

Witness Name: William Vineall

Statement No: WITN [0155001]

Exhibits: WV1/1–176

Dated: 21/11/2025

NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF WILLIAM VINEALL

Introduction

1. I make this statement on behalf of the Department of Health and Social Care ('the Department' or 'DHSC') in response to a Rule 9 request from the Nottingham Inquiry, dated 17 June 2025. I am authorised to make this statement on behalf of the Department.
2. I am currently Director, NHS Quality, Safety, Investigations and have been since 2020. Prior to that, from May 2016 I was Director of Acute Care and Quality Policy. Part of my roles have included oversight of on-going inquiries or investigations pertaining to the responsibilities of the Department. I have worked in DHSC since 1998 (including a spell in 2006 on the policy work underpinning the reform of mental health legislation in 2007; and the passage of the Mental Health (Approval Functions) Act 2012; I have been the sponsor of CQC since late 2012).
3. On behalf of the Department, I would like to extend my sympathies to the loved ones of Grace O'Malley-Kumar, Barnaby Webber, and Ian Coates, and to all affected by

the attack of 13 June 2023, including Wayne Birkett, Sharon Miller and Marcin Gawronski, who were seriously injured. As the Government Department with responsibility for the health service, social care and oversight of NHS England ('NHSE'), the Department is fully committed to cooperating to help the Inquiry get the answers we need.

4. By way of overview, I address within this statement a summary of the role of the Department, Secretary of State, and its relationship to other health and care bodies including NHSE and regulators. The statement will then cover the Department's role in assurance, including setting out the direction of travel for the Department and the new operating model described in the 10 Year Health Plan (**WV1/1 - DHSC0000096**) and in the Medium-Term Planning Framework (**WV1/2 - WITN0155002**), as well as give an overview of historic mental health legislation and policy work. It discusses guidance on information sharing, multi-agency working, and the monitoring of data. It summarises the updates to mental health legislation through the new Mental Health Bill, before detailing the Department's interaction with, and response to the attacks of Valdo Calocane ('VC'). It then sets out several recommendations to the Inquiry in the context of the Department's 10 Year Health Plan for England: Fit for the Future ('10 Year Health Plan') (**WV1/1- DHSC0000096**).
5. The Department has sought to find relevant documents but the timescales for completion of this statement have not permitted us to undertake an exhaustive search. Where it would assist the Inquiry for the Department to search for additional information to provide detail on relevant issues, we would be happy to do so.
6. This corporate statement is made on behalf of the Department, and it very largely covers matters that are not within my personal knowledge or recollection. This statement has therefore largely been prepared by officials within the Department and its legal advisors, but with my supervision. To ensure that the information provided is as comprehensive and accurate as possible and to avoid needless duplication of work, where relevant, information provided to other recent inquiries has been adapted and included in this witness statement, updated as appropriate.
7. This statement addresses the responsibilities of the Department and its role in respect of mental health services between 2019 and 2025, with reference to earlier

policies, reviews or information where relevant to the terms of reference or the issues raised by the request from the Inquiry.

Background

8. The NHS is made up of a large number of different organisations, many of which (such as GPs) are private contractors with the NHS, and who have interrelationships with each other. The provision of NHS services operates through different public, voluntary, and commercial organisations. The overall role of the Department is to secure resources, support and advise the Government's health and social care Ministers in setting strategic health and social care policy and be accountable for the operation of the many bodies operating within the NHS during the time relevant to this Inquiry. Conversely, NHSE has day-to-day responsibility for the NHS in England. Through dialogue and collaboration with NHSE as well as performance metrics, the Department is able to supervise the work of NHSE in its oversight of Trusts.
9. The principal organisational divide within NHS organisations is between those who are required to plan how resources should be allocated, and how and what types of care should be available for NHS patients – who are often called “commissioners”, explained below, and those organisations which have contracts with the commissioning bodies to deliver the actual services – known as “providers”. Integrated Care Boards (‘ICB’) are the primary commissioner of NHS services in the locality in which they are based. There are 42 ICBs. The Health and Care Act 2022 states that commissioners and providers should work together (there are representatives of both hospital trusts and local authority on the boards of ICBs). ICBs perform a role similar to the Clinical Commissioning Groups (‘CCGs’) which preceded them. Once an NHS commissioner has made a decision about which services to commission, then it enters into “arrangements” with providers, including NHS bodies but also with other organisations who agree to deliver those services to individuals who are referred to that service and have a need of it.
10. The Secretary of State is responsible for setting the strategic direction and the priorities for NHS bodies but has limited direct operational powers to specify what services the NHS should provide to which patients.

Role of the Department in relation to mental health and social services in England

11. The Department was, and remains, responsible for the following functions with respect to the health service, including:
 - a. Securing resources for the NHS within Government.
 - b. Overseeing and where necessary seeking to amend (with Parliamentary approval) the legislative framework for the NHS.
 - c. Representing the views and interests of the NHS within Government (e.g. the NHS as a major employer).
 - d. Developing and supporting strategy and policy for the NHS and dealing with exceptional events where it is right that a Department of State takes the lead (e.g. a pandemic).
 - e. Being accountable to Parliament for the NHS (through Parliamentary Questions, debates, Select Committees).

12. The issues for which the Department is accountable can be both general matters of policy and strategy and quite specific matters. Since the establishment of NHSE (formerly known as the National Health Service Commissioning Board) on 1 October 2012, the accountability for operational guidance and policy has been the primary responsibility of NHSE and other arm's length bodies ('ALB') and organisations – such as the Care Quality Commission ('CQC'). Ultimately, however, the Department is responsible for the oversight of these bodies to Parliament and is answerable in the round to Parliament for the performance of the NHS, including significant failures in care. At certain times some, but not all, of that accountability has been shared with NHSE and other organisations.

13. The Department's role is to support and advise the Government's health and social care Ministers in the discharge of their legal and parliamentary responsibilities by seeking to: shape strategic policy; assisting in the setting of the strategic direction for the health and care system and implementing agreed policy; and acting when required upon issues of national concern often through oversight of the Department's

operational ALBs. This role covers three main areas of health and social care in England:

- a. The promotion of a comprehensive health service through NHS-commissioned services, which is at present operated through NHSE and the clinical services that it then oversees.
- b. Public health, which is the subject of responsibility of both the UK Health Security Agency ('UKHSA') and local authorities who have Directors of Public Health and who liaise with UKHSA and the Department on issues of public healthcare.
- c. Adult social care, for which the Department has policy responsibility but the day-to-day running of which is the statutory responsibility of local authorities (of which there are 153).

14. The Department has a mental health policy team who are responsible for supporting Ministers to make policy decisions. The Department has oversight of key legislation relating to mental health, including the Mental Health Act 1983 ('Mental Health Act') and aspects of the Mental Capacity Act 2005. Further key, relevant pieces of legislation the Department has oversight of are provided at paragraph 30 below.

15. For completeness, I exhibit to this statement the Department's published Departmental Reports and Annual Reports and Accounts for the relevant period:

- a. 2019/20 (**WV1/3 - DHSC0000075**);
- b. 2020/21 (**WV1/4 - DHSC0000076**);
- c. 2021/22 (**WV1/5 - DHSC0000077**);
- d. 2022/23 (**WV1/6 - DHSC0000078**);
- e. 2023/24 (**WV1/7 - DHSC0000001**).

Role of the Secretary of State

Statutory duties

16. The central statutory duties and responsibilities of the Secretary of State as set out in the National Health Service Act 2006 ('the 2006 Act') include the duty to "*continue to secure the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness*": (s.1(1) of the 2006 Act). Whilst the Secretary of State maintains ministerial responsibility to Parliament for the provision of the health service (s.1(3) of the 2006 Act), the responsibility for ensuring the delivery of services lies with NHSE (see s.1H of the 2006 Act).
17. Under s.1A of the 2006 Act, the Secretary of State has to exercise his or her functions in relation to the health service "*with a view to securing continuous improvement in the quality of services provided to an individual in respect of the prevention, diagnosis or treatment of illness or the protection and improvement of public health*". These involve continuous improvement in the outcomes (s.1A(2)), which include, in particular, the effectiveness, safety of the services provided, and the quality of the experience undergone by patients. As described in case law, *R (AAA) v NHS Commissioning Board [2023] EWCA Civ 902*, these are "*target*" duties – i.e. they do not give rise to specific obligations in respect of individual patients or clinical services.
18. The Secretary of State has a duty under s. 1C of the 2006 Act to "*have regard to the need to reduce inequalities with respect to the benefits people in England can obtain from the health service when exercising his or her functions in relation to the health service*". The Secretary of State also must have due regard to the public sector equality duty (as part of s.149 of the Equality Act 2010), which includes requirements for those who exercise public functions to have "*due regard*" to the need to eliminate discrimination and harassment, advance equality of opportunity and foster good relations between those who do and do not share a relevant protected characteristic.
19. Under s. 247D of the 2006 Act, the Secretary of State has to publish an annual report about the NHS which must include the Secretary of State's assessment of the

effectiveness of the discharge of duties under s. 1A and 1C of the 2006 Act by the bodies used to provide services and support to the NHS (including NHSE, CQC, and the National Institute for Health and Care Excellence ('NICE')). In practice, this document is included as part of the Department's annual report and accounts, referenced at paragraph 15 above.

Commissioning

20. The vast majority of the health service is commissioned by either NHSE or ICBs, who commission services and allocate resources to a range of providers, including NHS Trusts, Foundation Trusts, and other providers (see paragraph 9 above). The Secretary of State directly commissions a very small range of services (none of which concern mental health care) and also has a number of public health functions (under s. 7A of the 2006 Act) which are mostly delegated to NHSE.

Mandate

21. The Secretary of State has a statutory requirement to have a 'mandate' to NHSE in place, which sets out objectives NHSE should seek to achieve in the exercise of its functions (s.13A of the 2006 Act). The mandate is a mechanism by which the Secretary of State sets NHSE's strategic direction and informs the metrics and targets against which NHSE performs. The Secretary of State has an obligation per s.13A(8) of the 2006 Act to consult with NHSE and others before specifying any objectives or requirements in the mandate. The Secretary of State therefore works with NHSE to develop the mandate. In addition to objectives, the mandate may contain requirements. If it does, these have to be given legal effect by regulations laid as soon as possible after the mandate itself. Until NHSE is formally dissolved, see paragraphs 102 to 107 below, the statutory requirement of the mandate will remain in place. There has been a move towards the mandate being used to provide a clearer strategic focus for the NHS. The Health and Care Act 2022 amended the previous requirement to issue the mandate annually and becomes a more enduring set of priorities. Recent Secretaries of State have also set fewer objectives signalling the need for the NHS to focus on a smaller number of top priorities.

22. The Department monitors NHSE's performance against mandate objectives and publishes an annual assessment letter from the Secretary of State to NHSE's Chair, which includes an assessment of how effectively NHSE has discharged its statutory duties and, in that year, the extent to which it met any requirements or objectives set out in the mandate.

23. NHSE has a number of aligned duties, including to assess the performance of ICBs, with powers to intervene, when necessary, as discussed at paragraphs 94 to 98 below.

Secretary of State's Power of Direction

24. Section 8 of the 2006 Act gives the Secretary of State the power of direction over NHS Trusts. NHS Trusts are bodies created under Part 2, Chapter 3 of the 2006 Act. NHS Trusts enter into acute services contracts with ICBs (and previously CCGs) to provide a wide range of community and hospital services to patients, including mental health services. Alongside NHS Trusts, services are also provided by NHS Foundation Trusts, which are public benefit corporations set up under Part 2 of Chapter 5 of the 2006 Act. They have boards of governors as well as a board of directors. NHS Foundation Trusts are now accountable to NHSE, but previously their accountability was to Monitor, the organisation that was established to oversee Foundation Trusts in the early 2000s. Monitor was subsequently combined with the NHS Trust Development Authority to form NHS Improvement and NHS Improvement was then merged into NHSE.

25. In practice and as a matter of policy, Secretaries of State have not exercised the s. 8 power of direction over Trusts themselves but have looked to the relevant Arms-Length Body to direct as needed.

26. The introduction of s.13Z2 of the 2006 Act, by the Health and Social Care Act 2012, granted the Secretary of State the power to issue directions to NHSE about the exercise of its functions in cases of significant failure. The Health and Care Act 2022 replaced s.13Z2 with s.13ZC which grants the Secretary of State a broader power to issue directions other than in cases of significant failure, subject to some specified exceptions. However, The Secretary of State cannot give a direction in relation to:

- a. The appointment or employment of a person;
- b. Whether individuals should receive a particular form of treatment; or
- c. The provision of any drug or medicine by the NHS unless NICE has made a recommendation and the direction is not inconsistent with it (s.13ZD of the 2006 Act).
- d. It should be noted that directions can be issued under s.253 of the 2006 Act by reason of an emergency if the Secretary of State considers that it is appropriate to do so.

27. The Secretary of State does, as set out under Schedule 10A of the 2006 Act, introduced by the Health and Care Act 2022, have a call-in power to intervene in NHS reconfigurations. For example, where services are being altered at a local or regional level by ICBs or Trusts, or the centralisation of certain services in one hospital alone in a region, or the closure/change in service provision to a particular geographic area. These powers came into force on 31 January 2024. Schedule 10A also places duties on NHS commissioning bodies to notify the Secretary of State about substantial reconfigurations of services and for NHS commissioning bodies and NHS trusts and foundation trusts to provide ministers with information and assistance about those changes.

The NHS Constitution for England

28. The NHS Constitution for England ("the Constitution") establishes the principles and values of the NHS in England and is accompanied by a Handbook (**WV1/8 - DHSC0000079**); (**WV1/9 - DHSC0000109**). The Secretary of State, all NHS bodies, NHS providers and local authorities exercising their public health functions, amongst others, are required to have regard to the Constitution (s.2 Health Act 2006), but the Constitution does not confer any legal rights and entitlements. The Constitution's guiding principles include:

- a. **Principle 1:** The NHS provides a comprehensive service, available to all. The Constitution explains that this service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal

regard, and that the NHS has a duty to treat each and every individual that it serves and to respect their human rights, alongside a wider social duty to promote equality.

- b. **Principle 4:** The patient will be at the heart of everything the NHS does. The Constitution explains that the NHS should support individuals to promote and manage their own health, and that NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers.
- c. **Principle 5:** The NHS works across organisational boundaries. The Constitution explains that the NHS is committed to joint working with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.
- d. **Principle 6:** The NHS is committed to providing best value for taxpayers' money. The Constitution explains that this includes providing the most effective, fair and sustainable use of finite resources.
- e. **Principle 7:** The NHS is accountable to the public, communities and patients that it serves. The Constitution notes on page 6-7 that *"the NHS is a national service funded through national taxation, and it is the government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians"* (WV1/8 - DHSC0000079)

Relationship between the Department and NHS

29. As mentioned above in paragraph 8 NHSE has day-to-day responsibility for the NHS in England. NHSE supports and oversees the commissioning of health services. NHSE responsibilities were subsequently widened following its merger with Health Education England, NHS Improvement (NHSI) and NHS Digital enabled under the

Health and Care Act 2022. To note, NHSI was previously responsible for overseeing the NHS's Foundation Trusts (following the operational merger of the Trust Development Authority and with Monitor in 2016), Trusts, and independent providers that provide NHS-funded care.

30. The Department's responsibilities in relation to, and its relationship with, NHS bodies are underpinned by a legal framework, which has evolved over time. Key pieces of legislation relevant to the terms of reference are the NHS Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, along with the Mental Health Act 1983, the Mental Capacity Act 2005 and the Mental Health Bill, which is currently undergoing Parliamentary scrutiny.

31. In addition to the above legislation, on 13 March 2025, the Secretary of State announced that he was 'abolishing the biggest quango in the world' (**WV1/10 - DHSC0000085**), with plans to bring NHS England into the Department over the next two years. As a result, the relationship between the Department and NHS England is undergoing significant changes. As announced to the House of Commons by the Secretary of State, this reform is set to 'deliver a much leaner top of the NHS', devolving 'more resources and responsibility to the frontline, to deliver better value for taxpayers' money and a better service for patients. Overall, this reform will help the NHS deliver the Government's three big shifts announced in the Ten-Year Plan. Since 3 November 2025, the Department and NHSE have established a single integrated senior management structure as a precursor of the Department and NHSE merger. The merger is discussed in further detail at paragraphs 102 to 107 below.

National Health Service Act 2006 ('the 2006 Act'), with reference to the Health and Social Care Act (2012) amendments

32. As discussed at paragraph 16 above, s.1 of the 2006 Act imposes a duty on the Secretary of State to continue to secure the "promotion in England of a comprehensive health service designed to secure improvement a - in the physical and mental health of the people of England b - in the prevention, diagnosis and treatment of physical and mental illness". This duty was amended by the Health and Care Act 2012, which provides for the Secretary of State to retain ministerial

- responsibility to Parliament for the provision of the health service (s.1(3) of the 2006 Act), and in relation to public health functions, which were previously exercised independently by Public Health England on the Secretary of State's behalf. Responsibility for these public health functions now lies with the UKHSA, for which the Department retains ministerial responsibility alongside the Office for Health Inequalities and Disparities, which has responsibility for health improvement and promotion.
33. Section 1H of the 2006 Act, as amended, created NHSE and made it subject to a concurrent duty to promote a comprehensive health service in England under s.1(1) of the 2006 Act, except in relation to the parts of the health service that are provided in pursuance of the public health functions of the Secretary of State or local authorities.
34. NHSE has responsibility for arranging the provision of services for the purposes of the health service in England, s.1H of the 2006 Act and for securing their provision through ICBs (Since 1 July 2022). The previous bodies responsible for commissioning services were CCGs. Neither the Secretary of State, nor the Department, were, during the period examined by this Inquiry, responsible for directly commissioning any NHS services.
35. Section 1D of the 2006 Act previously imposed a duty on the Secretary of State to have regard to the desirability of securing the autonomy of NHS bodies and providers when exercising their functions, and that unnecessary burdens are not placed upon them. This s.1D duty was revoked as of 1 July 2022 by s.73 of the Health and Care Act 2022 as part of a number of measures designed to promote collaborative working between NHSE and others – principally local authorities, public health bodies and those delivering clinical services (such as hospitals, GPs etc).
36. Section 3(1) of the 2006 Act provides that ICBs (and previously CCGs) must “*arrange for the provision*” of health services “*to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility*”. The Secretary of State has powers to require NHSE to arrange “*to such extent it considers necessary to meet all reasonable requirements*” for the provision of a defined range of services (s. 3B of the 2006 Act).

