

Thursday, 4 June 2026

1
2 (9.59 am)
3 MR CARR: Chair, may I call, please, William Vineall.
4 WILLIAM VINEALL (sworn)
5 Questioned by MR CARR
6 THE CHAIR: Yes.
7 MR CARR: Mr Vineall, I understand that before we start with
8 your evidence there's something you want to say on
9 behalf of the Department?
10 THE WITNESS: Yes, there were two comments I wanted to make.
11 First of all I want to send the Department of Health
12 and Social Care's, and indeed my own, sincerest
13 sympathies to the bereaved families of VC's killings and
14 the surviving victims of VC's attacks.
15 Secondly, the Department is ultimately responsible
16 for the healthcare system in England, and we have
17 listened to the evidence and we will learn very
18 carefully from this Inquiry.
19 THE CHAIR: Thank you. Yes.
20 MR CARR: Mr Vineall, you've prepared a statement for this
21 Inquiry on behalf of the Department dated
22 21 November 2025.
23 A. Yes.
24 Q. Is that statement true to the best of your knowledge and
25 belief?

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1 specify what services the NHS should provide to which
2 patients."
3 Just to expand on the difference that's being
4 highlighted there, so the setting of strategy aims and
5 operational powers; the operational powers, they rest
6 with individual Trusts, Commissioners.
7 A. That's correct, and then the operation of the day-to-day
8 NHS is overseen by NHS England, and they provide
9 assurance to the Department about the progress of the
10 NHS in relation to various priorities that may be
11 measured through different kinds of performance
12 frameworks, and indeed they may raise things of
13 significant importance in addition to that.
14 So they have, in a sense, they're the day-to-day
15 radar on to the NHS, but then they report in to the
16 Department with progress and other things that the
17 Department may request, and that's the broad division of
18 labour that we've had since we had the 2012 Act.
19 Q. So a number of different layers, Department at the top.
20 A. (The witness nodded)
21 Q. With different roles as well, NHSE --
22 A. Yes.
23 Q. -- Commissioners, Trusts?
24 A. Commissioners and Trusts, yeah. Commissioners and
25 Trusts formally accountable under the current

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1 A. Yes, it is.
2 Q. And as I've indicated, it's a statement on behalf of the
3 Department of Health and Social Care where you are the
4 Director of NHS Quality, Safety and Investigations?
5 A. That's right.
6 Q. That's a role you've had since 2020?
7 A. That's correct.
8 Q. But you've worked at the Department since 1998 --
9 A. Yes.
10 Q. -- in a number of different roles?
11 A. Yes.
12 Q. If we can start by understanding the Department's role
13 and responsibility. That's dealt with, it's page 3 of
14 your witness statement at paragraphs 8 to 10. And at
15 paragraph 8 you explain the role of the Department as
16 being:
17 "... to secure resources, support and advise the
18 Government's health and social care ministers in setting
19 strategic health and social care policy and to be
20 accountable for the operation of the many bodies ..."
21 And again at paragraph 10 at the bottom of the page,
22 we get a reference there to strategy:
23 "The Secretary of State is responsible for setting
24 the strategic direction and the priorities for NHS
25 bodies but has limited direct operational powers to

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1 arrangements to NHS England.
2 Q. And of course NHS England is to be abolished isn't it?
3 A. Yes, so NHS England is being abolished. We had the
4 second reading of the Bill that is going to lead to that
5 abolition on Monday, first clause, abolition of NHS
6 England, the vast majority of the rest of the Bill about
7 the different functions and how they will transfer.
8 And the reason for doing that is, I think, when the
9 government came in they had no particular fixed opinion
10 about the way we operated the day-to-day
11 responsibilities of the NHS, but they had a look at the
12 system and I think felt that there was a degree of
13 duplication, there was a bit of friction, it didn't
14 always feel straightforward for them in exercising their
15 Parliamentary and democratic accountabilities to always
16 get information in the way that they necessarily wished,
17 and that led to the decision to abolish NHS England on
18 13th March 2025.
19 I think the other additional point that was made at
20 that time was that the government, not just our
21 ministers, felt that it's clearly right to have
22 arm's length bodies but it's also right for governments
23 and departments and ministers to exercise their
24 accountability for which they're seen to be responsible
25 by the public.

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1 And what the Bill will do when it's passed, subject
 2 to it being passed, is make it clear and unambiguous
 3 that the responsibility for the things that currently
 4 NHS England do to oversee the NHS will pass into the
 5 Department. Indeed, will pass back to the Department.
 6 **Q.** So the operational function will come back to
 7 government?
 8 **A.** The operational function will come back, effectively.
 9 **Q.** Is there an indication as to when that's likely to be
 10 implemented?
 11 **A.** Well, I mean, yes, there is. We would like, subject to
 12 the Parliamentary passage, to get the Bill through by
 13 the end of the year because we're committed to coming
 14 together as a single organisation from April 2027.
 15 There are a couple of things that are contingent on the
 16 Bill, the most significant one being that the staff who
 17 currently work in NHS England who are going to come back
 18 into the department, you can't do that transfer until
 19 you have the legislative authority, and you no long
 20 longer have NHS England.
 21 And secondly -- and currently it's in the pack -- we
 22 operate an integrated single structure, but that isn't
 23 yet formalised and we want to bring that to a formal
 24 position. We have the Director Generals who are now
 25 appointed, in a sense, into the new nascent

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1 Department is to set overall strategic priorities for
 2 the healthcare system, a lot of which then NHS England
 3 execute on our behalf, but not the totality of them,
 4 it's different for public health, different for social
 5 care.

6 That, I mean as you've alluded to, I mean, is really
 7 one of the five core functions of a Department of State,
 8 setting strategic direction, money, that you've
 9 mentioned, and resources, not only that but accounting
 10 for it. Legislation, clearly, which is pretty centre
 11 stage to what we're talking about here and then also
 12 representing the interests of the NHS in government
 13 which includes taking charge of, you know, once in
 14 a lifetime, one-off events where the government is, if
 15 you like, the insurer of last resort -- something like
 16 Covid.

17 Then finally, sometimes overlooked, I think,
 18 supporting ministers in exercising their Parliamentary
 19 accountability, be that in speeches, debates, questions,
 20 all the other things that come to a Minister of State
 21 and we have to support them in that and provide them
 22 with the necessary information, sometimes going out to
 23 NHS England to get some of the details of information,
 24 but us being responsible for supporting ministers to
 25 exercise that democratic accountability as fully as they

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1 organisation, and then we have all the other staff for
 2 whom once, we've taken the Bill through Parliament,
 3 we'll be able to populate the structure beneath that.

4 So the timetabling of the Bill and our ability to
 5 get it through is quite important in order to deliver on
 6 our commitment to have a single Department of Health,
 7 including the vast majority of operations in NHS
 8 England, you know, up and running and working by this
 9 time next year.

10 **Q.** Well, returning to the position as it is now and as it
 11 was at the time that the Inquiry is concerned with, and
 12 we've just touched upon it, but you've got the
 13 Department responsible for securing resources and
 14 setting strategy, Commissioners deciding how resources
 15 should be allocated in their area, and what care and
 16 treatment should be available; is that right?

17 **A.** Yes, that's correct.

18 **Q.** With, as you've explained, NHSE, NHS England having
 19 day-to-day operational running subject to supervision by
 20 the Department?

21 **A.** Yes, correct.

22 **Q.** When you describe setting the strategy for the NHS, that
 23 involves, doesn't it, determining what the priorities
 24 and principles of treatment should be.

25 **A.** Yes, that's right. One of the key functions of the

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1 can.

2 **Q.** Then thinking through how the process works, the
 3 Department sets a strategy, obtains resources, passes
 4 that on, essentially, to the Commissioners for the
 5 Commissioners then to achieve the strategy with the
 6 resources that have been provided.

7 **A.** I mean, the thing we've had in the middle of that, which
 8 there's quite a lot of in the statement, is we had
 9 a mandate, which under the current arrangement, was
 10 effectively the way we set out what you've described,
 11 those strategic priorities, the core instructions.

12 The mandate used to be an annual issue and has
 13 become somewhat more long term, and obviously, since
 14 2022, which in one sense didn't make a difference to the
 15 basic division of labour you've described, but did
 16 formalise the four or five organisations we had
 17 performing the various functions, commissioning and
 18 provision, and digital, into the one organisation.

19 Since then the two organisations have been working
 20 more closely together, so there's been a trend over the
 21 time since 2012 of coming closer together, but obviously
 22 the changes we're going to make will be significant
 23 because you won't have NHS England in the future.

24 But the way we developed our, if you like,
 25 instructions was through the mandate and then the way

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1 NHS England tends to operationalise that is through
2 a planning framework with priorities that changes its
3 name over time but performs the same function and has a
4 number of objectives and a number of metrics which are
5 quite closely managed and therefore enables our
6 ministers, if they're asked a question, you know, "What
7 is the waiting time standard on X and how is it being
8 performed?" to be able to explain that accurately.

9 **Q.** The Inquiry has heard evidence on the challenges in
10 providing mental health care --

11 **A.** Yes.

12 **Q.** -- due to insufficient resources.

13 **A.** Yes.

14 **Q.** And it may be that there are strategic implications as
15 well, but just dealing with the resource point first.
16 Professor Lade Smith, she is the President of the Royal
17 College of Psychiatrists, she gave evidence that every
18 year the income a Chief Executive gets from the
19 commissioner is five to 10% less than needed. She gave
20 evidence that nearly every single Mental Health Trust
21 every year is required to deliver the same care, if not
22 more, on a decreasing budget with the result that every
23 Mental Health Trust is spending the whole time looking
24 for cost improvement savings.

25 And she referred to mental health being 20% of the
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1 needed to look at other improvements or developments,
2 although not badged as mental health, would assist, such
3 as growing community health services, such as expansion
4 of GPs, such as improvements to IT.

5 And then obviously there are some sums of money
6 addition to that revenue baseline, including the
7 573 million for capital over the next four years.

8 So I think the point that she's making, which is
9 finances can be a challenging thing, is probably true
10 across the NHS, but at the same time, we are committed
11 to supporting mental health services.

12 **Q.** Well, there are a few points. There's one,
13 ever-decreasing amounts. If we look at an article from
14 the HSJ, document RLIT0000051. And it's an article
15 dated 12 March 2026, describing spending on mental
16 health.

17 If we go down to the text you see the proportion
18 allocated to mental health for 2026 to 2027 was forecast
19 to be 8.4%, lower than 8.7 as it currently is, lower
20 than 9% as it had previously been.

21 And there's one point, isn't there, which is not
22 receiving more and being asked to do more for less. The
23 second point is the disparity and the disproportionate
24 amount of funding in relation to how much mental health
25 takes up of health needs and health services in the

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1 disease burden but only receiving 8.4% of the funding.

2 **A.** Well, a couple of things to say to that in response.

3 The savings requirement that she mentioned, that applies
4 to NHS Trusts across the board, not just Mental Health
5 Trusts, and, and even if people, you know, might say
6 it's challenging, has always been something that has
7 been required of Trusts for as long as I can remember,
8 not least because we have to, in a way, enable the
9 system to perform more efficiently year on year to
10 ensure that it is making use of resources most
11 effectively -- resources have risen over time, but using
12 those resources effectively.

13 On the question of the actual amounts, there was
14 a statement in Parliament in March that said that the
15 amount of money going to mental health was going up from
16 15.7 billion to 16.1, and that that represented in real
17 terms, ie when you have accounted for inflation,
18 a 140 million increase, and that we wanted to ensure
19 that those real terms increases stayed steady through
20 the lifetime of the spending review which is what the
21 media -- the mental health financial commitment is for.

22 We also said that although -- we said in the
23 statement, although the relative growth in the mental
24 health budget is a proportion of the total budget is
25 down by about a third of 1% this year. We did say you

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1 country.

2 **A.** Well, I don't think that the figure of the 20%, 9%, is
3 in here. Clearly government has to -- government and
4 departments have a fixed amount of money and need to
5 make decisions in the round about how they're going to
6 use those resources. And we've set out here what our
7 decision is for this year and made the point, as I've
8 said, that there is investment going in in other core
9 areas which we hope is supportive of mental health
10 services.

11 We have, in addition on the workforce side, just
12 recently completed the recruitment of 8,500 new staff,
13 about half of them nurses. And so we are trying to
14 address the issues which we acknowledge elsewhere in my
15 witness statement: that NHS mental health services feel
16 challenged in places.

17 I think it's also fair to say that we want to look
18 through the cross-government mental health strategy, not
19 wishing to ignore the point about resources, about how
20 the resources we have are better utilised, and if
21 there's more options for joined-up care, if there's
22 different configurations for services, all of those
23 things, in order that we can address some of the
24 challenges on these services.

25 **Q.** The -- if we turn to the third, page 3 of this article,

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1 and whilst we're looking at it, there's a post on here
2 which reflects evidence that we heard from Sir Rob
3 Behrens yesterday, who was the Parliamentary --
4 **A.** The HSO.

5 **Q.** -- and Health Service Ombudsman, and if you look in the
6 middle of this page there's a quote from Andy Bell who
7 says:

8 "Any increase in mental health funding is welcome,
9 but these figures show that the government is still
10 falling short of treating mental and physical health
11 equally."

12 And reports from the Parliamentary Health Ombudsman,
13 a report in particular from 2018, also made a similar
14 point of mental health not being given parity with
15 physical health; do you accept that?

16 **A.** I don't think I do accept it's not being given parity.
17 I think one of the reasons why we took the legislation
18 through was because we thought it was significantly
19 important that we had an updated legislative framework
20 to support mental health services.

21 I think there are other things that we're doing,
22 I've mentioned the forthcoming strategy, the MSF for
23 mental health, the investment in the various
24 community-based pilots, that show we do think it's
25 significantly important, and we don't think it has

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1 safer levels of care, and that's causing risk in the
2 community.

3 Now, does the Department recognise that there is
4 this issue with unsafe levels of bed occupancy across
5 the country?

6 **A.** I'm not sure I can give a particular answer on that
7 because I'm not an expert on bed numbers. I think we
8 would recognise, as I said earlier, that there are
9 challenges into the system, but we're also aware that
10 there has been a rising demand for services and one of
11 the reasons why we had the Fonagy review is to try to
12 get to the bottom of prevalence and the trends in
13 increasing services in order that we can understand
14 those better and try and explain some of the pressures.
15 They published an interim report in April, and if you
16 look at the prevalence figures, then they've gone up in
17 some places quite noticeably and we need to understand
18 why that is.

19 So I think a report like that plus the forthcoming
20 strategy is a contribution to understanding what these
21 pressures are.

22 **Q.** There has been, hasn't there, and we've heard evidence
23 on this, a general deterioration, downward trend of bed
24 numbers over decades in mental health?

25 **A.** Yes.

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1 a lower status than physical health.

2 **Q.** Do you expect Mental Health Trusts and mental health
3 providers to be able to deliver more for less? Do you
4 consider, or does the Department consider, that there is
5 room for further efficiencies?

6 **A.** I think, across the board, the Department's view is, in
7 order to meet its variety of objectives, we can always
8 look for efficiencies. I think we can also look, and
9 it's been a theme of the last year, in a sense since the
10 changes were announced, that we try and give more room
11 for a Trust to lead and to deliver in the way they see
12 fit according to local priorities rather than in a sense
13 their every move being marked from above.

14 And I do think that we need to, I mean, as you say,
15 look very carefully about how we use our workforce and
16 how we configure our services in order that we can meet
17 the challenges that are being described.

18 **Q.** To give a more particular example and to go back to the
19 evidence that we heard from Professor Lade Smith, and
20 this is on the issue of mental health beds --

21 **A.** Yes.

22 **Q.** -- and her evidence was that in many places across the
23 country, since 2022, bed occupancy has been 95%, in some
24 cases 100% plus, and that's in circumstances where her
25 evidence was: anything above 85% means you can't provide

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1 **Q.** From those on the ground, the position that's been
2 described in the Inquiry, there's a Dr Gibson, so he was
3 one of the psychiatrists involved in the treatment of
4 VC, and the evidence he gave was that there were fewer
5 beds to deal with a larger and sicker population, and so
6 there'd be multiple patients in the community at any one
7 time that are dangerous and need to come into hospital
8 but there were no beds for them?

