the roll-out of emotional health and well-being teams in schools have also been advanced. Do you want to talk about that regional mental health service, Peter? We recently appointed a lead for that.

Mr Peter Toogood (Department of Health): Thanks, Peter. The regional mental health service is one of the flagship programmes of work that we want to take forward in mental health services. It is one of the standout actions in the strategy that the Minister highlighted when the strategy was published. It is a way of bringing a regional consistency to mental health services across all trusts. It is not about building a new organisation but about making sure that what we have and what we are delivering is done in the best way possible, using our people in the best way to make sure that everyone has equitable access to services, no matter where you live.

As well as being a standout action, it is an enabling action in the strategy. So many different actions of the strategy follow from that. We put a lot of effort into making sure that we know what that service looks like. We now have a five-year implementation plan to turn the concept into reality. To lead on that delivery, we recently appointed a head of the regional mental health service, who is going to take that piece of work forward and bring it into reality. In the first instance, that means establishing what we will call a collaborative board, which will comprise not just the trusts but people from the community and voluntary sector, those with lived experience, trusts and other Departments, because of the collective nature that we need to address mental health services. That is how we get prominence and visibility: that is how we know and demonstrate its priority.

The Chairperson (Mr McCrossan): I appreciate the merits of the strategy. I have seen it and read it, and I listened to an evidence session on it last week. That is the strategy. That was 2021: we are now in 2024. What has been done to show the public that this has been prioritised? From what I am hearing, health waiting lists are a priority as are mental health services. Are they priorities, and what is the Department doing to ensure that that is the case? I do not want to hear about the merits of the strategy. I know what needs to be implemented: I want to know what has been done since 2021, when it was put on record that there was a very serious issue in mental health services. What I am hearing — hopefully, I am wrong and you are going to correct me — is that very little has happened. You are only reflecting on a strategy that is not yet implemented. What small changes, if any, have been implemented to improve the service and show that it is a priority for this Department?

Mr May: Let me repeat some of the things that I said in my opening statement. We have implemented a community perinatal mental health service across the region with teams in place in all five trusts. We have completed a three-year early intervention and prevention action plan, with progress made on the implementation of actions. We have completed and published an independent mental health workforce review, with work under way to begin planning implementation of the key recommendations. We have made an additional investment of £2 million in the child and adolescent mental health services to enhance existing provision and alleviate pressures, particularly in inpatient settings. We have rolled out the emotional health and well-being teams in schools with initial cohorts of schools identified and engaged. We have established a digital mental health board and appointed project leads to develop a digital mental health service action plan. We have completed a review to explore the optimal approach to engaging the community and voluntary sector in the development of mental health policy and provision.

Let me also say, in direct answer to your question, that the strategy had envisaged, and set out, a costed year-on-year framework over the 10 years as to how that would go. There is a harsh reality here: the Department has not been able to fund the strategy to the levels that were envisaged when it was published. That does not signal a lack of priority in the Department. Actually, it is a signal of the very serious financial challenges that the Department has been facing, certainly in the two years that I have been in post. As I have said, those challenges look likely to worsen next year, with concerns about our ability to continue to deliver current services let alone invest in new ones.

We have invested around £9 million in the strategy. We would like to do more. As I said, we will be in violent agreement on the need to do more and the importance of that. I know, having heard the Minister of Health talk on a number of occasions publicly and privately, that the mental health strategy is one of his key initiatives.

The Chairperson (Mr McCrossan): I appreciate your answers, permanent secretary, but I still do not think that you are getting the question that I am asking. There are a number of priorities for your Department, as there are for every Department. Multiple Departments have very fancy glossy strategies in place, as does Health for mental health services and a load of other areas, including the Bengoa report; I could list a mountain of them. I am being told that mental health services are a priority. We have launched an inquiry into that area for that exact reason. Services are collapsing. In fact, they are non-existent, and there is no data to give an accurate reflection of where things are. I am hearing that there is no money and that there is a restriction on the budget. We know that, but this is

not a new problem: the mental health challenges that we face today are not new, but they have worsened. You say that mental health services are a priority, but how do you deal with the competing priorities of your Department to ensure that those services are prioritised and protected for those who are most in need?

Mr May: Each year, we have looked at how much money we can invest in the mental health strategy within the budget that we have available. As I explained, we have engaged with partners and others who are interested and involved in the mental health space to ensure that we cover not just our priorities but their priorities. We have made the investments that I described in a context where, in both of the past two years, we had such a budgetary challenge that we were projecting an overspend until an agreement was reached with the UK Government, which resolved that issue. As accounting officer, my responsibility was to secure break-even, which limited the amount of investment that could be made. Of course, there are lots of competing priorities, and, each year, we work in a budget process with our trusts and other arm's-length bodies. Ultimately, our Minister — thankfully, Ministers are in post at the moment — sets the priorities and determines the budgets for the different areas. That is the process that we follow.

The Chairperson (Mr McCrossan): I will move on to other members shortly. If that is the case, is the current strategy, with its 35 recommendations — is that correct?

Mr Boylan: It has 35 actions.

The Chairperson (Mr McCrossan): Thirty-five recommendations. Is that realistic and achievable, given what you have just said?

Mr May: As I said, it remains our North Star and the direction of travel. We will go down that direction of travel as quickly as the budget allows us to. Clearly, we have not been progress at the speed envisaged by the strategy. As I said, this year, it is unlikely that we are going to be able to accelerate that, so it becomes less likely that we will be able to achieve it within the 10-year time frame. However, for the reasons that you and, doubtless, many other members here will draw out, there is an urgent need for us to be able to make those changes. We would all like to be able to invest in that area. There are other areas that we would like to be able to invest in: mental health is not the only area where there are challenges.

You made some comments about data and so on. I would like to come back to those, perhaps in response to some of the detailed questioning, because I do not accept the formulation that you used to say that there is not any data. That is inaccurate, and I would like the chance to explain why in more detail, but I will wait until we get into the detailed questions in that area.

The Chairperson (Mr McCrossan): We certainly will. The point that I was making is that the data is not reflective of the reality, but I thank you for your response.

Mr Stewart: Chair, you covered a couple of the points that I was going to make. Permanent secretary, thanks for coming today. On the budgetary picture that you painted, there has been a lot of talk about the impact on Health as a result of the tightening financial situation here in Northern Ireland. What is your initial assessment of the impact of that? Is there a chance, given what you said, that we could end up spending less in 2024-25 on mental health and the strategy than we did in 2023-24?

Mr May: We are not yet in a position to reach a judgement on exactly what the figure for spending on the mental health strategy will be this year compared with last year. There is detailed work to be done on that. However, the draft Budget numbers that I have seen would cause very substantial damage to health and social care services in a range of areas and make it incredibly difficult to break even.

Mr Boylan: You are very welcome. Thank you very much for your answers, so far. The Committee was struck by the sheer size of the mental health sums, with the 35 actions and the £1·2 billion cost. It is a priority, and I am glad that you are refocused on it, Peter. In your opinion, did the Department focus too much on developing the strategy as opposed to the expense of its delivery?

Mr May: I do not think so. One of the good things about the development of the strategy was that it came with a fully costed plan over the 10 years and a clear eye to implementation. Peter Toogood can say a little more about it, having been closely involved. It was developed during the COVID years. There was probably a different financial horizon at that time; it was not clear that we would have

ended up with the very severe budgetary challenge that we have had in the last two years and, it seems, will have for the coming year. That situation has changed the speed at which we have been able to make progress, but our commitment and focus on taking these actions forward and doing sensible work — either preparatory work or work towards substantively meeting the commitments — remains strong.

I do not know whether you want to say anything more about that, Peter.

Mr Boylan: Before you go on, you said that you believe so. My next question relates to what you said. Are you saying that the strategy is deliverable? You believe in the strategy. Is it deliverable over the period?

Mr May: I kind of answered that question in my response to the Chair, I think. I indicated that we have not been able to make the progress at the speed that was envisaged in 2021 and that, if the budgetary challenge continues, it will be extremely difficult to deliver the strategy within a 10-year time frame.

Mr Toogood: You are absolutely right to ask about the balance between development and implementation. We have been conscious of the need to not get that balance out of kilter. In developing and shaping the strategy — as Peter said, that process took place at a very difficult time for society — we engaged with over 300 people across a spectrum of users, including people with lived experience. When we put the strategy out to public consultation, we received 400 responses. People responded largely positively to what was there. We took time to do that over a 12-month period. We felt that it was right to do that in order to make sure that we got it right, starting on the right footing. You are right that, with 35 actions, it is ambitious, but we wanted to make sure that those were the right 35 actions.

The strategy was published in June 2021. Since its development, its implementation has primarily been shaped by the financial context in which we have been working. We have had single-year Budgets since then, which have inhibited how far forward we can go. To match that budgetary situation, we have published annual delivery plans. When looking after this work, it is important that we do not look at it and say, "It is all too difficult, so we are not going to do anything". In those delivery plans, we try to focus on what can be delivered with the limited resources that we have.

When he published the funding plan, the Minister was always clear that additional resource would be needed. That was not forthcoming, given the Budget at the time. We made a case and got the additional funding released from within the Department. Over those two years and two delivery plans, we have really tried to focus on stuff that we can do. I accept that a lot of it is preparatory work, but it is important preparatory work such as the workforce review and the outcomes framework. That is really important stuff for making sure that, when we make big changes, we do so from a sound footing.

It is fair to say that the real game changer will be when we get the additional funding that is highlighted in the funding plan. The majority of the funding will go on staffing and workforce; that is where we will start to feel the real material service change. At the moment, I think that we have gone about it pragmatically and sensibly in order to make sure that we are ready and that we on a sound footing. At this stage, I think that we have the right balance between development and what we have done on implementation.

Mr Boylan: This is my second point, and you may correct me: you said that you have spent £9 million to date. You outlined a number of key actions — you said them twice, to be fair. I am just following on from the Chair's points. Have you measured where you are at now in the first three years? Can you say where you are at? You keep talking about funding, which is grand and will be the subject of many questions. Where is that on the measure now, as we sit?

Mr May: As I said, we have commenced 20 of the 35 actions. We published the annual delivery plan that Peter described. Peter, can you say something about the extent to which that covers progress that has been made in the year previous as well?

Mr Toogood: As I said, there are only two plans; we are developing the third one at the moment. In the first year, we set out what we were going to do. That was the first plan following the strategy, which was for 2022-23. In the 2023-24 plan, we said, "This is what we are going to do, and this is how we did, looking backwards, and how far we got in year 1". We used that to help inform our priorities for year 2. We are doing the same at the moment. We are going through that process of, "What have we done, and what do we need to focus on in year 2?".

We are not doing that isolation as a Department. We are doing it with everybody who is involved in designing the strategy and delivering it, so it goes beyond the Department and the trusts. On what we have done to date and what we need to do to look forward, I am happy to say what are shaping up as our broad priorities because that is reflecting the learning that we have had, if that is helpful.

Mr Boylan: That leads on to my next question. I have only two other points. In the absence of funding, how are you prioritising the strategy? Also, what are you not going to be doing? Can you expand a wee bit on that?