Health and Social Care Act 2012 and introduction of the “mandate”

37. The Health and Social Care Act 2012 came substantively into force on 1 April 2013.

It made significant amendments to the 2006 Act. It gave effect to a wide range of structural changes to the NHS, with the abolition of Primary Care Trusts (‘PCTs’) and Strategic Health Authorities, who were responsible for commissioning health services under the 2006 Act. Responsibility for NHS commissioning passed to the newly created NHS Commissioning Board and CCGs. From 2012 to 2022 CCGs commissioned most NHS services and were supported by, and were accountable to, the NHS Commissioning Board (which came to be known as NHSE). CCGs were clinically led groups made up of GP practices and other clinicians within defined geographical boundaries within the whole of England. Within this period, CCGs were the commissioners under the 2006 Act, unless there was a specific duty on NHSE to commission that service. CCGs were subject to a number of duties more clearly set out in legislation than had been the case for PCTs. Section 3(1F) of the 2006 Act conferred a duty on CCGs to act consistently with the duty of the Secretary of State, and NHSE, under s.1 of the 2006 Act to promote a comprehensive health service.

38. The changes to the 2006 Act by the Health and Social Care Act 2012 were predominantly to establish a separation between the day-to-day running of the NHS and the strategic role of Ministers. To formalise this relationship, a system of assurance and assessment of NHS bodies was also introduced, including the provision of a mandate as discussed at paragraphs 21 to 23 above. From its introduction in 2012, the mandate was directed to the NHS Commissioning Board. Then from 2019 to 2022, the mandate was addressed to both NHSE (but NHS Improvement and Monitor also received letters from the Secretary of State – known as “remit letters” on an annual basis), and joint operational guidance was also set out addressed to both CCGs and NHS providers.

39. A mandate continued to be issued annually until 2022 when further legislative changes contained in the Health and Care Act 2022 provided new flexibility for the Secretary of State to decide when the mandate should be updated. The Department has continued to publish mandates to the NHS in 2021-22, 2022-23, 2023-24 and

2025. As noted above in paragraph 21, these changes reflect the approach of recent Secretaries of State to focus the mandates on a narrower set of priorities.

40. The mandates from the period 2018 to present are exhibited as follows:

- a. 2018/19 (**WV1/11 - DHSC0000002**);
- b. 2019/20 (**WV1/12 - DHSC0000049**);
- c. 2020/21 (**WV1/13 - DHSC0000003**);
- d. 2021/22 (**WV1/14 - DHSC0000004**);
- e. 2022-23 (**WV1/15 - DHSC0000110**);
- f. 2023 (**WV1/16 - DHSC0000005**);
- g. 2025 (**WV1/17 - DHSC0000111**).

41. The mandates in place during the period relevant to this Inquiry show that the Secretary of State considered that mental health provision required improvement.

42. The 2013-2015 mandate set out an objective to place mental health on a par with physical health, and to close the health gap between people with mental health problems and the population as a whole. This mandate also noted that access to mental health services was restricted, waiting times were longer than for other services, and there was no robust system of measurement in place to quantify the scale of the issue. This mandate set the expectation that the NHS Commissioning Board would comprehensively identify levels of access to, and waiting times for, mental health services, and to work with CCGs to address unacceptable delays and significantly improve access and waiting times for all mental health services (**WV1/18 - WITN0155003**).

43. The 2015-2016 mandate announced that from April 2015, NHSE would introduce access and waiting time standards for key mental health services, as a crucial first step on a journey to complete parity of esteem for mental health services. The 2015-2016 mandate set expectations for mental health crisis intervention and included the following: *“there remains a particular challenge around mental health crisis*

intervention. Only by working with key partners, including the police, can we ensure that people with mental health problems get the care they need in the most appropriate setting. To bring about the transformational change necessary, we expect NHS England to make rapid progress, working with CCGs and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services. To further this aim, NHS England will invest in effective models of liaison psychiatry in more acute hospitals during 2015/16. We also expect that by March 2016, every community will have plans to ensure no one in crisis will be turned away, based on the principles set out in the Mental Health Crisis Care Concordat” (WV1/19 - DHSC0000112); (WV1/20 - DHSC0000113).

44. The 2015-2016 mandate also included a provision on psychosis, and a commitment that: *“NHS England will ensure that by March 2016 more than 50% of patients experiencing a first episode of psychosis begin treatment with a NICE approved care package within two weeks of referral”.*

45. The 2016-2017 mandate set out that the Government wanted to *“see more services provided out of hospitals, a larger primary care workforce and greater integration with social care, so that care is more joined up to meet people’s physical health, mental health and social care needs”.* It also indicated that the Government wanted *“to see a system-wide transformation in children and young people’s mental health, with a greater focus on prevention and early intervention...Overall there should be measurable progress towards the parity of esteem for mental health enshrined in the NHS Constitution.” (WV1/21 - DHSC0000114).*

46. The 2018-2019 Mandate set out an objective to improve out of hospital care, including that people with mental health problems should *“receive better quality of care at all times, accessing the right support and treatment throughout all stages of life”.* It set out an expectation for NHSE to show measurable progress towards the parity of esteem for mental health, as documented in the NHS Constitution for England, particularly for those in vulnerable situations. It included specific ‘deliverables’ against overall goals. These ‘deliverables’ included delivering the 2018-19 Mental Health Five Year Forward View Implementation Plan recommendations,

working with system partners to deliver the Mental Health Five Year Data Plan and the Mental Health Workforce Strategy, implementing an improvement programme for crisis and acute mental healthcare, and working with NHS Digital to ensure robust data collection and reporting for out of area placements.

47. The 2022-2023 mandate focused on post-COVID-19 recovery. It restated a commitment to treat mental health with the same urgency as physical health, and work towards recovery of mental health services performance standards, including the Improving Access to Psychological Therapies ('IAPT') recovery rate. The mandate included that work "*should also continue to recover and expand access to broader mental health services, including children and young people's mental health, adult community mental health, IAPT...and urgent and emergency mental health services.*" (WV1/15 - DHSC0000110).
48. The 2023 mandate set a priority, amongst others, to deliver recovery from COVID-19 through the use of data and technology and set ambitions to improve access to mental health support for children, young people and adults, increase the number of adults and older adults talking therapies, and support systems to improve the quality of mental health care. This mandate also included a commitment to 800 new ambulances, including specialist mental health ambulances (WV1/16 - DHSC0000005). These ambulances were introduced from 2023 to provide more specialist care, with staff having received specific mental health training, and mental health professionals accompanying paramedics on emergency calls. NHS England also introduced mental health staff working in ambulance call centres.
49. The 2025 mandate sets out the ambitions of the 10 Year Health Plan, discussed at paragraphs 143 and 286 to 290 below. It also sets out the expectation that NHSE should "*improve patient flow through mental health crisis and acute pathways by providing new infrastructure for mental health crisis support to improve patient experience, outcomes and contribute to the avoidance of unnecessary A&E attendance*" (WV1/17 - DHSC0000111).

Specialised Services

50. While the majority of services are commissioned by ICBs, NHSE is responsible for arranging 'specialised services' as required by the Secretary of State under their powers in s. 3B of the 2006 Act. The specialised services NHSE is required to arrange are set out in regulations, and include adult secure mental health services, adult specialist eating disorder services, and a number of other specialised mental health services. The full list of specialised services is exhibited at **(WV1/22 - DHSC0000062)**.

51. Additionally, since 2022, NHSE has a duty under s. 4 of the 2006 Act to provide high security psychiatric services and hospital accommodation for individuals who are liable to be detained under the Mental Health Act 1983 and who, in the Secretary of State's opinion, require treatment under high security conditions due to their dangerous, violent, or criminal propensities. The Secretary of State must approve all providers of high security services, and may give directions to providers about the provision, and to NHSE about the exercise of its functions in relation to these services. The Secretary of State gives directions to anyone approved to provide high security psychiatric services via the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2019.

52. There are currently three high secure services in England: Ashworth Hospital in Merseyside, Broadmoor Hospital in Berkshire, and Rampton Hospital in Nottinghamshire.

Framework Agreement

53. The framework agreement, published in 2014 **(WV1/23 - DHSC0000061)**, sets out the broad governance framework within which NHSE (named the National Health Service Commissioning Board in law at that time), and the Department operate. It is agreed between DHSC and NHSE and approved by HM Treasury. The framework does not convey any legal powers or responsibilities, but both parties agree to operate within its terms. The Department expects the current framework to remain in place until NHSE is dissolved (subject to Parliamentary approval).

Integrated Care Boards

54. ICBs are responsible for commissioning the significant majority of health services in their areas, managing health budgets, and holding NHS providers to account.
55. As set out above, there are no direct lines of accountability between ICBs and the DHSC, as ICBs are accountable to NHSE. Nonetheless the Secretary of State can exercise their power of direction as discussed at paragraph 24 above. The Department's interactions with ICBs (and their predecessor bodies) typically occur via NHSE. The Department has regular formal and informal communication (at all levels) with NHSE about NHS performance and delivery and information exchange relating to local and regional matters would take place through these arrangements.
56. The Department's current plans for NHS reform include that many powers and duties that now sit with NHSE in relation to ICBs will sit with the Secretary of State. Plans for reform are covered in more detail in paragraphs 102 to 107.

NHS Trusts

57. Since the 1990s, following the introduction of the National Health Service and Community Care Act 1990, NHS providers of acute and community care have been organised into 'Trusts' and – from 2003 – 'Foundation Trusts', established by the Health and Social Care (Community Health and Standards) Act 2003 with additional freedoms. The relevant legislation gave more structure to provider organisations, putting in place boards with chairs, non-executives and executives, and allowing the development of both stronger governance and greater organisational autonomy.
58. While Trusts, and to a greater extent Foundation Trusts, had a degree of autonomy, this autonomy was not absolute. The Department of Health and NHS England from its inception in 2013 both continued to hold significant formal and informal power over provider organisations. Different policy frameworks and approaches have shifted this balance somewhat over time, though not in a single direction. The formation of Foundation Trusts in the 2000s was explicitly designed to increase both provider autonomy and the role of commissioners to deliver services efficiently. Unlike Trusts, Foundation Trusts could not be directed by the Secretary of State. Instead, they were

overseen by a council of governors and had significant flexibilities in terms of their financial management. NHS Trusts that met certain requirements for performance, clinical standards and governance and leadership could apply for Foundation Trust status, gaining additional freedoms and flexibilities which are set out in legislation. Foundation Trusts were independently regulated by Monitor who determined whether NHS Trusts were ready to become Foundation Trusts and ensured that Foundation Trusts continued to be financially sustainable, well-led and locally accountable.

59. There was a clear policy ambition for all Trusts to become Foundation Trusts by 2014. This, however, was not realised, in part because of concerns about care quality, particularly following the inquiries into Mid Staffordshire NHS Foundation Trust and failings in care at other providers (including FTs). This led to a more active oversight and regulation of the provider sector and less differentiation in approach. In effect, this led to the more consistent oversight between Trusts and Foundation Trusts.

60. Around a third of provider organisations are Trusts and the remainder are Foundation Trusts. As a result, provider organisations retain quite a lot of formal autonomy while in practice they are required to work as part of their wider systems.

61. The Department has regular formal and informal communication at all levels with NHS England about NHS performance and delivery. Information exchange relating to individual NHS Trusts and NHS Foundation Trusts typically takes place through NHS England.

Primary Care Providers

62. Primary care providers – including general practices – are independent contractors who provide nearly £20bn worth of NHS services. Every year the Government and NHSE consults with each sector covered by such contractors (which includes dentists, optometrists and community pharmacists) both about what services they provide, and the money providers are entitled to in return under their contract. The commissioning of primary care services is delegated from NHSE to ICBs to ensure that providers meet the needs of the local population.

Relationship between the Department and Adult Social Care in England

63. The Department sets the strategic and regulatory context within which the adult social care sector operates. The Department does not directly fund adult social care providers or directly deliver adult social care and much of the funding for adult social care is raised locally by local authorities. Local authorities have a duty under s. 5 of the Care Act 2014 to shape their care markets to meet the diverse needs of all local people. This includes commissioning a diverse range of care and support services that enable people to access quality care. Local authorities in England commission services through a predominantly outsourced market (of private, charitable and other third sector providers) of approximately 18,000 provider organisations.
64. The Department's adult social care remit relates to adult social care in England only. Responsibility for children's social care in England rests with the Department for Education; responsibility for adult social care in Scotland, Wales and Northern Ireland is devolved to their respective governments.

Funding

65. The Department is responsible for the statutory framework for adult social care and sets policy (including through regulation, direction and guidance), while the Ministry of Housing, Communities and Local Government ('MHCLG') oversees the overall sufficiency of local government funding for all services and the financial framework for providing funding to local government for these services through the Local Government Finance Settlement. MHCLG has overall responsibility for local government funding and provides grant funding from central to local government alongside locally raised revenues including council tax. Local government also has powers to raise monies for adult social care by way of a specific 'precept' which is added to the annual council tax. The Department makes an assessment of financial pressures in relation to adult social care, which is shared with His Majesty's Treasury and MHCLG and used to inform decisions regarding the Local Government Finance Settlement. The Government has made up to £3.7 billion of additional funding available for social care authorities in 2025-26, which includes an £880 million increase in the Social Care Grant (**WV1/24 - DHSC0000080**).

66. Unlike NHS-delivered healthcare, which broadly is free at the point of delivery, adult social care provision is means-tested. Anyone with assets below £23,250 will be eligible for financial support from their local authority, which varies according to what the individual can afford to contribute from their income and assets. Generally, anyone who has assets above £23,250 is considered a “self-funder” and therefore is expected to cover their care costs. However, self-funders may be entitled to a social care needs assessment if they appear to have needs, in some cases a self-funder's needs must be met by a local authority (although they can be charged back) and self-funders can access the advice service organised by the local authority as required under the Care Act 2014.

67. The Department has powers which allow it to provide guidance to local authorities on adult social care issues, including s. 78 of the Care Act 2014, which requires local authorities to act under the general guidance of the Secretary of State in carrying out their functions under Part 1 of the Act.

Regulatory Oversight

68. CQC is responsible for the registration, inspection, regulation, and monitoring of health and adult social care providers, including independent providers, to ensure they meet fundamental standards. It also publishes its findings and performance ratings to help people make informed choices about their care.

69. From December 2023 (as a result of legislative changes made under the Health and Care Act 2022 - s. 31 of the Health and Care Act 2022), CQC began assessing how well local authorities were meeting their duties under Part 1 of the Care Act 2014. These assessments evaluate how effectively local authorities are delivering adult social care, including how well they integrate care and support with wider health services, thus strengthening assurance across the system (**WV1/25 - DHSC0000081**).

Public Health

70. The authorities have duties in respect of public health, imposed by the Local Authorities (Public Health Functions and Entry to Premises by Healthwatch

Representatives) Regulations 2013. These regulations impose duties on local authorities to exercise prescribed public health functions of the Secretary of State and to take prescribed steps in exercise of public health functions of their own.

Integrated Care

71. Local authorities work with NHS bodies to provide integrated care services. There are 42 Integrated Care Systems in England, which are local partnerships formed of NHS organisations and upper-tier local authorities. They also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing (**WV1/26 - DHSC0000063**).

72. To facilitate integrated care, the NHS and local authorities can share funds and transfer resources between themselves (Primarily under s. 75 and s. 256 of the 2006 Act and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000).

73. Provisions made under s. 75 of the 2006 Act enable the following:

- a. NHS bodies can carry out local authorities' health-related functions together with their NHS functions;
- b. Local authorities can carry out NHS functions together with their local authority health-related functions;
- c. NHS bodies and local authorities can establish and run a pooled fund which is made up of contributions by the partners, and out of which payments may be made towards carrying out the functions that are within the scope of the arrangements so long as these arrangements are likely to lead to an improvement in the way in which the functions are exercised.

74. Section 75 does not allow for all possible health services to be transferred or be the subject of pooled budgets - none of these exceptions are relevant to the terms of reference for this Inquiry.

Section 117 After-care

75. Section 117 of the Mental Health Act places a duty on ICBs and local authorities to provide after-care to patients who have been detained in hospital for treatment under ss. 3, 37, 45A, 47 or 48 of the Act, who then cease to be detained and leave hospital. The duty is joint between a local social services authority and an ICB and the funding arrangements are frequently pooled, as is the provision of the relevant services.

76. The purpose of s. 117 of the Mental Health Act is to provide people with the right support that they need to live successfully and safely in the community following discharge from hospital. After-care services aim to meet a need arising from or related to the person's mental disorder and reduce the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment). The obligation under s. 117 applies to the individual eligible for after-care. All services which fall within the definition of after-care services must be provided free of charge (but there is the power to charge for services which do not come within such definition under the Care Act 2014 or other statutes – for example, local authority “ordinary” accommodation).

Regulators who oversee Mental Health Provision

Care Quality Commission (CQC)

77. CQC was established under the Health and Social Care Act 2008 as the independent regulator for both healthcare and adult social care services in England. It replaced three previous bodies: the Commission for Social Care Inspection, the Healthcare Commission, and the Mental Health Act Commission. Under paragraph 3(2) of schedule 1, Health and Social Care Act 2008, the Secretary of State must exercise their power to appoint non-executive members of CQC so as to secure that the knowledge and experience of non-executive members of CQC taken together includes knowledge and experience relating to health care, social care, and the Mental Health Act 1983.

78. Since 2009, CQC has been responsible for the regulatory oversight of specified health, adult social care and mental health services (The specified services are those defined as 'regulated activities' in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Organisations providing such services are required to register with CQC, are inspected by them, and CQC has power to take regulatory action (including criminal prosecutions) where appropriate.

79. CQC has a duty under the Mental Health Act 1983, a function previously exercised by the Mental Health Act Commission ('MHAC'), to monitor how services exercise their powers and discharge their duties relating to the detention of patients or their reception into guardianship (as defined under the Mental Health Act 1983), including when they are subject to community treatment orders. CQC's annual 'Monitoring the Mental Health Act' highlights and addresses emerging trends, areas of concern, and areas of improvement in the care of people detained under the Mental Health Act. CQC conducts visits and interviews people who are currently detained under the Mental Health Act and requires providers to take action when areas of concern or in need of improvement are identified. CQC has specific duties under the Mental Health Act, such as to provide a second opinion appointed doctor service (this provides independent oversight of compulsory treatment decisions made under the Mental Health Act – it is an important safeguard for people who do not, or cannot, agree to their treatment under the Act), to review complaints relating to the use of the Mental Health Act, and to make proposals for changes to the Code of Practice. CQC will be involved in advising on updates to the Code of Practice underpinning the Mental Health Act once the Mental Health Bill, currently in Parliament, receives Royal Assent.