9 He described constant pressure to discharge patients
10 back into the community, again because of lack of beds.
11 And he also suggested that, with Community Treatment
12 Orders, their effectiveness is undermined because of the
13 lack of unavailable bed to recall patients on a CTO
14 into.

15 Now, that state of affairs, that is one which puts
16 the public at risk, doesn't it, because of insufficient
17 numbers of beds?

18 **A.** Well, reduction in bed numbers has been a situation for
19 a long time. We certainly think that if somebody is on
20 a CTO and they need to be re-called to hospital for
21 treatment, then that should happen because that's the
22 legal requirement.

23 And there was other evidence, I can't remember who
24 said it, but there was other evidence recently where one
25 of the clinicians said, "Look, if I have to re-call

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1 somebody back to the hospital, you know, then I will."

2 And obviously this question that you're putting to
3 me about funding resources, bed pressures, what do you
4 do? That's one of the things that the 10-Year Plan set
5 out to challenge. Not an overnight solution, the
6 10-Year Plan, which is how do we get a movement of
7 services from hospital to community in order to better
8 engage with people and better treatment, and do it at
9 a more local level? And obviously there are some
10 developments in mental health services that are trying
11 to support that.

12 **Q.** Yes, we will come on to the plan. So far as issues of
13 strategy and resources that the Department is
14 responsible for, the points we've been exploring so far,
15 let's take the issue of beds, where does beds fit in the
16 Department strategy, or where has --

17 **A.** Well, it's largely -- I mean, it's largely fitted on, in
18 a sense, the NHS side of the house and obviously between
19 Commissioners and providers about exactly what the local
20 determination of beds is.

21 **Q.** So it's something that the Department hasn't taken
22 a position on, strategically?

23 **A.** I wouldn't say we've never taken a position, but it's
24 certainly something where, in the current
25 responsibilities, where there's a division of labour

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1 **Q.** -- and minimising the risk to the public and where the
2 Department's strategy fits into that, the Inquiry has
3 already explored in evidence, particularly with
4 Dr James, a witness on behalf of NHS England, the move
5 away that's happened in recent years from a lot of the
6 learning from the Ritchie report following --

7 **A.** Yeah.

8 **Q.** -- the Clunis Inquiry and the evidence that has already
9 been explored is Assertive Outreach had been
10 deprioritised and I'm going to come on to Assertive
11 Outreach with you shortly, funding for the National
12 Confidential Inquiry into Mental Health Homicides, that
13 was cut, guidance on assessing mental health risk to
14 others that was confused and outdated.

15 Now, there's been activity in those areas following
16 the Nottingham attacks --

17 **A.** Yes.

18 **Q.** -- but do you agree that the strategy for which the
19 Department is responsible has failed to prioritise
20 public safety in the years as we've moved away from the
21 Ritchie Report, failed to ensure that the learning from
22 that report continued to be heeded?

23 **A.** I don't think I'd agree with that really. I mean
24 obviously the original learning from the Ritchie Report
25 was heeded because the Department took the decision,

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1 between the day-to-day responsibility and then the
2 assurance back to us, that would largely be an NHS
3 England lead.

4 **Q.** Is this a consequence of the transition that we've seen
5 over the years from more hospital-based care towards
6 community care?

7 **A.** Well, I mean there's been policies of -- I mean, this is
8 generalising now -- of successive governments in
9 a number of areas to try and reduce hospital bed usage
10 and grow community services, because there's a lot of
11 evidence that that is where people want to be treated,
12 and we need to continue with that, as the 10-Year Plan
13 set out.

14 **Q.** On the issue of some of the funding, and I've summarised
15 the evidence that the Inquiry has already heard, you've
16 referred to the need for efficiencies to be made
17 throughout the NHS.

18 Do you agree that mental health services are not and
19 have not been adequately funded?

20 **A.** I wouldn't say they haven't been adequately funded but
21 I acknowledged in my witness statement that we recognise
22 that there are pressures on services.

23 **Q.** Turning specifically to issues and policies aimed at
24 protecting the public --

25 **A.** Yes.

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1 when it passed the 2007 Mental Health Act, to introduce
2 Community Treatment Orders which were indeed
3 a recommendation of the Ritchie Inquiry. When I worked
4 on mental health services in that year, that's what
5 I was working on. And there was a strong view that they
6 aided public protection, they should be introduced, they
7 were a useful tool to clinicians to have because you
8 could recall people and if necessary require medication
9 to be taken that hadn't been the case in the Christopher
10 Clunis example.

11 I think in strategic terms on Community Treatment
12 Orders we've kept a pretty consistent position, because
13 when Sir Simon Wessely did his report, there were some
14 people who were calling for the abolition of Community
15 Treatment Orders because they thought they were overly
16 restrictive. There was a view from the independent
17 review that they should be restricted for two years, and
18 the decision that the government made in the Act that
19 was passed last December was to maintain the Community
20 Treatment Orders as they were, but at the same time
21 introduce a second community clinician into the
22 arrangements so that there was two pairs of eyes, not
23 one, and to allow the nominated person to make
24 challenges into a Community Treatment Order.

25 So I think if you look at Community Treatment

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1 Orders, there's a pretty -- there's a consistency and
2 actually --

3 **Q.** They're set out in statute, as well --

4 **A.** And set out in statute --

5 **Q.** -- (*overspeaking*) -- They remain in statute.

6 **A.** -- set out in statute and remaining in statute, and we
7 have Community Treatment Orders. We think they're
8 a good thing to have on the statute.

9 One of the things that motivated Sir Simon Wessely's
10 report was that detentions had gone up quite
11 dramatically by about 16,000, and a portion of those
12 were Community Treatment Orders and therefore we needed
13 to look at the reasons for that, and the rough
14 conclusion through the Act is you need to use them more
15 accurately, you need to explain them, you need to
16 justify them, but they're on the statute book. So
17 I think that one is a consistency.

18 I think on the question of Assertive Outreach, I am
19 obviously the corporate witness here and I wasn't
20 directly involved. But if you look at the facts as
21 presented by Dr James, and indeed as presented by
22 Dr Dissanayaka and various other people, we had
23 a position after the 1999 National Service Framework
24 where all health authorities had to have Assertive
25 Outreach services by 2002. We had a figure of 263

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1 aimed at protecting the public and they're both matters
2 which arise from the Ritchie report, and they were
3 allowed to reduce in the years that went by. And my
4 query is whether you accept that reflects a strategy
5 which was not focused on protecting the public.

6 **A.** I don't think I quite accept there was -- I don't think
7 there was ever a strategy not to focus on protecting the
8 public. That's the first thing I'd say. And the
9 fundamental legislation which allows for the protection
10 of the public maintained throughout that period.

11 We had a position, as I was sort of saying earlier,
12 until, you know, a few years ago, say Covid and
13 afterwards, where what -- and this isn't to cast
14 aspersions, it's just to state some facts -- what the
15 Department did and what NHS England did, there was more
16 of a distance between those two activities than there is
17 now, and it appears over the period of time that for
18 a variety of reasons, those services went down. I don't
19 think -- well, I'm sure it wasn't a conscious decision
20 of the Department not to protect the public, and I think
21 for those things for which we have and had the direct
22 responsibility, we were quite clear that the Act should
23 continue to operate in the way that it was set out.

24 **Q.** From paragraph 125 of your statement onwards, so it's
25 page 41, we can put it on the screen because I'm not

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1 Assertive Outreach services by 2004. When we came -- or
2 not when we came, when it was looked at again in 2023,
3 I imagine in the light of these events, the report from
4 NHS England was that something like I think 23% of
5 people had Assertive Outreach services. So without
6 being clever on the maths, they'd gone from a high
7 position to a lesser position and I think something of
8 that may be to do with the fact that there were various
9 reports that said that they didn't make an impact on bed
10 numbers so they weren't a good thing to do.

11 Obviously there's been a considerable amount of work
12 since 2022, which I won't go into detail on right now,
13 to try to bring the trajectory back up of Assertive
14 Outreach. I can't tell you why there was the apparent
15 reduction in the services over that period of time, but
16 that seems to have been the case.

17 **Q.** -- (*overspeaking*) -- What my question was --

18 **A.** Okay.

19 **Q.** -- directed to, you talk about bringing the trajectory
20 back up, there's an acknowledgement that there has been
21 a reduction in Assertive Outreach. There was clearly
22 the issues with the National Confidential Inquiry being
23 defunded. You've referred to CTOs but they're obviously
24 set out in statute. But those are two areas, aren't
25 they, which are specifically aimed or predominantly

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1 going to go to each paragraph, but what you do in your
2 statement is to set out under the heading "Relevant
3 strategies and guidance from 2011 to present", and in
4 the paragraphs that follow it, for several pages, you
5 identify and summarise a number of policies in the years
6 following 2011.

7 Do you agree that those policies focus on the
8 promotion of good mental health, wellbeing, early
9 interventions, reducing restrictions, reducing coercive
10 practices? That's the theme that runs through --

11 **A.** Yes.

12 **Q.** -- the policies. Nothing in there specifically dealing
13 with risk to the public or protection of the public from
14 mental health patients?

15 **A.** (*The witness nodded*)

16 **Q.** If we look, for instance, at paragraph 137 on page 46,
17 it's a call for evidence for mental health and
18 wellbeing:

19 "... the Department launched a call for evidence
20 seeking the public's views on what the Department could
21 do to improve everybody's mental health and wellbeing
22 [in the prevention of] suicide.

23 Again, my question is similar to the one that I
24 asked about strategy, but do you agree that the policy
25 output from the Department reflects a lessening of

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1 a focus on the care for those with serious mental
 2 illness and the public protection required in respect of
 3 those patients?
 4 **A.** Well, I would think we were still concerned with those
 5 people you've described, but the areas where NHS England
 6 and with the Department that there was the particular
 7 focus on were the areas you've outlined here, like
 8 suicide prevention and talking therapies.
 9 **Q.** Paragraph 172, it's page 58. There you describe the
 10 "Best Practice in Managing Risks", this is updated in
 11 March 2009 and it covers both risk to self and risk to
 12 others, doesn't it?
 13 **A.** It does.
 14 **Q.** I won't put it up on screen, but the point is that that
 15 document was not updated, or has not been updated,
 16 following March 2009 to reflect further learning and
 17 understanding in the area of risk to others?
 18 **A.** You're right that the document hasn't been updated.
 19 I think it was considered to be quite good guidance and
 20 indeed some of the people here have alluded to that.
 21 And I think it set out quite carefully the fact that
 22 there's the question of risk to self and risk to others
 23 that is inherent in mental health legislation, and that
 24 it is extremely important that clinicians satisfy
 25 themselves through their various clinical processes of

25

1 protection to the public that's consistent with the
 2 legislation, and obviously there's going to be an
 3 elision of where NHS England comes into the Department
 4 and the Department's decision to make for a single
 5 position, which is obviously the logic of the merger.
 6 **Q.** Yes. In paragraph 172, it's gone off screen, but the
 7 next paragraph you refer to NHS England having published
 8 guidance on risks as outlined in paragraphs 179-182, but
 9 NHS England haven't published specific guidance on this
 10 issue of risk either, have they?
 11 **A.** No.
 12 **Q.** Is this something, particularly in light of the evidence
 13 that's been heard at this Inquiry, there have been some
 14 real problems with assessing risk of harm to others, is
 15 it recognised and will there be plans to ensure that
 16 there is proper updated and thorough guidance on risk of
 17 harm to others?
 18 **A.** I think, on the broad piece, if you like, in comparison
 19 with the 2009 document, we need to give serious
 20 consideration to that, yes. Obviously, as I said, one
 21 of the things that we'll have to do and we started
 22 doing, and it was alluded to by the Royal College of
 23 Psychiatrists on Monday, is to ensure that when we
 24 revise the Code of Practice we are able to give
 25 a clearer explanation and scenarios and parameters to

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1 that the risk to an individual and of that risk to
 2 others, and there was a reasonably clear codicil, which
 3 I notice has been reflected in the person from the Royal
 4 College of Psychiatrists who did their last risk
 5 guidance in 2016, that the question of using matrices(?)
 6 to make your judgements about risk should be very
 7 carefully handled, not relied on by itself --
 8 **Q.** Not wholly relied on?
 9 **A.** Not wholly relied on by itself, but could be used as
 10 a --
 11 **Q.** Structured professional judgement?
 12 **A.** Yes, as a supportive tool to structured professional
 13 judgement, but not used in isolation.
 14 **Q.** Is that guidance something that the Department ought to
 15 have revisited since 2009, or is it your view -- you've
 16 referred to it as pretty good guidance -- is it your
 17 view that it's fine and it stands the test of time?
 18 **A.** I'm not the world expert on this, but I think it was
 19 good guidance and has stood the test of time quite well.
 20 **Q.** Are there plans to revisit it and update it?
 21 **A.** There aren't any current plans to revisit it and update
 22 it, but clearly, with the passing of the Act, there's a
 23 need to do, you know, a number of things, not least with
 24 the Code of Practice, to make sure that all the
 25 documents that we have are presenting a view of risk and

26

1 what we mean by serious risk of harm.
 2 **Q.** Yes, I'm going to come onto that.
 3 **A.** Okay --
 4 **Q.** If I can deal with another discrete issue, it's document
 5 DHSC0000108, and this is the guidance from the
 6 Department on information sharing and suicide
 7 prevention?
 8 **A.** Yes.
 9 **Q.** A suicide consensus statement published in August 2021,
 10 and you refer to this in your statement.
 11 Now, again, in the Inquiry, we have heard evidence
 12 of concerns and confusion as to the circumstances in
 13 which clinicians may or may not share information,
 14 particularly where a patient doesn't consent, and
 15 perceived difficulties that that may arise.
 16 Now, of course important to have guidance on
 17 information sharing in respect of self-harm and making
 18 it clear what the principles are, but different
 19 principles and different factors may arise when it comes
 20 to information sharing in respect of a patient of yours
 21 who poses a risk to a third party; do you agree with
 22 that?
 23 **A.** Yes, that's right. And, I mean, I mean, what was
 24 interesting about this document was it tried to weave,
 25 as you've just said, into the specific situation of

28

1 suicide prevention, the various rules and approaches on
 2 information sharing: implied consent, "Yes, I'm treating
 3 the patient"; explicit consent, "I need your explicit
 4 consent for something outside direct patient care like
 5 research." And then the issue which we produced -- the
 6 Department, with NHS England, produced a piece of
 7 guidance on in 2025, which is a question of information
 8 sharing with the police that gets into the question of
 9 if you have a situation where there is a serious risk or
 10 a threat of harm, and that is to an individual or the
 11 public, then the clinician's ability to share that
 12 information is able to override other issues of patient
 13 confidentiality. Clearly that's an individual
 14 judgement, in individual situations, and --
 15 **Q.** But is it one that you -- is it one that you accept
 16 clinicians need some clear guidance on --
 17 **A.** Well, I mean in preparation for this, I asked the person
 18 who had written or who had led the writing of the police
 19 piece of guidance that I've just referred to, how they
 20 put it together and how they gave a pecking order of the
 21 examples, and they basically said, you know, "We give
 22 the examples according to the feedback that we're
 23 getting and we try to make it relevant for people. We
 24 don't include every single scenario, because people say
 25 'If you give me that much information it's not useful!'"