Mr May: One of the key areas that will be very difficult to advance is doing more on workforce because, to train people, you need additional funding to be able to recruit more people into the service. You need more posts. That will be one of the key constraints, and — going back to what the Chair said as well as what you said — until we are able to grow the workforce significantly, people will not feel that there is a difference on the ground, because the level and scale of the challenge is still getting bigger rather than getting smaller. Do you want to say something about how we set priorities in the strategy?

Mr Toogood: Yes. Again, it is about looking at the actions that are necessary and essential upon which to build. Picking up Peter's point, even though our ability to invest heavily in additional workforce will be constrained, our priorities for next year have the theme of workforce at the forefront of our minds, because that has to be at the forefront if we are going to change anything.

There are probably three key areas that we are going to look at next year, mindful of the workforce challenges. The first one is the regional mental health service that I talked about. That is about using what we have in the best way possible and providing the basis upon which to layer in the additionality.

The second priority is around the community and voluntary sector. We want to focus on that, because that is a huge workforce in the mental health services. We are conscious that that is an area that we need to be better at interacting with. We need to understand better what is there and what the community and voluntary sector can deliver and make sure that the sector plays a huge role in the delivery of services.

The third area is psychological therapies. That runs through the strategy and through our workforce review, and it is one area that has evidentially been proven to make really positive outcomes for people. Again, we need to do work on what the psychological therapies workforce will look like, and we have some options on the table that we are going to enact. Peter may say something about those shortly. That is where our minds are at. We learn from the past, we are mindful of what is going on in the external environment and we shape our priorities accordingly. That gives you a sense of where we are going next year.

Mr Brendan Whittle (Health and Social Care Board): Chair, If I may, I will give some additional information that might help answer Cathal Boylan's question on how we have prioritised in the past year. By way of example, the single biggest area that we put financial investment into last year was child and adolescent mental health services, and £1·9 million went into it. Our next most significant area of expenditure was our perinatal mental health service, to which the permanent secretary referred in his introductory remarks. One million pounds went into early intervention and prevention. The next highest level of expenditure was on our regional crisis service.

You can see that the available funding has been invested in early intervention, children, crisis support and perinatal services. Those areas were prioritised as a consequence of the areas that were prioritised in the one-year delivery plan. That plan was done in conjunction with people with lived experience, their carers and those who work in the service. Hopefully, that has been some help.

Mr Boylan: I will be careful not to delve into any other areas. I have a quick question: is there a built-in review? How much are the mental health bids for 2024-25?

Mr May: We use the annual delivery plans as a means of review. I am not sure whether a distinct review is built into the programme. For 2024-25, we are looking to maintain funding in the areas that we have identified. There are a couple of areas in which we have made bids, but, frankly, I am not expecting them to be met. One of those areas relates to workforce and to how it could be expanded when it comes to the transformation of not only mental health services but areas of which mental health is a part. Another area is looking at multidisciplinary teams (MDTs) in primary care, where mental health staff play a core part, along with social workers, physios and others. Again, it is our

aspiration to use the transformation funding for that. The funding has not yet been addressed, so I do not know how it will work out. The MDTs are another area where we have looked for additional funding.

Mr Gildernew: Thank you for your attendance at Committee and your answers so far. I will very briefly set the context. When the Committee was looking at which of the various areas of concern we would focus on, I said that mental health services were a key issue. I have seen constituents with significant difficulties. I will give an example, permanent secretary. I can send you this email response that I received from one trust. I have removed the names from it to protect confidentiality. It says:

> *"In relation to your inquiry on behalf of [your constituent] I can confirm that our Service Manager for the Community Mental Health Team has confirmed that a referral ... was received by the ... team on 28 March 2022.*
>
> *Regrettably the current waiting time from the date the referral was received is approximately 5 years, and [your constituent] remains on the waiting list."*

In the context of mental health there are questions as to whether the service will be of any benefit to that person, given the scale of that five-year wait. That is the real human impact of what we are dealing with.

I will focus on the workforce issues. There is a truism in health. We are blessed to have probably one of the best and most dedicated and devoted workforces anywhere in the world. The staff are working under impossible pressures at this stage. They are trying to cover gaps in staffing. At times, there are not even safe staffing levels, yet they work at the coalface. I will go into the issue of vacancies. Capacity and proper staffing has been highlighted as a major concern. About 10% of posts are currently vacant. I will come on to the review in a minute, but we do not have enough mental health professionals, as was touched on, to support service delivery. Will you provide a short answer on this: how vital is it that we fill those vacancies?

Mr May: As I said in answer to a previous question, I do not see how we will address the problems with breaching the waiting-time targets if we are not able to invest in additional workforce. We can stretch productivity only so far. It is a harsh reality, but, if we do not have funding to invest, it is very hard to see how we will turn the curve in that area.

Mr Gildernew: The mental health champion attended the Committee meeting last week and told us that, for her, building the mental health workforce should and needs to be the number-one priority in order to increase the services provided and access to those. I have seen the workforce review that was undertaken by the Department. It identifies the need for 2,000 extra staff over the next 10 years. Is that achievable or even realistic, given the current recruitment and retention issues in the health service?

Mr May: We currently have a one-year budget for 2024-25. With the budget that I expect the Department will receive, it will be very difficult to make significant progress on expanding the quantum of the workforce significantly. We continue to look at all sorts of innovative ways in which we can bring people into the workforce. It is not purely through the training route; there are other avenues that we can use.

Peter Toogood has explained that workforce will be the key theme for next year, but the budget is going to be a major constraint. I hope that we will move — I have said this for over 10 years — to multi-year Budgets, because working on a one-year basis is no way to run a health service or any public service. I hope that that will be possible very soon. That will, then, allow us to set a longer-term frame, and will enable me to answer your question more fully than I am able to today.

Mr Gildernew: Do you feel that the Department has acted urgently enough to get the staff that are needed in place?

Mr May: It is my belief that the Department is doing all that it can to implement the strategy in highly constrained circumstances. I do not wish to distract, but there are multiple areas where Health and Social Care is facing very significant pressures. It is not possible just to look at one area, no matter how big a priority it is, without also looking at the consequences across the whole of Health and Social Care.

I suspect that — I will not do it because it is not fair on MLAs — it is very hard to understand which area to take the money out of in order to put extra money into mental health, which is, essentially, the question. That is the only way that we could answer that, if we wish to put more money in. There is no additional money coming centrally. The only way that we can do it is by taking money out of a line somewhere else and putting it into mental health. That is a very difficult thing to do. You will know, from your time as Chair of the Health Committee, the very severe pressure on pretty much all aspects of Health and Social Care at the moment, including workforce pressures across the board.

Mr Gildernew: I recognise the benefit that a multi-year Budget would bring. Nevertheless, traditionally, there has always been a certain trajectory, and there are certain things that you can, almost, anticipate. I do not think that there has been a cut to Health for a significant period, despite the financial challenges. However, there is a long tail to staffing issues as well, so urgent action now is needed to even address the situation in two, three, four or five years, and up to seven years, depending on the health professionals. In that context, how many additional training places has your Department commissioned since the strategy was published?

Mr May: I have some data here. I can tell you that in 2018-19, there were 11 places for the clinical psychology doctorate at Queen's University. Last year, in 2023-24, there were 21 places. I have seen a figure of 23 somewhere as well, but I do not know whether that is the plan for next year. There has been more of a fluctuation over the years when it comes to mental health nurses. For a number of years, extra funding was available that allowed us to increase the number of nursing places overall. In 2019-2020, there were 130 places, and that increased and hit a high point of 195. At the moment, we are projecting 165 places for mental health nursing in 2024-25. That is the direct answer to your question in relation to some training places.

Mr Gildernew: Would those figures put us on a trajectory to solve the problem?

Mr May: Not in themselves, no, for all of the reasons that I have explained.

Mr Gildernew: OK. Thank you, permanent secretary.

The Chairperson (Mr McCrossan): I want to pick up on a number of points that Colm raised, and then we will go to David Honeyford. Obviously, you cannot train specialist mental health staff quickly, so what capacity is there currently in the system to train the number of staff that you need? Do you need to increase that particular training capacity, and have you drawn up plans to achieve that? How long will it take, if that has, indeed, happened?

A further point that I am hearing more and more since the return of the Assembly is about the loss of specialist staff to other jurisdictions. Is that the reality for your Department in this particular area?

Mr May: On the second point, I do not have an evidence base to support that — certainly not on mental health specifically. Will you just remind me of your first question? Apologies, Chair.

The Chairperson (Mr McCrossan): It was about specialist training for mental health staff. Is there the capacity in the system, by ensuring that staff are appropriately trained, to meet the demands that are there?

Mr May: As I said, in that area, as in many areas, we would like to make an additional investment, both in medical and nursing staff. That is also true for social workers, allied health professionals and many other specialities for doctors and nursing. I mentioned that there are other routes. The classical route is the doctorate in clinical psychology, but there are other training routes that graduate psychologists can consider. The first is a cognitive behavioural therapy (CBT) diploma. The second is becoming a psychological well-being practitioner (PWP). The third is becoming a clinical associate psychologist, and the fourth is a postgraduate certificate (PgCert) in foundations in applied psychology. Those are all alternative routes that can help us to increase our workforce in the short term and enable us, more quickly than the doctorate does, to bring people into the workforce. We are exploring all the options as to how we can best do that. Understandably, some people prefer to go down the classical doctorate route, so that is a challenge. Do you want to come in, Peter?

The Chairperson (Mr McCrossan): My point is about accessing services, which will be touched on more widely as we go ahead. If someone presents today with a mental health issue, they will be sent or referred to a very busy A&E. Take Altnagelvin as an example. That person, who is in a vulnerable

state, may have to wait for, in some instances, up to two days before they are properly seen. Staff in A&E departments have told me that they are not trained to cope with the complex challenges faced by those with severe mental health issues. Yet, they are put into A&E, and I am told that it is the best place to send them. What is your view on that? Staff in A&E who deal with that at the coalface are telling me and, I am sure, others that they are not properly trained to deal with someone with severe mental health issues.

Mr May: There are a few points that I will make, but some of my colleagues who are closer to the detail may want to add to it. There are a number of ways in which people can access mental health services. The reason the emergency department (ED) is one of those is that, under the Mental Health (Northern Ireland) Order 1986, it is a place of safety. That is why some people end up in emergency departments. However, people can access mental health services, on a crisis basis, through primary care, GP out-of-hours services and the crisis service without going to an emergency department. Brendan, do you want to add to that?

Mr Whittle: I am happy to pick that up. As the permanent secretary says, emergency departments, as places of safety, are the right place for those in need of medical assistance. For many people, however, they are not. There is a range of alternatives, but they are not universal across every trust area. That is why crisis support services will be prioritised, going forward, in the mental health strategy. There are arrangements other than EDs in place.

By way of example, Assembly Members will be well aware of the regional telephone support services: Lifeline; Samaritans; and Childline. There are places in the community where people can access support; for example, crisis cafes. There is support, through primary care GPs, from mental health practitioners in the primary care teams. There is also the multi-agency triage team (MATT), which works alongside the police and the Ambulance Service, that supports individuals who present to those services. It can direct them away from ED and get them the appropriate help when needed. In hospitals, there are mental health liaison services. Each of the trusts has crisis-response and home-treatment teams.