National Institute for Health and Care Excellence ('NICE')

80. NICE is an executive non-departmental public body, sponsored by DHSC, which provides national guidance and advice to improve health and social care. NICE sets out quality standards to be followed by clinicians and practitioners when devising or delivering treatments, with some priority areas for quality improvement.

81. NICE has published guidance and quality standards which may be of interest to the Inquiry as per the Terms of Reference, including 'Psychosis and schizophrenia in adults' (2015) (**WV1/27 - DHSC0000064**), 'Psychosis and schizophrenia in adults: prevention and management' (2014) (**WV1/28 - DHSC0000065**) 'Transition between inpatient mental health settings and community or care home settings' (2017) (**WV1/29 - DHSC0000066**) and 'Violent and aggressive behaviours in people with mental health problems' (2017) (**WV1/30 - DHSC0000067**).

General Medical Council ('GMC')

82. The GMC regulates doctor, anaesthesia associates and physician associates in the United Kingdom. The GMC sets professional standards, as set out in *Good Medical Practice*, and detailed guidance (**WV1/31 - DHSC0000082**); (**WV1/32 - DHSC0000068**), quality assures education, investigates complaints and oversees other professional health and care regulators.

Health and Care Professions Council ('HCPC')

83. HCPC is a body which regulates fifteen health and care professions in the UK, including professionals relevant to mental health care such as Occupational Therapists. It has published standards of conduct, performance and ethics for these professionals which include principles such as 'respect confidentiality', 'manage risk', 'report concerns about safety', 'be open when things go wrong', and 'keep records of your work' (**WV1/33 - DHSC0000069**).

Social Work England

84. Social Work England is a non-departmental public body, established by the Children and Social Work Act 2017, operating at an arm's length from government. It regulates social workers in England and sets professional standards, with a focus on public protection. These professional standards include expectations that social workers in England must 'be accountable for the quality of practice and decisions' and 'act safely, respectfully and with professional integrity' (**WV1/34 - DHSC0000070**).

Nursing and Midwifery Council

85. The Nursing and Midwifery Council regulates registered nurses, midwives and nursing associates (in England). They set standards for professional conduct, hold the register of those who have the relevant nursing and midwifery qualifications, have oversight of nursing education, and investigate complaints and take enforcement action against those registered with them. They publish a Code of Practice for professional standards and guidance on how those standards operate in practice.

Professional Standards Authority

86. The Professional Standards Authority oversees 10 UK healthcare professional regulators (which includes those outlined above). They also accredit organisations who hold registers of health and care practitioners not regulated by law, for example, counsellors. The Professional Standards Authority provides a “quality mark” for such registers which shows that they meet relevant standards to protect the public from harm and to have standards of competence and professional behaviour in the way that these practitioners operate. These registers include those providing psychological services (such as the British Psychological Society, the British Psychoanalytic Council, the British Association of Counsellors and Psychotherapists – to give three examples).

Department’s role in assurance

87. I am asked what role, if any, the Department had in ensuring NHSE, ICBs, NHS Trusts, primary care providers and social care providers improved health care and social care services and patient outcomes. The Secretary of State has Ministerial responsibility to Parliament for the provision of the health service in England and DHSC is responsible for the health and care legislative framework, however most day-to-day operational management in the NHS, including mental health services, takes place at arms-length from the Department. Apart from Special Health Authorities, all other organisations in the NHS have their own statutory functions conferred by legislation, rather than by delegation from the Secretary of State.

88. Nonetheless, CQC can conduct an investigation either by request of the Secretary of State (s. 48), or by its own initiative with the Secretary of State's approval. Section 53 of the Health and Social Care Act 2008 requires CQC to keep the Secretary of State informed about the provision of NHS health care and adult social services in general, and about the carrying on of regulated activities.

89. Ministerial powers that focus on significant failure by health bodies include those as set out within the Health and Social Care Act 2008 (for CQC in relation to NHS and Local Authority services), the Health and Care Act 2022 (in relation to NHSE) and the 2006 Act (in relation to both).

Ministerial power to intervene in relation to CQC

90. Section 82 of the Health and Social Care Act 2008 provides for circumstances where the Secretary of State can intervene and issue a direction to CQC. Section 82 also enables the Secretary of State to carry out functions of CQC or arrange for a third party to do so if CQC fails to comply with the direction.

Ministerial power to intervene in relation to NHSE

91. As discussed in paragraph 26 above, s. 13ZC 2006 Act confers a power on the Secretary of State to intervene in cases of significant failure of NHSE to carry out any of its functions. The Secretary of State may give a direction that they consider that NHSE is failing or has failed to discharge any of its functions and that they consider that the failure is significant. Section 13ZE then applies and the Secretary of State may discharge the functions to which the direction relates or make arrangements for any other person to discharge them on their behalf, but they must publish the reasons for doing so. To the best of the Department's knowledge, s. 13ZC has only been exercised once since the introduction of this section and then in relation to the need to provide data in 2024 (**WV1/35 - WITN0155004**).

92. Paragraph 238 of the Explanatory Notes to the Health and Social Care Act 2012 (which inserted s. 13Z2 – the predecessor to s. 13ZC) provided a number of examples of what amounted to significant failure including that: *'it might be appropriate for the Secretary of State to intervene in a particular case, for example if*

the NHS Commissioning Board failed to allocate funds to a particular CCG or if it failed to commission a service as required by the NHS Act.'

93. The Department's Accounting Officer System sets out the relationships and processes within the Department and explains who is accountable within the Department for various obligations. The latest edition was published in 2018 (**WV1/36 - DHSC0000071**), with earlier editions published in 2017 (**WV1/37 - DHSC0000072**), and 2012 (**WV1/38 - DHSC0000036**).

Assurance in the NHS

94. While the Department is responsible for overall health policy, NHSE currently has day-to-day responsibility for the NHS in England. NHSE oversees the commissioning of health services and has responsibility for specific oversight of healthcare providers. System-level accountability is critical to overseeing the performance of the system when issues have to be addressed by more than one organisation. It is also important to hold individual organisations to account for their performance and delivery of their statutory duties. NHSE is currently responsible for holding to account NHS providers (NHS Trusts and NHS Foundation Trusts) and ICBs - both for their performance and ensuring they meet their statutory duties. The NHS Oversight Framework outlines NHSE's approach to oversight of ICBs and Trusts. NHSE manages the delivery of NHS services through local, regional, and national arrangements. CQC has regulatory oversight of health and social care providers in England. The Department holds NHSE and CQC to account in relation to these roles and has regular formal and informal communication (at all levels) with both organisations about the performance and regulation of the NHS. Information exchange relating to individual Trusts would take place through these arrangements.

95. In terms of oversight:

- a. CQC monitors the quality and safety of the care provided by Trusts. It carries out inspections and produces reports setting out their findings. Information is also regularly shared between NHSE and CQC including all patient safety incident records received by LFPSE. CQC shares concerns about services

regionally via Regional Quality Groups, and nationally via the national Joint Strategic Oversight Group which includes other regulators such as the GMC.

- b. NHSE is responsible for the oversight of Trusts, using information provided by Trusts, ICBs, regulators and others. It has the duty to monitor NHS trusts in the carrying out of their functions, and to provide such advice, guidance or other support as it considers appropriate to help them fulfil those functions. NHSE's NHS Oversight Framework describes a consistent and transparent approach to assessing ICBs and NHS trusts and Foundation Trusts, ensuring public accountability for performance and providing a foundation for how NHSE works with systems and providers to support improvement. Broadly speaking, NHSE regional teams oversee the performance of ICBs on delivery against the Framework via oversight meetings. The 2025/26 Oversight Framework is underpinned by a streamlined set of delivery metrics, aligned with priorities in the 2025/26 Planning Guidance, allowing NHS trusts to focus on recovering their operational performance (**WV1/39 - DHSC0000073**). This includes expectations around quality and financial balance.
- c. The relevant ICB and NHSE regional teams undertake assessment of Trusts, considering issues such as:
 - i. Oversight Framework metrics and comparison regionally and nationally;
 - ii. collation of soft intelligence from ICB and NHSE sources;
 - iii. consideration of any quality and safety concerns known and any relevant CQC reports and related action plans;
 - iv. triangulating patient safety incident data with wider intelligence (such as whistleblowing/speaking up cases, media reports, complaints, incident records, police investigations etc).

96. Each financial year, NHSE must conduct a performance assessment of how well each ICB has discharged its functions and publish a summary of each assessment. For 2025/26, NHSE will report ICB performance against the full suite of oversight metrics, but they will not issue a comparative rating. ICBs will still be assessed through a statutory annual assessment (**WV1/40 - DHSC0000074**), which reviews

how well each ICB is performing its statutory duties. Where there are performance or governance concerns, NHSE will step in, and they may use regulatory powers to secure improvement. The Secretary of State may publish guidance on the function of NHSE to conduct performance assessments of each ICB under s. 14Z59 of the 2006 Act but has not used this power.

97. Where an ICB or Trust is failing, or at risk of failing, NHSE is able to issue directions, as well as guidance and other interventions. NHSE also has powers to support Foundation Trusts. For example, where a Foundation Trust requires support and intervention, the NHS Oversight Framework will help to identify that need. NHSE is able through the provider licence to put in place structured interventions including leadership support or changes, with the aim of returning the Foundation Trust to improved performance, and to a position where it can manage and address its own challenges.

98. In 2012, the Health and Social Care Act established Healthwatch England, which was designed to be the national champion of patients' interests. Healthwatch England was set up as a CQC-hosted statutory committee to ensure that the voices of people, including those with mental health problems and their families, were more central to the assessment of quality in health services, including specialist mental health provision. There are local Healthwatch networks which operate to provide patients' voices at a local level.

Changes to regulatory oversight

99. Dr Penny Dash conducted a review of patient safety across the health and care landscape between October 2024 (**WV1/41 - DHSC0000083**) and July 2025 (**WV1/42 - DHSC0000084**). Her review focused on six key organisations overseen by DHSC: CQC, the National Guardian's Office, Healthwatch England (and the local Healthwatch network), the Patient Safety Commissioner, the Health Services Safety Investigations Body and the patient-safety learning related functions of NHS Resolution, an ALB that as well as managing clinical negligence claims from the NHS on behalf of DHSC, provides expertise to the NHS on resolving disputes fairly and sharing learning for improvement. Dr Dash worked closely with senior leaders at the

six organisations and heard from more than 100 individuals or organisations with an interest in patient safety.

100. Dr Dash found that there has been a shift towards safety (compared to other areas of quality of care) over the last five to ten years, with considerable resources deployed, but relatively small improvements seen. In addition, she found that there had been limited strategic thinking and planning on improving quality of care. Dr Dash also found that there are many organisations carrying out reviews and investigations, leading to an overwhelming number of recommendations, and that this can cause confusion for patients and users. At the same time, she found that “customer experience” is not given the attention that it deserves in the NHS, with few boards having an executive director for user or customer experience.

101. Dr Dash made nine recommendations which the Government has accepted in full. Dr Dash’s findings and recommendations have informed the 10 Year Health Plan (**WV1/43 - DHSC0000086**). Dr Dash’s recommendations, which the Government accepted, are:

- a. To revamp, revitalise and significantly enhance the role of the National Quality Board.
- b. To continue to rebuild CQC with a clear remit and responsibility.
- c. To continue the Health Services Safety Investigations Body’s role as a centre of excellence for investigations, clarify the remit of any future investigations, and transfer its functions to CQC.
- d. To transfer the hosting arrangement of the Patient Safety Commissioner to the Medicines and Healthcare products Regulatory Agency, and broader patient safety work to a new directorate for patient experience within NHSE, transferring in due course to the new proposed structure within DHSC.
- e. To bring together the work of local Healthwatch organisations, and the engagement functions of ICBs and providers, to ensure patient and wider community input into the planning and design of services. To close down local Healthwatch organisations and Healthwatch England.

- f. To streamline functions relating to staff voice, including by closing down the role of National Guardian for freedom to speak up in the NHS and the National Guardian's Office.
- g. To reinforce the responsibility and accountability of commissioners and providers in the delivery and assurance of high-quality care.
- h. To give technology, data and analytics a far more significant role in supporting the quality of health and social care.
- i. To create a national strategy for quality in adult social care, underpinned by clear evidence.

Future Reform of NHSE

102. On 13 March 2025, the Prime Minister announced that NHSE will be integrated into a restructured Department of Health and Social Care (**WV1/10 - DHSC0000085**). Since then, the Department and NHSE have been working together closely to develop their approach to how this change is delivered in a way that provides better services for patients, better value for taxpayers and better supports the broader health and care ecosystem.

103. A joint Transformation Programme has been established, the 'DHSC-NHSE Transformation Programme'. Richard Barker took on the position as Senior Responsible Officer of the Programme on 13 May 2025 and has dual reporting lines to the DHSC Permanent Secretary (Samantha Jones) and the Chief Executive of NHSE (Sir James Mackey) (**WV1/44 - WITN0155005**).

104. In line with the 10 Year Health Plan, the Programme's aim is to form a new single, more efficient and leaner organisation (**WV1/43 - DHSC0000086**). Specifically, the intention is to build a future Department that:

- a. Provides clear leadership for public health, healthcare and adult social care – reflecting the differences and synergies between different areas of responsibility;

- b. Fosters collective responsibility for shared objectives rather than competing priorities or silos;
- c. Empowers local systems with clear and streamlined priorities and accountabilities;
- d. Eliminates duplication and maximises value for money;
- e. Operates with greater efficiency and focus, with clarity on what the centre should and should not do;
- f. Empowers leaders to lead whilst treating all staff with dignity, honesty and respect (**WV1/45 - WITN0155006**).

105. Following a careful review of the breadth of work undertaken by the current DHSC and NHSE, and how the respective teams currently interact, an executive structure for the future Department has been agreed and shared with staff (**WV1/46 - WITN0155007**). Since 3 November 2025, the Department and NHSE have established a single integrated senior management structure as a precursor of the Department and NHSE merger. These pragmatic transitional arrangements will support our move towards a formal merger, subject to the passage of legislation.

106. The Department currently anticipates that the new merged DHSC will be established in early 2027, subject to the passage of legislation, i.e. approximately 2 years after the announcement. Ahead of that point, NHSE will continue to be legally responsible for all of its current statutory functions, as will DHSC. The Department will publish an impact assessment as part of its work on the primary legislation.

107. The Department will provide the Inquiry with further updates on the merger of DHSC and NHSE, including what impact the changes will have on national mental health policy and delivery, as the plans develop.

Brief Introduction to NHS Mental Health Services

108. The mental health system within the NHS is split into three tiers: primary, secondary, and specialist (sometimes known as “tertiary”) care:

- a. **Primary Mental Health Services** – This is the entry level of care for the NHS. Primary services include **GPs** and **talking therapy services**.
- b. **Secondary Mental Health Services** – Secondary care covers general community and hospital care. Community care includes services such as **mental health teams**, staffed by professionals such as psychiatrists and psychologists, who patients will be referred to for additional support. Hospital care includes **inpatient treatment**, for those detained under the Mental Health Act or for ‘informal’ patients who consent to be treated in hospital for their mental disorder. To note, community care can also include **Voluntary, Community and Social Enterprise (VCSE)** support.
- c. **Specialist care** – is highly specialist care, covering specialist community and hospital care. Community tertiary care includes **assertive outreach teams**. Specialist hospital care includes **secure units** for patients detained under the Mental Health Act who present a greater level of risk than general mental health services can safely manage.

109. Common Mental Health Teams in local areas can include the following:

- a. **Community mental health teams** provide short and long-term care and treatment in the community.
- b. **Crisis teams** support people having a mental health crisis in the community, offering short-term support to help to prevent hospital admission, or to arrange this if required. Crisis teams will also support when someone is discharged from a short stay in hospital. Crisis teams may offer medication, arrange visits and ensure join-up with other services to get long-term support, such as social services.
- c. **Early intervention in psychosis (‘EIP’) teams** are multidisciplinary community mental health services that provide treatment and support to people experiencing or at high risk of developing psychosis. A national access and waiting time standard were introduced in 2016 for this service.

- d. **Assertive outreach ('AO') teams** support those who need intensive support because of complex mental health needs. Please see paragraph 152 for more detail on this service.

Overview of Mental Health Legislation, Departmental Policies, Strategies and Guidance

110. The Department's mental health policy agenda during the relevant period and the preceding years included the establishment and rollout of key interventions that continue today. This included: Talking Therapies (formerly Improving Access to Psychological Therapies); Early Intervention in Psychosis services; shifting mental health care from hospital settings to the community; reforms to the Mental Health Act; improving crisis care access; mental health support in schools; and suicide prevention. The development of this agenda can be tracked in the evolution of Government mandates discussed at paragraphs 41 to 49 above.
111. For the purposes of this statement, I have described policies related to mental health of particular relevance to this Inquiry in chronological order. I have drawn out where they involve areas most relevant to the Inquiry's terms of reference, namely, severe mental illness ('SMI') learning and review and involvement of patients and carers in decision making and planning. This summary focuses on overarching policy and programmes that set national direction and priorities for local areas which the Department has either developed or convened others to develop.

The Mental Health Act 1983

112. The Mental Health Act sets the legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves and/or others, supported by a statutory 'Code of Practice', last updated in 2015 (**WV1/47 - DHSC0000007**).
113. The Mental Health Act can be used both in emergency situations (with the Mental Health Act allowing someone to be quickly detained) or in a more planned way, as part of 'stepping up' someone's care when they are mentally unwell, but where they do not consent to admission to hospital. It is available to either clinicians

and Approved Mental Health Professionals ('AMHPs') or the police, to act when someone is acutely unwell and a potential risk to themselves or others.

114. Reforms in 2007 were implemented to modernise and clarify aspects of the Mental Health Act. At least in part, the amendments made by the Act were in response to concerns about people with serious mental disorders living in the community and the risks that they posed to the public.