29

1 and I want to spend a bit more time looking at that.
 2 We've referred to the Ritchie Report --
 3 **A.** Yeah.
 4 **Q.** -- and the introduction of Assertive Outreach teams
 5 following that, and it's right, isn't it, that they were
 6 identified as being important because they allowed for
 7 engagement of those more difficult, disengaged and risky
 8 patients?
 9 **A.** Yeah, consistent engagement of people who, as you say,
 10 are more risky, however are in the community, and are
 11 often in a situation where they need a wraparound of
 12 social support because they don't have, you know, the
 13 wherewithal and circumstances to do that themselves, and
 14 Assertive Outreach is about a long-term consistent
 15 approach that doesn't necessarily say, "I'm going to get
 16 to an endpoint of perfection or entire stability," but
 17 is able to support and hold people, and give them
 18 support they need and to have a therapeutic relationship
 19 that's based on trust and engagement, a lot of the
 20 things, in a sense, that were discussed during the
 21 passage of the Bill.
 22 **Q.** Yes. And why it's important and why it protects the
 23 public is because those who are engaged with services
 24 are less likely to present a risk of violence. So all
 25 of the studies show it's --

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1 So I do accept that there may be a case of what
 2 we're learning through this Inquiry and the VC case that
 3 we should be able to illustrate more clearly for
 4 practitioners in the kind of situations that we're here
 5 to discuss today, how that information sharing might
 6 work.

7 **Q.** Yes, and information sharing with the police is one
 8 point and that's an important point, but what about
 9 a document such as this one, information sharing and
 10 protection of the public? So one that's not necessarily
 11 limited to information sharing with the police, because
 12 I mean the other agencies that it's necessary to share
 13 information with.

14 **A.** I mean, you could do that, but I would hope that the
 15 basic guidance we have is informative, that obviously
 16 people, if they are uncertain in any given situation,
 17 can go to their Caldicott Guardian in the Trust, because
 18 that's what they're there for, to give on-the-ground
 19 advice, and obviously when we come to the revisions of
 20 the Code of Practice we need to look carefully about
 21 what you do in these kinds of situations.

22 But I'm happy to take away the issue of whether
 23 something bespoke for the kind of situations that have
 24 brought us here today would be helpful.

25 **Q.** You've given some evidence already on Assertive Outreach

30

1 **A.** Yes.
 2 **Q.** -- disengagement is something that's going to increase
 3 -- (*overspeaking*) --
 4 **A.** Yes, I mean the studies that were in the pack, if you
 5 leave aside the bed issue, basically say if you have
 6 a long-term relationship, the chances of reducing of the
 7 harm of that risk to themselves or others, be it on
 8 a range of things including violence, is reduced. It's
 9 never neutralised because you can't neutralise it, and
 10 you can never entirely predict what an individual is
 11 going to do, but it is an approach that shows
 12 significant benefits. But it is quite, you know, time
 13 intensive and flows over a long period of time.
 14 **Q.** If we can just chart, in outline terms, what happened
 15 with Assertive Outreach. So if we look first, please,
 16 it's document DHSC0000097, and this is the 1999
 17 "National Service Framework". Then if we go to page 50
 18 of this document, please. There are two paragraphs
 19 I want to take you to. The paragraph at the top of the
 20 page, where it identifies:
 21 "... around half those with severe and enduring
 22 mental illness have lost contact with specialist mental
 23 health services, leaving their GP to provide continuing
 24 care."

25 And so that is, as it were, the challenge, isn't it:

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1 those who have disengaged or are disengaged.
 2 And then if we look three paragraphs from the
 3 bottom, it describes:
 4 "Community Mental Health Teams may work with other
 5 specialist teams covering early intervention; assertive
 6 outreach; home treatment; the needs of those with
 7 co-morbidity".
 8 Then the next paragraph describes, doesn't it:
 9 "Assertive outreach or assertive community treatment
 10 is a form of intensive case management that provides
 11 a clinically effective approach to managing the care of
 12 severely mentally ill people in the community.
 13 "Staff providing comprehensive assertive outreach
 14 care for clients will visit them at home, act as an
 15 advocate, and liaise with other services such as the GP
 16 or social services."
 17 Now the final paragraph on the page states:
 18 "Assertive outreach can establish a more stable
 19 community base, and reduce time spent in hospital."
 20 We can touch upon the research in a moment as to
 21 whether or not Assertive Outreach does reduce time in
 22 hospital, but do you agree that the main benefit of
 23 Assertive Outreach is not so much what its impact on
 24 hospital time is, it's really: does it result in
 25 patients who are engaged and therefore less at risk?

33

1 Q. It's a pity it had so much traction for the reason?
 2 A. For the reason I've just been going through.
 3 Q. In fact, there are other studies, there's a 2015 paper
 4 in your pack, which shows that actually Assertive
 5 Outreach does and can reduce hospital admission.
 6 So we can look, for instance, at DHSC0000123 and
 7 that's a 2015 paper, which suggests it does have
 8 a positive reaction on hospital time. So the paper
 9 studies are mixed, aren't they?
 10 A. Yeah, I mean, the papers in the pack and the meta
 11 analysis, the one that was sort of Cochran, said it was
 12 undoubtedly the case, based on the studies, that you got
 13 probably better engagement and better outcomes,
 14 particularly with those people in challenging social
 15 circumstances, including homeless people, and probably
 16 combining that with the other studies.
 17 If you look in a long enough time period, you can
 18 demonstrate bed savings as well, but probably in that
 19 order, one, two. And obviously, if you look at the
 20 evidence of Dr Dissanayaka, I've been to see his
 21 service, he pointed that over the period of however many
 22 years it was, there'd been a substantial reduction in
 23 use of bed days in Leeds, but that --
 24 Q. Yes, and he has produced --
 25 A. But you need quite a long time to show that series

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1 A. Yeah, I mean, it's a way of -- to go back to your
 2 earlier point -- providing effective public protection
 3 because if you didn't engage with these people they
 4 might be more risky.
 5 And then the other side of the coin, in a sense, in
 6 terms of mental health legislation, is also trying to
 7 provide the best possible services, therapeutic benefit
 8 per the current Act and, therefore, you get a situation
 9 where you have people who are more stable and therefore
 10 less of a risk to the wider population.
 11 Assertive Outreach does both of those things, so
 12 it's not just one or the other, and the argument with
 13 CTOs in 2006 was the same. They are a measure of public
 14 protection, as I've said, but they also have
 15 a therapeutic benefit because there are studies that
 16 show that people are better off and more stable as a
 17 result of those services.
 18 Q. The evidence THAT we've heard, and you touch upon the
 19 REACT study in your statement, but that study, it's
 20 a study that took place in London, which found that
 21 Assertive Outreach did not reduce bed use. That seems
 22 to have been something of a turning point for Assertive
 23 Outreach teams?
 24 A. I think apparently so. I mean, I think it's a bit of
 25 a pity it had so much traction.

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1 because the nature of the people that you're caring for
 2 mean that it's a long-term, not a short-term process.
 3 Q. Now, given the point that we've covered, which is
 4 actually measuring the success of Assertive Outreach
 5 really isn't it about bed time, it's more about the
 6 question of engagement and protecting the public, what's
 7 the view of the Department as to why the REACT study did
 8 gain traction, which you said is unfortunate, and did
 9 lead to the decline of Assertive Outreach teams?
 10 A. Well, I don't know the answer to that because I haven't
 11 been able to find any evidence that demonstrated that
 12 that was the decision that, in a sense, was positively
 13 taken during that period, but it is -- I mean,
 14 objectively, it must be what happened.
 15 Q. It's not something then that was part of any Department
 16 strategy?
 17 A. No. No.
 18 Q. You explain in your statement, it's paragraph 53,
 19 page 156, and this is the work that has been done
 20 recently in respect of Assertive Outreach, and so the
 21 Department agreed with NHS England for a review of
 22 community mental service and for evidence to support the
 23 development of a model of Assertive Outreach. And that
 24 led to the NHS England publication which you quote in
 25 that paragraph, and we can go to it, please, it's

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1 DHSC0000101.
 2 This is the July 2024 publication guidance on
 3 intensive and assertive community mental health
 4 treatment. As you mentioned before, the movement now,
 5 the trajectory, is to try to get Assertive Outreach
 6 reprioritised?
 7 **A.** That's correct.
 8 **Q.** If we look, please, at page 20 of this document -- it's
 9 under the heading number: "4. Features of intensive and
 10 assertive community care", what NHS England do here in
 11 those first two paragraphs is they draw a distinction,
 12 don't they, between, on the one hand, the intensive and
 13 assertive community care, so the principles within
 14 community care almost?
 15 **A.** Yes.
 16 **Q.** Then, on the other hand, the second paragraph, Assertive
 17 Outreach, which is a distinctive evidence-based service,
 18 and we can see there in the hyperlink reference to the
 19 Dartmouth Fidelity Scale.
 20 You say you've visited Dr Dissanayaka's Assertive
 21 Outreach Team --
 22 **A.** *(The witness nodded)*
 23 **Q.** -- in Yorkshire. That's in the second element, isn't
 24 it, it's a dedicated -- *(overspeaking)* --
 25 **A.** Yeah, although it's not written like this in the

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1 **A.** I shouldn't have said that.
 2 **Q.** -- but what I want to explore is just, particularly in
 3 light of the evidence that this Inquiry has heard, also
 4 the evidence that we've had from Dr Dissanayaka, that
 5 the gulf that may appear between on the one hand
 6 a dedicated Assertive Outreach Team and then on the
 7 other hand having some assertive principles within
 8 community mental health.
 9 Now, we can look at his statement, Dr Dissanayaka's
 10 statement, and WITN0412001.
 11 It's page 5, it's his paragraph 13, and he describes
 12 there:
 13 "Assertive Outreach is a very clearly defined model
 14 ..."
 15 He makes reference to the Dartmouth Fidelity Scale,
 16 which we've already talked about, and what he's
 17 describing is the capital A, capital O that you referred
 18 to a few moments ago.
 19 But in respect of that first paragraph in the NHS
 20 England document referring to assertive principles, what
 21 this doctor says, it's five lines down in this
 22 paragraph, he says:
 23 "... there's no such thing as an 'Assertive ...
 24 approach' as key components cannot be delivered without
 25 a dedicated team. ... it requires a dedicated

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1 paragraph, that is, in a sense, capital A, capital O,
 2 Assertive Outreach service against the Dartmouth scale
 3 with Fidelity with a standalone as a separate service.
 4 Then the paragraph above is describing an approach
 5 to intensive and assertive support which, I'm not
 6 a clinician, but is maybe, you know, half a notch
 7 different or down, if you want, in terms of intensity,
 8 and this guidance, which, sort of going back to your
 9 earlier point about the trajectory, it came out, you
 10 know, within a month of the new government coming into
 11 power, and was saying to the NHS in the light of what we
 12 had, by then, learnt from these events related to VC,
 13 was that we needed to effectively put people on notice
 14 to develop and start to re-provision their services, be
 15 that the second paragraph approach, like Dr Dissanayaka,
 16 or be it the first paragraph approach.
 17 Obviously, that was, you know, quite a directive
 18 piece of guidance and, in addition, asked people to
 19 assess the position of their services against, you know,
 20 the NICE criteria and come back to NHS England and say
 21 what did they have, basically.
 22 **Q.** Yes. I just want to go back to the description of that
 23 first paragraph as being half a notch down, and
 24 I appreciate you weren't being necessarily scientific
 25 there --

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1 multidisciplinary team with the key skills and
 2 experience required for working with poorly engaged high
 3 risk psychotic patients ..."
 4 If we go further in his statement, please, page 26,
 5 and at paragraph 49. Again, here he's describing, as
 6 I understand it, Assertive Outreach-type principles. He
 7 said:
 8 "It should be made clear that this umbrella term,
 9 unlike Assertive Outreach, is not a clearly defined
 10 model of care. What this document describes ..."
 11 And he's referring to the NHSE document we were just
 12 looking at:
 13 "... is what might be considered good general
 14 principles of care, and then separately, the gold
 15 standard of Assertive Outreach."
 16 And in your answer you've already acknowledged there
 17 is clearly a difference between them, it's that notch
 18 below. On the one hand you've got what's a good
 19 principle; on the other you've got a dedicated
 20 specialist service to a Fidelity Scale. The gulf
 21 between them is huge, don't you accept?
 22 **A.** Well, I can't tell you whether the gulf between them is
 23 huge or not, but I think the things that aren't, let's
 24 call them capital A, capital O, Assertive Outreach, are
 25 still an identifiable and notable service that provides

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1 the principles of Assertive Outreach, but as he said,
2 maybe not at the gold standard that his service runs.
3 And obviously, I mean I read this carefully because
4 I'd been to the service and I read it against the
5 guidance that you just put up. And obviously the
6 guidance that came out from NHS England was saying, as
7 he points at here, something slightly different, which
8 is we want to know what people are doing on both
9 approaches, not just the one.

10 **Q.** Yes, we can go back to the guidance. It's DHSC0000101.
11 Again, if we just look at that first paragraph under
12 heading 4.

13 The context of my questions here is that the EIP
14 service that was treating VC in this case, it had within
15 its principles, within its guidance, references to
16 assertive principles, but it's clear on the evidence
17 that we've heard from the nurses working in that service
18 that they were wholly ill equipped to deal with VC when
19 he disengaged and became what they described as an
20 Assertive Outreach patient. They weren't trained for
21 it, didn't know how to do it, didn't have the resources
22 for it.

23 And -- sorry, it's page 20 of this document. That
24 first paragraph of having a service provision designed
25 to meet the needs of the group of people described,

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1 And when Adrian was here, he said, you know, there
2 is a question of looking at what is most appropriate for
3 the local population. I mean, going back to the earlier
4 question you were asking me about, that is something
5 that ICBs with Trusts overseen by NHS England do. In
6 a sense, that's what they do on a day-to-day basis, and
7 it is, you know, this was obviously a clear reminder as
8 the trajectory of Assertive Outreach services were
9 growing, that everybody needed to be able to justify and
10 explain what they had, perhaps in a way that they hadn't
11 thought about as seriously before 2023.

12 **Q.** So your point is that a capital A, capital O service --
13 or part of your point is that a capital A, capital O
14 service might not be appropriate for --

15 **A.** -- (*overspeaking*) -- Might not be appropriate
16 everywhere.

17 **Q.** -- everywhere in the country in more rural and sparsely
18 populated areas.

19 But if we go, please, to page 21 of this document
20 from NHS England, the second paragraph on the page where
21 it's referring to ICBs:

22 "... some ... may already commission 'assertive
23 outreach' teams or similar, others may not already
24 current commission a specific time team or service that
25 is focused on intensive and assertive approaches. A key

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1 I mean that could be describing, couldn't it, just, for
2 instance in an EIP team or in a Community Mental Health
3 Team, having a sentence saying: well, when someone
4 disengages, be assertive about trying to re-engage them?

5 **A.** Well, I think it's more than that. I think the approach
6 that NHS England took, I mean it's clear from these
7 paragraphs, is not to dictate a single service model,
8 but to say that people needed to explain how this group
9 of patients were going to be catered for and the
10 decisions locally about what is most appropriate, given
11 the population, given the resources, and I mean it's
12 true that in a lot of urban areas there is quite a, you
13 know, clear need for services kinds of this because you
14 get patients like this -- I mean it's a slight
15 generalisation -- but tend to congregate more in urban
16 areas than other areas.

17 And obviously when the Chief Executive of the
18 hospital came a couple weeks ago he said: well, in
19 a sense we've got paragraph 1 services at the moment,
20 but we would like to build up to a full Assertive
21 Outreach service, capital A, capital O.

22 And obviously, there are examples of other urban
23 places where they've gone down that route and places
24 where there's a different population that have gone down
25 the route in the first paragraph.

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1 message of this guidance is that while ICBs are not
2 required to commission assertive outreach teams, meeting
3 the needs of individuals described in chapter 2 requires
4 dedicated resource."

5 Now, that's quite open-ended, isn't it? In respect
6 of, for instance, urban areas where, I think from your
7 answer, you acknowledge a dedicated AO team would work,
8 those areas in fact really need them, don't they?

9 **A.** I think more of them need them than might need them in
10 the less populated areas, and obviously what this was
11 saying was that, one way or another, you need to meet
12 these individuals' needs and find a resource, whether
13 it's at the gold standard service or the next level
14 service.

15 **Q.** When you say gold standard service, that's just
16 a dedicated team that --

17 **A.** Yeah, that's capital A, capital O, whatever you want to
18 call it, he used the words "gold standard", but the
19 Dartmouth Fidelity, as distinguished from the others.