I accept the point in terms of —

The Chairperson (Mr McCrossan): There are a number of points to this. Mr Toogood told the Committee a few moments ago that the Department is aware of what is going on in the external environment, particularly in relation to mental health services. What I have just heard tells me that that is not the case, because many people listening today would argue strongly that A&E, particularly at Altnagelvin Hospital, is not a place of safety. It is not a place of safety for either the vulnerable people who go through the door or the staff who work in that chaotic environment.

You suggest that GPs can see people with mental health issues. The waiting list to see a GPs is significant. You cannot see a GP today if you present with a mental health issue. You cannot see the community mental health team if you are not already known to it as having a pre-registered illness. The reality is that access to the service is non-existent except through A&E, and it is not a safe environment. I find it deeply troubling, to be honest, Mr May, permanent secretary, that the Department considers that it is. Actually, senior departmental officials would do well to sit in an A&E at a weekend to see how safe it is. The former manager of the A&E in Derry, and many other staff, have told me that it is not a place of safety for vulnerable people.

Mr May: There may be a risk of a misunderstanding here. A "place of safety" under the Mental Health Order is a specific legal issue. Nobody believes that it is desirable for people to spend long periods of time in emergency departments. I know that Altnagelvin has been doing a lot of work to try to reduce and eliminate the number of times that that happens —

The Chairperson (Mr McCrossan): Mr May, is the ED in Altnagelvin, just as an example, a safe place? It is important, because recent headlines, going beyond the issue of those with a mental health illness, have pointed out that that is not the case. We all know that Altnagelvin — it is one example of many, and one that I am very aware of — is not a safe place for people with illness let alone people with vulnerabilities. It is not. Even senior figures in the trust would argue that it is not a safe place and, in fact, that it is not fit for purpose.

Mr May: We would all acknowledge that it is an undesirable place for people with mental health problems to remain. The purpose of our service is to maximise safety. The reality is that those with

severe mental health illnesses always have risks to safety. We have to try to manage and mitigate those as best we can.

Dr Corr, you manage those services within a trust environment. Would you like to say something about how safety is managed in the context of, for example, someone presenting to an emergency department?

Dr Corr: We appreciate that there is very significant complexity in all that you are talking out, Chair. We should attempt to think about crisis attendances and routine attendances in relation to mental health as two separate issues. It is important for us to make sure that we address both of those. It is important that both parts of that really important part of the spectrum are addressed. We have talked a little about crisis, and I am happy to pick up on the issues that you mention.

As Peter mentioned, the Mental Health Order has a legislative clause that allows for certain areas to be specified as a "place of safety" for an assessment to be carried out and for a person to be held pending an assessment. An ED is, definitionally, one of those areas. The issues around the complexity of EDs are largely to do with the general busyness of EDs — we all know about the pressures across the ED system — and the prolonged nature of waits on occasions.

Prolonged waits is really to do with bed occupancy if an individual requires to be admitted. Within EDs and hospitals, there are mental health liaison services. They are professional and senior qualified practitioners with mental health experience who work in the hospital system. If a person arrives in distress and is very unwell, those practitioners will see that person within the two-hour period, complete an assessment, devise a care plan, provide support and perhaps prescribe medication. There is a range of provision across Northern Ireland in relation to that. Not all trusts have 24/7 services; some trusts have nine-to-five services and are supported through crisis response services thereafter. The support is there at many of our EDs, and it is always available.

The issue that you raise about prolonged waits is because of a problem in a different part of the system: acute bed pressures. If mental health liaison sees an individual, completes an assessment and feels that that individual requires detention or admission to hospital under the Mental Health Order, a process is gone through with the GP and the approved social worker (ASW), who is a senior practitioner who makes those determinations under the legislation, and conveyance of that person to hospital is arranged.

The complexity in Northern Ireland is that we find ourselves in a position of over-occupancy across our hospitals. On many days, we do not have a bed available. A significant amount of work needs to be done to create bed stock to enable a person to be admitted. That may mean that there needs to be an assessment of where an individual who is, at that point, in the ED should most safely remain while awaiting the bed to be facilitated and to be conveyed. That is really the issue. There is certainly an issue with an ED being a busy and challenging environment.

It is important, though, for people to go to an ED. It is important that we send a message to make sure that people know that they can go to an ED. They may need their physical health checked. If someone has cut themselves, overdosed or attempted to hang themselves, there could be a physical issue that needs checked as well as their mental health needing checked. It is important that we do not inadvertently send the wrong message.

The Chairperson (Mr McCrossan): I appreciate that, but it is not in line with reality, because trusts across Northern Ireland put out the message, "On busy days, do not come to A&E unless it is an emergency". Those who are at crisis point often do not believe that they are an emergency and do not want to sit in a busy ED. That is feedback that each of us has had from constituents. Permanent secretary, you have said that it is legally safe. Is it clinically safe? That is the question.

Mr May: I am not a clinician, so I am not equipped to make that judgement. I have indicated, having spoken to clinicians, that the service makes every effort to mitigate and manage safety issues. You cannot eliminate safety issues when there are severe mental health illnesses, whether that be in an emergency department or, indeed, any other setting.

The Chairperson (Mr McCrossan): I will continue briefly and then move on. I will give you an example of an experience in an ED. There are people sitting in EDs who go there because they cannot see their GP and cannot get access to the community mental health team, whether they are known to that team or not. They present to an ED and may sit there for a period of up to two days,

depending, as Dr Corr rightly points out, on the availability of beds. We are aware of the challenges with that, and I appreciate how severe those challenges are. However, they are sitting in an ED that is very busy and where they are surrounded by people. The staff are overworked, exhausted and dealing with multiple other patients who have multiple issues. Those vulnerable people, who are in a very poor state of mental health, are sitting on a seat for hours, if not a couple of days. I am aware of occasions — I have raised this — when a vulnerable individual has left the ED and it was some time before that was noticed. That is not a clinically safe environment for a vulnerable person, I am sure you will agree.

Mr May: I am happy to respond on any individual case that you would like to raise with me specifically.

The Chairperson (Mr McCrossan): There are multiple cases. The point that I am making — this is the key starting point for access to services — is that, unless there is a physical injury, an emergency department is not the most appropriate place for those vulnerable people.

Mr May: As Dr Corr explained, we risk sending the wrong message. Emergency departments are designated as a "place of safety" for a reason. It is really important that we do not go down the wrong path here.

The Chairperson (Mr McCrossan): That may be the case in writing, but it is not the case in reality. I really need the Department of Health to understand that emergency departments are buckling under severe pressure and that sending vulnerable people to those emergency departments in their current form, without addressing the concerns of trusts across Northern Ireland, is making the issue much worse.

Mr May: I accept that our emergency departments are under severe pressure. In answer to other MLAs' questions, I have highlighted the severe pressures on all parts of our system and the very significant risks. No one is minimising those risks. We all want to be able to take many more actions to try to mitigate those risks than we are currently in a position to take. As I said at the beginning, we are in violent agreement about the way in which we need to try to develop the service and move it forward. The key inhibitor is the means by which to achieve that. It is a source of great frustration to those who work in emergency departments, but also to those who manage trusts and those in the Department, that we are constrained in that way. It is very difficult to make the change that is needed.

Dr Corr: Chair, I will come in to offer reassurance on behalf of my director colleague from the Western Trust. I am very conscious that she is, in collaboration with colleagues from the ED, in the midst of a specific improvement project on the identification of a separate and safe space for individuals while they are waiting. We receive feedback from MLAs, service users and families, and we work to do what we can to create more appropriate environments. It is important to acknowledge that that work is ongoing and an improvement project is under way. Hopefully, that will make the situation better for individuals during the waiting period.

The Chairperson (Mr McCrossan): Thank you, Dr Corr. I have a very good relationship with the Western Trust, and I am very aware of the good work that it does, but I am also aware of its concerns about the emergency department, which need to be addressed by the Department of Health. We will move on.

Mr Honeyford: Thank you for being with us. I want to look at funding and why we do not have enough funds being spent on mental health. Before I do that, as you pricked my interest, I will ask a supplementary to Cathal's question. Peter, you mentioned getting better at using voluntary services and organisations. In all our constituencies, we have fabulous voluntary-sector services that do great work. I am concerned about how that is funded. Do you expect a voluntary service to, effectively, deliver services for the Department and fundraise to keep themselves alive at the same time? Are you suggesting that that is the way forward?

Mr May: One of the strengths of the development of the mental health strategy was that it engaged widely, including with the community and voluntary sector. It is a very varied sector, as you know, with large organisations that deliver services but also a lot of voluntary services that are not necessarily looking for funding. There are more of those voluntary services than there are of the big deliverers of community services. It can be hard when you try to bundle everything into one box, as you, potentially, end up looking through the wrong lens. Clearly, if we commission a service that involves the community and voluntary sector, that will usually be on the basis of some form of competitive process by which we agree on the appropriate cost for the service.

Peter, David has picked up on a point that you made about use of the community and voluntary sector, so do you want to add something?

Mr Toogood: As Peter has outlined, at the moment, we engage with the sector in a suboptimal way, to be honest. It is very much along the lines of us wanting a service and going through a procurement: it is a provider-supplier relationship. On a related piece of work on children's services and social care, there is a recommendation to change the dynamic of the relationship between us and the community and voluntary sector. That theme runs through to mental health services. It runs through to how we engage in the broadest sense. The Department's desire is to change the dynamic away from being one of, "This is what we want, you will provide and we will hold you to account". We still need to do that, but we need to do it in a co-joined way.

We need the community and voluntary sector to plan, develop and deliver services. We are getting better at the development bit — the community and voluntary sector has been involved in all this — but we need to do more on the planning and delivering. We commission a lot of work from the community and voluntary sector. We would not be able to deliver our mental health services without that sector. That is why I mentioned that, next year, it will be a big priority for us to make that better. We know that we are not there yet, but there is an absolute desire to do that.

Mr Honeyford: Those organisations need security of funding on the other side, but I will leave that for now.

Figure 6 of the Audit Office report indicates that, proportionately, there are significantly lower levels of funding for mental health here than there are in other jurisdictions. In England, for example, the proportionate spend on mental health from the health budget is nearly three times higher than it is here. Why can we not do that?

Mr May: We started from a low base. Through the strategy, we aspire to increase the level of per capita spend. The most recent figures that I have are that the spend is just over £200 per capita and that the proportion spent on mental health services is 7%. That is my understanding of the situation now, whereas the figures in the Audit Office report were accurate in 2019-2020. Therefore, we have made some progress but, obviously, we have a long way to go. I think that the mental health strategy sets an aspiration or target for 10% of the health budget to be spent on mental health services. Is that correct?

Mr Toogood: That is the target for the percentage of the total mental health budget to be spent on CAMHS.

Mr May: My apologies: I got the wrong percentages.

Mr Honeyford: You talked earlier about how we could choose to take money out of something else and put it into mental health. However, the finance associated with implementation of the health strategy is not available from within the departmental resources, yet it is in England. We spend more on health per capita here than they do in England. If we spend proportionately more here than they spend in England and there is a 10% difference, which is roughly £600 million, I do not understand why the budget is not available. I cannot get my head around that. It is available in GB, but it is not available here and we have to take the money out of something else. What is being overspent on, from which the money can be moved and spent on mental health?

Mr May: The Fiscal Council report covers this in some detail. One of the key areas of analysis is the levels of need here compared to those in England. It is widely accepted, by pretty much all commentators, that Northern Ireland has higher levels of need than is the case elsewhere.