115. In particular, the 2007 Act:

a. **Provided a single definition of mental disorder: “any disorder or disability of the mind”, in contrast with four types of mental disorder which had been specified before – which were mental illness, mental impairment, psychopathic disorder and severe mental impairment.** The Act also clarified that those with learning disabilities alone would not meet the criteria for detention under the Mental Health Act unless it was associated with “abnormally aggressive or seriously irresponsible” conduct.

b. **Introduced a new test:** the appropriate medical treatment test for admission to detention under the Mental Health Act. In the Mental Health Act as originally drafted, detention and treatment on grounds of mental impairment or psychopathic disorder would only be authorised if it was considered that treatment was “likely to alleviate or prevent a deterioration” of a patient’s condition. The government was concerned that some people with a personality disorder who were perceived to be a danger to the public might not be detained as clinicians would argue that there was no treatment that they could offer that would meet this requirement. The definition was therefore changed to a broader one of the availability of “appropriate medical treatment” - which removed from the detention criteria any mention of whether the patient’s condition was treatable. The 2007 Act also added in a new section to provide that, once detained, the purpose of any medical treatment is to alleviate or prevent a worsening of the disorder or its symptoms, and included a requirement that the appropriate treatment is actually available.

c. **Broadened the range of professionals who undertake statutory responsibilities for assessments and decisions about detention and discharge under the Mental Health Act, including introducing the role of AMHPs and that of the Responsible Clinician ('RC').** An AMHP was an extension of the previous role of Approved Social Worker (who under the Mental Health Act had the power to apply for someone to be detained under the Act). This role was expanded to a wider range of professionals by the creation of the AMHP, so that nurses, psychologists and occupational therapists could take up such a role. The RC created a wider set of personnel for those who had the power to authorise the medical treatment of patients (if they did not consent) and discharge people from hospital or extend their detention. In the original Mental Health Act as drafted, it was usually the consultant psychiatrist who had such powers and was called the "registered medical officer". Under the Act as amended, these powers can be exercised by a registered medical practitioner, but also other professionals such as nurses, psychologists and social workers who undertake the necessary training, hence the change of term to responsible clinicians.

d. **Introduced supervised community treatment orders ('CTOs').** CTOs provide a framework to help manage the risk that some of those who have a mental disorder pose to themselves or others in the community. CTOs allow individuals detained under the Mental Health Act to be discharged into the community subject to conditions imposed by clinicians to ensure continued treatment, if there is otherwise a risk of serious harm and if they will benefit therapeutically. CTOs aim to ensure that the person who is discharged maintains contact with mental health services to provide support and prevent relapse. Patients on CTOs can be recalled to hospital under the Act if they do not comply with their conditions.

116. The Act introduced the right of patients to displace their nearest relative upon application and for the county court to displace the nearest relative if there are grounds to do so. A nearest relative is a member of the family who has rights and responsibilities if the person is either detained in hospital under the Mental Health Act on a compulsory or assessment basis or is under a community treatment order or

subject to a guardianship order. Section 26 of the Mental Health Act sets out who will be the nearest relative in respect of familial relationships. A nearest relative can, for example, complete an application to detain their relative under the Mental Health Act (although this is rarely used in practice) or to have them made subject to guardianship, block some forms of detention taking place, or discharge the patient if detained and apply to the mental health tribunal if this is refused. They can also ask for an assessment for admission to hospital to be arranged and must be given written reasons if this does not take place.

117. In October 2017, the government asked Sir Simon Wessely (then President of the Royal College of Psychiatrists) to undertake an Independent Review into the Mental Health Act. This was prompted by concerns being raised about the rising numbers of people being detained under the Mental Health Act and the disproportionate numbers of people from black and minority ethnic groups who were detained under the Act. It was also intended that the review should consider whether some of the processes in place under the Act were in line with modern mental health practice. The review was limited to mental health provision in England and Wales, as Scotland and Northern Ireland have separate legislation. The review examined a range of evidence sources, including speaking to those who had experience of being subject to the Act to discover which areas of the Act needed reform. The interim report in May 2018 set out its early findings.
118. As a result of the interim report, the review set up topic groups on each area to examine potential reform, which then formed the basis of the final report published in December 2018 (**WV1/48 - DHSC0000087**); (**WV1/49 - WITN0155008**).
119. Following this, the Government published a White Paper, Reforming the Mental Health Act (**WV1/50 - DHSC0000020**), in January 2021 which accepted the vast majority of the review's recommendations. After a public consultation on the proposed reforms, to which the Government responded, a Draft Bill was published in 2022 (**WV1/51 - DHSC0000021**). The Mental Health Bill was introduced to the UK Parliament on 6 November 2024 and is currently being considered by Parliament (as of November 2025). Further details of the reforms in the Mental Health Bill are included at paragraphs 218 to 223 below.

Mental Health Act – Code of Practice

120. The Mental Health Act Code of Practice provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and AMHPs on how they should carry out functions under the Mental Health Act. For example, it gives statutory guidance to registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder. Section 118(2D) of the Mental Health Act sets out that specified persons must have regard to the Code of Practice when carrying out specified functions under the Act, including registered medical practitioners, approved clinicians, managers and staff of hospitals, independent hospitals and care homes, and AMHPs in relation to the admission of patients to hospitals.
121. It is a legal requirement to have regard to the Code when carrying out functions under the Mental Health Act. It is not a legal requirement to comply with the Code, however case law has confirmed that the Code must be followed unless there are “cogent” reasons not to do so (*R (Munjaz) v Ashworth Hospital [2005] UKHL 58*). That means that there will be some occasions when the Code is not followed, but those not doing so will have to justify the reasons why the Code was not followed.
122. CQC looks at the Mental Health Act’s Code of Practice and compliance with it by those providing mental health services as part of its regular inspection activity. The Code provides specific guidance on the operation of the Mental Health Act, including aspects of treatment and care such as patient involvement in decision-making, and sets out specific procedures and timescales including review of practices such as, for example, seclusion or long-term segregation. The Code also provides guidance which applies to all medical treatment for mental disorders, not just for those subject to the Act. Departures from the Code may lead to breaches of CQC Regulations which will be reflected in inspection reports, ratings of the service and enforcement activity. Departures from the Mental Health Act’s Code of Practice that result in significant risk, safeguarding concerns or breaches of human rights could lead to a downgrading of the CQC rating. CQC can comment on failure to observe the Code in their annual ‘Monitoring the Mental Health Act’ report where this has arisen as a theme across England. For example, the 2022/2023 annual report noted non-

compliance with the Code of Practice in respect of policies around restrictive practice **(WV1/52 - DHSC0000116)**.

123. Whilst the Act sets out the criteria for detention, in paragraph 14.10 the Code sets out factors to consider when considering detention under the Act for the protection of others:

“14.10 In considering whether detention is necessary for the protection of other people, the factors to consider are the nature of the risk to other people arising from the patient’s mental disorder, the likelihood that harm will result and the severity of any potential harm, taking into account:

- *that it is not always possible to differentiate risk of harm to the patient from the risk of harm to others*
- *the reliability of the available evidence, including any relevant details of the patient’s clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions*
- *the willingness and ability of those who live with the patient and those who provide care and support to the patient to cope with and manage the risk*
- *whether other methods of managing the risk are available, and*
- *harm to other people including psychological as well as physical harm.”*

124. The Code of Practice (2015) sets out the following on CTOs:

- a. **29.11** In assessing the patient’s suitability for a CTO, the responsible clinician must be satisfied that the patient requires medical treatment for mental disorder for their **own health or safety or for the protection of others**, and that appropriate treatment is, or would be, available for the patient in the community.
- b. **29.12** In making a decision to place the patient on a CTO the responsible clinician must assess what risk there would be of the patient’s condition

deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

- c. **29.13** In assessing that risk the responsible clinician should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care.
- d. **29.14** Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's capacity to make decisions about their care and treatment and attitude to treatment and risk of relapse, the circumstances into which the patient would be discharged, and the willingness and ability of family and/or carers to provide support (especially where aspects of the care plan depend on them).

Relevant strategies and guidance from 2011 to present

125. In 2011, 'No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages' was published by the Coalition Government (**WV1/53 - DHSC0000041**). The Strategy asserted that the quality of mental health care in recent years had improved in terms of early intervention and community-based services, but that progress was uneven in the provision of services between different areas and conditions and not all groups benefitted equally, in particular many people from black and minority ethnic communities. This Strategy aimed to address this by putting more power in the hands of local areas and increasing focus on outcomes. It aimed to "mainstream" mental health and establish parity of esteem between services for people with mental and physical ill health. The Department worked with a wide range of partner organisations, including user and carer representatives, providers, local Government and other Government Departments, to agree six shared objectives underpinning the strategy and six key shared outcomes indicators for mental health, and areas for action for each. The shared objectives were that:

- a. More people will have good mental health;
- b. More people with mental health problems will recover;
- c. More people with mental health problems will have good physical health;
- d. More people will have a positive experience of care and support;
- e. Fewer people will suffer avoidable harm;
- f. Fewer people will experience stigma and discrimination;
- g. Oversight of implementation was the responsibility of the Government Cabinet Sub-committee on Public Health (**WV1/54 - WITN0155009**).

126. This Strategy was accompanied by a plan to expand access to IAPT services for four years from April 2011, which offer NICE approved treatments for depression and anxiety. This was a national programme, with access and outcome targets, underpinned by a national data collection so that NHSE could see and monitor progress which was reported to Ministers. In 2023/24 1.26 million referrals were made to NHS Talking Therapies services, more than any year since 2012/13. In 2023/24, of those that accessed NHS Talking Therapies, 90.3% of them did so within 6 weeks. Approximately, 7 of every 10 people (66.8%) who finished a course of treatment said that they had improved, while almost half (47.1%) said that they had recovered (**WV1/55 - DHSC0000106**). To note, these sorts of therapies are not the same as the kind required for enduring mental illness (such as that relevant to the terms of reference for this Inquiry).

127. In 2014, '**Closing the Gap: Priorities for essential change in mental health**' was published by the Department (**WV1/56 - DHSC0000011**). This set out shorter term priorities to achieve the longer-term vision outlined in the 2011 Mental Health Strategy (**WV1/53 - DHSC0000041**). It set out 25 areas for change in local service planning and delivery in the next two to three years focusing on: increasing access to services, integrating physical and mental health care, earlier promotion of mental wellbeing and improving the quality of life of people with mental ill health. This included commitments to new measures of care quality, new CQC models for

regulating mental health services – which sought to identify quality failings earlier and represent patient voice more broadly – and specialist community perinatal mental health teams as well as introducing clear waiting times for the first time, to mirror the approach in elective care.

- a. In 2014, **'Achieving better access to Mental Health Services by 2020' (WV1/57 - DHSC0000012)** was published by the Department and NHSE. This set out three phases to change mental health services. This included increasing capacity and introducing waiting time standards to improve access to mental health services. It was supported by £80 million investment to deliver the programme. It aimed to achieve parity between physical and mental health services and one of the main levers was (in 2015/16) to introduce the following access and waiting standards:
- b. 75% of people referred to the IAPT programme will be treated within 6 weeks of referral, and 95% treated within 18 weeks of referral **(WV1/57 - DHSC0000012)**.
- c. At least 50% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral **(WV1/58 - DHSC0000088)**.

128. It was also accompanied by £30m targeted investment on effective models of liaison psychiatry in more acute hospitals (to note, liaison psychiatry deals with the interface between physical and psychological health and provides specialist mental health assessment and treatment for patients attending general hospitals). Availability of liaison psychiatry informed CQC inspections at that time and therefore contributed to ratings **(WV1/57 - DHSC0000012)**.

129. In 2016, NHSE published an implementation programme in response to recommendations from the Mental Health Taskforce commissioned by Sir Simon Stevens, Chief Executive of NHSE, on behalf of the NHS. **'Implementing the Five Year Forward View for Mental Health' (WV1/59 - DHSC0000015)** set out trajectories and plans for delivering key commitments across children and young people's mental health, perinatal mental health, common mental health disorders,

community acute and crisis care, secure care pathways, health and justice, suicide prevention as well as supporting models of care, workforce and infrastructure. For instance, the plan set out the ambition to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions, supported by financial and workforce commitments, which would contribute towards parity.

130. In 2017, a Private Member's Bill was introduced known as 'Seni's Law' and was debated in Parliament. This became the **Mental Health Units (Use of Force) Act 2018**. It aimed to reduce unnecessary and inappropriate use of restraint in mental health hospitals, and to ensure better accountability and transparency over the use of force in mental health units. After public consultation, the Government published accompanying statutory guidance in 2021 on improved record keeping and reporting of data, and the quality of staff training and investigations (**WV1/60 - DHSC0000028**). The Act also requires relevant health organisations to appoint a responsible person to a mental health unit, who must publish and keep under review a policy on the use of force on patients by staff who work in the unit, and to record any use of force on a patient by staff.

131. In 2017, DHSC coordinated the **National Guidance on Learning from Deaths (WV1/61 - DHSC0000090)** for the National Quality Board to help standardise and improve how NHS providers identify, report, investigate and learn from deaths. This is covered in greater detail later in the statement in paragraph 230.

132. In 2018, PHE published **Health Matters: Reducing Health Inequalities in Mental Illness (WV1/62 - DHSC0000091)**. This guidance describes inequalities experienced by people with mental illness and suggests local actions to reduce inequalities in mental illness and improve physical health and life chances of people living with mental illness. In particular, it suggests preventative local action to reduce inequalities in mental illness, including providing tools to help local areas develop a mental health and wellbeing Joint Strategic Needs Assessment, and suggesting early detection and intervention to address physical health needs of people with mental illness. This guidance also addresses providing support for people with co-occurring conditions and supporting workers in non-mental health roles to meet the needs of

people with a mental illness and supporting workers in mental health roles to address physical health and prevention. This guidance has a focus on adults with more severe and enduring mental illness.

133. Published in 2019, **'The NHS Long Term Plan' (WV1/63 - DHSC0000013)** set out ten-year priorities for the NHS including five-year funding packages for specific programmes of work. Priorities for inpatient mental health settings included eliminating inappropriate out of area placements, reducing the average length of stay, capital investment to upgrade the physical environment, and reducing suicides. This also included a commitment for NHSE to design a new Mental Health Safety Improvement Programme, which would have a focus on suicide prevention and reduction in suicides for mental health inpatients.
134. Also published in 2019, the **'NHS Mental Health Implementation Plan' (WV1/64 - DHSC0000016)** set trajectories and plans for delivering the remaining 'Five Year Forward View for Mental Health' commitments and building on these to deliver the 2019 'NHS Long Term Plan' commitments. This included setting trajectories for all areas to meet, and some flexible objectives where local areas could tailor their implementation according to local need. The Plan mirrored commitments in the 'NHS Long Term Plan' around increased crisis provision for children and young people, combining crisis assessment, and intensive home treatment functions, and care closer to home (rather than inpatient settings). It set out the ambition to eradicate inappropriate out of area placements as a means to improve inpatient therapeutic care, alongside increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. It was expected that this should contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings.
135. In 2019 NHSE published the **Community Mental Health Framework for Adults and Older Adults**, which was commissioned by NHSE in 2017 (**WV1/65 - DHSC0000092**). This guidance set out the NHS's vision for a new place-based community mental health model and plans for the modernisation of community mental health services to shift to a whole person, more holistic approach to treatment.

The aim of the Framework was that people with mental health problems would be able to:

- a. Access mental health care where and when they need it, and be able to move through the system easily, so that people who need intensive input receive it in the appropriate place, rather than face being discharged to no support;
- b. Manage their condition or move towards individualised recovery on their own terms, surrounded by their families, carers and social networks, and supported in their local community;
- c. Contribute to and be participants in the communities that sustain them, to whatever extent is comfortable to them.

136. Published in 2021, the '**COVID-19 mental health and wellbeing recovery action plan**' (**WV1/66 - DHSC0000017**) outlined the Government's plans to prevent, mitigate and respond to the mental health impacts of the COVID-19 pandemic. The Plan committed an additional £500 million Government investment to help address new pressures brought about by the pandemic so that delivery of the 'NHS Long Term Plan' and Mental Health Act reforms remained on track.

137. **Call for Evidence for the Mental Health and Wellbeing Plan:** Additionally, in April 2022 the Department launched a call for evidence (**WV1/67 - DHSC0000059**) seeking the public's views on what the Department could do to improve everybody's mental health and wellbeing and prevent suicide. The original intention was that this would inform the development of a mental health and wellbeing plan, and a separate, suicide prevention strategy. In 2023, the decision was taken to incorporate tackling mental ill health into a major conditions strategy. All responses received via the mental health and wellbeing call for evidence were considered to inform the development of the 'Major Conditions Strategy: case for change and our strategic framework' (**WV1/68 - DHSC0000018**) and 'Suicide Prevention Strategy for England' (**WV1/69 - DHSC0000093**), which were both published in 2023. The outcome of the call for evidence was also published in 2023. The broad topics respondents were asked centred around promoting positive wellbeing, preventing the onset of mental ill health, intervening earlier when people need support with their mental health,

improving the quality and effectiveness of treatment for mental health conditions, and supporting people living with mental health conditions to live well. Key findings which emerged from the call for evidence included care closer to home and in the community, a focus on prevention, more NHS funding for staff and training, and the importance of early intervention.

138. In 2023 **'The Suicide Prevention Strategy for England'** (WV1/69A -DHSC0000010), replaced the 2012 strategy and set out priority areas for action to reduce suicides (WV1/70 - DHSC0000117). Mental health patients were identified as a priority group and effective crisis support was identified as a priority area for action across the NHS and wider organisations.
139. In 2023, NHSE launched the **'Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme'** (WV1/71 - DHSC0000094) to support cultural change and a reimagined model of care across NHS funded mental health, learning disability and autism inpatient services. This includes redesigning and localising services, reducing restrictive practices, developing a commissioning framework which provides guidance for those responsible for the commissioning of mental health inpatient services to ensure services are inclusive and deliver safe, personalised and therapeutic care (WV1/72 - DHSC0000095), and supporting local oversight and support arrangements. It is intended to eventually eliminate the model of care where particular 'setting conditions' and/or characteristics of service models do not contribute to the delivery of high quality, person-centred care. As part of this work, it was understood that particular settings which provide such practices can develop or are predisposed to creating "closed cultures" i.e. a culture where outside norms and behaviours are superseded by the culture of the institution – which can often lead to poor provision of care, bullying of patients and abuse which becomes "normalised" because of the culture created by the provision.
140. Published in 2023 by DHSC, the paper **'Major Conditions Strategy: case for change and our strategic framework'** (WV1/68 - DHSC0000018) focuses on six groups of conditions that are collectively the greatest contributors to ill-health and early mortality, including all forms of mental ill health.