20 I mean, what he's saying here is that whilst you
21 might not have to commission that particular service,
22 you need to meet the needs of the individuals, which was
23 why we repeated that requirement in the 10-Year Plan to
24 make sure that we get a full coverage of these services.

25 **Q.** Does the Department not take the view that in areas

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1 where a dedicated Assertive Outreach Team would be
2 appropriate, so urban areas, areas of more population,
3 this shouldn't be a matter of discretion: they are
4 needed for the public protection reasons that we have
5 used?

6 So it shouldn't be left up to an ICB to decide:
7 well, actually, we're not going to put our resources
8 into an AO team, we're just going to have AO principles
9 in our Community Mental Health Team guides?

10 **A.** Well, as I described earlier, the system that we have at
11 the moment is that ICBs report into NHS England and,
12 working within NHS Trusts, have to decide what is the
13 best service for their local community based on that
14 community's needs. And the guidance here from NHS
15 England is setting up two options, but not the third
16 option of not having it at all.

17 **Q.** The Department's view? The Department's position? Is
18 that adequate? Is it adequate that, on the basis of
19 this guidance, an urban area that would benefit from
20 Assertive Outreach is not mandated to have an Assertive
21 Outreach Team?

22 **A.** I think this guidance is appropriate and it's the
23 guidance we are working with at the present time.

24 **Q.** Your statement, it's paragraph 158, you describe there
25 that, as part of the 10-Year Plan -- and we're going to

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1 "[three] sickness to prevention."

2 Now, in terms of "hospital to community", we have
3 heard evidence from Professor Kendall specifically in
4 relation to mental health, but the vision of shifting
5 the NHS from hospital to community, what is the
6 Department vision there? Can you add some meat to the
7 bone-- (*overspeaking*) --

8 **A.** Yeah, I mean, the Department thinks, as explained in the
9 10-Year Plan, that moving to a community-based level of
10 service is what many people in the public want, is more
11 convenient, and will bring care closer to home, and that
12 maintaining just the predominant focus on the hospital
13 system is not going to actually deliver the health
14 benefits that we want. And if you look over the course
15 of recent years, resources have actually shifted, in
16 broad terms, from community to hospital, whereas they
17 should be going in the other direction.

18 **Q.** The view is that the NHS currently is too hospital
19 centric?

20 **A.** Yes, effectively.

21 **Q.** It would be accepted, wouldn't it, that there are going
22 to be certain health conditions, serious health
23 conditions --

24 **A.** Yeah.

25 **Q.** -- that can only be treated properly in a hospital?

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1 come onto the 10-Year Plan in a moment -- there is
2 a commitment to approving Assertive Outreach care and
3 treatment to ensure a hundred per cent national
4 coverage.

5 That commitment to improving Assertive Outreach
6 care, is it in that more broad sense, so having --

7 **A.** I suppose it's reflecting the guidance which is
8 currently driving what the NHS does.

9 **Q.** Can we look, please, at the 10-Year Plan. It's
10 DHSC0000096. This is the "Fit for ... Future: 10 Year
11 Health Plan for England", this is an executive summary.

12 If we can just deal first with some of the
13 principles and please expand on any to explain what the
14 provision is. At page 1 here, we've got:

15 "From hospital to community: the Neighbourhood
16 Health Service, designed around you."

17 Then page 3, four paragraphs down, there's reference
18 to a choice that is stark for the NHS. At the end of
19 that paragraph it is said that the plan being chosen is
20 one that represents a break with the past. It's a move
21 away from the status quo.

22 Then, on page 4, there is the proposal to:

23 "... reinvent the NHS through 3 radical shifts:

24 "[one] hospital to community.

25 "[two] analogue to digital, [and]

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1 **A.** Yes, it is not an absolute statement covering every
2 eventuality.

3 **Q.** Now. There's little in the 10-Year Plan dealing with
4 serious mental health. There is at page 6, it is the
5 penultimate paragraph on page 6, an investment or
6 proposed investment of up to 120 million to develop more
7 dedicated mental health emergency departments, to ensure
8 fast, same-day access to specialist support.

9 That would be geared, wouldn't it, towards patients
10 in crisis, presumably -- (*overspeaking*) --

11 **A.** Yes, patients in crisis who don't have a convenient
12 place to attend that suits their needs, and go
13 elsewhere, be it to the GP or maybe sometimes to the
14 hospital or to A&E, and finding a way of giving people
15 fast and effective treatment that engages them as soon
16 as possible and stops, you know, the condition they have
17 worsening.

18 I mean, as you said, just to pick up on one thing
19 you said, you were talking about the fact that, you
20 know, mental health doesn't feature particularly heavily
21 in the document. The document was a 10-Year Plan, was
22 a vision, and could not be oracular of every single
23 condition and every single situation. That's why we
24 come onto it later. You know, we've got the
25 cross-government strategy and the MSF both focusing on

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1 mental health, but this is an example of trying to shift
 2 the focus, you know, out of the core hospital setting
 3 and give people the appropriate care that they need in
 4 -- (*overspeaking*) --
 5 Q. Yes, and it's not going to go through a list of every
 6 illness, it is setting high level principles.
 7 A. Exactly, yeah.
 8 Q. But the principles in here would apply also to --
 9 A. Yes, correct.
 10 Q. -- treating mental health.
 11 A. Yes, yes.
 12 Q. But as --
 13 A. But, as you said, it doesn't apply to every single
 14 condition or circumstance.
 15 Q. Just like with physical health, if somebody has
 16 a serious physical condition, and that is going to
 17 require hospital treatment.
 18 A. Yes.
 19 Q. Also with mental health, somebody who has got a serious
 20 mental health condition --
 21 A. Is going to need hospital treatment-- (*overspeaking*) --
 22 Q. -- a neighbourhood approach might not work.
 23 Now the Inquiry has heard from Professor Tim Kendall
 24 from NHS England, and he's pioneering these 24/7
 25 Neighbourhood Mental Health Centres, these neighbourhood

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1 services under one roof, literally, in order that you
 2 don't have quite such a separation of the services, and
 3 it's easier for people to move between the different
 4 services. Slightly going back on the assertive
 5 outreach, sort of not capital A, capital O, it allows
 6 people to enter services in the way that they find most
 7 useful for them. So "No wrong door" is the phrase they
 8 use. And obviously it tries to takes services from,
 9 take people from other parts of primary care where they
 10 may inappropriately present and, the one I visited, to
 11 reach in to the hospital to try to support people who
 12 maybe don't need to be in hospital, and to provide, if
 13 you like, in the second level of Assertive Outreach. In
 14 the instance, I went next door to a standalone Assertive
 15 Outreach, so in a sense they were complementary.
 16 The two-year pilot formally ended, or the two-year
 17 funding for the pilots formally ended, at the end of
 18 March. There were actually 16 other places that wanted
 19 to adopt a similar model even though they weren't
 20 funded, and we're waiting, as you said, for the
 21 evaluation to come out and then we'll consider what the
 22 next steps are, and the evaluation, I think, is over the
 23 summer, or shortly afterwards.
 24 And obviously, we would hope that they provide the
 25 evidence that the hospital-to-community shift is

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1 hubs, there's currently six --
 2 A. There are six across the country, yes.
 3 Q. -- (*overspeaking*) -- pilot sites, and we were told that
 4 Ipsos MORI are conducting or are going to report on
 5 them, and that report is due later in the year.
 6 What's the Department's view on this neighbourhood
 7 model for mental health? Is that something that aligns
 8 with and fits within -- (*overspeaking*) --
 9 A. Yeah, I think it does. And obviously, as Tim said in
 10 his statement before he ceased to work at NHS England,
 11 he was integral to getting these set up. The motivation
 12 for them was some of the stories about very bad
 13 institutional care in hospitals, Essex and Manchester,
 14 which hit the headlines in 2023.
 15 So I suppose, in a sense, these community-based
 16 mental health centres are trying, one, to do the
 17 hospital-to-community shift that you've just described,
 18 but in a sense they're also trying to get downstream of
 19 people's conditions and try and engage early as
 20 possible. So when the 10-Year Plan talks about, you
 21 know, sickness to health, you might, in the mental
 22 health situation, say from institutional care to more
 23 therapeutic care.
 24 I've visited one of the centres, and obviously what
 25 it does is it tries to bring together a number of

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1 an effective one, and that's in a sense why we did the
 2 pilots, some urban, some rural.
 3 Q. So it's in line with the 10-Year Plan
 4 -- (*overspeaking*) --
 5 A. It is. I mean it was --
 6 Q. -- (*overspeaking*) -- The hope of the Department is
 7 that --
 8 A. Yeah, I mean --
 9 Q. -- (*overspeaking*) -- it proves to be successful and
 10 they're rolled out.
 11 A. Yes. It was begun before the 10-Year Plan, but it is
 12 a rather good illustration of 10-Year Plan principles,
 13 hospital-to-community shift.
 14 Q. You mention the one you've visited, and I may have
 15 misheard you, but I think you said the one you visited,
 16 it had next door to it, a standalone assertive --
 17 A. It had one in the same city. That's what I meant by
 18 next door. And it was providing the non-capital A
 19 capital O assertive outreach to the population that it
 20 was serving, because the populations that these pilots
 21 serve are quite small, they're 30-50,000. So one of the
 22 issues post-the reporting of the evaluation is whether,
 23 in those areas, you want to scale it up for it to be
 24 a more typical service, you know, across a larger area,
 25 across a commissioner or however people decide to take

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1 it forward.

2 **Q.** The principles of the model for these neighbourhood
3 hubs, they're principles, aren't they, of promoting
4 freedom, autonomy and choice?

5 **A.** Yes.

6 **Q.** Patient being in control of their care, deciding about
7 what they want and what they don't want.

8 **A.** That's right. I mean there's also a strong vein of
9 engagement, so you can get alongside those people, and
10 ensure, a bit like AO, that you don't discharge people
11 from care but you're able to monitor them safely.

12 **Q.** Well, the hope is that the model will prove attractive,
13 be more attractive for users. They can go to one of
14 these hubs which, some of them will be in residential
15 type --

16 **A.** Yeah.

17 **Q.** -- houses, they're more local, they're not in
18 a hospital.

19 **A.** I think there's also a point that -- I mean, going back
20 to the earlier points you were making, is that if you do
21 that, you can give a greater sense of protection to
22 those people, because they are better engaged, they are
23 better monitored, they are better understood. So in
24 a sense for some of those people, who inevitably will
25 have a sort of variable track of progress, one is nearer

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1 ... often demonstrate poor awareness of their illness,
2 not recognising they are unwell and, consequently,
3 non-compliance with treatment, disengagement from
4 community services ... frequent relapses ... repeated
5 detentions ... history of keeping or using weapons ..."

6 Now those types of patients, clearly the
7 neighbourhood hub would hope to have engaged with people
8 before they've deteriorated to this level, but these
9 types of patients who exist, who are the ones requiring
10 Assertive Outreach in Dr Dissanayaka's area, there's
11 a real risk for them, isn't there, just in shifting
12 services more locally and putting them in a residential
13 building isn't going to be sufficient to engage them and
14 it's -- (overspeaking) --

15 **A.** Well, there's certainly going to be a cohort of patients
16 where you need to engage them as described here. When
17 I went to visit the Leeds service, you know, the basis
18 of the Leeds service was in a residential area, albeit
19 the staff were in a health centre --

20 **Q.** Was the Leeds service, when you said you visited a hub
21 and there was -- (overspeaking) --

22 **A.** The Leeds one was Dr Dissanayaka's service and the
23 community-based hub was elsewhere in Birmingham. So
24 there were two. They were two different things. Sorry,
25 I should have made that clear.

55

1 to that, so to the point at which, you know, there are
2 occasions clearly where you need to refer into hospital,
3 that would be better able to be managed because there is
4 that closer engagement.

5 **Q.** Yes, and where that is successful, and that will be
6 a good thing, where these neighbourhood models are able
7 to engage with somebody and it's more local for someone
8 and they feel more at home, then that's all positive --

9 **A.** Yeah.

10 **Q.** -- and in line with the 10-Year Plan, but you will
11 recognise, won't you, there will be those patients,
12 there will be those with serious mental illness for whom
13 this approach is not going to work, those who lack
14 insight, don't believe they're unwell, aren't taking
15 medication, precisely the kind of issues that we've been
16 grappling with in this Inquiry?

17 **A.** Yes, that's right. It won't cover every eventuality.

18 **Q.** And if we just look at the sort of patients that
19 Dr Dissanayaka describes as being on his case load, so
20 it's back to his witness statement, please, WITN0412001,
21 page 13, please, paragraph 25.

22 And it's four lines down in this paragraph where he
23 describes his typical patient:

24 "... psychotic illness, usually Schizophrenia,
25 Bipolar Affective Disorder, Schizoaffective Disorder.

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1 So, you know, the staff basis was, you know, in
2 a quite sizeable health centre but in a neighbourhood
3 area. The basis of the service, because I went out on
4 one of the visits, was the staff going out to see the
5 patients in their homes.

6 **Q.** Does it follow from your answers that you recognise that
7 this neighbourhood model, these neighbourhood hubs, will
8 not be a complete answer, and they're only going to be
9 able to keep the public safe if they co-exist with, for
10 instance, in areas that need them, dedicated Assertive
11 Outreach teams in --

12 **A.** Well --

13 **Q.** -- and specialist teams who will go and find people who
14 just aren't going to turn up at --

15 **A.** I think it slightly depends on the configuration of the
16 services and, as I said before, there are going to be
17 some places, I can't tell you what the configuration of
18 the services in the other Neighbourhood Mental Health
19 Centres where you're going to have the two services
20 existing alongside one another, and there's probably
21 situations where you won't, and that all comes back to
22 the guidance from NHS England which is you need to look
23 at the needs of your local population amongst this
24 cohort of people and make sure those needs are being
25 met. And there are roughly two broad approaches to that

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1 in the Assertive Outreach world and, as we've been
2 discussing, the community-based Mental Health Centre
3 could be -- could certainly be providing the second
4 tier, and, I suppose, potentially could provide the
5 first as well.

6 The critical thing about the Neighbourhood Mental
7 Health Centres is that they bring a number of services
8 together and they enable an easier cross-pollination
9 between those services that's also easier for the users.

10 **Q.** Yes, we discussed the principles of these neighbourhood
11 hubs, and I won't take you through to the documents but
12 they're obviously borne out of a programme promoted by
13 the World Health Organization --

14 **A.** Yes.

15 **Q.** The UN, the principles of non-coercion are very strong
16 and part of the founding principles. But is the
17 position that whilst they do align with the 10-Year
18 Plan, and whilst the Department considers that they will
19 be attractive for some patients, it's recognised that
20 for the sorts of patients that we've considered, the
21 ones who lack insight, present with a risk of violence,
22 aren't taking medication, they are not going to be
23 adequate and something needs to be put in place to
24 engage and treat those, which is not going to be
25 a neighbourhood hub?

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1 you couldn't have a capital AO service. I'm not aware
2 within the six pilots, we have one at the moment, and
3 obviously, going back to your research point, one of the
4 attractions of those models was that there was quite
5 a lot of decent -- international evidence, from places
6 like Lille and Trieste, that they worked, and therefore
7 we wanted to see if they can work here.

8 **Q.** Yes. The final point before the break and when
9 referring to the first, as it were, Assertive Outreach
10 principle, what you're describing -- or Assertive
11 Outreach Model of Care, what you're describing there is
12 something which is not adherent to the Fidelity Scale,
13 it is a principle which --

14 **A.** Might have components of that. Might have components of
15 a fully fledged model, but isn't the same as that fully
16 fledged model.

17 **Q.** But it could, for instance, be as simple as I've
18 indicated, in the guidance for a particular service,
19 saying: well, when somebody disengages, be assertive?

20 **A.** Yeah. I think we would be precautionary about that
21 because every learning from what we've had here is that
22 it's not -- I mean, the point he made in his criticism
23 of the Theemis Report, wasn't it, it's not just an
24 attitude of mind that gives you assertive --

25 **Q.** What is the definition of that? So we had one model

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1 **A.** Well, I suppose I'd order it the other way round and say
2 there are going to be some standalone Assertive Outreach
3 services like we have now, as we've discussed in the
4 Leeds example, that are going to exist for these kinds
5 of patients.