As I said, we started from a certain position and we are looking to change that. We are always looking at how we can make efficiencies and savings. The Department has launched a number of pieces of work designed to look at how we spend our money and whether there are areas from which we ought to reallocate money to different areas. However, that work has not yet concluded. My experience so far, in the two years that I have been in the Department, is that there is often a lot of complexity around the reasons for spend, which can be difficult to unpick. We are always looking at that, but I suggest that any MLA here will find it difficult to say, "That is the bit of money that is being wasted and needs to be taken away and put into mental health".

Mr Honeyford: We are not the experts on budgets, so I am not —

Mr May: What I am saying is that, with the expertise that we have, I have not yet identified where that money would come from.

Mr Honeyford: A report from the Nuffield Trust says that £410 million is being spent on hospitals, as people are staying in hospital too long because we do not have other services. If that is addressed, there is £410 million of your £600 million. That is what I am saying. Where are we overspending so that we are not spending on mental health?

Mr May: Addressing that is primarily about investing in social care in order that there is somewhere for the people who are in hospital to go and be safely cared for. That is the reason that they are kept in hospital for longer. You cannot just take that cost and assume that the money should be spent on mental health; that is money that would need to be spent on social care. It is right that, this year, we have made an investment in social care to put the national living wage in place but also to go beyond that to try to encourage more people to join the social care workforce. That is a key constraint for us, and it is one of the reasons why we have lengths of stay that are longer than we would like.

Mr Honeyford: Is it simply that there is a lack of transformation and we are not getting on with it? Is that a part of this?

Mr May: There is always a need to do more on transformation, but we have delivered a lot already. I will move away from mental health specifically, as we have talked about the things that we have done in mental health services under the strategy. The move to try to separate the elective space from the urgent and emergency space, through the creation of elective overnight centres in the South West Acute Hospital, Daisy Hill and the Mater, the introduction of day-procedure centres in Lagan Valley and Omagh, and the introduction of rapid diagnostic centres in Whiteabbey and South Tyrone, are all examples of transformation. We are simplifying the pathways and making it less likely that individuals will not get their procedure because of an urgent and emergency pressure at the same time. In the past year, we have also moved a number of services, including general surgery moving in a couple of locations and maternity services moving from Causeway to Antrim.

There are indications of where transformation is happening, but, yes, there is more to do on transformation. Your question indicates a supposition that, if we transform, health will become cheaper. We have to recognise that we have very high levels of unmet need. We are talking about one aspect of that today: mental health. The first thing we would do in transformation is to try to meet that unmet need, but that will not actually save money in the short term. Just to be clear, there is no magic button whereby you transform something and lots of money will come back.

Mr Honeyford: I am not suggesting that in the slightest. You said that any MLA would find it difficult to say where the money should be taken from, and I said that I read a report that indicated that there could be £410 million of a saving that they are not spending in England. If you look at part three of the Audit Office report, you will see that overall funding levels have increased in the past decade but mental health's overall share of the health and social care budget has actually reduced. Given the significant impact of poor mental health on individuals and wider society, I suggest that reducing the overall budget reduces the early intervention that Daniel talked about earlier and the ability to treat people quickly at that interface. Given the little allocation to mental health, is mental health a poor relation? You would agree that it is having the opposite effect: by spending less on it, we are actually putting further pressure on the rest of the health service and making the situation worse.

Mr May: The point I was trying to make is that we are increasing, both in real and proportionate terms, the amount that we spend on mental health. You referenced figure 6, which shows funding in 2019-2020 of £298 million. The funding in 2023-24 was £388 million, which was 7% as opposed to 5·7%. That is a step in the right direction. Would it be desirable to do more? Absolutely. I heard you — perhaps I heard incorrectly — suggest that the amount we spend is going down, and that is not the case.

Mr Honeyford: The report clearly states that it has gone down in percentage terms.

Mr May: The report is from a certain point in time. I am giving you more up-to-date information. It is not that I disagree with what is in the report.

Mr Honeyford: OK. Should the Department set a target for the share of the budget that should be allocated to mental health, and have a plan and time frame to work towards that and to match GB?

Mr May: That would be a matter for a Minister. A Minister could take that decision. I am not sure that that is a call for a Department or a permanent secretary to make.

Ms Brownlee: I want to follow up on a point that David made. He talked about the voluntary and community sector, and it is great to see that it is being recognised. One of the responses from the Department of Health was around the mapping report of current crisis services, including in the community and voluntary sector. Has that been finalised yet?

Mr May: Can you remind me which report you are referring to?

Ms Brownlee: It was in the Health Minister's response to this question for written answer:

> *"To ask the Minister of Health what action is being taken to help people in emergency mental health and addiction crisis."*

A lengthy response detailed:

> *"A mapping report of current crisis services including community and voluntary sector is currently been [sic] finalised."*

Has that been completed?

Mr May: I do not have the question in front of me.

Mr Whittle: I can help with that.

Mr May: If it is on the regional mental health crisis service, Brendan can say a bit more about that.

Mr Whittle: It has not been finalised yet. A workshop is planned for 30 May this year, which will bring forward the finalisation of that. Subject to approvals, it will then be approved. It is nearly there, but it is not finished.

Ms Brownlee: No problem. Can I confirm that all the stakeholders from the community and voluntary sector will be at that meeting?

Mr Whittle: Yes.

Ms Brownlee: On communication with the community and voluntary sector, one of the things that I hear is that a lot of the meetings happen during the day when, given the nature of their jobs, people in the community and voluntary sector are working. How do you work with them to ensure that their views are taken on board and that they can deliver for you?

Mr May: We try to involve the community and voluntary sector widely in a range of work, not just in relation to mental health. If individuals come to meetings and say that they are having challenges with the approach that we are taking, we will work with them to set up future meetings in way that works for them. A significant number of those organisations have employed staff who can accommodate office hours, but, where that is not possible, we will always look at alternatives.

Ms Brownlee: What are the challenges that you find with the community and voluntary sector?

Mr May: What are the challenges?

Ms Brownlee: The challenges or barriers that you are finding.

Mr May: Peter drew out the direction that we are trying to take to recognise that there may still need to be contractual relationships in the delivery of services so that I, as accounting officer, can be assured that we get proper value for money. Alongside that, we need to develop the right sort of engagement

relationship with our community and voluntary sector partners so that we can understand where they can add the most value, listen to them and take their views into account in developing our strategies. As I said, that has largely been the case with mental health.

Mr Toogood: May I add to that? Since the development of the strategy, one of the biggest challenges for the mental health sector has been the breadth of providers — the sheer size and scale of it. There are some providers whose sole focus is mental health and others who may not have that focus but do mental health work as well. We have found it challenging to get a coherent voice. Who speaks for the sector? From whom can we get meaningful feedback that is helpful and that will ultimately benefit the people who need services?

We have been engaging on how we get that feedback and how we support the sector to engage better with us. Is there a way to do it? Do we need to put in some resource to help bring the sector together? We are going to explore a number of options because getting that right will unpick all the other stuff that Peter and I mentioned. That has been our focus to date. As I said at the start, it is about putting ourselves on a sound footing. I went in to it naively and said, "Come on, let's speak to each other", but I then realised that it is not as easy as that. We need to do it in a more structured way. I am comfortable that that is a priority for us, because we need to crack the problem.

Ms Brownlee: You mentioned value for money. The best value for money that you will ever get is probably from the community and voluntary sector, but one of the barriers that I hear about from people in the sector is the strenuous reporting that they have to do. It is about accountability, which, of course, has to be done, but we are seeing that the level of data in the Department is not what it should be. There is a bit of a breakdown there. Have you looked at reviewing reporting for the community and voluntary sector or at additional support for it?

Mr May: At a high level, you are right to say that there is a balance to be struck. If we did not have enough evidence that the service that was being bought was being delivered, through internal audit or external audit, we would, rightly, be held to account for that. We have to get the right balance. I have always been clear, with organisations with which I have worked, that, if they identify that we are asking for information that, they think, has no value, they should draw that to our attention so that we can look at whether there is another way to do it, either by not collecting the information or by collecting it in a different way that makes sense. That is at a high level; I do not know whether you want to draw out any specifics.

Mr Toogood: There are no specifics. That is a particular, practical issue about how we change the relationship between us and are not counting every appointment or whatever.

Dr Corr: May I come in? One of the opportunities that lies ahead for us is through the implementation of the next phase of the outcomes reports. We are working towards the implementation of the outcomes framework in statutory services, because that is where the great majority of activity occurs. After that, the next phase will be to look at the C&V sector, in order to rationalise and have a consistent framework across the statutory and C&V sectors. That will be helpful. You make an important point.

The Chairperson (Mr McCrossan): Thank you, Dr Corr.

I will follow on briefly from David's questions on funding. Should the Department not set targets for increasing the mental health share of the health budget towards matching the levels elsewhere in the United Kingdom and for a time frame in which to do that?

Mr May: As I said to Mr Honeyford, that is a matter for a Minister to determine; if they wish to set a target, that is entirely their prerogative.

The Chairperson (Mr McCrossan): OK. Thank you.

Ms Forsythe: Thanks very much for your answers so far. I will focus on an area that has been mentioned a few times: data and outcomes. Before getting into the cold, hard facts, numbers and data, I make the point that gathering correct data is important so that we can comment on successful outcomes. I was struck by a few members asking what we have done so far in the three years, and that was answered with, "We have spent money on this," and, "We have progressed 20 out of 35 outcomes". It would have been nice to hear an estimate of how many lives may have been saved in

Northern Ireland over the past three years. We are sitting with more than 200 deaths a year by suicide. It is important to bring into the room the fact that that is what we are talking about.

Mr May: It is very hard to prove cause and effect in those terms. I can give you statistics for suicides. There were fewer suicides last year than there were the year before that. I could not say with any confidence, however, that that reduction is purely down to actions taken in relation to the mental health strategy. It would be impossible to do that. I am not clear that data will ever answer that question in those terms, but I am very happy to explain what we have been doing.

Ms Forsythe: Absolutely. I just wanted to make that point in order to bring it back to the very real situation that we are dealing with.

The Northern Ireland Audit Office report very much highlighted the fact that the current data does not provide a complete picture of the effectiveness of services. Last week, the mental health champion gave evidence to the Committee and reiterated that fact. She noted that, as a professional, she found so many gaps and inconsistencies in what has been reported by the trusts that she has had to gather her own data. As the accounting officer, are you comfortable with the current level of spend of £350 million a year on those mental health services, when you do not have clear evidence of what you are getting for that money?

Mr May: There are a couple of dimensions to that. We have internal assurance frameworks in the Department and with our providers. Those frameworks are designed so that they look carefully at the way in which money is spent and at whether we get value for money for that money. I referenced the fact that the work of our internal and external audit represents two of the fundamental ways in which that assurance is provided.

We recently introduced a patient-level costing system through the strategic planning and performance group (SPPG), which is part of the Department. That is still being rolled out, but it will give us the ability to benchmark — including benchmarking against GB — on the outcomes and performance that we deliver.

We mentioned that the biggest initiative relates to outcome measures. That is being incorporated into the new Encompass system that is being rolled out. As you know, it went live in the South Eastern Trust last November. It will go live in Belfast in June, in the Northern Trust in November and in the Southern Trust and the Western Trust in March 2025. Data for the first of those trusts should be available this autumn. That will enable coherent measurement of performance across trusts for the first time.