141. **NHS Planning Guidance:** DHSC works in partnership with NHSE to produce annual planning guidance. This has consistently included specific guidance and targets for mental health with a focus on delivering strategic ambitions for mental health care under the NHS Long Term Plan and the Five Year Forward View for Mental Health. Links to planning guidance within the requested time period are exhibited at **(WV1/73 - WITN0155010)**.
142. **Discharge from mental health inpatient settings (2024): (WV1/74 - WITN0155011)** This statutory guidance published by DHSC and NHSE sets out how health and care systems should work together to support discharge from all mental health and learning disability inpatient settings. It sets out best practice on how NHS bodies and local authorities should work closely together to support the discharge process and ensure the right support in the community, and provides clarity in relation to responsibilities, and patient and carer involvement in discharge planning. This guidance is discussed at greater detail at paragraph 201. The Annexes to this guidance provide statutory guidance for the implementation and discharge of the duties under s. 117 of the Mental Health Act in the provision of after care services within the community.
143. **Fit for the Future: 10 Year Health Plan (2025) (WV1/1 - DHSC0000096):** As part of the Government's health mission to build a health service fit for the future, it has published the 10 Year Health Plan to reform the NHS through three radical shifts: hospital to community, analogue to digital and sickness to prevention. This plan, and its key aims for mental health, are discussed in greater detail at paragraphs 286 to 290.

Previous policy work

144. There has been specific policy work in the Department over a broader period of time on the below topics. Some of these policies are no longer in place or have been superseded. Where that is the case, it is indicated below.

Reducing inappropriate out of area placements ('OAPs')

145. Many people receiving mental health services end up being treated or accommodated very far from where they originally lived. It is recognised that this lessens the ties to their families, friends and communities and can often lead them to be very isolated (which does not assist their recovery). Over the past 25 years, governments have sought to reduce reliance on out of area placements for those with mental health difficulties. This policy was first introduced in the 'National Service Framework for Mental Health' in 1999 (**WV1/75 - DHSC0000097**) and remained a core aim in the 2019 'NHS Long Term Plan' (**WV1/63 - DHSC0000013**) and in the NHSE 2024/25 'Priorities and Operational Planning Guidance' (**WV1/76 - DHSC0000098**). The 2019 NHS Long Term Plan set out plans to eliminate inappropriate OAPs by 2023/24. This was not achieved in that timescale due to factors such as the pandemic and difficulties in patient flow through the system. This aim was accompanied by a recognition that spending more time in hospital than necessary did not lead to good outcomes for patients, and policies were introduced to reduce length of stay. The 2019 NHS Long Term Plan sought to bring the typical length of stay back to the national average of 32 days, which was expected to contribute to ending OAPs. This is still current policy.

Ensuring timely follow up after someone is discharged from inpatient facilities

146. A standard expectation that patients would receive follow up support within seven days of discharge from inpatient facilities was set in the 1999 'National Service Framework for Mental Health'. In the 2011 mental health strategy, the proportion of people discharged from inpatient care who are followed up within seven days was included as an indicator of success. This standard later became more specific and ambitious. The 2019 NHS Long Term Plan included a financial incentive where providers were paid for achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge. A 72-hour follow-up standard has therefore been included in Schedule 4A of the NHS Standard Contract since 1 April 2020, which states that 'all people discharged from ICB-commissioned inpatient mental health services should be followed up within 72 hours' (**WV1/77 - WITN0155012**).

Ensuring that patients, carers and families are included in decision making, planning and information sharing

147. 'The National Service Framework for Mental Health' in 1999 stated that people with serious mental illness should be involved with service review and development and in 2011, the Government strategy as referred to in paragraph 125 ("No health without Mental Health") highlighted the importance of including patients in discharge planning, including those in child and adolescent mental health services. In 2000, 'The NHS Plan' (**WV1/78 - DHSC0000129**) placed emphasis on building on patient advocacy services in mental health and learning disability and autism services. The National Confidential Inquiry into Suicide and Homicide in Mental Health ('NCISH') report 'Safety First' (**WV1/79 - DHSC0000022**), included the 12 points to a safer service guidance, which set out the importance of sharing information with families during reviews of suicides. The 2002 suicide prevention strategy encouraged services to implement this guidance.

148. In 2014, the Government announced that departments were expected to use the Family Test as part of quality assessment of services and that carers should be closely involved in decisions about service provision. The 'Five Year Forward View for Mental Health' and implementation plan in 2016, again emphasised that co-production of services with people with lived experience, their families and carers, is a principle to be followed by local areas when developing and implementing their own local delivery plans.

Providing therapeutic care, in the least restrictive environment

149. The principle of providing care in the least restrictive environment as close to home as possible is a consistent theme through many of the policy, programmes and recommendations discussed in this statement, including the Mental Health Act. In the 'National Service Framework for Mental Health', local organisations were asked to review the appropriateness of bed use annually, and 'The NHS Plan' in 2000 set a goal of moving 400 people from high secure mental health hospitals to more appropriate accommodation by 2004. In 2011, the Department committed to keeping detention and community treatment orders under the Mental Health Act under review.

Paragraphs 1.1 and 8.8 of the 2015 revision of the statutory Code of Practice, which supports the Mental Health Act, discussed further at paragraph 191, that the least restrictive option should always be considered when making decisions in relation to care, support and treatment **(WV1/80 - WITN0155013)**.

150. This was followed by the 'Mental Health Units (Use of Force) Act 2018', which aimed to reduce unnecessary and inappropriate use of restraint in mental health hospitals. In October 2020 the Government announced capital investment of over £400 million over 4 years to improve mental health facilities by eradicating dormitories and giving patients the privacy of their own bedroom **(WV1/81 - DHSC0000119)**. As of March 2024, over 600 beds had been replaced across 34 sites.

Improving access to services and reducing waiting times

151. Between 1999 and 2000, there was more focus on alleviating bed pressures and increasing medium secure beds for mental health services. 'The NHS Plan' 2000 committed to an additional 7,000 extra beds in hospitals and intermediate care after the National Beds Inquiry found that the NHS did not have the right beds in the right places. Then, starting with the National Service Framework, published in 2005, **(WV/82 - DHSC0000099)**; **(WV1/83 - DHSC0000120)**, the aspiration was to shift care and increase capacity in community mental health services (including crisis services), in part to reduce the need for inappropriate stays in hospital and/or inappropriate out of area placements for mental health inpatients. 'Implementing the Five Year Forward View for Mental Health' (2016) noted that the national target for the NHS of reaching at least 70,000 more children and young people by 2020/21 would need to be delivered by NHS-funded community services. In delivering this expansion within community-based services, clinical commissioning groups should have commissioned improved access to 24/7 crisis resolution and liaison mental health services.

Assertive Outreach

152. Assertive Outreach ('AO') takes a multidisciplinary approach (including nurses, social workers, doctors, support workers, and occupational therapists), where all staff are involved in providing an individual care package which is tailored to the person's

needs. The objective of this model is maintaining people in the community wherever possible and to provide assertive, holistic and rehabilitative care with greater intensity of input than a standard team. A feature of this approach is that under this model of care, services seek out people and work with them in locations they feel comfortable, rather than requiring them to attend clinics. There should also be clear and rapid routes to assessment under the Mental Health Act should the patient's mental health needs escalate. A study by the University of Manchester, published in 2020, showed that 94% of homicides committed by people with schizophrenia were committed by people who had a history of alcohol or drug misuse or who were not in receipt of planned treatment. A key objective of more assertive models of care is to increase treatment adherence.

153. In 1999, the Department issued guidance on AO services for those at risk of disengagement with services as part of its National Service Framework for Mental Health, which established national standards for mental health **(WV/75 - DHSC0000097)**. The 2000 National Health Service Plan identified assertive outreach as a necessary component of community mental health provision **(WV1/84 - DHSC0000121)** and in 2001 the Department of Health published the Mental Health Policy Implementation Guide which aimed to support the delivery of adult mental health policy locally. Among other things, the Guide sets out who assertive outreach services are for and what they are intended to achieve. The Guide also outlines management and operational procedures.

154. According to 2023 NHSE benchmarking data, around a third of trusts had AO services. AO services were much more prevalent in the early 2000s. However, whilst international studies show that AO can reduce frequency and length of hospitalisation, increase engagement and retention in care and improve social functioning, the primary outcome of reduced hospitalisations was not replicated in an influential UK study conducted between 1999 and 2002 (the REACT study: randomised evaluation of assertive community treatment in north London, 2006) **(WV1/85 - DHSC0000122)**. However, subsequent studies have shown that AO services can have a positive impact on the target cohort of patients, including improving outcomes and reducing hospitalisation **(WV1/86 - DHSC0000123)**;

(WV1/87 - DHSC0000505); (WV1/88 - DHSC0000125); (WV1/89 - DHSC0000126); (WV1/90 - DHSC0000127); (WV1/91 - DHSC0000128).

155. Following the REACT study, and in the context of increasing pressure on health budgets, some local areas took decisions to prioritise other interventions, meaning some areas did not continue services in line with the AO model. While dedicated AO teams may have been discontinued, some areas will have maintained assertive approaches within existing services.
156. In 2024, the Department agreed with NHSE that NHSE should immediately review all community mental health services and commission a review of the evidence to support the development of a model of Assertive Outreach **(WV1/92 - WITN0155014)**. Following a requirement in the 2024/25 NHS Priorities and Operational Planning guidance for all ICBs to *"review their community services...to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge"* **(WV1/94 - DHSC0000101)**, in July 2024 (updated February 2025) NHSE issued accompanying guidance to ICBs on intensive and assertive community mental health care to support ICBs in this review.
157. The guidance sets out that while ICBs are not required to commission assertive outreach teams, meeting the needs of all individuals with a severe mental illness requires dedicated resource for intensive and assertive community care **(WV1/94 - DHSC0000101)**. This is in keeping with the direction provided in the 10 Year Health Plan that services should be less siloed and more joined-up, with multi-disciplinary teams providing more person-centred care. The guidance sets out the evidence base for the assertive outreach model and discusses the objectives of the model of care. The guidance is clear that community mental health services should consider how to meet the needs of patients who need more intensive and assertive care in the community in the context of the whole population, ensuring they can provide the best possible care for everyone with a severe mental illness and step up the intensity of support when required to meet the needs of patients.
158. As part of the 10 Year Health Plan, the Department has committed to improve AO care and treatment to ensure 100% national coverage in the next decade, with a

focus on narrowing mental health inequalities, please see paragraphs 248 and 286 to 290 for more detail.

Crisis care, including liaison teams in A&E

159. 'The NHS Plan' 2000 included plans for the establishment of 335 crisis resolution teams over the next 3 years and for all people in contact with specialist mental health services to be able to access crisis resolution services at any time by 2004. These teams were made up chiefly of mental health nurses, with additional input from social workers, consultant psychiatrists, psychologists, and occupational therapists. The intent was to treat around 100,000 people who would have otherwise been admitted to hospital, to reduce pressure on acute inpatient unit and the occurrence of out of area admissions.

160. The 'Five Year Forward View' of October 2014 set a goal for all acute hospitals to have "all-age" liaison mental health services available in their emergency departments and inpatient wards by 2020/21 to support people with SMI and to reduce inappropriate hospital care and out of area placements. The importance of good access to crisis care features in the majority of policy documents, starting with the National Service Framework, as well as the role of crisis alternatives and community crisis care in reducing inappropriate hospital stays and out of area placements.

161. When an individual has been detained under s. 135 or s. 136 of the Mental Health Act, 'Places of Safety' also form part of crisis care as a space where they can temporarily be held safely and receive support. In 2014, the Department published the Crisis Care Concordat, a joint agreement between key organisations in the mental health system which sought to improve outcomes for people experiencing mental health crises, which is discussed more in paragraphs 195 to 197. In later years (2016, 2019) there were more dedicated programmes for rolling out crisis care in the community and ensuring a wider provision of psychiatric liaison teams in emergency departments. For example, the implementation of the 2019 'NHS Long Term Plan' set out the intent for mental health liaison services to be available in all acute hospital

A&E departments and inpatient wards in 2023/24, which has now been achieved. 88 mental health ambulances have been provided as committed to in the 2023 Mandate.

Addressing inequalities, stigma and culture of care

162. Multiple disadvantage is commonly defined as the co-occurrence and interaction of two or more adverse circumstances or social problems leading to social exclusion, marginalisation and extreme inequality. The circumstances of people facing multiple disadvantage are often shaped by long-term experiences of trauma, deprivation, poverty, abuse, and neglect. Common experiences for people facing multiple disadvantage include domestic violence, homelessness, displacement, drug and alcohol misuse, mental ill health and contact with the criminal justice system.
163. The intersection of adverse circumstances can have a compounding effect which leads to significantly worse health outcomes for people with multiple disadvantage than the rest of the population and higher intensity use of public services including health, social care and crisis services.
164. People with multiple disadvantage often struggle to get the coordinated support they need to address overlapping and interconnected problems and face significant barriers to accessing support in health and care services.
165. In November 2008 the then Government commissioned an independent strategic review of health inequalities, chaired by Professor Sir Michael Marmot, with the purpose to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The Review's findings were subsequently published as 'Fair Society, Healthy Lives: The Marmot Review' (**WV1/95 - DHSC0000102**). Among the key messages of the report was the existence of a social gradient in health – that is, the lower a person's 'social gradient' (using the term Professor Marmot uses), the worse his or her health. Among other findings, the report noted at page 54 that "*Mental health is very closely related to many forms of inequality. The social gradient is particularly pronounced for severe mental illness.*"
166. The Department has been working to address issues of multiple disadvantage for some time, in line with the Public Sector Equality Duty and its predecessors in

other legislation. For example, a national inequalities target was introduced for the first time in 'The NHS Plan' 2000 to reinforce local targets for reducing health inequalities (**WV1/78 - DHSC0000129**). Later, the 2019 'NHS Long Term Plan', citing concerns about increasing inequalities, set out plans for new, funded, NHS action to strengthen its contribution to prevention and health inequalities. This included every local area across England being required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years and provide an improved therapeutic offer in inpatient mental health services by increased investment in interventions and activities.

167. Current Departmental activity to address multiple disadvantage includes the Changing Futures programme, a £77 million initiative between Government and The National Lottery Community Fund which tests innovative approaches to improving outcomes and driving system change for people experiencing multiple disadvantage. Changing Futures funds fifteen local areas over four years to work in partnership to create more accessible, flexible and personalised services for people experiencing multiple disadvantage. The programme works with those who are experiencing a combination of: homelessness; substance misuse; mental health issues; domestic abuse and contact with the criminal justice system (**WV1/96 - DHSC0000103**).

Research related to inequalities

168. Research undertaken over decades has identified that mental health services often fail to meet the needs of minority groups, as they lack the cultural competence to understand different beliefs, backgrounds, and experiences. This can prevent individuals from accessing support before reaching a crisis point, increasing the likelihood of detention.
169. In response to an independent inquiry into the death of David Bennett (**WV1/97 - DHSC0000023**) in 2003, the Government published 'Delivering race equality in mental health care: An action plan for reform inside and outside services' (**WV1/98 - DHSC0000104**) which included commitments to ensure staff receive training in cultural sensitivity and awareness, a commitment to eliminate institutional racism in mental health services, actions to encourage a more diverse workforce and policies

to reduce unsafe use of restraint. The Government-commissioned Independent Review of the Mental Health Act (**WV1/93 - DHSC0000024**) in 2018 highlighted high rates of detention, racial disparities in detentions and CTOs, poor patient experience, and the particular disadvantages experienced by people with a learning disability and those with autism.

170. The Patient Carer and Race Equality Framework ('PCREF') arose from a recommendation from the Independent Review and was developed by NHSE under the Advancing Mental Health Equalities Programme (**WV1/99 - DHSC0000105**). The PCREF framework outlines the participatory approach to anti-racism that mental health trusts and providers should take to improve experience of care for racialised and ethnically and culturally diverse communities. DHSC are involved in PCREF and participate in its steering board at an official level, however this framework is "owned" by NHSE.

171. An evidence briefing the Department prepared during the passage of the Mental Health Bill sets out an overview of research into racial disparities in mental health care and treatment (**WV1/100 - WITN0155015**). Key trends include:

- a. In 2023/24 Black or Black British detention rates were over three and a half times higher than that of the White British group (this ratio was broadly stable since 2017/18 (**WV1/101 - DHSC0000130**)). Mixed and Asian ethnic groups also experienced elevated rates of detention, though to a lesser extent.
- b. Black or Black British people have longer periods of detention and more repeated admissions (**WV1/101 - DHSC0000130**) and are also more likely to be subject to police holding powers under the Mental Health Act (**WV1/102 - DHSC0000131**).
- c. In 2023/24, Black or Black British people were issued with Community Treatment Orders at seven times the rate of White or White British people (**WV1/101 - DHSC0000130**). This disparity was highest in 2021/22, where Black or Black British people had a standardised CTO rate which was 11 times those of White or White British people.

Guidance on Assessing and Managing Risk in Mental Health Services

172. In June 2007 (updated March 2009), the Department published the guidance 'Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment' (**WV1/103 - DHSC0000038**) and 'Management of Risk to Self and Others in Mental Health Services', for mental health professionals working with service users to assess risk. It underpins risk assessment with principles for good practice for all mental health settings and provides a list of tools offering structure to risk management. This was the last guidance dedicated to reducing risk of harm to the public from mental health patients published by the Department.

173. NHSE has subsequently published guidance on risk, as outlined in paragraphs 179 to 182, for services.

Wellbeing and Mental Health: Applying All Our Health (2016)

174. The Inquiry has asked specifically about the Wellbeing and Mental Health Guidance in the 'Applying All our Health Guidance' series (**WV1/104 - DHSC0000132**), an online resource to help health professionals prevent ill health and promote wellbeing as part of their everyday practice. This guidance covers topics such as 'promoting mental health in your professional practice', 'preventing mental health problems', 'understanding local needs' and 'measuring impact'. It gives specific recommendations to frontline professionals and provides online tools for further support.

Information sharing to support organisations and professionals to share data for care or where there is a risk of harm

175. The Department is responsible for setting the strategic direction for use of data held in the health and care system, this means ensuring national policies support the effective, safe and appropriate use of data.