6 There is a requirement, according to the guidance
7 from NHS England, that all people who have assertive and
8 intensive mental health needs and are in the community
9 are supported either by the service I've just described
10 or by something similar. Then, thirdly, that the
11 community-based mental health centres could provide the
12 second of those.

13 I don't entirely rule them out providing the first
14 because we've got to see what --

15 **Q.** When you say provide the second, are you talking about
16 the actual --

17 **A.** The lower case. I'm providing the -- so the
18 community-based mental health centres, some of them are
19 already providing the lower case AO. I don't think it
20 is --

21 **Q.** That's the AO principles, essentially, it's not --

22 **A.** Yes, I don't think it -- no, I don't think it's in --
23 the only point I'm trying to make, I'm over-complicating
24 it -- is I don't think it is inherent necessarily in the
25 design of the community-based mental health teams that

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1 which is Fidelity Scale --

2 **A.** Yes.

3 **Q.** -- it has research backing it up, and then we have
4 Assertive Outreach principles which isn't research
5 backed and isn't it clearly defined and could be as
6 little as reminding staff in a guidance that if
7 somebody's disengaged --

8 **A.** Well, I am at the extent of my knowledge here, but
9 I don't think we would want it to be as gentle as that.
10 The point I was making is that it would need to be
11 a service, even if it isn't the same as the standalone
12 service. It can't just be an attitude of mind; it's got
13 to be services.

14 **MR CARR:** Yes, Chair, that might be an appropriate time.

15 **THE CHAIR:** Yes, right, well we'll come back at 11.50.

16 (11.30 am)

(A short break)

17 (11.50 am)

18 **THE CHAIR:** Yes, Mr Carr.

19 **MR CARR:** Thank you. Mr Vineall, if we can turn now,
20 please, to reform of the Mental Health Act and I'm going
21 to deal only with the issue of detention criteria.

22 **A.** Okay.

23 **Q.** The context to that, in your statement, it's your
24 paragraph 216, you describe the reforms as reflecting

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1 the -- the reforms more broadly as reflecting the
2 recommendations made by Sir Simon Wessely's review.

3 Then on the question of detention criteria, at
4 page 71, subparagraphs to 218, and specifically
5 subparagraph (c) on that page, you refer to the reform
6 as:

7 "Strengthening and clarifying the detention
8 criteria. The new criteria will make clear that people
9 will only be detained if they pose a risk of serious
10 harm to themselves and/or others, and if there is
11 a reasonable prospect that they will benefit from the
12 proposed treatment."

13 Just on that point, I mean, the way you have
14 described the test there is not as it appears in the
15 actual Act, is it, there's no actual reference to risk
16 or risk of harm in the new Act.

17 **A.** Yeah, I mean, it uses the word "serious harm" in
18 conjunction with "nature, degree and likelihood" as
19 a two-part consideration that you need -- every
20 clinician needs to bear in mind when they're considering
21 detention.

22 **Q.** We'll come to that, but the Act on its face doesn't say,
23 "can detain if there's a serious risk of harm", the
24 wording is different?

25 **A.** The wording is different, yeah.

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1 the word, as serious as this, then it is important that
2 it's put in the legislation. So that first of all it's
3 in the mind of a clinician whenever they're making
4 a decision to section in conjunction with the other
5 three components --

6 **Q.** That's the statutory test?

7 **A.** That's the statutory test. And, therefore, secondly,
8 that clearly, like everything else, you will reflect
9 that in due course in a revised Code of Practice. So in
10 a sense, you know, giving illustrations, embellishing
11 and making clear what that means.

12 But I think, I would say, as somebody who has done a
13 number of pieces of legislation, if you want to make an
14 important change and you want to give it a status and
15 you want to give it a permanency, that is the purpose of
16 primary legislation, rather than something like the
17 Code.

18 **Q.** -- (*overspeaking*) -- is intended to establish, this is
19 an important change?

20 **A.** Yes.

21 **Q.** It's not just a matter of clarifying what was before, it
22 is a change.

23 **A.** Yes.

24 **Q.** Now, in respect of Sir Simon Wessely's review, the
25 wording that we have ended up with in the Act is

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1 **Q.** At paragraph 272, it's page 92, you say:

2 "The planned reforms will not change the fundamental
3 powers and purpose of the Mental Health Act, which is to
4 detain and treat people when they are so unwell they
5 become a risk to themselves or others. Changes to the
6 detention criteria will not prevent clinicians from
7 acting when there is a serious risk."

8 It's clear, isn't it, that the test for detention
9 has changed? This isn't just a matter of clarifying
10 what was before, the legal test is now different?

11 **A.** Yes, that's correct because one of the things that Sir
12 Simon Wessely found in his review was that the criteria
13 were considered vague and risk of serious harm, use of
14 the phrase "serious harm" is a new development in the
15 legislation reflecting that and some other subsequent
16 discussions.

17 **Q.** If the aim was simply to clarify, not to change, as it
18 were, the threshold for detention, just to clarify what
19 that threshold was, that could have been done simply by
20 way of updating the Code of Practice, couldn't it?

21 **A.** Well, you could have made clear in the Code of Practice
22 the parameters in which you expected people to operate
23 according to the Act. But given this was, sort of, you
24 know, once-in-a-generation change to legislation,
25 I think if you're going to do something, not to overuse

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1 a departure from the test recommended in the independent
2 review, isn't it?

3 **A.** Yes.

4 **Q.** What was recommended in the independent review so far as
5 detention criteria was a "substantial likelihood of
6 significant harm", whereas what we have is "serious harm
7 may be caused" and then "detention is necessary given
8 the nature, degree and likelihood of the harm".

9 Do you know why the wording of the independent
10 review was rejected in favour of what we now have?

11 **A.** Well, I think the view through the discussions between
12 Sir Simon's review, and then obviously the act of taking
13 things through Parliament, was that we felt "risk of
14 serious harm" was the right place to put the criteria,
15 rather than using the term Sir Simon had used, and that
16 we wanted to make it clear that this was something that
17 needed to be considered on every occasion, and that
18 "risk of serious harm" was the right pitch rather than
19 needing to say "significant", which, in a sense, is
20 a notch up.

21 **Q.** Well, it's much lower, isn't it, as far as the detention
22 criteria is concerned?

23 **A.** Well, surely if you've got to prove significance, that's
24 a higher bar than a "serious risk" of harm, "risk of
25 serious harm". And --

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1 Q. Just to be clear, so the test -- the Act as is -- well,
 2 let's put it on the screen. We can use Alex Ruck
 3 Keene's document. It's WITN0288007, and then page 4,
 4 "Admission for treatment". Yes, it's the bit in red
 5 that has been added, so if we can have that in the
 6 middle of the page. Thank you. And really, it's (2)(b)
 7 and (2)(c) read together, isn't it, which are --
 8 A. Yeah, they are the two --
 9 Q. -- criteria.
 10 A. -- critical bits.
 11 Q. And now, in order for the criteria to be met it has to
 12 be "serious harm", not "significant harm", and are you
 13 saying you think "serious harm" is a lower bar than
 14 "significant harm"?
 15 A. Yeah, I would say that "serious" is not quite as strong
 16 a word as "significant".
 17 Q. And whereas previously it was "substantial likelihood",
 18 now we have "necessary, given the nature, degree and
 19 likelihood of the harm". So the "likelihood" element
 20 isn't it, as it were, qualified in the statute?
 21 A. Yeah, but we're saying to people making the decision
 22 that you need to look at the nature, degree, and
 23 likelihood together in the round, and consider them all
 24 as a piece. So you could have something that is
 25 a pretty low likelihood, but is something of a nature,

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1 So "may be caused" allows that, you know, realistic
 2 element of, you know, uncertainty or to be determined
 3 subject to the treatment, to be managed within the
 4 legislation. And therefore, the intention was to give,
 5 in a sense, a flexibility and a recognition of the
 6 nature of the decisions that clinicians have to make
 7 which, you know, we all understand in some cases can be
 8 fine.

9 Q. Then the second part of her critique is in respect of
 10 "likelihood". If we look at page 68, paragraph 214
 11 onwards where she sets out the difficulty with
 12 prediction and what "likelihood" may be interpreted to
 13 mean?

14 Now, obviously we don't have the Code of Practice,
 15 but from the answer that you gave a few moments ago,
 16 something with a low likelihood but a serious outcome,
 17 it sounds like what you're envisaging is not that it's
 18 necessary to show that it's likely that serious harm may
 19 be caused, but -- (*overspeaking*) --

20 A. Yeah, it's --

21 Q. -- (*overspeaking*) -- take that into --

22 A. Yes, it's not a percentage test with a threshold that
 23 you have to predict in order to consider that your
 24 treatment is going to be sensible or effective or at
 25 least alleviating the symptoms. It is just that you

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1 "I'm going to hit you", that's quite serious, and you
 2 could have, conversely, something that is quite
 3 a likelihood but something that by its nature is not at
 4 all significant, and --

5 Q. And this is all to be set out in the revised Code of
 6 Practice?

7 A. Yes, it's important, I mean, when Lade Smith was talking
 8 on Monday she said it's important we give illustrations
 9 in the Code, and she said "serious harm" could be the
 10 person is very ill, is seriously ill.

11 Q. We can go to her statement, because there was a critique
 12 of this wording in her statement. It's WITN0320001.
 13 Then page 67, please. So in the second half of that
 14 page, paragraphs 208 to 211, and in fact into 213 on the
 15 next page, concerns here are raised, aren't they, about
 16 the use of the term "may be caused"?

17 She explains that it's introducing a new concept
 18 into the Mental Health Act, causation, and the wording
 19 of the requirement is ambiguous.

20 A. Well, my understanding is the reason why "may be caused"
 21 was included was because we clearly understand that when
 22 clinicians are making a diagnosis, they can't be
 23 a hundred per cent certain that what they diagnose and
 24 what the cause are necessarily going to run entirely
 25 together.

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1 have to consider the likelihood as well as the nature
 2 and degree in order to come to this decision, because we
 3 completely understand that you write things in
 4 legislation and then you have to make sure they
 5 translate in practice. Clearly, that's the purpose of
 6 the Code, I mean, particularly with this legislation, we
 7 have something like the Code, because you need
 8 illustrations and understandings and that's why we want
 9 to work with all colleagues to ensure that we get a Code
 10 of Practice that is understood and gives sets of
 11 examples that allow people to be guided on things like
 12 "may be caused" and "likelihood" and what we mean by
 13 "serious harm".

14 Q. Where did the thinking that serious harm would be
 15 lowering the threshold rather than significant harm;
 16 where did that thinking come from?

17 A. I can't tell you where that thinking came from, but
 18 I know it was a conclusion in the end that that was the
 19 appropriate criteria rather than what had been
 20 recommended.

21 Obviously, when -- I mean, when -- this work really
 22 went on in a number of batches. There was the run of
 23 work from Sir Simon's review to getting to the end of
 24 the pre-legislative scrutiny, which was March 2024, just
 25 before the government change, and then when the present

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1 government or the Government came in, they had, I
2 suppose, two intentions in their mind: one was that they
3 were very keen to introduce revised legislation, but
4 number two, they also wanted to be assured that, in the
5 light of the VC events, the legislation gave the right
6 amount to your points before the break about public
7 protection.

8 So we did a number of things, including removing
9 from what we'd received back from PLS, the question
10 about how soon the harm may be caused, because we
11 thought "imminent" shouldn't be a consideration and in
12 fact early engagement with services is sensible, and we
13 continued with the care and treatment plans which are
14 obviously critical for setting out what the requirements
15 for anybody's treatment are, and that's set out in the
16 statute now.

17 Then, in addition, a component of the care and
18 treatment plan is the Safety Management Plan and we
19 agreed during the passage of the bill that that would be
20 something that was included in the regulations that
21 defined the Care and Treatment Plan. So there was
22 a legislative removal of something that we thought
23 wasn't right and there was some strengthening of in the
24 sense of the supporting infrastructure for when people
25 are enacting this.

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1 it. I think it's clear. I think it puts it on the face
2 of the Act. It wasn't there before. I've explained her
3 particular legislative concerns, but obviously we
4 entirely recognise that we need to work with her and all
5 other people to ensure that the understanding of what
6 the legislation intends is made clear in the Code.

7 **Q.** Your statement, and you've said it a few times in your
8 evidence so far today, refers to, or shorthands this as
9 a risk of serious harm; wouldn't it have just been
10 preferable for the Act simply to say "A risk of serious
11 harm"?

12 **A.** No, I think the way we've done it is appropriate,
13 recognising that people need to operate it in practice.

14 **Q.** You will -- you were provided, for the purposes of
15 giving evidence today, with a copy or an extract from
16 Professor Lade Smith's statement, it's WITN0320001 --
17 well, we're on it, page 70, paragraph 220. That's
18 where, on behalf of the Royal College, she puts forward
19 the formulation that you can see on that page where
20 really the operative paragraphs are (b) and (c), so:

21 "... significant risk of serious harm ... [and]:

22 "... necessary, given the nature or degree of the
23 harm, for the patient to receive medical treatment ..."

24 What's your view on that wording? Do you see it as
25 being an improvement of what's in the Act?

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1 Then that was done, as some of the stuff in my pack,
2 that was done over the period during July and November
3 because the ministers, our ministers, wanted to be
4 assured that we were introducing a piece of legislation
5 that was appropriate to the modernisation of the
6 framework per Sir Simon's review, and also provided the
7 sufficient protections which were at the heart of the
8 legislation.

9 Clearly these criteria operate within a set of
10 legislations, each fundamental point is still to be able
11 to require people to have treatment against their will
12 if it's in their interests or for the protection of
13 others.

14 **Q.** Do you recognise, certainly on the face of the Act as
15 it's reformed -- and I appreciate the Code of Practice
16 is yet to come -- but do you recognise the validity of
17 the concerns being raised here by Professor Lade Smith
18 that on the face of the Act, the term you used,
19 clinicians are going to be required to determine
20 a likelihood of a harm, whether it's serious, and
21 whether it may occur? It's somewhat convoluted and it
22 appears from what Professor Lade Smith is highlighting,
23 one that the Royal College is concerned about in its
24 application?

25 **A.** I don't think I'd use the word "convoluted" to describe

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1 **A.** Well, no, I think what's in the Act is the position that
2 the government came to following the quite significant
3 consultations and then the Parliamentary process.
4 I mean, on point (b) we've discussed the serious harm.
5 On point (c), if you look at the wording proposed here,
6 the choices that people are presented with are "nature
7 or degree", so there's a binary division. Whereas we're
8 offering, we're not offering, we are saying "nature,
9 degree and likelihood". So if you're a clinician under
10 this scenario, you have one choice to make between
11 nature and degree.

12 **Q.** So this would be less flexible?

13 **A.** This would be less flexible. So if you're looking at
14 our Act, you have the nature, the degree, and the
15 likelihood. You need to consider all three. How you
16 balance the three is up to the individual clinician,
17 whereas this is directing people to make a judgement on
18 the nature or the degree.

19 So I would say that our -- the legislation gives
20 a flexibility and encourages clinicians to think around
21 the issue that is perhaps broader -- (*overspeaking*) --

22 **Q.** On the wording of 3(c) -- and it may be that is a matter
23 for the Code of Practice -- but on the wording of 3(c)
24 it would appear to involve all three, this is nature,
25 degree, and likelihood of harm, so all three of those

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1 -- (overspeaking) --

2 **A.** In the legislation, yeah, all three. Exactly. I mean,
3 I entirely take your point that it would be very
4 important in the Code that we need to one, unpack what
5 the words mean and, secondly, give them illustrations in
6 order that people can consistently apply what the
7 legislation is trying to achieve.

8 **Q.** Is that usual? We have here a change that's been
9 introduced. So the Act has been reformed, with these
10 concepts, it appears, not finding favour with the Royal
11 College representing those who are most expert in this
12 area and those who are going to be responsible for
13 implementing the test. It's a departure from what was
14 recommended in the independent review, and their
15 understanding, interpretation and application is
16 contingent on a Code of Practice which has not yet been
17 determined?