Those are only some of the steps that we have taken. I can describe a number of other important steps that have been taken to gather information and to further put that information into the public domain. Do we have more to do? We absolutely do. We have, however, had a real focus on that in the last two or three years, and that has been helped not least by the Audit Office report. We have made a lot of progress.

Ms Forsythe: Thank you. A lot of this refers to targets for improvements in the future. I am asking whether you, as the accounting officer, are comfortable with the current level of spend, before those improvements to mental health services are made, of £350 million a year?

Mr May: I have already been asked whether a lot more money should not be spent on mental health, and I agreed that it would be desirable to increase the total spend on mental health. I guess that that is part of the answer.

As I said, I am confident that there is a sufficient level of information through our internal assurance framework to enable us. Brendan may want to say something about the work that the SPPG does in overseeing and managing the performance of the five trusts, which are the main providers of those services, to give you more assurance that we understand exactly what is going on and have a clear line of sight on that.

Mr Whittle: I am happy to give some further clarification. A significant amount of data is collected, which, frequently, is service activity data. That will include the number of people who are seen, the waiting lists, the breaches and the throughput. There was a query earlier about the robustness of that information. I am satisfied that that information, which is received from the five trusts, is robust. We get the activity data monthly. Where there is variance between one trust and another, SPPG staff will

make contact with the trust in order to understand the variance. If the waiting lists rates are different from one trust to another, that will be followed up.

I acknowledge completely, however, that — the strategy has acknowledged it too — that is activity; it is not the outcomes piece. The outcomes are about what difference has been made to an individual after they received treatment. What we know from Dr Corr and the other trusts is that, at a trust level, the before and after measures are captured by clinicians. They will look at well-being scales and outcomes scales for clinicians. Our ambition for the future is that the strategic outcomes framework will enable us to aggregate that together, so that we can take a holistic view of how well we are doing. The real prize for us all will be if we can do that across not just statutory but community intervention, so that we can see where we are getting the best value for our investment.

In terms of our assurance today on the activity that is provided by the trusts: are people are working hard; are we are seeing the activity; and do we know what we are spending the money on? Yes. However, the outcomes are determined at a clinical level, and our ambition is to lift that up into our planning level.

Ms Forsythe: Thank you. You have clarified the point that I was trying to tease out: you are spending money, and you are measuring the fact that people have walked through the system, but you are not currently measuring outcomes at a high level to show that you are getting value for that money.

You talked about differences between trusts, and I appreciate Dr Corr's comments about the Northern Trust. Last week, we heard from the mental health champion. She is a professional, and she is struggling to compare that data. Is there consistency in the data that is coming through from all trusts?

Mr Whittle: There is consistency in the data that is coming through to the strategic planning and performance group on performance and activity levels. If I heard the mental health champion correctly last week when she was giving evidence, she commented about freedom of information requests from journalists and others. The challenge is about the question that is asked and how you make sense of the answer if the question is asked in different ways. I cannot comment about what is being asked, but what I can say is —.

Ms Forsythe: The point that I wanted to ask about was this: is there consistent data coming through to you, and are you reviewing it, as a Department, for any regional disparities? Are there particular mental health crises in certain trust areas that require targeted spend?

Mr Whittle: The answer is this: yes, we are consistently looking at the data that is coming in from across the five trusts with regard to activity, waiting lists and breaches, and we do that on a monthly basis. There is a —

Mr May: Service delivery plan.

Mr Whittle: — service delivery plan, which sets out our expected activity across HSC with regard to mental health. We have looked at how we would expect to see that activity increase, post the pandemic period. We have been tracking that trajectory to see whether it is going in the right direction, and we are confident that it is. Are we measuring the activity that is coming through? The answer to that is yes. Where there is variance, or unwarranted variance, that is picked up with trusts to understand it. If there is a need for a particular trust to take alternative or different action, an action plan is agreed, and we will monitor that with the trust to take it through. I am confident in that regard. However, I go back to the caveat that the data is about activity and breaches but not outcomes. We know that, however, which is why we want to develop the outcomes framework.

Ms Forsythe: Absolutely.

Mr May: We are well on with that; we are a matter of months away from having it in place.

Ms Forsythe: That is great.

How have we ended up with a mental health strategy with 35 key actions, given the limited data available? It has been formed on the basis of limited data, so how can we be confident of a baseline, and how will we be able to accurately monitor our progress and how we are performing?

Mr May: The answer to that is probably very similar to the answer that Brendan has already given: we have robust data in a whole range of different areas. That gives us a good framework. We are looking to grow and expand that, including through the strategy in terms of how we develop our ability to have better data across the whole range of things. For me, we know enough to have confidence that the recommendations that we have made in the mental health strategy are well based. I believe that the mental health champion and the other people who were engaged in the development of the strategy broadly agree that they are the right areas of focus. When you have that kind of broad consensus, you can take some confidence from that.

Ms Forsythe: Absolutely. You said that the regional outcomes framework was months away. Is there a timeline for implementing that, and a cost associated with it? It seems to be the answer to a lot of our data-collection issues.

Mr May: I do not have a broken down cost for that because it is being implemented through the Encompass roll-out. Encompass is an investment of hundreds of millions of pounds in health and social care. It will be bound up in that, and I do not have a specific for that. However, it is currently being worked through. My understanding is that, by the autumn of this year, the outcomes framework will be in place. Clearly, that will work for only the trusts that are on Encompass. I have explained that there is a roll-out in the next 12 months; by this time next year, all the trusts will be reporting using the same outcomes measures through Encompass. That should provide the level of interconnectivity right across all five trusts that you are aspiring to.

Ms Forsythe: That is great. Will the proposed outcomes framework measurements be embedded in the Encompass system, or will a further action be needed to extract that?

Mr May: They will be embedded in the system.

Mr Toogood: I will elaborate on what Peter has just said. The outcomes framework is there: it has been developed, and it was approved by the Minister in October 2022. It is about when that is available, which is very much tied in with the Encompass roll-out. It is being embedded. We have regular meetings. As well as developing the outcomes framework, we have also developed a range of outcome measures. They are universal measures that test the overall mental health of an individual. They are well-known tools, such as the Warwick-Edinburgh mental well-being scales and KIDSCREEN-27. They are universal measures. Some very specific measures are also being embedded in Encompass, such as the health anxiety inventory, the Rosenberg self-esteem scale and the eating disorder examination. There is also some stuff around substance use and alcohol use. Those are being embedded.

We meet regularly with Epic, which is the company that is developing Encompass. There is a checkpoint with the individuals who are embedding that, and we have a checklist as to where each of those measures are in terms of being available for use in the system. There are some licensing issues around some of those measures, but, again, that is all in a managed programme to make sure that they are available. Petra, you have been involved in a lot of stuff around that. Do you want to add anything?

Mr May: Just to conclude, I do not want to leave the Committee with the idea that, when Encompass goes live, everything will be solved. That is not the way of the world.

The Chairperson (Mr McCrossan): I was just about to ask you that question. *[Laughter.]*

Mr May: I am glad that I got there first, Chair. Encompass will be a big step forward, but a programme will be needed to build on what comes out of it. Once you have the data, you then have to work out how to make proper use of it, and so on. There will be a programme over a couple of years in order to develop that and make it work. I did not want to give the impression that, with one bound, we will be free. That is never the way, I am afraid.

Ms Forsythe: Does the Department keep data on how many referrals of individuals it makes through GPs and trusts directly into the voluntary and community sector?

Mr May: That is quite a complicated question, because there are so many different conditions that someone might have. Dr Corr, do you —?

Ms Forsythe: It is not so much about the specifics and the measurability. My point is about capturing. I know that you talked about the review for the future and how to engage with the voluntary and community sector. I am really concerned, because I know that there have been thousands, and, in some areas, there have been an awful lot more than there have been in others. I want to make sure that that is being captured.

I hope that you have seen the letter that has come out today from 51 community and voluntary groups, a number of them mental health organisations — Action Mental Health and Mencap are on the list — calling on the Health Minister to restore their core funding because they are at risk of collapse. Last year, when there was a cliff edge for funding, a number of representatives from different trusts got in touch with me to say, "We can only refer people to these organisations. If they were to collapse, we would have nowhere to refer people to". I want to ensure that that is highlighted as being urgent. If that core funding falls — it is not, in the grand scheme of things, an awful lot of the Department of Health's budget — and those voluntary and community-sector groups cease to exist, how many patients across Northern Ireland will, immediately, before we can go further with the strategy, have nowhere to access services in 2024-25? I am very concerned that we are at crisis point: we are on the brink, and, if those organisations go, we will be left with thousands of patients in need of services and nowhere to refer them.

Mr May: I understand what you say, but I have not seen the letter, which you said, maybe, only came today. I am sure that it will be there when I go back to my office. It is correct that, last year, we were able to pay only 50% of the core grant, but the core grant is a very small proportion of the total amount that we, as a Department, invest in the community and voluntary sector. The core grant is designed to help people with their corporate overheads and to do any advocacy work that they need to do. We contract separately for the delivery of services, and Health and Social Care collectively invests, in that way, many tens of millions of pounds in the voluntary and community sector; those amounts were not cut last year. I am not minimising the challenge, and I recognise the concern of the voluntary and community sector, but, in context, the total amount that we invest remains a very high proportion of what it was. There tends to be a focus on the £1·75 million that was not made available last year, so I want to draw out the fact that funding for the actual service provision is in the tens of millions, and I think that that is what you are concerned about, as I would be.

Ms Forsythe: No. Do you accept that the Department should, as a matter of urgency, gather and collate the data on this to clarify and quantify the scale of the impact that the voluntary and community sector has on the delivery of mental health services in Northern Ireland in order to ensure that, in all their funding, those organisations are secured as a key priority of the Department?

Mr May: We have that information on a point-by-point basis, but we do not collect it all together in one place.

Ms Forsythe: Will your review of and engagement with the voluntary and community sector include development of the means to gather data from organisations that are not funded by the Department? I have spoken to a few local organisations that, because they do not get direct funding from the trust or the Department, do not send their data anywhere. They provide significant mental health services in the greater Newry and Mourne area, so I wonder whether your engagement with the sector will include development of a way of capturing that. The organisations are not directly funded by the Department, but they provide essential services.

Mr May: I have not been made aware of that issue, but I am happy for us to look at what is possible in that area. There may be some complexity, inevitably, but let us see if we can do even some of it and maybe make improvements.

Ms Forsythe: Absolutely. Thank you very much. If we cannot gather all the information and use it in a meaningful way, we are spending money without knowing what we are getting for it. The strategy called for in the report has been costed at £1·2 billion, which is a significant increase, so we need to be able to stand over what we are getting for the money that we already spend in Northern Ireland.

Mr May: I hope that what we have said has given you some assurance that we know what we are getting for the money that we spend.

Ms Forsythe: Thank you.

The Chairperson (Mr McCrossan): There were some very important questions from Diane, permanent secretary. The data collation issues are of concern to all Committee members, and we have had a number of conversations about that. You have answered a few questions about Encompass. One criticism of its limitations is that GPs and others in primary care can view patient records and make patient referrals but cannot update records, which is a challenge. Basically, what has been done about that to ensure that Encompass can properly cover those various gaps? Are you assured that that will be the case when it is rolled out?