176. Organisations and individuals delivering health and care services to patients need to be able to access the information they require to provide safe, appropriate and timely care. They need to be able to identify risks and, where required, share

information with partner organisations while respecting privacy and maintaining public trust.

177. There is a range of law and guidance to support organisations and professionals to share data for an individual's direct care or where they may represent a threat to themselves or others. These include:

- a. Articles 6(1)(e) and 9(2)(h) of UKGDPR, which provide a legal basis for sharing data for an individual's direct care under UK Data Legislation;
- b. Section 251B of the Health and Social Care Act 2012, which places a duty on health and social care commissioners and providers to share information with each other to facilitate the delivery of services to individuals.
- c. Implied consent, which provides a legal basis for sharing an individual's data for the purposes of their direct care, under the common law duty of confidentiality;
- d. Powers to share data where there is an overriding public interest (such as where the individual is a threat to themselves or others) without breaching the common law duty of confidentiality.

178. The Department is aware of the following guidance produced by NHSE to support organisations and professionals to share data for an individual's direct care or where they may represent a danger to themselves or others.

NHSE Guidance

179. Use and Share Information with Confidence guidance (**WV1/105 - DHSC0000166**).
180. Consent and Confidential Patient Information (**WV1/106 - DHSC0000167**).
181. NHSE's 2023 guidance on Data and Clinical record sharing (updated 2025) (**WV1/107 - DHSC0000060**).
182. NHSE guidance on sharing information with police (**WV1/108 - DHSC0000133**).

Information Commissioners Office ('ICO') or National Data Guardian Guidance

183. The Caldicott Principles (**WV1/109 - DHSC0000134**) provide a framework for sharing health and care information and include a principle that 'the duty to share information for individual care is as important as the duty to protect patient confidentiality'. All health and care organisations must appoint a Caldicott Guardian, a senior person responsible for protecting the confidentiality of individuals' health and care information and ensuring it is appropriately used, to advise on issues such as sharing with outside agencies like the police.
184. ICO guidance on sharing information for mental health emergencies is exhibited here (**WV1/110 - DHSC0000135**).

Medical Professional bodies' guidance

185. The GMC's Good Medical Practice (**WV1/111 - DHSC0000136**) sets out the principles, values, and standards of professional behaviour expected of medical professionals. These include requirements to promptly share all relevant information about patients with others involved in their care and ensuring that all records of work are clear and accurate.
186. GMC's 'Disclosing patients' personal information: a framework' includes guidance on when information about a patient may be shared in the public interest (**WV1/112 - DHSC0000137**).
187. The common law duty of confidentiality enables data to be shared where:
- a. The individual has consented. For an individual's direct care, health professionals are generally able to rely on a concept called "implied consent", on the basis that the individual reasonably expects their data to be shared for the purposes of their care;
 - b. The individual has provided their "explicit consent" – this is required from the individual where the purpose for using or sharing their confidential information is not something they would reasonably expect, or for a purpose that is not to do with their direct care;

- c. A legal power to share exists which explicitly sets the common law duty of confidentiality aside;
- d. There is an overriding public interest.

188. However, there are no legal definitions of what constitutes 'direct care' or an overriding public interest. This can lead to confusion about whether the sharing of data is lawful, and consequently a risk-averse approach to sharing. To address this there is a range of guidance including NHSE's 'Sharing information with the Police' (**WV1/108 - DHSC0000133**) and the GMC's 'Confidentiality: Good Practice in handling patient information' (**WV1/113 - DHSC0000138**) which provides advice on sharing in the public interest.

189. Local authorities must cooperate with each of their relevant partners, as described in s. 6(7) of the Care Act 2014, in relation to their functions under Part 1 of the Care Act, and those partners must also cooperate with the local authority in the exercise of their functions relevant to care and support, including those to protect adults, and carers.

Guidance on multi-agency working

190. In respect of multi-agency working concerning mental health patients, the Department has led and contributed to several key pieces of guidance.

Mental Health Act - Code of Practice

191. Most notably, the Mental Health Act's Code of Practice (**WV1/47 - DHSC0000007**) provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and AMHPs on how they should carry out functions under the Mental Health Act in practice. The most recent update to the Code took place in 2015. The guidance was developed by the Department of Health and the Home Office, informed by consultation with expert health, policing and social care stakeholders, including:

- a. AMHP Leads Network, Association of Ambulance Chief Executives, Association of Police and Crime Commissioners, British Association of Social

Workers, CQC, Mind, NHSE, Rethink, Royal College of Nursing, Royal College of Psychiatry, and the Welsh Government.

192. The 2015 Code of Practice covers multi-agency plans for patient transformation, the Mental Health Act's Links to Multi-Agency Public Protection Arrangements ('MAPPA').
193. The Department published a 'Reference Guide to the Mental Health Act 1983' in 2015 to complement the revised Code of Practice (**WV1/114 - DHSC0000139**).
194. The Government will update the Code of Practice following the Mental Health Bill's Royal Assent, in consultation with external agencies and organisations.

Mental Health Crisis Care Concordat

195. The NHS Mandate in 2014/15 (published in 2013) made it a requirement for the NHS that 'every community has plans to ensure no one in mental health crisis will be turned away from health services' (**WV1/115 - DHSC0000140**). Subsequently in February 2014, the Department signed the Mental Health Crisis Care Concordat (**WV1/20 - DHSC0000113**) on improving outcomes for people experiencing mental health crises. Signatories to this Concordat included, among others, the Association of Ambulance Chief Executives, the Association of Chief Police Officers, the Association of Directors of Adult Social Services, the British Transport Police, NHSE, and the Royal College of Psychiatrists. These national organisations committed to working together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England, including access to support before crisis point, urgent and emergency access to crisis care, and the right quality of treatment and care when in crisis. The Concordat was a response to a perceived lack of consistency and quality in crisis care, with a particular focus on improving outcomes for vulnerable individuals and reducing their disproportionate interaction with the criminal justice system, especially via police involvement.

196. Signatories committed to the following joint statement:

"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the

support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first. We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery. Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England.” (WV1/20 - DHSC0000113).

197. Crisis care also featured in the NHS Long Term Plan in 2019, with a commitment that ‘in the next ten years we are committed to ensuring the NHS will provide a single point of access and timely, universal mental health crisis care for everyone’ (WV1/63 - DHSC0000013). In 2022, CQC conducted a review of the quality, safety and effectiveness of care for those experiencing a mental health crisis as part of their commitment to the Crisis Care Concordat (WV1/116 - DHSC0000107), (WV1/117 - DHSC0000037).

Mental Health Act 1983: Implementing Changes to Police Powers

198. In 2017 the Department and Home Office published joint non-statutory guidance to support the implementation of changes made to the police powers and safety provisions in the Mental Health Act, made by the Policing and Crime Act 2017 (WV1/118 - DHSC0000039). The Policing and Crime Act 2017 made changes to the police’s powers under ss. 135 and 136 of the Mental Health Act to take a person to, or keep a person at, a place of safety. The changes also limited the use of police stations as places of safety. The Mental Health Act (Places of Safety) Regulations 2017 specify when and how a police station can be used as a place of safety for adults experiencing mental health crises, and sought to restrict the use of them to where there are exceptional circumstances and where no other place of safety exists.

National Partnership Agreement: Right Care, Right Person (‘RCRP’)

199. In 2023, the new National Partnership Agreement outlined the principles that local areas are encouraged to adopt to implement Right Care, Right Person (‘RCRP’) (WV1/119 - WITN0155016). It set out a national commitment from the Department,

the Home Office, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHSE to work to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs. It is important that people in need of mental health support, or in a mental health crisis, are supported by mental health specialists with the relevant training, skills and expertise and that police officers can focus their time on investigating and preventing crime. This agreement provides a framework for assisting police with decision-making about when they should be involved in responding to reported incidents involving people with mental health needs.

200. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents which relate to people with mental health needs. The threshold for a police response to a mental health-related incident is: to investigate a crime that has occurred or is occurring, or to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm. Where it is appropriate for the police to be involved in responding, this will continue to happen, but the police should only be involved for as long as is necessary, and in conjunction with health and/or social care services. Under RCRP, police will continue to respond in cases where there is a duty to investigate a crime and protect people when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

Discharge from Mental Health Settings Guidance

201. The Government published statutory guidance in 2024 on discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults (**WV1/74 - WITN0155011**). This guidance was made as a result of ss. 72 and 82 of the 2006 Act, as amended by s. 75 of the Health and Care Act 2022, which granted the Secretary of State new powers to publish guidance. The guidance is designed to give organisations across the health and care system greater clarity about what the 'duties to cooperate', referred to in ss. 72 and 82, mean in practice in the context of discharge from these settings. It aims to share and promote best practice in relation to how NHS bodies and local authorities can work closely together

to support the discharge process and ensure the right support in the community. As part of this, it provides clarity on where responsibilities sit within the discharge process, including funding responsibilities, and provides guidance on patient and carer involvement in discharge planning. Three of the main principles are: chosen carers should be involved in the discharge process as early as possible; there should be ongoing communication between hospital teams and community services involved in onward care during the admission; and post-discharge and information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person. The Annexes to this guidance provide guidance on the duties under s. 117 of the Mental Health Act.

Consensus statement for information sharing and suicide prevention

202. In August 2021, DHSC published a consensus statement (**WV1/120 - DHSC0000108**) aiming to address the balance between reducing suicide risk through sharing of information, and respecting patient confidentiality. This statement was produced jointly with organisations such as the Royal College of Psychiatrists, the Royal College of Nursing, Directors of Adult Social Services, and the Mental Health Network NHS Confederation. The Department commissioned the Zero Suicide Alliance to produce guidance for health and social care staff on how to use the consensus statement and how to engage with patients when discussing confidentiality and consent to share information (**WV1/121 - DHSC0000141**).

Data and quality monitoring

203. DHSC does not collect data on the quality and safety of mental health services itself but does receive and review insights from the health and care system, for example the CQC, Prevention of Future Deaths Reports from the coronial service, and the NCISH Annual Report, described at paragraphs 204 to 214 below. The National Confidential Inquiry into Suicide and Safety in Mental Health ('NCISH') was established at the University of Manchester in 1996, and leads research into suicide prevention in clinical services, with an overall aim of improving safety for all mental health patients.

CQC

204. CQC publishes an annual statutory 'Monitoring the Mental Health Act' report. This reflects the views of thousands of patients interviewed each year and aims to drive improvements in policy and practice.
205. Of particular interest to the Inquiry may be the 2022/23 Monitoring the Mental Health Act report (**WV1/122 - DHSC0000142**), which highlights the challenge the mental health sector faces due to retention and staffing shortages. The 2023/24 Monitoring the Mental Health Act report (published after the events of 13 June 2023) (**WV1/123 - DHSC0000143**) references the special review of the Nottinghamshire Healthcare NHS Foundation Trust, and notes that CQC identified "*systemic issues with community health care, including a shortage of mental health staff, and a lack of integration between mental health services and other healthcare, social care, and support services. We warned – and continue to warn – that without action these systemic issues pose an inherent risk to patient and public safety.*" (**WV1/124 - DHSC0000144**).
206. The 2023/24 Monitoring the Mental Health Act report (**WV1/125 - WITN0155017**) was based on the findings from 823 monitoring visits (which covered 870 wards) carried out during 2023/24. This involved speaking with 4,634 patients (3,343 in private interviews and 1,291 in more informal situations) and 1,435 carers. Beyond reporting on the findings and outcomes from their monitoring visits, the annual report also covers data and evidence associated with the Second Opinion Appointed Doctor service, complaints, and deaths of detained patients and patients subject to a CTO, among other things.
207. The State of Care report is CQC's annual assessment of health and social care in England. It explores key trends, highlights areas needing improvement, and showcases examples of good and outstanding care (**WV1/126 - WITN0155018**). Mental health services are one of the four key sectors the report focuses on. For instance, the 2021/22 edition of State of Care notes "*In our community mental health survey 2021, only 2 in 5 respondents felt they had 'definitely' seen NHS mental health services enough for their needs in the last 12 months*" (**WV1/127 - DHSC0000145**).

This was the lowest score across the period from 2014 to 2021. The 2023/24 State of Care report found that the demand for adult mental health services continued to grow, and key challenges included access to mental health services, with people living in deprived areas, women, and people from 'other' ethnic minority groups more likely to attend urgent and emergency care departments, and problems with staffing the mental health workforce (**WV1/123 - DHSC0000143**). The 2024/25 State of Care report noted that demand in mental health services continued to grow (an increase of 15% from 2022/23) coupled with lengthy waits that persist as well as increasingly complex needs. CQC also noted that more high-risk cases are being managed in the community due to challenges with accessing hospital and more care in the community.

Prevention of Future Deaths Reports

208. Since 2013, Coroners have a duty to issue a Prevention of Future Deaths ('PFD') report as part of the reforms issued under the Coroners and Justice Act 2009 (Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009). If something is revealed during an investigation which gives rise to concern of a risk to life caused by present or future circumstances, and if they think action should be taken to prevent or reduce the risk of death created in these circumstances, then the coroner must report the matter to a person or organisation they believe may have power to take such action.

209. Recipients of PFD reports have a statutory duty under regulation 28 of the Coroners (Investigations) Regulations 2013 to respond within 56 calendar days explaining what action they propose, or why no action is proposed. The Department receives a high volume of PFD reports each year, only a small proportion of which are relevant to the issues considered by the Inquiry. On reviewing PFDs addressed to the Department between 2019 and 2023, the Department has found four PFDs which it considers may be of particular relevance to the Inquiry. These are exhibited, along with the Department's responses (where publicly available) here: (**WV1/128 - WITN0155019**); (**WV1/129 - WITN0155020**); (**WV1/130 - WITN0155021**); (**WV1/131 - WITN0155022**) (**WV1/132 - WITN0155023**).

210. The Department continued to meet its statutory obligations in responding to PFDs, but it recognised that the increasing volume of reports made it challenging to maintain timely and consistent management, and that more could be done to learn from the reports and implement the actions it had committed to in the responses. There was a need to strengthen case management, coordination, and accountability. The Department therefore reviewed its internal processes and has made significant improvements. A dedicated PFD Oversight Team has been established to manage all incoming reports and ensure timely and effective responses. This team acts as the main point of contact with coroners, handling incoming and outgoing PFD correspondence. Monthly statistics on compliance rates are also shared with the Department's Executive Committee to ensure the Department is meeting its statutory obligation. Each PFD response is now led by the relevant policy team(s), ensuring specific concerns raised by coroners are addressed.

211. Responses are now reviewed and signed off by the relevant Senior Civil Servant (SCS) before being submitted for Ministerial approval. This ensures that policy teams are more clearly accountable for the quality and content of PFD responses and are better able to incorporate learning from individual PFDs into their ongoing policy work. The Department continues to collaborate closely with other Government Departments, regulators and the Chief Coroner's Office where relevant, to obtain relevant contributions as part of responding to PFDs, but also to share learning and to apply a consistent approach to handling PFDs.

Other examples

212. The NCISH Annual Report is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHSE to provide findings relating to people who died by suicide across all UK countries. These reports are exhibited at (**WV1/133 - DHSC0000146**). Additional findings were presented on the number of people under mental health care who have been convicted of homicide. In 2018, NHSE took the decision to decommission this research programme into homicides.

213. However, the NHS will be re-commissioning the NCISH to provide data relating to homicides. This will re-open an avenue to understanding the common themes

nationally on homicide and mental health and allow us to continue to learn lessons to inform policy and action. NCISH have said they are resuming a detailed data collection into patient homicide, which will expand on the national homicide inquiry that ended in 2018 **(WV1/134 - DHSC0000147); (WV1/135 - WITN0155024)**. They plan to explore new questions, additional methodologies and to work with affected families.

214. In relation to patient safety and in response to high-profile failings in patient safety in Greater Manchester Mental Health NHS Foundation Trust, Essex Partnership University NHS Foundation Trust and Tees, and Esk and Wear Valleys NHS Foundation Trust, the Department commissioned a Rapid Review into data on mental health inpatient settings in January 2023 **(WV1/136 - WITN0155025)**. This sought to produce recommendations to improve the way data and information is used in relation to patient safety in mental health inpatient care services and pathways, including complaints, user voice and whistleblowing alerts. The review covered data on mental health inpatient services collected by national bodies, regional teams, local systems, providers of NHS-funded care, and others with a role in collecting information related to patient safety.

Mental Health Bill

215. The Mental Health Bill delivers the Government's manifesto commitment to modernise legislation to give patients greater choice, autonomy, enhanced rights and support, and ensure everyone is treated with dignity and respect throughout their care and treatment. The Bill includes measures to improve the care and support of people with a learning disability and autistic people, aiming to reduce reliance on hospital-based care.

216. The Mental Health Bill reflects recommendations made by an Independent Review, led by Professor Sir Simon Wessely ('the Independent Review') **(WV1/137 - WITN0155026); (WV1/49 - WITN0155008)**. Between 2005/06 and 2015/16, in the lead up to the Independent Review, the number of detentions under the Mental Health Act rose by over a third from 47,400 to 63,622 (to note, in 2016-17, the way NHSE sourced and produced these statistics changed **(WV1/138 - DHSC0000148)**;

(WV1/139 - DHSC0000149). Figures from 2016/17 onwards are therefore not directly comparable to previous years). A disproportionate number of people from black and minority ethnic groups were also detained or subject to CTOs, which was a key area of concern leading to the review. The review also recognised that many of the processes in the Act were out of step with a modern mental health system, for example, not reflecting the wider shift to giving patients more choice and autonomy about their care and recognising the positive impact involving patients in their own care can have. This is common practice in accordance with the NHS Constitution, but the review found this was not reflected for patients detained under the Act.

217. The planned reforms arising from the review and subsequent White Paper consultation do not change the fundamental powers and purpose of the Mental Health Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others. In advance of the Bill's introduction to Parliament in 2024, the Department reviewed the reforms to ensure the updated Act will continue to provide the necessary powers to enable clinicians to act to protect patients and the public. However, when the very serious decision is taken to detain someone, the reforms will ensure there is a modern framework for the use of these powers, to ensure patients are treated with dignity and respect and that they receive care and treatment which supports recovery. Whilst overall there is a desire to see a reduction in the use of the Mental Health Act given concerns around rising rates of detention under the Act, the legislative changes do not intend to prohibit or reduce use of these powers whenever they are needed. The Government recognises that improvements to mental health community and crisis services are needed to support a longer-term reduction in admissions under the Mental Health Act.