18 **A.** Well, to take the Code first, clearly you can't write
19 the new Code until you've passed the legislation, which
20 has only just happened. And obviously the Code of
21 Practice and the importance of understanding and
22 interpreting and having a shared sense of what
23 legislation means is particularly important in mental
24 health legislation. Because it's complicated, the
25 decisions are often quite fine.

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1 **Q.** What are the options if -- the Code of Practice is going
2 to have to operate within the terms of the legislation,
3 obviously -- what are the options left if the wording
4 proves to be unworkable in a manner that can't be
5 remedied by the Code of Practice?

6 **A.** Well, I don't think that's likely to happen and
7 obviously the CQC monitors the operation of the Mental
8 Health Act, including the Code of Practice. So clearly,
9 we would know reasonably quickly the challenges that
10 might be inherent in any new legislation.

11 But realistically, I think that the process of
12 engaging on the Code of Practice ought to enable us to
13 come to a consensus of the understanding of the
14 legislation, but, as I said at the start, government's
15 role is to take legislation through. This was far from
16 a rush job; it took over eight years over a number of
17 successive governments, and this is the position we're
18 at now.

19 So I think the first step that everybody can make is
20 to engage in the revision of the Code of Practice.

21 **Q.** Is the Department committed to awaiting the report of
22 this Inquiry before finalising the new Code of Practice?

23 **A.** Yes, we are, because although we started work on the
24 Code of Practice now, it's going to take some time.

25 This Inquiry is due to report next year. The Code of

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1 So the Code of Practice, if you look at the current
2 version, is over 400 pages long, so it's quite
3 an undertaking. We don't, for other legislation that we
4 have, have something equivalent, but we do here, and
5 that, I think, actually reflects the importance of the
6 issues and the importance that this government and any
7 other government has on ensuring that the practice of
8 the legislation is consistent but enables the
9 flexibility which clinicians clearly need in order to
10 carry out their duties.

11 I think, on the other point -- I mean obviously
12 everybody has a very valid view, but the fact is, we
13 spent the best part of eight years, successive
14 governments, going from Sir Simon's review to the
15 completion of the Act. There was a pre-legislative
16 scrutiny; there was a White Paper; there was
17 a pre-legislative scrutiny; there was the response to
18 pre-legislative scrutiny; there was the government's
19 response to pre-legislative scrutiny; and then there was
20 a Bill that went through the full stages of the
21 democratic process.

22 Now that is the process we operate as government,
23 that is quite thorough, and this was the set of
24 conclusions we came to and, at the end of the day, the
25 government is elected to make decisions.

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1 Practice is not due for what we call the Phase 1 changes
2 which are the things about the interpretation and usage
3 of the Act, rather than anything that impacts on the
4 workforce, to publish the Code of Practice until some
5 time in '28, '29.

6 So there is very much, you know, and we would
7 entirely welcome the findings of the Inquiry, as
8 a stakeholder and a Core Participant, to be able to help
9 us shape what we do in the Code of Practice. By this
10 time next year we will have made significant steps
11 further forward than we have now, but it won't be
12 a completed process. And obviously, as I said in my
13 remarks at the start, we are committed to listening
14 extremely carefully to the findings of the Inquiry.

15 **Q.** You set out in your statement the work that's been done
16 by the Department in light of the recommendations in the
17 reports of the CQC. So Section 48 report.

18 **A.** Yes.

19 **Q.** And also the Theemis Report. The statement is dated
20 November 2025. Can you update the Inquiry on any
21 additional work or developments on that front?

22 **A.** Yeah, we had a report from CQC in December 2025 that
23 reported that of the 39 recommendations, half were
24 complete and half were on track.

25 There were a couple of things that were outstanding,

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1 including joint working protocol with GPs, timely access
2 to care to treatment. There was a third one that was
3 about publishing Assertive Outreach progress which came
4 about by NHS England publishing the results of the
5 original review in January 2026.

6 There is one for the Department, or which the
7 Department was a component player in, which is waiting
8 times for community mental health services. That has
9 not yet been yet delivered because we want to do that
10 through the cross-government strategy on mental health,
11 and I suppose the other thing to say on the CQC Review
12 is that we've just commissioned a further update,
13 six months since December, and secondly, that CQC both
14 remain "Requires improvement" under the CQC system,
15 so --

16 **Q.** The Trust remains --

17 **A.** Sorry, the Trust, yes, thank you. And in addition, the
18 Trust was in the Recovery and Support Programme of NHS
19 England. That's now called the Provider Improvement
20 National Oversight Framework which puts you into
21 a provider improvement programme. And CQC remains in
22 that and is getting -- and the Trust remains in that and
23 is getting the maximum levels of support.

24 So I think it's very important that we continue that
25 monitoring carefully and in a sense, as you get further

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1 **Q.** As you've accepted, there wasn't any substantive
2 national policy or strategy guidance on Assertive
3 Outreach between 1999, 2001, and then 2024. There was
4 a gap there in dealing with that.

5 Now, the Ritchie report had made quite specific
6 recommendations for the operation of Assertive Outreach,
7 hadn't it --

8 **A.** *(The witness nodded)*

9 **Q.** -- for an identified class of patient, including
10 ring-fencing of roles and time, and limitations on
11 volume of work to allow for intensive oversight.

12 **A.** *(The witness nodded)*

13 **Q.** It was really quite thorough going in understanding
14 Assertive Outreach. You've accepted as well that there
15 was reduction in the use of Assertive Outreach in that
16 period between roughly 2001 to 2024, and you've said
17 that there was a variety of reasons for that. Yeah.

18 **A.** Yes.

19 **Q.** But that was never a strategy, you've said, but you
20 can't really say why it happened? Is that fair to say
21 that? All you know is that objectively it happened?

22 **A.** Yes.

23 **Q.** This is where I turn to monitoring. Was there or should
24 there have been a responsibility on the Department to
25 monitor how the learning and recommendations of the

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1 away from any of these reviews, completed not completed,
2 over the passage of time that starts to move on. We
3 need to ensure that the Trust's improvement continuum
4 continue over a sustained period of time, and obviously
5 NHS England is in a sense running that rune over the
6 Trust on our behalf, and clearly when the NHS England
7 functions come back into the Department in a year's
8 time, we would expect still to have a function of that
9 kind, very much so, and therefore we would want -- and
10 I just wanted to assure everybody that we would want
11 a continuity of oversight of the Trust and it's
12 improvement, regardless of any changes that are made to
13 the departmental structures.

14 **MR CARR:** Thank you, Chair. Those are my questions.

15 **THE CHAIR:** Yes, Mr Moloney.

16 **Questioned by MR MOLONEY**

17 **MR MOLONEY:** Mr Vineall, I ask questions on behalf of the
18 bereaved families.

19 You've been asked a great deal about Assertive
20 Outreach and you've just spoken about monitoring. I'd
21 like to ask you about a combination of the two, please,
22 and that's that we know that Assertive Outreach was
23 introduced building on the conclusions of the Ritchie
24 Report.

25 **A.** Yes.

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1 Ritchie Inquiry were being honoured? So that -- and
2 this is not meant to be critical of you personally,
3 Mr Vineall, please, but if you're asked, as the
4 corporate witness for DHSC, how did it happen, you'd be
5 able to give an answer by looking at how -- whether or
6 not it had been monitored and what had been found by
7 monitoring?

8 **A.** It's a good question. As I said before, it's the case
9 that you've described that for one reason or another
10 there was a diminution.

11 **Q.** Yes.

12 **A.** I think certainly -- and this isn't it to make a wider
13 point -- in the period sort of up to 2009 where we were
14 moving out of the original NSF and into other
15 approaches, monitoring arrangements were fairly strict.
16 We had a situation then which was the government policy,
17 which was to separate out the functions of the
18 Department and NHS England and, in a sense, for there to
19 be the responsibility for the day-to-day running and
20 some of the day-to-day decisions to move further away
21 from the Department.

22 **Q.** Yeah.

23 **A.** As I explained earlier, that position that has now -- or
24 is in the process of being reversed, and I think
25 a learning point I would take from the example you've

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1 just given is that it is important that when we have
2 policies that are evidence based or policies that arise
3 out of inquiries, we are able to have a consistent
4 follow through.

5 Now, I think I've explained the answer in terms of
6 the Department. I mean, obviously on the Inquiry side,
7 which I work quite closely on, there is work in the
8 light of the Penny Dash reviews to look at how we are --
9 how we not just stay close to the immediate response to
10 an Inquiry's recommendations, a bit like what I was just
11 saying on the CQC, but how you are then able to follow
12 through on the impact, you know, over a period of time,
13 particularly where you have an evidence base to refer
14 to.

15 **Q.** Yeah, thank you.

16 Then may I ask you just this: we've spoken about --
17 some witnesses have spoken about, as it were, shifting
18 emphasis in services over time. Is it possible that the
19 reduced use of what I'd call "Ritchie Inquiry Assertive
20 Outreach" was -- arose from a relative decline in
21 emphasis on protection of the public in the operation of
22 services?

23 **A.** Well, I wouldn't say that because I don't think we, as
24 a Department, ever said that and, as I was saying
25 earlier, we carried on with legislation, which over the

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1 stream of funding made available at the spending review
2 to support the growth in Assertive Outreach services.
3 There has been a push and a sort of pressure and
4 a cajoling for local systems to prioritise Assertive
5 Outreach, and since the guidance has come out, local
6 areas have started to do that in places, but there's
7 more to do.

8 **Q.** Can I take that, then, into what is certainly
9 a potential for the future, which is the use of
10 neighbourhood hubs --

11 **A.** Yes.

12 **Q.** -- and just ask about funding in terms of those
13 neighbourhood hubs and the implications for funding in
14 Assertive Outreach.

15 So firstly, and it may be too early to ask you this
16 question, Mr Vineall, but does the Department, if
17 there's a move to neighbourhood hubs envisage funding
18 for those being provided by local Trusts?

19 **A.** Well, the answer to that is twofold. The first part is
20 that if neighbourhood hubs prove successful post-the
21 evaluation, it would be for ICBs, with local Trusts, to
22 determine how they work locally. So for the one I
23 visited, they said: we've got it in two places, if it
24 works we're going to have to work out how we might
25 spread that out more broadly.

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1 period of time that you've described it, in many ways
2 strengthened protection. I mean, the CTO system was
3 introduced, was the legislative flipside of the Ritchie
4 Report and was introduced during that period.

5 So I think from the point of view of the Department,
6 and the fact of the legislation that's on the statute
7 book, there was a consistent position. I do think there
8 is a thing that we will need to look at, which is how do
9 you ensure that in the operation of services in the
10 light of legislation or in light of the changing
11 patterns that you ensure there is a consistency where
12 that is needed?

13 **Q.** So, essentially, if that did happen, then of course that
14 wasn't a departmental policy that could have happened,
15 but it was not due to any departmental --

16 **A.** Yes, we didn't have a policy that said we will diminish
17 public protection in relation to mental health
18 legislation.

19 **Q.** Of course. Yes, now the 2024 guidance and the 10-Year
20 Plan commits again to the Assertive Outreach Model,
21 doesn't it?

22 **A.** Yes.

23 **Q.** Is any specific funding being provided by the Department
24 for that purpose?

25 **A.** No, is the short answer. So there wasn't any specific

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1 **Q.** Yes.

2 **A.** So that's the first answer.

3 The second answer is there is a share of the
4 473 million capital funding that is available across
5 ICBs to take forward three things: out-of-area
6 placements, the emergency mental health centres and the
7 neighbourhood hubs.

8 So there will be choices for people to make, subject
9 to the findings of the research.

10 **Q.** Now, if neighbourhood hubs are adopted, would the
11 Department envisage separate fundings for Assertive
12 Outreach teams to operate concurrently?

13 **A.** We don't have any funding stream for that at the present
14 time.

15 **Q.** Now just finally just a few questions about
16 neighbourhood hubs. You've accepted candidly, as
17 Professor Kendall did, that such centres will not be
18 right for all patients.

19 **A.** Correct.

20 **Q.** That care-avoidant patients, the very type of patients
21 that Assertive Outreach was designed to cater for, VC,
22 in reality, may well just move in order to avoid the
23 reach of the neighbourhood centre.

24 **A.** I am not sure about that so much because I think,
25 certainly for the one I visited, they had a large

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1 emphasis on first of all trying to reach out to the
2 people who had been out of contact with services, and
3 secondly, equivalent, although not in the same context
4 as a capital A, capital O Assertive Outreach service,
5 being able to follow people up, having no particular,
6 you know, no right door of entry.

7 So I would say certainly one of the things that they
8 were trying to address was those people who are hard to
9 engage. So I think the non-engaging cohort of patients
10 is not outwith the community hubs.

11 **Q.** But you'd accept the practical difficulties in terms of,
12 as it were, funding for somebody who moves from, say,
13 Nottingham to Birmingham or Nottingham to Coventry?

14 **A.** Well, I suppose the hopeful funding answer would be that
15 they'd move from one place to another and they'd both
16 have the right facilities for Assertive Outreach, be
17 that the standalone or be that some other form of
18 service.

19 **Q.** I was thinking more of the practicality of a medical
20 professional from one Trust travelling half the way
21 across the country to another Trust to try to find
22 somebody.

23 **A.** Well, one would hope that if the people did move, that
24 the services in the next area were live enough to their
25 needs that they would pick it up.

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1 **A.** Yeah, I couldn't agree more with that. I mean, as
2 I said earlier, you've got to make sure that you're
3 catering for all the different patients you might find
4 in an area. There might be a greater concentration of
5 VC-like patients in some areas than others. The thrust
6 of the guidance in 2024 was to meet the needs across the
7 board, not just the AO VC type patients, but all
8 patients.

9 **Q.** Yes, because -- and underlying that is a recognition,
10 there must be, mustn't there -- when it goes wrong in
11 somebody in respect of like VC, it can go very badly
12 wrong.

13 **A.** Yes, and that's why we have all the protections that
14 there are in the legislation and Assertive Outreach
15 services as well. I mean, you need both. You don't
16 just need the legislation to say we have these powers
17 over certain individuals; you need the services that are
18 available as well.

19 **Q.** Yes, and statistics tell us that a large percentage of
20 people with serious mental illness who kill are not
21 engaging with services, are they?

22 **A.** Well, I think that is a difficulty, which is why things
23 like the Assertive Outreach service is so important.

24 **MR MOLONEY:** Thank you.

25 **THE CHAIR:** Yes, Ms Cartwright.

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1 **Q.** And I'll leave that, but patient-led care might be good
2 for some patients as well but there are patients who
3 perhaps should not be trusted with leading their care,
4 aren't there?

5 **A.** Well, there are some patients who, by the nature of
6 mental health legislation, have to be given compulsory
7 treatment because that's the nature of their illness,
8 and obviously the legislation is built on that as the
9 fundamental provision of care.

10 **Q.** Yeah. But in essence, just to, as it were, just press
11 that slightly, please, Mr Vineall, there are patients
12 who don't tell the truth about taking medication, they
13 pretend to take medication, they suspect medical
14 professionals and they don't cooperate, and they deceive
15 medical professionals, don't they? And they're not
16 great candidates for leading their care, are they?

17 **A.** There are patients who are hard to engage and there are
18 patients who need compulsory treatment, and there are
19 patients who need a very high level of monitoring,
20 I agree, and that is why we have a Mental Health Act.

21 **Q.** Yeah. It's not just as simple as that, is it? Because
22 there are times when people fall through the cracks and
23 is it very important in any future decisions about use
24 of neighbourhood hubs that the cohort of patients like
25 VC are not forgotten?

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1 Questioned by MS CARTWRIGHT

2 **MS CARTWRIGHT:** Good afternoon, Mr Vineall, I ask questions
3 on behalf of the survivors.

4 **A.** Yes.

5 **Q.** Could I just return to the amendments to the Mental
6 Health Act and the thresholds for detention.