Mr May: The current plan is to roll it out in secondary care, in the five trusts. It is probably the largest single change programme that Health and Social Care has ever faced, because it involves every individual who has contact with a patient having to fundamentally change the way in which they work and to do so many times every day. As a result, it is a massive enterprise. Getting it right in secondary care will bring about huge benefits and move us forward in a lot of different ways, including, importantly, by bringing benefits for patient safety.

You are right that there will always be interface issues. You mentioned GPs. The independent sector is another interface area. After we have completed the roll-out in the trusts, we will have to think about whether there is further that we can sensibly go. What we are seeking to do already makes us the most ambitious region anywhere, because we are rolling out Encompass on an integrated health and social care basis. That has not been done elsewhere. Other places have done a little bit on social care but not the two areas together. It is already a significant change programme, and change programmes always bring risk. It is important that you ensure that you get the right scheduling and scope for that programme at the start. By all means, let us then look at whether it is possible and sensible to do more. Our ambition at the moment is to make it work in secondary care in the first instance.

The Chairperson (Mr McCrossan): I appreciate that. I hope that it will be resolved, because we cannot have the situation in which a GP can make referrals but cannot then update the records on whether the person has been treated and what the outcome was. That creates an issue.

Mr May: If the GP made a referral, the hospital will update the records, and the GP will have access to those and be able to see what has been done as a result. That is one of the advantages. It cuts down on the need for letters and all of those things.

Mr Boylan: I have a wee question as a follow-up. That was quite interesting. I will bring us back to the focus of the Committee and its mental health inquiry. I want to ask this straight out: how did we develop such a strategy without information, which we do not have, on workforce, delivery and funding? As Diane said, there is limited data on those three things?

Mr May: A good part of the strategy is about setting out where we need to do more in order to put things in place. One action was to do a workforce review, which has now been completed. That was recognised as something that needed to be in place but that was not in place at the time of the strategy. It is like a lot of these things —.

Mr Boylan: Peter, that brings me back to the baseline. The baseline level of information on all those things must have been very low. That is the point of the question. What was the starting point? What was the information baseline?

Mr May: It is recognised that the return of an Executive and a Minister of Health in 2020 brought a new focus on mental health. The mental health action plan and the mental health strategy have moved us forward very substantially from where we were. That is widely recognised. We are trying to make sure that we have solid foundations across all the different areas.

Dr Corr: I am keen to offer some reassurance that the trusts have significant amounts of data. I know exactly what my workforce is. I know the professional breakdown, the gaps, the vacancies and the levels of sickness absence. I have the performance tools, and I know where my breaches are. That is the same for all my colleagues across the five trusts. We have a robust set of data.

The report referenced issues that speak to inconsistent approaches in structures, which make it difficult to compare the Northern Trust with the Western Trust, Southern Trust or Belfast Trust, for example, because we call things by different names. Our structures are also organised in slightly different ways. Some community mental health teams (CMHTs) may do some things, and others may do other slightly different things. Others may have congregated functions. One of the key opportunities

that the mental health strategy and the foundation and enabling works of the mental health strategy will enable us to do is to bring consistency across all of the postcodes in Northern Ireland to what we are doing and what we call it to allow us to then ensure that the data that I collect in the Northern Trust and the data that my colleagues collect across other trusts are very easily compared. I think that it is really important for us to offer a level of assurance to you today that I have significant and robust data that enables me to safely manage my services when it comes to workforce, governance, safety and our performance and outcomes.

Mr Boylan: It is not a criticism of the workforce or the strategy. I was just trying to delve into what, exactly, is the strategy's focus.

Mr May: As Petra described, we had all the data on how many people we had in the workforce in 2020 or 2021. What there was not was a clear analysis of what it would take for the future, and that was the purpose of the workforce review. There was a future-pointing direction for what would be needed if we were to address all of the problems in mental health.

Dr Corr: To build on Peter's comment, the workforce review is a very helpful, evidence-based and forward-looking document, and there has been very significant engagement and involvement with a whole range of professional groups and with all of the providers. So, I think that it is a very helpful framework for us moving forward. I lend support to that as a direction of travel.

The Chairperson (Mr McCrossan): Thank you, Dr Corr. I will follow on a bit in relation to that before I come to John, who has been extremely patient. On the collation of data across the trusts, if different things are done in different ways and are not consistent across trusts, how can you see the full picture from the data that is there? Surely, there will be gaps.

Dr Corr: I will immediately come in, and I do so with a level of enthusiasm. We have agreed data definitions that have come to us from our colleagues in the strategic planning and performance group (SPPG). Therefore, we all count the same things in the same ways. We are quite clear in our data definitions, so we know that, structurally, things look different, are called different things and are organised in slightly different ways. That makes it really difficult, and we appreciate that. That is why we are all very committed to the centralised and consistent approach in the mental health strategy. I acknowledge that those consistent data definitions are there. Peter gave you data on waiting times in, for example, CAMHS, mental health services or dementia services, and we have a clear set of data definitions that colleagues in SPPG manage with tenacity.

The Chairperson (Mr McCrossan): I have a supplementary point to that. You mentioned the waiting list data. In the only trust in which this has been rolled out to date, it is my understanding that that trust is saying that it cannot provide any waiting list data. I am talking about Encompass. Is that the case?

Mr May: The South Eastern Trust is the trust that has gone live first, and we have taken longer than we had hoped to be able to produce full data from Encompass. It is about getting the right comparability so that we can be assured that it is on the same basis as everywhere else. Huge progress has been made in recent weeks, and we now receive through the SPPG, the part of the Department that looks at performance, over 90% of the data sets that we need through Encompass. I believe that mental health data is among that 90%.

The Chairperson (Mr McCrossan): Very briefly, permanent secretary, I would appreciate your answer to this. Encompass has been rolled out in that particular trust. That issue was identified, and there have been moves to improve access to that data. Is that what you are saying?

Mr May: Yes, I am saying that there was a comparability issue with what was being counted on Encompass being the same as what was being counted by other trusts. We have been addressing that, and, once it is addressed for one trust, it will work for all of the trusts. There is an advantage, in that there is always more snagging with the first to go live in these situations.

The Chairperson (Mr McCrossan): It was just a snagging issue.

Mr May: Yes.

Mr Gildernew: I have a very small point on the data. I want to pull it right back to that case that I mentioned to you. Paragraph 4.22 of the Audit Office report highlights the, frankly, unacceptable

waiting lists. It gave figures as of March 2022, coincidentally, which was the date that I was speaking about with reference to my constituent. The report states:

> *"the longest wait in adult mental health services was around a year (321 days)."*

I have an email stating that my constituent had been waiting for five years. How can those two pieces of data marry up or tally?

Mr May: It will depend on the condition concerned. Dr Corr, you might be more of an expert than I am. There are lots of definitions.

Dr Corr: The overarching picture that Peter gave at the beginning, which you are referring to, Colm, was for adult mental health services and the Audit Office report. There are specific waiting lists for specific conditions that may have differing waiting times, so it may well be a specific condition that has a particularly long wait.

Mr Gildernew: I guess that we can all agree that that is really unacceptable. I wanted to focus on the data part of that.

Mr Stewart: Thanks again for coming along today and for your answers thus far.

I want to touch on CAMHS. Many of your answers so far have overlapped into that area, but it is important to dive specifically into that topic itself. I will start with the funding. Paragraph 3.19 of the Audit Office report identifies that the level of funding for CAMHS services was 7·7% of the mental health budget for 2021-22, which falls short of the 10% that you had set out in the strategy. I am curious to know why that was the case. What is the current percentage of funding for CAMHS, and, as a result, what impact will the underfunding be having on vulnerable young people

Mr May: Thank you for the question. CAMHS is 8% of the total mental health planned expenditure. We are investing £30·7 million in 2023-24. The reason why we have not achieved the 10% is very similar to the discussion that we had earlier about how it would be desirable to invest more in mental health generally. It is about where the new money will come from in a world where we have not had new money to invest because of the very serious pressures on our budget for the last two or three years. That situation looks like persisting, and that is restricting our ability to increase the budget. We highlighted the fact that we have invested £1·9 million — I think that I said £2 million — of the mental health strategy money in extra CAMHS provision, particularly in the inpatient setting. On a recent visit to Beechcroft, I could see the difference that that makes to the way of working. I talked to some of the staff on that occasion.

Mr Stewart: To quantify that, we are, effectively, currently spending 20% less on CAMHS than we want to spend. We are spending 8%, not 10%, so I am curious to know how that is being rolled out on the ground. What services are not being delivered that would and should be delivered if the full amount could be spent? Is there any way to quantify that?

Mr May: I guess that the logical and clear consequence of that is that there is not the same capacity in the CAMHS system. I referenced the fact that, I think, 1,100 people are not being seen within the nine-week target. They will have been triaged before that, but they are not actually getting the treatment that they deserve. As a result, not only but particularly because of COVID, we have seen increased acuity, particularly in children and adolescents. For example, to use one statistic, the percentage of eating disorder admissions to the general adolescent inpatient unit has nearly tripled in the last five years, so, proportionately, that is obviously a much greater problem than it was before. It was probably made worse by COVID because there was less interaction with peers and less opportunity to catch that early, and that has meant that more of those people are facing more severe challenges that take longer to address and resolve through our mental health services.

Mr Whittle: I can add to that. When we look at the number of referrals to child and adolescent mental health services, we see that children are frequently being treated for longer, and that is to do with the increased acuity, the condition and the treatment tale that goes with them. Children are coming in with eating disorders or psychosis, and those are issues that require a significant level of support. As people stay in the service longer, the demand on the service increases. We continue to have the throughput referrals, but the children whom we treat are being treated for longer, which means that the activity that the workforce is doing is greater.

Mr Stewart: OK. That leads me on to my next question. The report also says that there are lower levels of referral acceptance by CAMHS. Last week, in our discussions with the mental health champion, she suggested that that reflects what are termed "inappropriate referrals" — people's problems not being severe enough to meet the threshold. Yet, children's conditions continued to deteriorate in that time. I just wonder what more can be done to get earlier access and intervention. Last week, we talked about invest to save with the mental health champion. If we can get in early, treat and nip those issues in the bud as quickly as possible — giving young people early access to mental health services — is there a case for invest to save within that? What more can be done to open up access to CAMHS?

Mr May: Currently, around 70% of referrals to CAMHS meet the criteria. In adult mental health services, that number is closer to 85%, so there is a gap. We referenced the fact that, under the mental health strategy, there was investment in early intervention services and that a three-year plan was put in place. We all agree, in principle, that a greater "shift left" — that is jargon for moving things out of the acute setting and into the community setting where issues can be addressed before clinicians need to get involved — would be desirable.

A lot of work is done to try to increase the amount of material that is available to children and young people and to their parents about the kinds of approaches that can assist. I do not disagree that we could do more. There is always more that you can do in that space. It is absolutely the right direction of travel. It brings us back to some of the questions that we have been asked. The community and voluntary sector could perhaps provide those services. Clinical psychologists or clinical psychiatrists, should I say, would not necessarily need to be involved in that work.

Mr Stewart: OK. Thank you, permanent secretary.