Overview of Proposed Legislative Reforms

218. The Mental Health Bill will improve patient safeguards by **(WV1/140 - DHSC0000150)**:

- a. Requiring the Secretary of State to include the four guiding principles identified by the Independent Review and co-designed with service users – Choice and

Autonomy, Least Restriction, Therapeutic Benefit and the Person as an Individual – in the statement of principles in the statutory Code of Practice.

- b. Introducing statutory care and treatment plans for patients detained under the Mental Health Act, (and on CTOs or subject to guardianship) excluding those under short term detention. This is to ensure that patients have a comprehensive and up to date plan in place outlining what treatment and support they need to progress towards recovery and their safe and effective discharge. Patients and others, such as their Nominated Person, will be consulted on these statutory plans where this is appropriate and practicable.
- c. Strengthening and clarifying the detention criteria. The new criteria will make clear that people will only be detained if they pose a risk of serious harm to themselves and/or others, and if there is a reasonable prospect that they will benefit from the proposed treatment.
- d. In response to a recommendation by the Joint Select Committee on the Draft Mental Health Bill, who reviewed the Bill in the Pre-Legislative Scrutiny Process, the Department has removed the proposed new requirement for clinicians to consider 'how soon' harm may occur from the detention criteria, to avoid the suggestion that harms must be imminent and to ensure clinicians are not dissuaded from making beneficial early interventions **(WV1/141 - DHSC0000151); (WV1/142 - DHSC0000152)**.
- e. When deciding to discharge a patient, the responsible clinician will need to consult with another professional who has been involved in the patient's care and treatment, whether that be in the community or hospital, to strengthen informed decision making around discharge and to formalise best practice. It is particularly important that the second professional is of a different profession to the responsible clinician, therefore providing a different perspective. The second professional may also have had more regular contact with the patient than the responsible clinician, for example a nurse compared to a consultant psychiatrist. There should be communication and collaboration between responsible agencies from an early point in the patient's detention to ensure their safe and timely discharge and continued care and support after hospital:

- f. Reforming the use of CTOs to reflect the revised detention criteria, to increase oversight and scrutiny of decision making, and to create new powers to enable the 'Nominated Person' to object when appropriate (see below).
- g. Mental Health Tribunals are independent panels which review the detention of individuals under the Mental Health Act. The Bill seeks to improve oversight of a patient's detention by increasing the frequency that patients can appeal and ensuring that those who do not appeal are referred automatically more frequently. It will also provide the Mental Health Tribunal with a power to recommend that a plan for the provision of community aftercare services is made to facilitate patient discharge.

219. The Bill will improve patient choice and autonomy by:

- a. Introducing a new clinical checklist requiring clinicians to, among other things, support the patient to be involved in decision making about their treatment, and to consider their wishes and feelings (including any relevant written statement made by the patient when they had capacity). This supports the principles of choice and autonomy and treating the patient as an individual, helping ensure decisions are patient centred and not merely based on assumptions about the patient or clinicians' preferences.
- b. Introducing duties on health commissioners that, in particular, aim to facilitate people at risk of detention to make an Advance Choice Document, while they are well and in the community. This document is intended to contain a record of individual's decisions regarding their care and treatment, wishes, feelings, beliefs and values. This should then be used by mental health professionals if the individual is later assessed and/or detained under the Mental Health Act or admitted as an informal patient and loses their capacity or competence to make relevant decisions.
- c. Strengthening treatment safeguards, so that when someone with the relevant capacity is given medical treatment which is against their expressed wishes and feelings, either at the time or in advance, there are cogent reasons to do so, and treatment is certified by the second opinion appointed doctor's service.

We will also be giving patients who lack the relevant mental capacity to consent to medical treatment earlier access to the second opinion appointed doctor's service.

- d. Allowing patients to choose someone to be their 'Nominated Person' to protect their rights, replacing the current Nearest Relative, and strengthening duties on clinicians to involve patients and the nominated person in care and treatment planning and decision making.
- e. Expanding access to Independent Mental Health Advocates ('IMHAs') to voluntary patients in England, who are not detained under the Act, and introducing an opt-out approach for detained patients so that all qualifying patients will be interviewed to see if they want to use IMHA services. IMHAs are specialist advocates who represent and support patients' rights. By further improving access to IMHA services, the reforms will help ensure that patients do not miss out on the valuable support IMHAs provide.
- f. Ensuring decisions around care and treatment, and how the wishes of patients and views of carers have been considered, are clearly articulated and recorded through care and treatment plans. This supports greater transparency around clinical decision making, allowing for decisions to be scrutinised, where necessary.

220. The Bill will limit the detention of people with a learning disability and autistic people (without a qualifying co-occurring mental health condition) by:

- a. Restricting the use of Part II of the Act (relating to patients not detained by the criminal justice system) for people with a learning disability and autistic people. It will no longer be possible to detain a person with a learning disability or autistic person under Part II, s. 3 unless they have a co-occurring mental disorder that warrants hospital treatment. Detention under Part II, s. 2 will still be possible for a maximum of 28 days for assessment. This change will affect civil patients only. Hospital will remain an option for those patients in contact with the criminal justice system (under Part III of the Act) where the only alternative to detention in hospital is prison.

- b. Placing Care (Education) and Treatment Reviews on a statutory footing so that an NHS commissioning body must take steps to ensure reviews are held when a patient with a learning disability or an autistic patient is detained in hospital, as well as placing a duty on certain bodies to have regard to the review recommendations.
 - c. Creating a duty on ICBs to establish and maintain a register of people with a learning disability and autistic people who have risk factors for detention (these factors will be specified in regulations made by the Secretary of State) and who consent to being included. A duty will also be placed on that body and on local authorities to have regard to any information obtained for, or contained in, the register or shared under the provisions and seek to ensure the needs of these people can be met without detaining them.
221. The Bill will improve access to mental health care and treatment for people in the criminal justice system by:
- a. Ending the use of prison and police cells as 'places of safety' under the Mental Health Act. As a result of the introduction of The Mental Health Act (Places of Safety) Regulations 2017, discussed at paragraph 161 above, the number of people detained in a police cell under the Mental Health Act has decreased. The Bill will end the use of police cells as places of safety. This is in line with the Independent Review recommendation that police cells should be removed altogether as a place of safety in the Mental Health Act by 2023/24 to ensure that people in crisis get the support they need from clinicians in hospital, without being subjected to the criminalising and traumatising experience of time spent as though they were under arrest. Under the Bill, which retains the right of the police to use powers under the Bill to remove a person from a public space (under s. 136) or private premises (under s. 135) for the purpose of a mental health assessment or other arrangements, they will take them to a suitable place of safety, such as a hospital.
 - b. Ending the use of remand for own protection under the Bail Act where the Court's sole concern is the defendant's mental health.

- c. Introducing a statutory 28-day time-limit for transfers from prison and other places of detention to hospital when a person requires treatment under the Act.
 - d. Introducing a sub-set of Conditional Discharge to be called 'Supervised Discharge', to provide for a small number of restricted patients that are no longer benefitting from being in hospital to be discharged from hospital into arrangements in the community amounting to a deprivation of liberty (to note, restricted patients are detained under Part 3 of the Mental Health Act and are subject to specific restrictions to protect the public from serious harm after criminal proceedings).
 - e. Introducing new powers to enable patients remanded by the Crown Dependencies' courts to transfer to suitably secure hospitals in England and Wales for treatment and assessment.
222. The Bill ensures the Mental Health Act continues to provide clinicians with power to act where there are concerns around public protection (and patient safety), and has taken steps to strengthen this:
- a. The revised detention criteria will not hinder a clinician's ability to detain someone where it is necessary to protect either themselves or others. Introducing the threshold of 'risk of serious harm' to the detention criteria will require clinicians (and subsequently the Mental Health Tribunal) to consider risk as part of the assessment or tribunal process. Formalising this requirement will ensure that risk to the public or the patient is a key element of a clinician's assessment.
 - b. Details of the reasons for detention will be recorded in the relevant statutory forms and in the patient's care and treatment plan. This audit trail aims to strengthen transparency around clinical decision making. It also helps make sure there is a clear record of the patient's history.
 - c. Changes to detention periods do not prevent the detention of people for a longer period, if necessary, including where it is assessed as necessary for

the protection of themselves or others. Detention can be renewed and there is no limit on the number of renewals.

- d. The Bill increases the rigour of the protocol around discharging someone from detention, bringing it more closely in line with the statutory protocol around renewing someone's detention and the new protocol for renewing or ending someone's CTO. The power to give compulsory treatment to patients (i.e. treatment without the patient's consent) is still available, but the Bill has introduced greater safeguards to ensure this power is only used when necessary and appropriate. The clinical checklist requires the clinician to have regard to all relevant circumstances in making clinical decisions regarding the patient's care and treatment while they are detained. In the case of a patient who is a risk to others, this would include weighing up in individual cases the patient's wishes and feelings and what is best from a public protection perspective to ensure effective management of the patient's risk.
- e. Families and carers will be more involved in decision making, as people who often know patients best and the signs they are becoming unwell or a risk to themselves or others. The clinical checklist and other changes to the treatment safeguards aim to increase requirements on clinicians to consult patients, their families and carers. Advance Choice Documents will allow people to set out in advance who should be involved in their care and the opportunity to identify their Nominated Person which, as discussed, will replace the system for the nearest relative. The details of what needs to be included in a patient's care and treatment plan will be set out in regulations. The Department has already set out in a memorandum from DHSC and the Ministry of Justice to the Delegated Powers and Regulatory Reform Committee (**WV1/143 - DHSC0000153**) that the Department expects care and treatment plans will include the outcome of any assessment of the patient's safety, and the plan for managing that, as well as details of the services the patient may need to meet the needs arising from their mental disorder.

223. Further detail of the reforms in the Bill are included in its Explanatory Notes and Impact Assessment: (**WV1/144 - WITN0155027**); (**WV1/145 - WITN0155028**).

Anticipated Impact of Reforms

224. As a result of the reforms in this legislation, the Department would expect that *“patients and service users should experience improved choice, less coercion and restriction of their liberties, care that is more consistently respectful, and meets their individual needs”* (p. 228 of the Independent Review). That is, patients should feel supported to share their wishes and preferences, that their voice is respected and used to inform their care and treatment, and restrictive practice or compulsory treatment is only to be used in limited cases where there is good reason, for example to alleviate the patient’s serious suffering. Overall, these reforms seek to improve patient experience, health outcomes and quality of life, and the delivery of more appropriate and cost-effective services, including reducing length of inpatient stays. By improving experience of services, the Department hopes this will increase trust and that patients will choose to engage. If patients do engage with services and continue treatment, whether as inpatients or once back in the community, this will support recovery, prevent future crisis and keep patients and others safe.
225. The fundamental powers of the Mental Health Act will remain, and whilst the reforms encourage the involvement of patients in care and treatment decisions, clinicians will continue to have the power to overrule views and require treatment when it is in the interest of patient, or wider, safety.
226. Research evidence suggests that interventions that focus on involving service users in defining preferences and planning for their care in the event of a future mental health crisis, including Advance Choice Documents, have been found to sometimes reduce the risk of hospital admissions **(WV1/146 - DHSC0000154)**.
227. The Department expects that the change in detention criteria for people with a learning disability and autistic people will lead to a reduction in the number of detentions in this population.
228. The use of CTOs is expected to reduce as a result of changes in the CTO criteria. The Mental Health Bill’s impact assessment assumes that CTOs will decrease gradually to a total 20% reduction over a five-year period from the point at which CTO reforms are implemented, relative to the baseline **(WV1/144 -**

WITN0155027). It is expected that the reforms will help to address the well documented racial disparity in the use of CTOs. CTOs will still be available to keep patients and others safe where they meet the CTO criteria.

Overview of system response and clinical accountability where there is a death or homicide related to mental health

229. If a patient dies while detained under the Mental Health Act, then a coroner will investigate and hold an inquest, if they deem it necessary. As discussed above at paragraph 208, coroners have a duty to issue a Prevention of Future Deaths report if something revealed during an investigation gives rise to concern of a risk to life caused by present or future circumstances, and if they think action should be taken to prevent or reduce the risk of death created in these circumstances.

230. Any such death also triggers the application of the National Learning from Deaths Policy Framework (2017), for which guidance was coordinated by DHSC for the National Quality Board (**WV1/61 - DHSC0000090**). This Framework was produced as part of a national programme that was initiated and managed by DHSC in response to CQC's review report *Learning, Candour and Accountability* (2016) (**WV1/147 - DHSC0000155**). The review was commissioned by the former Secretary of State, Jeremy Hunt, following the death of Connor Sparrowhawk at a learning disability inpatient unit in Oxford in 2013, and examined the way NHS Trusts review and investigate deaths of patients in England. The review found that in some organisations, learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed.

231. A cross-system programme board on Learning from Deaths, chaired by the Department, ran from 2017 to 2019 with a specific remit to provide delivery assurance of the CQC report's seven recommendations, including delivering the aforementioned first ever National Guidance on Learning from Deaths. Under the national guidance (National Guidance on Learning from Deaths issued in March 2017), if there is reason to believe that the death of a patient with severe mental health illness was more likely than not due to problems in care, it must be subject to a patient safety incident investigation by the mental health provider. More widely,

organisations must have a policy for using case record review for learning from deaths. This involves a systematic review of patient records to identify areas of improvement in healthcare, using a standardised method like “Structured Judgement Review” (SJR). The process is mandated (via the National Learning from Deaths Guidance/programme) and supplemented by guidance from the Royal College of Psychiatrists. Any deaths of inpatients detained under the Mental Health Act thought to be due to problems in care – including self-inflicted death - must be investigated. The National Guidance also states that providers must fully support investigations by the Prison and Probation Ombudsman or the Independent Police Complaints Commission where required to do so. Compliance with National Guidance on Learning from Deaths is a requirement for all Trusts under the NHS Standard Contract.

232. NHSE and DHSC do not directly collect outputs from the case record review process at Trust level. Trusts however are expected to record all identified patient safety incidents as normal via Local Risk Management Systems (‘LRMS’) such as “Datix”, and collate this for input into the Learn from Patient Safety Events Service (‘LFPSE’). Data from LFPSE is analysed centrally for underreported or new risks, and at a local level helps Trusts to understand their local reporting practices and learning. The incidents are not separately identified to LFPSE though so we cannot say which incident records come from this route.

233. CQC can also assess how a Trust is learning from deaths through their “well-led” key question. Under its assessment framework, CQC assesses learning from deaths under their quality statement, ‘Learning, Improvement and Innovation’ (**WV1/148 - DHSC0000156**). Where specific concerns are identified in regard to learning and improvement, CQC can use its enforcement powers to take action with individual providers and report its findings of good and poor progress in individual assessment reports or national publication. CQC shares information on prosecutions with the Department; the Department may also request information on enforcement activity.

234. CQC has conducted the following reviews which may be of interest to the Inquiry:

- a. 'Learning, candour and accountability' (2016) which examined how NHS trusts review and investigate patient deaths **(WV1/149 - DHSC0000157)**.
- b. In 2019 CQC published a review of the first year of NHS trusts implementing the national guidance on learning from deaths **(WV1/150 - DHSC0000158); (WV1/151 - DHSC0000159)**.

235. The Patient Safety Incident Response Framework ('PSIRF') has been introduced by NHSE and focuses on supporting safety learning and improvement at the service level across the NHS, including when there is a death or homicide related to mental health. The PSIRF was introduced from 1 April 2024 as a contractual obligation for all Trusts (and does not alter requirements of *National Guidance on Learning from Deaths* as described in the above paragraph). PSIRF overhauls the way Trusts respond to patient safety incidents; the focus is on how incidents happen, more effective learning and meaningful engagement with service users, families and carers. Under the predecessor framework (Serious Incident Framework), providers were only required to investigate patient safety incidents that reached the threshold for being defined as 'serious'. This sometimes meant that less serious incidents were not investigated or learned from.

236. The aim of PSIRF is to deliver a more flexible, transparent and compassionate approach to learning, responses and investigations. The PSIRF promotes a range of system-based approaches for learning from patient safety incidents, rather than methods that assume simplistic, linear identification of a single cause. The focus is on identifying system-based learning, not causes and individual accountability where other processes exist for that purpose (e.g. Human Resources, coronial investigation, police investigation). An aim of the PSIRF is to reduce the need to commission an independent investigation following a patient safety incident, however NHSE and ICBs may still decide to commission one if considered necessary and specific criteria is met, for example if the provider is perceived to be too close to the matter to be objective.

237. In addition, NHSE commissions independent investigations into homicides committed by patients being treated for mental illness. The purpose of an

independent investigation is to thoroughly review the care and treatment received by the patient.

Learning prior to 2023 in respects of other incidents of serious violence/homicides

238. High profile inquiries following incidents of serious violence or homicides have influenced national policy, most notably the Ritchie Inquiry into the Care and Treatment of Christopher Clunis, published in 1994, following the killing of Jonathan Zito in 1992.
239. The Ritchie Inquiry recommended improvements to the Supervised Discharge Order, which allowed patients to be detained from hospital under the supervision of health professionals with conditions attached to their release. The Ritchie Inquiry recommended changes which would facilitate care in the community for patients who were subject to s. 117 after-care under the Mental Health Act. The patient would be subject to recall to hospital if they failed to comply with their agreed aftercare plan **(WV1/152 - DHSC0000160)**. This was the pre-cursor to Community Treatment Orders, which were introduced in November 2008 as part of the 2007 reforms to the Mental Health Act, discussed at paragraphs 275 to 280.
240. An Inquiry took place following the Michael Stone murders in 1996. Following these killings and wider concerns about high risk individuals being excluded from treatment, the treatability test (which required that treatment for a patient must be "*likely to alleviate or prevent a deterioration of his condition*") was removed from the detention criteria contained within the Mental Health Act as set out above at paragraph 115b **(WV1/153 - WITN0155029)**; **(WV1/154 - DHSC0000161)**. There was concern that this criterion could be interpreted as excluding some conditions, like personality disorders, which some people might consider to be untreatable, potentially preventing individuals from receiving necessary care and thereby potentially increasing risk of harm. This was replaced by the 'appropriate medical treatment' test. As set out in explanatory notes for the 2007 MHA, the criteria were updated to remove the requirement that treatment is likely to alleviate or prevent a deterioration of the patient's condition, and replaced with the requirement that "appropriate treatment is available for the patient".