7 **A.** Yes.

8 **Q.** Obviously, the Act has now been enacted.

9 **A.** Yes.

10 **Q.** But can you give any guidance as to when the changes in
11 Section 5 of the Mental Health Act 2025, which
12 essentially implements the changes to Section 2 and
13 Section 3, are likely to come into force?

14 **A.** Yeah, I mean, the Act has been passed, but of course it
15 hasn't been enacted because we haven't turned on any of
16 the provisions yet.

17 **Q.** Well, you have, you turned on the provisions in
18 February.

19 **A.** Well, the one on supervised discharge, that one
20 excepted.

21 As I said earlier, the plan for the Code of Practice
22 and therefore the first part of the reforms to be
23 switched on is in 2028/2029, current plan.

24 **Q.** That's just what I want to be clear about, so --

25 **A.** That would include something like detention criteria.

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1 Q. Right, so there are the amendments to Section 2 and
 2 Section 3, they are not going to come into force until
 3 the Code of Practice has been finalised --
 4 A. That's right.
 5 Q. -- is that your evidence?
 6 A. That's right.
 7 Q. So that those changes to Section 2, Section 3, shouldn't
 8 come until 2028/2029?
 9 A. That's correct.
 10 Q. Right. Can I ask you just to revisit what you've said
 11 about it's going to be really important that these
 12 provisions are capable of working in practice; would you
 13 agree?
 14 A. Yes.
 15 Q. Obviously the new concepts that have been added,
 16 obviously the previous statutory criteria for detention
 17 under Section 2 or Section 3, a well-trodden path, but
 18 there are these new concepts now that have to be met in
 19 Section 2 and Section 3. Obviously, one of them
 20 significantly being serious harm "may be caused" to the
 21 patient or significantly, from a public safety
 22 perspective, to another person. And would you therefore
 23 agree that the issues that this Inquiry has been
 24 examining around information sharing between the police
 25 and hospitals and clinicians needs to be absolutely

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1 merge NHS England in with the Department is work on the
 2 single patient record and the policy justification or,
 3 if you like, the rationale for the single patient record
 4 is that you can have effective sharing of information in
 5 the interests of the safety of patients.

6 Something the Theemis Report said also and that
 7 we've heard here is that there are a lot of instances
 8 where people didn't have the full picture, so I do agree
 9 that that's going to be very important.

10 Q. I'll come back to the Theemis Report in a moment but can
 11 I just then finish -- again, it's the same point, you've
 12 explored with Mr Carr, the additional, as well as
 13 serious harm, there is now enacted, not "nature or
 14 degree", which I think was the answer you gave to
 15 Mr Carr, that it's going to be for the clinician to
 16 balance all three to make a judgement on nature or
 17 degree --

18 A. Nature, degree, and likelihood, yes.

19 Q. It is. Obviously nature or degree is the relevant factor
 20 for the mental disorder, but for the harm it's given the
 21 nature, degree and likelihood. So all three are going
 22 to have to be present and considered by the clinician.
 23 And again on questions of likelihood of harm, would you
 24 also agree the same point we've examined for serious
 25 harm means all of the information sharing about risk

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1 ironed out to ensure that all relevant risk information
 2 about a patient that's held by the police or any other
 3 agency is essentially you get over the data issues to
 4 ensure clinicians have access to the relevant evidence
 5 as to serious harm?

6 A. Yes, I would agree with that. I think that's something
 7 that we need to tackle in the Code in part in terms of
 8 how we implement the new sections that you've just
 9 described to me. But at the same time, I said to
 10 previous counsel that we needed to give consideration
 11 about whether there should be further clarification
 12 about information sharing in some of these areas to
 13 enable the correct sharing of information.

14 Q. Because, as you say, it's going to be absolutely key
 15 that when important decisions about patient safety and
 16 detention are being considered, and obviously these
 17 criteria also apply to when someone doesn't meet the
 18 threshold any more and would have to be discharged --

19 A. Yes.

20 Q. -- that there has to be complete certainty that all
 21 relevant information as to serious harm sits in that
 22 patient's medical records for the clinicians considering
 23 detention to have available to them?

24 A. Yes, I would agree with that, and obviously one of the
 25 only other two policy areas that's in the new Bill to

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1 that's held by the police or any other agency needs to
 2 have structures in place that means it is in the patient
 3 record --

4 A. Yes, I would agree with that.

5 Q. -- so that those clinicians consider it. Thank you.

6 Now you've obviously been asked questions about the
 7 Theemis Report and the recommendations that are being
 8 implemented, and can I just check that when those --
 9 that Theemis Report is being reviewed it's been done
 10 through the lens, particularly again on the risk factors
 11 that we've explored, that that investigation had
 12 a significant deficit of information, because whilst the
 13 investigation tried, on a number of occasions, to engage
 14 the Nottinghamshire Police, Nottinghamshire Police were
 15 unable to engage with the review as they remained under
 16 investigation by the IOPC in relation to the matters
 17 directly associated with the Terms of Reference of the
 18 Review.

19 And so is the Department keeping in mind, when they
 20 review the recommendations of the Theemis Review that
 21 essentially one of the major parties who had information
 22 as to risk of VC, did not engage with the Theemis
 23 review?

24 A. Yeah, I think it's important that we continue to look
 25 carefully at the Theemis review, particularly, as you

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1 said, the question of consistent delivery of care and
2 the handling of risk, because that, in a sense, is the
3 gist of what it was focusing on. And one of the things
4 we hope to publish very soon, or NHS England intends to
5 publish soon, is the Personalised Care Framework which,
6 in essence, tries to put down the basics of how you
7 should deal with cases like VC, having a named
8 consultant, making sure there's continuity of care,
9 making sure the services are linked-up.

10 Now there wasn't a precise Theemis recommendation
11 that said, "Please produce something like this," but
12 that is meant to address the spirit of the Theemis
13 review and that is why it's important that we continue
14 to get regular updates about its implementation.

15 **Q.** Thank you. Can we then, briefly, please, look at your
16 paragraph 75 in your witness statement, please.

17 WITN0155001. Thank you. It is page 23, paragraph 75.

18 You've helpfully dealt with the Section 117
19 aftercare and you make clear in your statement that:

20 "Section 117 Mental Health Act places a duty on ICBs
21 and local authorities to provide after-care to patients
22 who have been detained in hospital for treatment under
23 [relevant for this case] ss. 3 ... who then cease to be
24 detained and leave hospital."

25 You set out that:

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1 that ICBs will be strategic Commissioners, has there
2 been any look at more flexibilities that will be given
3 to ICBs to ensure appropriate aftercare for patients who
4 have been detained under Section 3 for treatment comes
5 into place?

6 **A.** We haven't looked at that, but there's no reason why we
7 shouldn't, because what you're saying is 117 aftercare
8 is a complete package of care that the person needs
9 regardless of their health or social care status and,
10 therefore, with the changes to ICBs to ensure that that
11 is still consistently applied.

12 There is nothing, to my knowledge, in the changes
13 that have just been made to the ICBs that will impact on
14 the operation of Section 117 aftercare, but it's a sort
15 of thing when you're taking -- when you've taken a big
16 piece of legislation through and you're taking another
17 one through that you should double check on. So I'm
18 happy to do that.

19 **Q.** Could you see that this could be in a further way where
20 patient safety and Section 117 to ensure essentially
21 that the right treatment --

22 **A.** You mean that it would be embellishing it?

23 **Q.** Pardon?

24 **A.** You mean that it was would be embellishing it; is that
25 your point?

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1 "The duty is joint between local social services
2 authority and an ICB and the funding arrangements are
3 frequently pooled, as is the provision of the relevant
4 service."

5 But you go on to detail the significance, I think,
6 from a patient safety perspective but also for the
7 public, that:

8 "The purpose of s. 117 is to provide people with the
9 right support they need to live successfully and safely
10 in the community following discharge from hospital.
11 After-care services aim to meet a need arising from or
12 related to the person's mental disorder and reduce the
13 risk of a deterioration of the patient's mental
14 condition (and, accordingly, reducing the risk of the
15 patient requiring admission to hospital again for
16 treatment)."

17 Then you go on to say that:

18 "The obligation under s. 117 applies to the
19 individual eligible for after-care. All services which
20 fall within the definition of after-care services must
21 be provided free of charge ..."

22 Save then for the caveat you've referenced under the
23 Care Act 2014.

24 So can I ask you then under the reforms that are
25 coming in with the Health Bill and I think the intention

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1 **Q.** Well, essentially patient safety and preventing relapse
2 of those who have been on a Section 3 is another area
3 where ensuring, for some of the evidence that this
4 Inquiry has heard, that appropriate funding and packages
5 of care are in place for those who have been detained
6 under Section 3?

7 **A.** Yes, I see what you mean. There is sufficient funding
8 to make a reality of Section 117 aftercare, yes.

9 **Q.** Again, briefly on that theme, please, paragraph 96 of
10 your statement on page 29. Paragraph 96, please. Thank
11 you.

12 You talk about how that:

13 "Each financial year, NHS [England should have been
14 conducting] performance assessments of how well each ICB
15 discharged its functions and publish a summary of each
16 assessment."

17 Do you know whether there was a particular focus on
18 how ICBs were discharging their Section 117 function?

19 **A.** I don't know if there's that particular focus.

20 **Q.** No, but in terms of the new --

21 **A.** But there could be.

22 **Q.** -- relationship where the ICBs will be accountable to
23 the Department of Health and Social Care, is this
24 something that could be worked into the framework of an
25 assessment or a review that the Department

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1 -- (*overspeaking*) --

2 **A.** Yes, it could be --

3 **Q.** Thank you.

4 **A.** -- and we can take that -- it will be that much easier

5 to do because in a sense it will come straight to the

6 Department. So if that's a concern then the answer

7 is: yes, we can.

8 **Q.** Finally, in the knowledge of what you said about the

9 Code not coming into place until 2028/2029, obviously

10 the provisions that have come into force so far in the

11 Mental Health Act in February, of conditional discharges

12 with deprivation of liberty, and in light of the

13 significant -- essentially the change in the law in DoLS

14 that took place this week with the Attorney General's

15 Northern Ireland reference, is the Department going to

16 be issuing clear guidance to those having to consider

17 the provision that is in place around conditional

18 discharges with the -- (*overspeaking*) --

19 **A.** We don't have any current plans to, and I'm not sure if

20 the Ministry of Justice did so but if it's felt

21 necessary, we can do that.

22 **MS CARTWRIGHT:** Thank you very much for answering my

23 questions.

24 **THE CHAIR:** Ms Heaven.

25 **Questioned by MS HEAVEN**

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1 I understand it, this is relating only to PFDs that had

2 come directly to the Department of Health and Social

3 Care; is that correct?

4 **A.** That's correct.

5 **Q.** So this would seem to suggest that the DHSC did not even

6 have sufficient resources to keep on top of, and learn

7 from, its own PFDs? So additional resource had to be

8 put in place.

9 **A.** I think the position was there had been -- over time,

10 the number of PFDs had grown, so the Department changed

11 its arrangements in order that we could respond properly

12 to that growing volume.

13 **Q.** Because you needed to improve DHSC learning for your own

14 PFDs?

15 **A.** Yes, and our learning and our processes in order to be

16 able to take forward the learning.

17 **Q.** But of course, there are lots of PFDs -- they don't all

18 go to the Department of Health and Social Care -- that

19 relate to health.

20 **A.** Yes.

21 **Q.** Just thinking about national oversight, it's right,

22 isn't it, that there's no national oversight by the

23 Department of Health and Social Care of health-related

24 PFDs issued across England by Coroners?

25 **A.** Yes.

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1 **MS HEAVEN:** Good afternoon. Some questions on behalf of

2 VC's family, please.

3 **A.** Yes.

4 **Q.** It relates to Coronial Prevent Future Deaths reports,

5 national oversight --

6 **A.** Yes.

7 **Q.** -- and accountability.

8 So can we pick this up firstly in your witness

9 statement paragraph 210, so internal page 68, bottom

10 right, please.

11 Just to situate you, the headings above, we don't

12 need to go to them but they do relate to PFDs, you've

13 got a heading there.

14 **A.** Yeah.

15 **Q.** You explain here:

16 "The Department continued to meet its statutory

17 obligations in responding to PFDs, but it recognised

18 that the increasing volume of reports made it

19 challenging to maintain timely and consistent

20 management, and that more could be done to learn from

21 ... reports and implement the actions it had committed

22 to in the responses. There was a need to strengthen

23 case management, coordination, and accountability."

24 And you explain that a dedicated PFD Oversight Team

25 had been established to manage this. So as

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1 **Q.** CQC can consider PFDs and compliance but that's in the

2 context of an inspection whenever that may happen;

3 correct?

4 **A.** That's right.

5 **Q.** Now the reason this is relevant in this Public Inquiry

6 is because we've seen how the Nottinghamshire Trust was

7 receiving PFDs. They were not being scrutinised by the

8 ICB, and the responses were not being scrutinised,

9 certainly from January 2021 to July 2023. So no

10 oversight, no accountability, and there doesn't even

11 seem to have been an awareness that this was happening

12 at the level of NHS England.

13 Before I ask you the question, another bit of

14 context. This was important because the Coroner was

15 raising, for a number of years, the very same systemic

16 concerns that have featured so heavily in this Inquiry.

17 So that's things like poor risk assessment, inadequate

18 discharge planning, poor engagement with families and

19 carers.

20 So is the Chair to understand that between 2021 and

21 2023, and possibly longer, the Department of Health and

22 Social Care also had no idea that there was poor

23 oversight by the ICB and NHS England of these PFDs that

24 were going to Nottingham?

25 **A.** I don't know for sure but we probably weren't as aware

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1 as we should have been.

2 **Q.** Well, are you aware of any evidence that you were aware,
3 bearing in mind that your Department doesn't even
4 oversee PFDs?

5 **A.** I'm not aware to the level of an individual ICB, no.

6 **Q.** And just thinking about how this gap is to be closed,
7 it's right, isn't it, that the new Health Bill 2026 also
8 doesn't provide for the Department of Health and Social
9 Care or indeed any other body to have greater national
10 oversight in relation to PFDs?

11 **A.** There isn't a clause in relation to that, no.

12 **Q.** And isn't it right that this inhibits the government's
13 ability to learn from serious, often systemic concerns,
14 that are being raised by Coroners into health-related
15 deaths nationally?

16 **A.** Well, I think we can better learn from what PFD
17 Coroners' reports come to by some of the processes that
18 we've put in place here.

19 **Q.** Well, what processes?

20 **A.** The processes of having the dedicated PFD oversight team
21 and being the main point of contact with Coroners. So
22 the point of that was to have a better look in the round
23 about what we were learning from PFD reports.

24 **Q.** Well, my understanding from paragraph 210 is your
25 oversight team is only dealing with the PFDs that come

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1 **Q.** Sorry, I'm focusing on your Department.

2 **A.** Okay, okay.

3 **Q.** It does seem, doesn't there, that there is a gap in your
4 Department, certainly, and its ability to learn to
5 inform government policy, to bring together all of the
6 findings that are coming from these different
7 investigations?

8 **A.** Well, I wouldn't say that entirely because, as I've
9 said, we're able to look at the PFD reports across the
10 Department, and when we have other Inquiries and
11 investigations we certainly have internal mechanisms
12 that bring together, you know, the variety of evidence
13 that they've brought forward and then we respond.

14 **Q.** Just another thing that's been heard in the Inquiry is
15 concerns from coroners that don't trigger a PFD. We
16 know in this Inquiry that those concerns were not moving
17 above the Board up to the ICB, probably because there
18 was no positive duty on the Trust to raise those
19 concerns with the ICB; it was left to their discretion.

20 Would it be a good idea to place a positive duty for
21 all coronial concerns, particularly if they're systemic
22 in nature, to be notified to the new ICB and indeed be
23 published in their annual report, including any
24 response, to improve transparency?

25 **A.** Well, I can't answer that off the top of my head. That

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1 direct to the Department of Health and Social Care?

2 **A.** Yeah, that's right, that's right.