That leads on to the next aspect. Data from the Children's Commissioner indicates that the number of children receiving emergency referrals to CAMHS from A&E departments doubled between 2018 and 2021. I believe that that number continues to grow. We have already discussed, through the Chair, that we accept that emergency departments are not the best place to treat mental health issues, particularly for young people. What is that increase down to, and what more can be done? Has there been a failure in CAMHS, for example, to deal with that? Why are children ending up in accident and emergency as opposed to other services?

Mr May: This is not about a failure in CAMHS. I have indicated that COVID, in particular, has led to increased acuity in a range of different ways. I used eating disorders as one example, but there will be others. What is happening is that people are presenting with much more serious illness than was the case previously. That is probably because they were isolated during the lockdowns and did not have the same exposure to people outside their family, friends or others who might have spotted an emergent problem.

I will give you one statistic. The number of people detained under the Mental Health Order has risen by 7%, from 18% in 2018-19 to 25% in 2022-23. If you are being detained under the Mental Health Order, it means that you are experiencing a much more serious illness. If people are approaching A&E in a crisis context, it may be that CAMHS was not involved previously. Therefore, it is not that CAMHS failed; it is that people are emerging with much more serious problems.

Mr Stewart: You might not have this today, but is there data on how many of those who presented to EDs were originally in contact with CAMHS and how many of those who presented to EDs were turned down for CAMHS? Did they fall into that 30% of people who requested assistance but did not qualify?

Mr May: I do not have data on those numbers. I do not know whether we collect that, but I am happy to look and see. Do you want to add to that, Brendan?

Mr Whittle: I do not have the numbers, but the 30% who do not meet the criteria are not left. In discussion with the service during the week, one of the issues was, "What is the workload? What is the tale of that 30%?". That 30% are followed up, and the appropriate referrals are made. They may, indeed, end up going to the community and voluntary sector or being referred in that direction. It is not that the shutter goes down. There is an appropriate referral pathway for them to get the support that they need. They would be lower-level dependency at that stage than the ones who are accepted.

Mr May: I will see whether we hold data on the number of young people who appear at emergency departments with a severe mental health problem having already been through CAMHS. I will see what we can get.

Mr Stewart: It would be useful if we could get that.

Dr Corr: It is potentially helpful to note that CAMHS has a crisis part. There is a recognition that, on occasion, there can be a rapid deterioration in a young person's presentation. As a result of that, there is a crisis pathway into CAMHS that facilitates easy access. That can be supported through the ED as well as through the CAMHS processes in each trust.

Mr Stewart: I have one last point on this. Permanent secretary, could you tease out the referral pathways for CAMHS? Also, what roles do schools play currently? What more could be done in a collaborative approach between the two Departments to make referring from schools to CAMHS easier? Also, given the pressures on GP surgeries, what other channels are open? As the Chair outlined, we all know the difficulty in getting an appointment with a GP, so can other avenues be pursued?

Mr May: We are doing a lot of joint work with the Department of Education. We published a children and young persons' emotional health and well-being in education framework in 2021. The main emphasis there is to support educational settings to promote emotional health and well-being at a universal level through a holistic and multidisciplinary approach.

That is one of the areas. I have a long table that I will not try to read out, because tables do not make for good reading. However, other initiatives include the health and education SEN partnership pilot to improve outcomes for children with special educational needs; the Sure Start speech, language and communication service, which is a regional programme commissioned by the Department of Education in partnership with us and the Public Health Agency; and a Belfast-wide early years project, which is being developed and piloted in the Belfast Trust in relation to Sure Start, and it aims to promote opportunities through play to encourage children to develop emotionally, socially, intellectually and physically.

That is just a flavour of the collaboration that we have with the Department of Education. Schools are one of the keys ways in which to tackle this early. If problems of a mental health nature are beginning to manifest, there are established ways in which teachers and others can contact statutory services in health in order to seek assistance and support.

Mr Toogood: I will just draw out something from the table.

A Member: Please do.

Mr Toogood: The framework is the overall way in which we are working with the Department of Education in relation to schools. However, there are a couple of important initiatives within that on which we lead from the health side. Peter mentioned the emotional well-being teams in schools: a multidisciplinary team working in a post-primary setting, promoting emotional health and well-being and ensuring that schools are aware of the appropriate pathways to support. We have staff in trusts dedicated to providing that service.

It is about being preventative. It is about working with pupils and staff as well. The aim is to reduce the risk of longer-term, more severe conditions developing. We are working with 46 schools, which is a good start, and we plan to work with 68 next year. That is an important initiative to make sure that everyone in a school setting is clear about what pathways are available, and it also builds a knowledge base.

That is the main one. There are lots of others. If you like, we can give you more. There are really good initiatives under that framework whereby we are trying to get ahead of the curve.

Mr Stewart: The Chair is probably sick of me talking about invest to save, but it is such an important aspect, particularly when it comes to child and adolescent services. It will be great to see the data on how successful those schemes are and the overall saving that could be made year after year at early intervention stage. We know that the impact of mental ill health here is over £3·6 billion a year. That is massive, so the more that we can put into this at the earliest possible stage, the better. It would free

up so much logistically for the Department and free up so much more in the system. It could be a game changer in that respect.

The Chairperson (Mr McCrossan): My questions will follow on from a couple of John's. There is a bit of a disparity between trusts. In the Western Trust, 83% of referrals for CAMHS support are accepted, but in the Belfast Trust and the South Eastern Trust, only 70% are accepted. Do all the trusts apply similar tests to identify acceptance? Is there a disparity in provision between each trust area?

Mr May: They all apply the same guidance for cases. There could be multiple reasons why there are different levels of acceptance or rejection of cases. Obviously, we would like to reduce the number of cases that do not meet the threshold, because the threshold should be understood and known before a referral is made. That is an ambition that we have. As I said, in adult mental health services, the numbers of cases that do not meet the threshold have reduced significantly in recent years. However, the same rules apply to everybody.

Mr Whittle: Just by way of clarification, let me say that all five trusts operate the regionally agreed threshold criteria. There is no difference between the five trusts in the criteria that are applied in order for people to be accepted into CAMHS, which happens either through step 4 or step 3.

The Chairperson (Mr McCrossan): When you look at the actual numbers, you see that the acceptance rate is 83% in the Western Trust, as I said, and only 70% in others. That is a 13% difference, which, when you drill down into the numbers, you see is quite significant. Why are so many referrals turned down in other areas? Do we know?

Mr May: I do not have a detailed answer to that, I am afraid, Chair.

The Chairperson (Mr McCrossan): It would be helpful if we could find that out, because —.

Mr May: I could certainly find out the main reasons why cases are not seen to meet the threshold. It may be more difficult to understand why those cases are coming forward, but I will see what we can find out.

The Chairperson (Mr McCrossan): That is very helpful.

Mr Delargy: Thank you for your presentation, folks. My questions are fairly straightforward. I have two: the first is on the finances of interventions; and the second is on early intervention and your links with Education.

Could you give me a breakdown of the finances that you are putting into early intervention, please? Could you compare that with the amount that you believe is needed for early intervention?

Mr May: The data that I have relates to the amount that we are funding through the mental health strategy. There is currently £1 million allocated for 2023-24. That has enabled 268 family referrals to the early intervention and prevention service; 70 children and young people with complex needs to be engaged through individual and group sessions; and over 2,000 people to have registered for online courses for parents. That is the allocation there. There will be, I am sure, other moneys in the existing mental health budget that are used for early intervention, but I do not have the data and do not know how easy it is to break it out. However, we can see whether we can offer anything more.

The second half of your question is difficult, in the sense that it asks how much we would ideally need. I do not know whether the mental health strategy, in that 10-year costing, broke out how much we need for early intervention year-on-year. Peter, can you remember?

Mr Toogood: No. I think that it did not do that because of the nature of early intervention and prevention, as it goes across so many different aspects of work. Actions 1 and 2 in the strategy are about developing an early intervention and prevention action plan, which we have done. That is the £1 million that Peter talked about, and we have allocated to that particular area. A whole range of activity involves shifting work to engaging earlier in the lifespan. For example, we just talked about the work with the Department of Education on the emotional well-being framework. That is jointly funded between the two Departments. DE has committed to providing between £4 million and £5 million per year. We provide £1·5 million per year. The range of activities that that funds is preventative. It is absolutely about getting in early in the lifespan to try to stop conditions developing. I talked about

emotional well-being teams in schools. We have a Text-a-Nurse service in the post-primary setting, which I am sure that many of you have heard about, and regional integrated support for education in the primary school sector. It will be a job of work to pull together everything that is preventative. One of the actions in the early intervention and prevention action plan is to scope activity, because the work is not limited to the Department of Health. It is absolutely cross-departmental, and it goes across every Department. When the work started, I was surprised by the sheer breadth of activity that already happens right across government, including local government, and every sector. That is being scoped out, but we have not pulled it together into one number.

Mr Delargy: Could that number be pulled together during the inquiry? That would be useful for our information. I appreciate that you probably do not have this figure to hand, but it would be great if, once you have mapped that and mapped how much is spent on early intervention as a whole, a comparative number for several years, say from 2018 or 2019 onwards, could be delivered during the inquiry. That will allow us to monitor how much has been spent, whether it has increased and how effective it has been. That data would be pertinent for in the inquiry.

My second question touches on the cross-departmental working that you just mentioned. That is essential. I used to work as a primary school teacher, so I am very much aware of the increasing need in schools for mental health support, particularly at the early intervention stage and, as you mentioned, for a preventative approach. I also chair the all-party group on mental health, and it recently commissioned a report, which I know that you have been involved in, that is about early intervention in schools. We have continuously seen the disparity between schools that put a lot of resources, time and energy into well-being, mental health and a preventative curriculum, and other schools that do not have the capacity or skill set to do that. It is important to support schools by doing that and, as you say, that it all comes together in a preventative place.

I invite you formally to the launch of the report. An invite has been sent from MindWise this afternoon, I believe. The cross-departmental working ensures that we do not work in silos. I am keen to hear about the work that you have already done with the Department of Education and the work that you plan to do in order to ensure that there is a collaborative approach.

Mr May: You requested the data on prevention, so we will certainly look at what we hold. There will be some definitional challenges on what does and does not count as prevention. That may make it difficult to provide the five-year horizon that you asked for, but we will be able to do some of that. We will try to offer you some examples, even if it is not a comprehensive picture.

On the work with the Department of Education and in schools, we in our Department are very supportive of the efforts that have been made. I am happy to look at your invitation and to make sure that the Department is represented at a senior level at the event. The work that we do with the Department is multifaceted, and I have run through a few of the areas, as Peter did. I do not want to repeat myself, but one of the other areas of work with the Department of Education is the A Life Deserved strategy for looked-after children. We know that that is a particular community that faces real challenges with life chances. Our Departments and arm's-length bodies are cooperating on the implementation of the strategy's commitments to action, including how we pool resources to support the implementation of the emotional health and well-being in education framework.

As I indicated, there are a range of other areas, including, for example, an Education Authority-led programme to assist all schools to develop a whole-school approach to emotional health and well-being, which is very much in the space that you talked about. That involves providing participating schools with a framework to assess emotional health and well-being policy and practice; to implement actions to develop those in their schools; and to receive training to provide staff with the knowledge, skills and confidence to understand and promote emotional health and well-being in their school. That started in the last academic year and will run into this. We can provide other examples, but there is a lot of joint working. You can always do more: that is the reality. We are constrained to some extent, but be assured that we are doing a whole raft of things with the Department.