3 **Q.** So it's not going to be a forum in which you're going to
4 learn about all health-related PFDs across England, is
5 it?

6 **A.** There isn't a mechanism for that. There isn't
7 a mechanism from other departments to look at their
8 issues across the piece either.

9 **Q.** So if the government is not tracking serious concerns
10 being raised by Coroners in the context of PFDs, does it
11 also follow that it's not able to combine those concerns
12 with the findings of Public Inquiries, the findings of
13 other independent investigations, to consider globally
14 whether similar systemic problems are occurring?

15 **A.** Well, we are tracking them in relation to our
16 department, and other departments are tracking them in
17 relation to their departments. I think, when Inquiries
18 report, that tends to pick up some of these issues and
19 whoever the responding department is will then look
20 carefully at the PFD reports.

21 If you're saying across Whitehall is there a system
22 for looking across the piece at PFDs, there isn't,
23 because the Coroners and Justice Act is set up to
24 send--- (*overspeaking*)--- those reports to the specific
25 responsible department.

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1 would be quite an undertaking. I think we could look
2 very carefully at how ICBs, within their present set of
3 powers, make sure that they address PFD reports and
4 raise them where necessary.

5 **MS HEAVEN:** Okay, thank you. Those are my questions.

6 **THE CHAIR:** Yes, Ms Patry.

7 **Questioned by MS PATRY**

8 **MS PATRY:** Mr Vineall, I appear on behalf of the University
9 of Nottingham.

10 **A.** Yes.

11 **Q.** I'm going to ask you about one topic, please. You've
12 been asked a little bit about it: information sharing,
13 or what the Chair has eloquently described as the
14 information gap.

15 **A.** Yes.

16 **Q.** Before I ask you my question, I will -- I want to set
17 out a little bit of context because I'm not aware of how
18 familiar you are with the factual evidence that's been
19 given to the Inquiry. So I promise I'll get to the
20 question, I'm just going to set a little bit of context
21 for you.

22 **A.** Okay, that's fine.

23 **Q.** I'm sure you're aware that VC was a student at the
24 University of Nottingham, and during that period the
25 University's position is that there was very poor

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1 information sharing in relation to risk, from mental
2 health services to the University. If I can just give
3 you some examples. On his first admission, for example,
4 the Brook Court incidents, including the very serious
5 incident involving the student who jumped out the
6 window --

7 **A.** -- Feven.

8 **Q.** -- We weren't told about that by mental health services
9 at all, "we found out about his admission to hospital
10 because his mother contacted us".

11 In relation to his third admission, in
12 September 2021, the assault on PC Pritchard, "we were
13 told nothing at all by mental health services and it
14 wasn't until a student had been assaulted that we were
15 made aware of that".

16 Now, we've had a range of responses from NHS staff
17 as to why information wasn't shared, ranging from "We
18 didn't know that we had to share the information" right
19 through to "We're sorry", Dr Lloyd, for example, "I'm
20 sorry, that information should have been shared". She,
21 of course, is in the context of the EIP team not having
22 shared that he was disengaging.

23 Now, were you aware of that factual background?

24 **A.** Yes, because I've been following the Inquiry, and --
25 I mean, not every detail that you've mentioned, but

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1 if necessary?

2 **A.** Well, I'm happy to take that away certainly in relation
3 to the point you make about guidance. I think the point
4 about legislation is more complicated.

5 I think, to give you a more general answer, it is
6 important that people understand that the importance of
7 sharing information for all its obvious purposes, is as
8 important as the duties to patient confidentiality and
9 that was exactly why we amended the Caldicott Principles
10 to include that. I mean, that was about 10 years ago,
11 because people -- I mean, to summarise what you've
12 said -- people were reticent about sharing information
13 when actually the requirement was to share information.

14 So I do agree that between us, we've got more work
15 to do on that. I think there is an issue that if you
16 read the various guidances, it does make rather clear
17 that you should be able to share the information, if
18 there's a particular serious risk, if there's an
19 override on the patient confidentiality, but for one
20 reason or another, that isn't as clearly understood as
21 it should be.

22 **Q.** Particularly in respect of universities, right? Because
23 you might think more clearly about the police or about
24 sharing with the family, or something like that?

25 **A.** I think there will be an important learning from this

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1 obviously there were lots of instances where people have
2 been here and said, "I would or I might have made
3 a different decision had I had the full set of
4 information".

5 **Q.** So I understand that your position is there is a range
6 of departmental guidance and professional bodies have
7 also produced guidance. But there seems to be, given
8 the evidence we've heard, a real information gap about
9 when risk information can be shared. So the question I
10 have for you is -- actually, one more bit of context.

11 We've starting working towards having
12 an information-sharing agreement with our local Trust
13 but of course that would have one major disadvantage, it
14 would only allow us to share information with one Trust?

15 **A.** Yes.

16 **Q.** And nationally, when students move around, for example,
17 we wouldn't be able to information share in any other
18 way.

19 So can I ask you this: would the Department
20 undertake to work with the University, and the higher
21 education sector more widely, of course, to provide
22 a legal framework, and particularly guidance, I think in
23 this context, for the national sharing of relevant risk
24 information between Universities and relevant primary or
25 secondary care providers with the assistance of the ICO,

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1 that universities are a core partner to the NHS
2 particularly in the places where they, you know, they
3 have a big presence like in a place like Nottingham, and
4 we need to be more aware of that in the guidance we
5 produce in the future. So they're an acknowledged
6 partner rather than somebody that's maybe put more on
7 the side.

8 **Q.** One very small final question which is this: it's
9 important obviously to have guidance in order to give
10 guidance to NHS staff about what should be shared, but
11 isn't another useful purpose of such guidance: the
12 University can show it to someone and say: "well, look,
13 this is what the guidance says. This is why we have
14 made the decision we have about sharing or not sharing."
15 Also they can say, "Here's the guidance, you now need to
16 share this information with us." It has that dual
17 purpose guidance, doesn't it?

18 **A.** I would agree and I think if we're going to do some work
19 on guidance, then we need to make sure we do it in
20 conjunction with universities in order that it works for
21 them as well.

22 **MS PATRY:** I could not be more grateful for that answer.

23 Thank you very much.

24 **A.** Okay.

25 **THE CHAIR:** Yes, any questions?

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Questioned by MR ROSSER

MR ROSSER: Mr Vineall, you know that I ask questions on behalf of the Department of Health and Social Care.

A. Yes.

Q. You explained, earlier on in your evidence, when asked about the Department's role, that the decision had been taken essentially to combine the functions of NHS England and the Department of Health and Social Care. Can I ask to be put up, please, DHSC0000509, page 4, please.

This is the oral statement given that accompanied that announcement and when you were answering you referred to duplication. Were you aware of the outcome of Dame Patricia Hewitt's review in that, for example, one local service was required to send 250 reports and forms to NHS England and the Department of Health and Social Care in a single month?

A. Yes, I was aware of the broad purpose of the Review, because it was one of the things that illustrated, in a way, that the over-management of the NHS had been to the detriment of it being able to make its own sensible decisions, and obviously one of the purposes of -- well, one of the policies in relation to the merger of NHS England into the Department is not only that we have a clearer single centre and all the accountabilities

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wasn't, in the end, to the benefit of the ministers for whom the service is there to serve.

Q. Thank you. I'll move on from that document. You've discussed during your evidence capital funding and revenue funding. Can you just explain in simple terms what the difference is between the two, please?

A. Well, the 16.1 million -- billion for revenue is for the day-to-day running of the services, be that the core services or the high secure services, or the couple of services that we sort of have special improvements and monies for.

And then the capital funds, which in total is about 6 billion, 6.6 billion, has components which are earmarked for more specific objectives because obviously capital in a sense is more discretionary than revenue, and of that, there's 473 million for the range of capital projects for mental health services, which is, you know, a good outcome to be in that position where that is specifically for mental health services.

So the capital pot in total is always smaller than the revenue pot, and it is allocated, if you like, in a more specific way, whereas the revenue pot goes out broadly in baseline allocations to different organisations with a few extra bits on top.

Q. So just to be clear, the 8.4% figure that was referenced

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that I was discussing earlier, but at the same time, and as I mention, we give responsibility back to local Trusts and boards to make decisions.

That has increased in pace over the last year, since Sir Jim Mackey became the Chair -- the Chief Executive of NHS England, and there are statements peppered throughout the 10-Year Plan that refer to local responsibility for local services, like the quality of services is the responsibility of the NHS Trust Board.

So we do want to get to a position where there is in a sense less checking and more enabling for people, balanced, as we've had in the earlier discussions, with the ability to monitor broad trends in policy and the key performance indicators.

Q. Indeed, we can see that this statement continues to state that the Hewitt Review concluded that having two organisations doing the same jobs has led to, and -- quoted --

A. Yes.

Q. -- "tensions, wasted time and needless frictional costs."

A. Yes, I think I used the word "friction" so there was a, I mean, you know, I've worked in the system and I think what it was saying there was that it gave complexities to those people who were working in the system and that

110

earlier --

A. Is revenue.

Q. That's revenue spending rather than capital spending?

A. Yes.

Q. Thank you. Finally then, you were asked about a number of policies set out in your witness statement.

A. Yes.

Q. And it was suggested that there's nothing in those policies that specifically deals with the risk to public or protection of the public from mental health patients.

Does that mean that that's simply not considered or does it still form part of those policies?

A. Well, it still forms part of the policies, and what I was trying to say was that the overall fundamental policy in relation to mental health is the legislation which is at its core, and that was unchanged in the period discussed, and the fundamentals are unchanged, despite the changes that we have made, which is to protect the public and individuals where there's a risk of harm according to people's mental health condition.

MR ROSSER: Thank you. Thank you, Chair, I've got nothing further.

Questioned by THE CHAIR

THE CHAIR: Yes, I just wanted to ask a couple of questions.

Firstly, in relation to what I'm going to call Dartmouth

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1 AO --

2 **A.** Yes.

3 **THE CHAIR:** -- and then elements of AO. Is not the reason

4 that it fell away because the Dartmouth model and the

5 Ritchie model, if you can put it that way, is something

6 which is low caseload, high intensity, quite expensive

7 for a relatively low number of patients, but they are

8 the most difficult patients so that when cuts came it

9 looks expensive?

10 **A.** I think that's a fair point. I mean, clearly it is

11 a more expensive service because it is a more intensive

12 service. I think the point that we failed to -- or that

13 was failed to communicate in that time was that that was

14 still money well spent because this was a particular

15 cohort of patients that needed support, hence we've said

16 now that people need to prioritise those service

17 developments, and indeed they're starting to do so.

18 **THE CHAIR:** But isn't the risk still there even that if --

19 (*overspeaking*) --

20 **A.** Well, the risk -- (*overspeaking*) --

21 **THE CHAIR:** -- essentially, sorry, if you essentially have

22 an option between elements of, which are incorporated

23 perhaps into another environment like the community hub,

24 as against a dedicated intense team, separate,

25 freestanding, given the decisions that have to be made

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1 where we have an absence of services, we're not

2 recognising the importance of those services, and that

3 people are using, as you said, resources as a reason for

4 not recognising these needs. I think we've sort of, you

5 know, with the help of the Inquiry, we've established

6 that that's a position we're not going to return to.

7 **THE CHAIR:** But one has a potential, that's to say community

8 hubs, has a potential funding stream based on the pilots

9 that have been carried out, whereas AO in the pure

10 sense, in the Dartmouth sense, doesn't?

11 **A.** You're right. You're correct on that. I mean obviously

12 the commitment is to have a hundred per cent Assertive

13 Outreach treatment services by 2035. Now I know that's

14 a long way away. I hope we get there before then, but

15 obviously there is the opportunity for the government at

16 future spending reviews to make decisions about funding.

17 There wasn't a decision to have specific funding this

18 time round. We're going to need to look, because we'll

19 be carefully monitoring how those services are

20 developing, and obviously it will be a decision for the

21 government of the day then to decide whether resourcing

22 or not is something that's indicated.

23 **THE CHAIR:** The community hubs are static in a sense, aren't

24 they, they are where they are, they're part of the

25 community.

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1 about funding, isn't it that going to happen again?

2 **A.** I don't think it will happen again -- I can't say with

3 absolutely guarantee it won't happen again -- I don't

4 think it can happen again because I think the

5 distinction between having any kind of service or no

6 service at all, that is now made perfectly clear that

7 you need to have a service.

8 **THE CHAIR:** Yes.

9 **A.** And in the guidance it was saying you've got to come

10 back and explain how you were meeting the needs of the

11 population.

12 I do think, and it's what the guidance says, which

13 is that there are the two alternatives or, if you like,

14 the two variations. I think it's going to be incumbent

15 on the Commissioners and NHS England, as it stands at

16 the moment, in monitoring their responses, that to the

17 point you're making, the judgements about the kind of AO

18 service or the judgements about the way you support this

19 cohort of patients is appropriate to the needs of the

20 population. Obviously, in a place like Nottingham, they

21 didn't -- by 2023, they didn't really have any service

22 it all. There was a modicum of it within the EIP. Now

23 they've got in the sense the lower case "service" and

24 they're moving to the upper case "Service".

25 So I don't think we'll be in the position again

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1 **A.** Yes.

2 **THE CHAIR:** -- (*overspeaking*) -- community, whereas the AO

3 function, it's a bit like having settlements, if you

4 like, of hunter-gatherers.

5 **A.** Yes.

6 **THE CHAIR:** Because you need to bring in the group to

7 contact the group who are difficult to reach --

8 **A.** Yeah --

9 **THE CHAIR:** So they're really in a sense doing different

10 things, aren't they?

11 **A.** They're certainly differently constructed. I mean, the

12 AO service has a building that has some staff in and

13 they spend most of their time going out and finding the

14 people, as you said. The community hubs have a set of

15 services which are, to your words, static and in situ.

16 They do, as I was saying from the one I visited,

17 there is an element, maybe quite a large element of them

18 going out and finding people as well. That's certainly

19 what I was told when I went to the service. But there

20 is a set number of services that are in one place for

21 people to come in, whereas if you wanted to go into, Dr

22 Dissanayaka's AO service, you go into a building that

23 has a bunch of staff in, most of whom are out there

24 visiting the patient. So it is a different thing. It

25 is a different thing.

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1 **THE CHAIR:** Yes. Just in relation to the wording of the
2 Act, you say you've been following the evidence, and
3 you've probably followed the fact that some clinicians
4 have expressed difficulty in making decisions on the
5 basis of the existing Act, for example in relation to
6 nature or degree in one case.
7 But you've mentioned the Feven incident, which you
8 have referred to, where there has been evidence that it
9 was viewed not as causing the injury, because she jumped
10 herself --
11 **A.** Yes.
12 **THE CHAIR:** And that is the causation difficulty, isn't it,
13 brought in as caused to another?
14 **A.** Yes --
15 **THE CHAIR:** It creates a bit of difficulty
16 -- (*overspeaking*) -- doesn't it?
17 **A.** Well, yes, I mean, caused it herself, is maybe a bit of
18 a stretch because -- (*overspeaking*) --
19 **THE CHAIR:** Well, it may very well be, but -- (*overspeaking*)
20 --
21 **A.** The reason why she jumped out of the window was because
22 somebody was trying to break down her door.
23 **THE CHAIR:** Yes, but I think the evidence is not that
24 everybody thought of it that way.
25 **A.** No, and I mean indeed --
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1 **THE CHAIR:** So that's the difficulty, isn't it?
2 **A.** I mean, yes, and, I mean, you said it on the day it was
3 discussed, that the police said that wasn't an example
4 of serious violence and you said "no, breaking a door
5 down is", which I would agree with.
6 These things, I think, illustrate the fact that
7 people need to understand what we mean by the
8 legislation, with worked examples in order that we all
9 have a shared understanding, and that is very much what
10 the Code is about. Obviously, we would very much
11 welcome, you know, the observations of the Inquiry in
12 order that we can reflect that in the Code when it does
13 eventually be published.
14 **THE CHAIR:** Thank you. Right, thank you. We'll break now
15 until 2.05.
16 **(1.07 pm)**
17 **(The short adjournment)**
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