Mr Delargy: I appreciate that. I am aware of a lot of the work that you already do. It will be important for us when you pull together that five-year spread of data, because, when we have looked at data in the past, we have found that it can be quite hard to find a consistent set of data. It is often measured against different variables and is not consistent. It would be really useful, when pulling that together for the Department, for you to use a consistent methodology and to look at comparable factors across those five years. We need to make sure that whatever is measured in year 1 is also measured in year

5. That will allow us to have the best and most up-to-date data. Thank you for your answers, and I look forward to working with you.

Mr May: As I said, we will do the best that we can. There will be some definitional challenges, but we can compare like with like by comparing programmes that we are delivering now with those from five years ago, and we can give you the results of that. Defining what counts as prevention or early intervention, however, is a bit of a challenge.

The Chairperson (Mr McCrossan): Pádraig, thank you very much for that. On collaboration and early intervention, post-primary schools are funded to provide counselling services. Funding was available through the Department of Education's Engage programme. That funding has recently been removed. That contradicts what we are trying to achieve through early intervention, and there is huge concern about those services being removed. It is important to put that on the record.

Mr Gildernew: A crucial area has not been touched on, and I want to place it on the record and get a quick answer from you about it. I first became aware of it, and then I became ever-increasingly aware of it, when I was working as a social worker. It relates to dual diagnoses of addictions and mental health issues. I deal increasingly with people who have been removed from one part or another of the service as a result of another condition that they may have. They are told that they will be removed from addiction services until they get help with their mental health problem but are then told that there is no service to offer them. The same is happening to those with addiction issues. It is not fair on people that the same service is bouncing them around and locating the problem within the individual. Do we need to radically reform how we approach the entire issue in order to ensure that people get joined-up treatment for addiction and mental health, given the correlation between two?

Mr May: You are right to highlight dual diagnosis as an important issue. It is recognised in the mental health strategy, and it is also in the substance use strategic commissioning and implementation plan. We are looking at how to make the joins. As part of that, we made recurrent funding of about £70,000 available each year to enable the appointment of a co-occurring mental health and substance use project manager. Recruitment for that post is under way. We hope that the investment will enhance and integrate the pathways between mental health and substance use treatment and help address the problems that you identified.

The Chairperson (Mr McCrossan): Thank you. It is an important area, which has been raised with many of us by our constituents.

You have been extremely patient. We have covered almost everything at this point. One thing jumped out at me about an earlier point relating to waiting lists that was made at the beginning of the session. The Northern Ireland Audit Office report, which is very good, identifies the growing waiting lists for mental health treatment, and you already clearly identified the issues. The lists are well above pre-pandemic levels, which is of concern. The growth in waiting lists occurred despite a significant reduction in the number of referrals that mental health services accept. It is estimated in the report, at paragraph 4.10, that that reduction is in the region of 20%. That is hugely significant. Why are waiting lists growing, despite the reduced number of referrals? Is that a reflection of a failure of mental health services for those who need that support?

Mr May: Thanks for the question. I do not believe that it is a sign of a failure in mental health services. I think, for the reasons that I explained, that it is a symptom of the demand and capacity gap. Referrals are down, but, particularly in adult mental health, the level of accepted cases is now higher than it was, so the gap is not as big as it looks. It is about a 10% gap in practice. I have explained — colleagues have also tried to explain this — that the big challenge is the increased level of acuity and therefore the longer periods of treatment that individuals need when they come into the service. That is what is taking longer, and it means that there is a slower throughput of cases because we have to, and you are absolutely right about this, meet the needs of the individuals who require those services. That is the key challenge, and that is what is making that apparent dislocation, as it were. I understand why you asked the question, because it looks as though we are just doing enough, but, in practice, as I tried to explain, activity levels are up by 15% or 16% in adult mental health and psychotherapy. That is an indication that we are doing more, but we are still not meeting the need that we have. We recognise that there is a huge challenge, I am afraid, not just in mental health but the waiting lists.

The Chairperson (Mr McCrossan): I appreciate your answer to that, permanent secretary. I was just seeking a reassurance that it is your firm view that the gap does not reflect a reduction in the

performance of mental health services but that, in actual fact, demand has increased. Is that what you are saying overall?

Mr May: Yes.

Ms Brownlee: We have touched on this a bit today, but we know that vulnerable people are not getting the support that they need and that other public-sector organisations and Departments are picking it up. For example, the PSNI deals with 20,000 mental ill health call-outs every year. I think that those call-outs have been increasing year-on-year, with a slight dip during COVID. From the Department's point of view, where risk is concerned, how are you dealing with that, and what actions will you take if the PSNI refuses to take those calls?

Mr May: We are doing some work with the PSNI to look at the right care/right person model and how that might apply in Northern Ireland. There is a need for us to make sure that we work that through in some detail before any steps are taken to go down that path, because there are some risks with individuals who need that support, and the police are the first responders. It is really important that we understand that. It has been a core part of our policing model that policing has recognised that the wider dimensions of an individual's well-being are important. The police do that as well as doing law enforcement, which is their core purpose. We are engaging with the PSNI and the Public Health Agency, and we are looking at what they are proposing in this space and how that would work with the exact concern that you raised in mind.

Ms Brownlee: Is that progressing, yes?

Mr May: Yes.

Ms Brownlee: We touched on this during John's questions. We know the devastating statistics. Autistic adults are nine times more likely to die by suicide, with autistic children 20 times more likely to self-harm. Obviously, those are shocking statistics. Mental health professionals who are not trained to understand or communicate with autistic individuals are serving them at the point of contact. Is anything being done in the Department of Health to address that and to make sure that we have appropriate services for people with autism or SEN?

Mr May: Autism and SEN raise a slightly wider variety of questions. An autism strategy was published in 2023 and was designed to cover a five-year period. A delivery plan was published, and it is a source of regret that, because of funding challenges, we have not been able to advance all aspects of that strategy to date.

Ms Brownlee: Have any aspects of it been delivered to date?

Mr May: Yes. In collaboration with the Equality Commission, we have been working to develop guidance for employers in order to increase understanding and support for autistic people who are in employment. The Housing Executive has delivered autism capacity-building sessions for 400 staff, and those have a greater understanding of the sensory environment and communication needs of autistic people. The Department of Health and the Cedar Foundation have delivered that training. The Health and Social Care leadership centre has been commissioned to take forward work to develop proposals for the development of a regional autism information service in order to provide signposting to services and support. We have funded the development of GP training videos across all trusts in order to increase understanding of the challenges that autistic people experience and how reasonable adjustments can support people who are attending medical appointments and so on. Those are some of the steps that we have taken under the strategy.

Ms Brownlee: With CAMHS, for instance, or people who presenting to A&E in crisis, do you take a record of those individuals if they have autism or, indeed, SEN?

Mr May: I do not know the answer to that, but I am happy to try to find out for you.

Ms Brownlee: I think that it is important to know what the levels and demand are.

Mr May: I know that it is not your speciality, Dr Corr, but do you know the answer to that?

Dr Corr: I chair the autism forum in the Northern Trust, so I am reasonably —.

Mr May: You are the expert.

Dr Corr: There are many experts in the field. I suppose I have a reasonable understanding. One of the pieces of work that has been done in our trust has been to augment the skills and training of staff who interface with autistic individuals. Similar work has been done in other trusts through that forum and through partnership working. As you said, there are types of communication that can be more effective and supportive and calming for those individuals at times of stress. One of the pieces of work that we have done is on supporting our ED staff and various staff, including mental health staff, across our services. I am conscious that some of our community and voluntary partner providers have done some work on the JAM work, which you may be or not be aware of.

Mr May: That is the Just a Minute card.

Dr Corr: Absolutely. That approach has been found to be really helpful. There is an increase in the use of those approaches.

I do not have an answer to the question about whether we keep a record in emergency departments of when an autistic person arrives. It is probably unlikely, but we can potentially come back on that. It is probably more important that we ensure that staff and society more generally, including people in hotels, restaurants and shops, are all supported to develop skills of engagement with autistic individuals.

Mr Whittle: Chair, I will give a further piece of clarification. Going back to children, we are finalising a children and young people's emotional health and well-being framework. That framework will give a single approach, point of referral and diagnostic pathway to people with neurodevelopmental issues. It will be going out to consultation this year. Our hope is that it will standardise the referral pathway, and it will also mean that we will move to providing help at the point of need rather than being pinned to a diagnostic confirmation of autism. It is about getting early help at the point that someone presents. Hopefully, that will help our children and young people.

Ms Brownlee: I appreciate that. I have a last question.

Mr Boylan: It takes an hour and a half to get home, Cheryl.

Ms Brownlee: Sorry.

Mr Gildernew: The final, final question.

Ms Brownlee: I want to take you back to the strategy development. You mentioned that there are 400 respondents to the mental health consultation document. Is that correct?

Mr May: Yes.

Ms Brownlee: I have looked at the consultation document. We always talk about a person-centred service, but it looks as though there are certain barriers with that documentation for people. Areas of social and economic deprivation are disproportionately affected by mental health. How can you ensure that the people who have gone through the service are actively engaging with your consultation documents and that their views are reflected?

Mr May: Peter, you probably know the detail of this. I imagine that we use a number of organisations to help to engage that community. We tend to work through organisations that can help, and we hold different sorts of engagement forums and so on. Classically, that is the way that you approach those problems, and I am sure that that happened in that case.

Ms Brownlee: As important as that is, of course, it is important to get the voices of the people who have been through the services as well and to make that sure that —.

Mr May: That was my point. We work through organisations to engage people so that their voices are heard, we get to hear them properly and they are able to express themselves.

Mr Toogood: We have used that tool across a range of areas, not just in the mental health strategy. That includes the production of alternative documents in easy-read format or a version for children and young people and so on. We will see what we need to do in order to do that. You are right: we know that we cannot reach everyone ourselves, so we use our partners. A good example is our work with our community and voluntary partners in particular to reach the people whom we need to reach.

Dr Corr: As a final, final point, let me say that, in mental health services in trusts, we all have experts by experience who are service-user consultants and who consult on our behalf from their perspective and the service users that they represent in our area in order to ensure that there is feedback. They have networks, and that allows them to hear those voices and share them back through us. They link in, through the SPPG, to a central coordinating point into the policy as well. There are myriad ways, but it is, obviously, really important that we hear the voices of service users and of families and carers.

Ms Brownlee: I appreciate that.

The Chairperson (Mr McCrossan): Thank you, Cheryl. Thank you, Mr May, Mr Toogood, Mr Whittle and Dr Corr. We appreciate your patience and for being here and taking our questions. I know that you take the issue very seriously. It is a major challenge for our population. No family, nor any of us in this room, has not been touched by the challenges in mental health and the challenges that the service faces. It is important at this point that we put firmly on record our deep appreciation to all the staff who work in the health and social care trusts and who do a fantastic job on a daily basis —

Mr May: We will make sure that that is passed on to them.

The Chairperson (Mr McCrossan): — and all the various officials, who keep the clock ticking daily and keep the show on the road. The service needs a lot of help and a lot of work, but the inquiry is key to highlighting some of the very real issues that exist. We appreciate your time today and your patience in sitting with us today.

Mr May: Thank you very much.