241. This meant that, in order to justify detention, appropriate medical treatment needed to be available, taking account of the nature and degree of the patient's mental disorder and all other circumstances of the case. Section 145 defines medical treatment as: medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. The key change therefore is that the pre-2007 criteria required that treatment was likely to be effective at treating the person's condition, whereas post-2007 the criteria required that the purpose of treatment should be to prevent a worsening of the disorder or one or more of its symptoms or manifestations.

VC

242. This section will expressly reference the attacks of 13 June 2023.

243. The Inquiry has asked the Department what measures ought to have been in place as of 13 June 2023 to reduce the risk of serious violence/homicide by mental health patients in light of previous learning. The Department's position is that there should be the necessary levers in the system to correctly support patients at the right time and manage risks, and these are outlined below.

What services must be provided to ensure adequate care

244. Learning suggests that high quality care for people with serious mental illness should demonstrate a number of key attributes:
- a. Where a person's needs are too serious or complex to be managed in primary care, they should have simple and timely access to community-based care, currently through referrals by GPs.
 - b. Care should be person-centred, holistic and joined up around the totality of the patient's needs, bringing in support from the NHS, voluntary and community sector, and social care sector as required. There should be continuity of care underpinned by appropriate sharing of information, effective handovers when people move between community and inpatient services, appropriate use of CTOs, and where appropriate, advanced care planning

involving any chosen carers, family or friends. This supports better patient experience, avoids unnecessary blockages and inefficiencies and reduces the risk of people falling through gaps with potential consequential harm to themselves or others. There includes careful consideration and risk assessment around discharge from services or moving people through the system (e.g. returning to primary care).

- c. Where needed there should be swift access to more specialist care, for instance EIP, Rehabilitation, Psychological Therapies, Individual Placement and Support, and Specialist Clinics, as well as medical treatment.
- d. Where people under the care of community mental health services have disengaged or are at risk of disengagement with mental health services, there should be proactive and assertive mechanisms in place for teams to contact and work with the patient to promote re-engagement and/or escalation of intervention as required. We know that disengagement from services (alongside co-occurring substance misuse) is a key risk factor for homicide, as shown in NCISH's data collection into patient homicide, discussed at paragraph 213 above.
- e. There should be effective systems in place to manage individual risk and ensure a shared understanding of risk across relevant professionals involved in the patient's care, including with other agencies where appropriate.

245. The system should support people with multiple or complex needs, especially those associated with higher risk factors, for example, mental disorder and substance misuse. People should not be prohibited from accessing support on the basis of a co-occurring need. We know that common risk factors for these incidents are co-occurring substance misuse (coupled with disengagement from services).

- a. There should be effective crisis care to respond to people experiencing mental health crisis either for the first time or where ongoing needs have escalated, underpinned as appropriate by advanced planning with the patient.

- b. Where needed the Mental Health Act should provide the means for intervention when someone presents a risk to themselves or others and does not consent to treatment. CTOs should be used as clinically appropriate to help manage risk and ensure that the person who is discharged maintains contact with mental health services to provide support and prevent relapse.

Reflections on adequacy of provision

246. Due to rising demand and acuity, the Department is aware that the mental health system is subject to significant capacity pressures and possible ensuing impact on quality and safety and care. It is often hard for an individual patient to receive interventions, because the thresholds adopted by various mental health teams are high and appropriate follow up contacts may be hindered due to staff capacity. This may make it more difficult to ensure early intervention for those that need it, due to longer wait times for services.
247. The Government has recognised that services have been under strain and has sought to take steps to address this over a number of years, both through funding and changes to care models, via the Five Year Forward View for Mental Health and the NHS Long Term Plan (see paragraphs 129 and 133 to 134). However, while much has been done to address insufficient provision of support, such as increasing funding and service expansion and transformation, it has not been sufficient to address the increase in demand in recent years.
248. Going forward, as set out in the 10 Year Health Plan, in moving to neighbourhood care models for mental health, we will seek to remove excessive referrals and handovers in the system with the intention of providing open access holistic support delivered by one integrated team - comprising NHS professionals and others with a relevant remit for supporting people with serious mental illness. The 10 Year Health Plan also proposes a more effective response to people experiencing mental health crisis and commits to improving assertive outreach care and treatment to ensure 100% national coverage in the next decade.

DHSC's awareness of VC

249. The Department did not receive any correspondence relating to VC between 2019 and 13 June 2023. The Department has also searched its records and can confirm that there is no record of the Department being aware of VC at any time before 13 June 2023.

250. As requested by the Inquiry, DHSC has been conducting internal searches to identify relevant communications received by the Department before 13 June 2023 regarding the quality, safety and risk of mental health services in Nottingham. The results of the searches that we have done to date have not found any further communications.

251. CQC inspected services provided by Nottinghamshire Healthcare NHS Foundation Trust on several occasions over the period of concern to the Inquiry, including two full trust-wide inspections in 2019 and 2022. The Trust was awarded the rating of 'requires improvement' on both occasions. In the 2019 inspection, acute wards for adults of working age and psychiatric intensive care units were found to be inadequate and were subject to further inspections in 2020.

DHSC's actions following VC's attacks

252. By the time VC received his sentence in January 2024, the Department was aware of a number of issues relating to Nottinghamshire Healthcare NHS Foundation Trust. This included the trust's role in previously providing mental health care to VC, reports that over 30 staff working at Highbury Hospital had been suspended over reports of falsification of observation records, and that Rampton Hospital (one of the three high secure hospitals across the country) had recently had its CQC inspection rating downgraded from "requires improvement" to "inadequate" (**WV1/155 - WITN0155030**).

CQC Review

253. Based on these concerns, the Secretary of State asked CQC to do a review under s. 48 of the Health and Social Care Act 2008 (**WV1/155 - WITN0155030**). On

29 January 2024, the Department announced the undertaking of this special review into Nottinghamshire Healthcare NHS Foundation Trust (**WV1/156 - WITN0155031**). The CQC explored 3 specific areas:

- a. A rapid review of the available evidence related to the care of VC.
- b. An assessment of patient safety and quality of care provided by Nottinghamshire Healthcare NHS Foundation Trust.
- c. An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity.

254. The full terms of reference were published by the Department on 26 March 2024 (**WV1/157 - WITN0155032**).

255. Part 1 of CQC's review, covering strands 2 and 3 was published on 26 March 2024 (**WV1/155 - WITN0155030**) and part 2 of CQC's review, relating to the care of VC, was published on 13 August 2024 (**WV1/158 - WITN0155033**). Overall, the report was highly critical of the Trust, with CQC stating that "the gaps and challenges we have identified at NHFT are longstanding issues at the trust which need to be addressed" and that despite "some evidence of improvement, we continue to have concerns about the quality and safety of patients at NHFT".

256. In total, across both CQC reports, there were 39 recommendations – eight recommendations were made in relation to Rampton Hospital, 18 for local action at the Trust, and 13 requiring action led by NHSE or CQC. The Department was named in two recommendations:

"We recommend NHS England:

4(b) works with DHSC to define and agree clear standards in waiting times for community mental health services alongside those already established for EIP services and crisis services.

4(e) works with the Royal College of Psychiatrists and DHSC to review the Community mental health framework for adults to standardise pathways of care and

ensure there is a specific pathway for individuals who require assertive support and may be hard to engage.” (WV1/155 - WITN0155030).

257. On 13 August 2024, following CQC’s publication of their part 2 report, the Secretary of State responded to the findings and provided an update on the series of measures that had been undertaken since the publication of the part 1 report in March 2024 (**WV1/159 - DHSC0000162**). This included national measures that the NHS had already undertaken such as: ensuring that every provider of mental health services has clear policies and practice in place to treat patients with serious mental illness; issuing guidance to trusts reiterating instructions not to discharge patients with serious mental health issues if they do not attend appointments; and establishing an expert advisory group to oversee the development of core standards for safe care in community mental health services, as well as specific actions the local trust has taken, such as putting a new crisis telephone system in place. As set out in paragraph 266, the Department will request a further update from NHSE in November 2025 on the progress made on the implementation of the CQC s. 48 recommendations. This will be in addition to updates received on 23 October 2024, 4 December 2024, and 7 August 2025.

Theemis Consulting Ltd Investigation

258. Alongside the CQC s. 48 review, NHSE commissioned Theemis Consulting Ltd to undertake an independent investigation. The purpose of this investigation was to identify learning for NHS-delivered care from the care and treatment provided to VC. The investigation’s findings were published on 5 February 2025 with a series of national and local recommendations set across 12 areas of improvement (**WV1/160 - WITN0155034**). Two of the recommendations – focussed on care delivery and risk – were directed towards NHSE to lead.

Theemis recommendation on care delivery

259. On care delivery, the investigation found that “the offer of care and treatment available for VC was not always sufficient to meet his needs” and this included the service having difficulty in providing VC with support when he did not wish or was unable to maintain contact with services. The investigation also found that they do

not believe the experience of VC as being unique in how some people with severe and enduring mental illness are supported by mental health services.

260. The investigation recognised that NHSE is aware of the need to improve the quality and effectiveness in a number of areas and has developed several programmes of work to take this forward to improve the outcomes and experience for people who use mental health services. However, the review's findings suggest that there needs to be "significant continued focus at all levels to meet the mental health needs of people and the communities served".

261. The recommendation relating to care delivery was that:

"NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community.

National leaders should, in the next six months, include, as part of this debate, the following key areas:

- The demands on mental health services have increased over recent years. Services are often delivered across complex multi-agency systems. People who use mental health services frequently have multiple needs that require significant support to enable them to live well. National leaders must be confident that the financial resources currently available are sufficient to meet the needs of those experiencing severe and enduring mental illness.*
- What safe and effective delivery of care should look like for those with severe and enduring mental illness. This should include the consistency of oversight of care across inpatient and community services including the use and application of relevant parts of the Mental Health Act.*
- The debate should ensure that the resources for the community model of care are sufficient to meet the needs for severe and enduring mental illness and is supported by an appropriate number of inpatient beds in the context of increasing*

demand and acuity. This must be supported by a sufficiently trained and developed workforce, including people with lived experience.

- *The dissonance between what people think should be happening, for example care described in national policies and guidance compared to what is actually being delivered in some services.*
- *The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care. National leaders should assure themselves that there aren't negative consequences of some of the actions.*
- *That care for those with severe and enduring mental illness is commissioned and delivered in line with evidence-based practice and co-produced with people with lived experience. Commissioners should assure themselves that services they are commissioning are being delivered as intended.*
- *Whether the recurring, common themes that are identified in similar reviews are an accepted risk in the system or whether there are fundamental changes that can be made to mitigate these risks further.” (WV1/160 - WITN0155034)*

Theemis recommendation on risk

262. The investigation found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case. Discussion with national experts and those with lived experience, as part of the investigation, suggests that this issue is not isolated to this case.

263. The recommendation on risk was that:

“NHS England should, in the next six months consider:

- *How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and public settings, together with the appropriate implementation of adequate safety measures.*

- *What mechanisms are in place to communicate risk across multiple agencies to hold, share and communicate risk in real time.*
- *How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need.*
- *Given that The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes.” (WV1/160 - WITN0155034).*

264. The Department and the Secretary of State have sought assurances from NHSE on progress against the recommendations from all three strands of the CQC review, and that learning was being considered and applied throughout the country (where applicable).

265. This has included a meeting with CQC and NHSE on 31 July 2024 to discuss how they and the Nottinghamshire Healthcare NHS Foundation Trust are progressing the recommendations and how they will work together to make swift, sustained improvements to mental health services (WV1/161 - WITN0155035). The Secretary of State also requested regular progress reports, with NHSE providing updates on 4 December 2024 (WV1/162 - WITN0155036) and on 7 August 2025 (WV1/163 - WITN0155037), which also included an update on progress made in relation to the recommendations set out in the Theemis report (WV1/160 - WITN0155034).

266. A further update will be sought by the Department from NHSE in November 2025. NHSE have provided an indication of progress against the implementation of the recommendations made in both reviews. For instance, we know from the update received on 7 August 2025 from NHSE that between a third and half of the recommendations made in the CQC s. 48 reviews are now complete. Outstanding recommendations cut across a range of themes including risk assessment, crisis care, discharge and medication monitoring. Most remaining recommendations are addressed to NHFT though some are for other bodies such as NHS England. Similarly, several actions underpinning the recommendations in the Theemis report

are now complete though none of the recommendations themselves have been marked as closed by NHS England. The Department will continue to monitor NHSE's progress against the two reviews' recommendations.

Mental Health Bill Review

267. The Department reviewed the Mental Health Bill ahead of its introduction to Parliament on 6 November 2024 in light of VC's attacks. While the Department was confident that the Bill overall provided the right package of reforms, and that it would help address some of the issues that emerged from CQC's report around strengthening family and carer involvement in care planning, it was decided that the following additional improvements to the policy could be made, focusing on discharge and detention criteria as explained below **(WV1/164 - WITN0155038)**; **(WV1/165 - WITN0155039)**; **(WV1/166 - WITN0155040)**.

Discharge

268. The decision to discharge a patient from inpatient care is a key point with regards to management of the patient's health and safety.

269. The Department considers that the Bill strikes the right balance between improving patient rights and ensuring public protection. Improving patient rights should not be seen in conflict with patient and public safety: better care and treatment, focused on the individual's needs, helps support engagement with services and treatment, supporting recovery and keeping people well. For instance, statutory care and treatment plans aim to ensure that patients have a clear and personalised strategy in place to meet their needs arising from or relating to mental disorder, describing what is needed to progress them towards recovery and their timely discharge from detention in hospital or from a CTO. The required contents of the plan will be set out in regulations to comprehensively cover what is needed to meet the above needs during their hospital detention, and also to set out what services the patient may need after their hospital stay. The Department anticipates the plan will provide an important source of evidence of key clinical decisions, such as the reasons behind the individual's detention, and whether proper process has

been followed, ensuring greater transparency and allowing for scrutiny around clinical decision making and the care planning process.

270. The Department is also introducing a new requirement for the responsible clinician to consult another person who has been professionally involved with the patient's care, whether that be while in the community or hospital, before they can decide to discharge a patient from the Mental Health Act. The Department also intends to specify in regulations that the new statutory care and treatment plan includes the outcome of any assessment of the patient's safety, including potential risks to self and (if applicable) others, and a plan for managing that, and, following discharge, details of services the patient may need on discharge to meet the needs arising from their mental disorder. The Department is also considering if revisions are needed to the statutory guidance on discharge.

Detention Criteria

271. The Mental Health Bill takes forward recommendations from the Independent Review to clarify the detention criteria, align the threshold for detention with the significant decision to deprive someone of their liberty and ensure that people are only detained when there is a 'reasonable prospect' that they will benefit from treatment. This does not require the decision maker to conclude that it is more likely than not that the patient will benefit from the treatment.

272. The planned reforms will not change the fundamental powers and purpose of the Mental Health Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others. Changes to the detention criteria will not prevent clinicians from acting when there is a serious risk. The new criteria explicitly require decision makers to consider the risk of serious harm and the likelihood of these harms occurring in order to justify detention. This will ensure that any risks to the public and patient are consistently considered as part of the assessment process and will also protect patients from lengthy detentions when these risks are unlikely to occur.

273. The Bill maintains the power to give compulsory treatment to patients, as this is sometimes the only option to getting a person well again; however, the Department

has introduced greater safeguards to ensure this power is only used when necessary and appropriate. The planned reforms will not change the fundamental powers and purpose of the Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others.

274. Ahead of the Mental Health Bill's introduction, the Department reviewed the new detention criteria in the Bill to consider the impact of the Bill upon the detention of those who are a risk to themselves and others. This review included engagement with stakeholders in July and August 2024 **(WV1/167 - WITN0155041)**. Following this review, the Department removed the phrase 'how soon [the harm may occur]' from the draft detention criteria, which would have required clinicians to consider the timeframe in which harms may occur if the person was not detained. Some stakeholders had raised concerns that there was a risk that this may be misinterpreted to mean that a harm must be imminent in order to justify detention which could have prevented timely interventions being made under the Act **(WV1/168 - WITN0155042); (WV1/169 - WITN0155043); (WV1/170 - WITN0155044); (WV1/171 - WITN0155045); (WV1/172 - WITN0155046)**. If a clinician considers that a person's aggression or dangerousness is a symptom or manifestation of the person's mental disorder, treatment outcomes which reduce this, without alleviating the underlying mental disorder, can still be classed as appropriate medical treatment and satisfy the detention criteria.

Community Treatment Orders

275. Since CTOs were introduced, their use has been much higher than anticipated; over 5,000 people are currently on a CTO. CTOs are often experienced as coercive and restrictive by people who are subject to them, and evidence shows they are disproportionately used for people from an ethnic minority background. Randomised controlled trials looking at the use of CTOs have provided no evidence that CTOs prevent readmission. However, the Independent Review acknowledged that there are a small number of people for whom CTOs represent the least restrictive option and that clinicians, families and carers of patients report improvement in the patient's engagement with services and treatment compliance which is important in preventing relapse.

276. The Department maintains its position that CTOs should remain in place. It is our view that some patient groups, including those with eating disorders and forensic patients, benefit from the framework that CTOs provide to help prevent deterioration of mental health and subsequent readmission following disengagement with treatment in the community. It is important to retain CTOs, but that they are used only when necessary and proportionate. The Mental Health Bill set out to achieve this, and the Department has taken forward almost all of the Independent Review's recommendations for reform.
277. Under the changes to be brought about by the Mental Health Bill, a person will not be able to be discharged from a CTO without agreement from a community clinician who has oversight of the person's engagement with treatment in the community and whether their symptoms are deteriorating – this additional professional oversight should mean that they cannot be discharged until they are ready. The Bill also introduces more frequent automatic referrals to the tribunal to ensure that the CTO remains appropriate for the individual.
278. The Department is clear that the Mental Health Act, now and when reformed by the Bill, provides the necessary legislative powers to enable clinicians to manage and support high risk patients.
279. Supervision of patients is not just about detention but about ensuring that people are supported in the community. The Department knows that a common theme when these tragic incidents occur is people not getting the treatment and care they need before they become so unwell that their illness affects their ability to understand their need for care and treatment, and, equally, the threat they pose to themselves and others if they do not receive appropriate care and treatment.
280. The onus must be on services to provide the right care and treatment to patients based on their individual needs and history of what works or does not work for them. Where engagement is a challenge, the onus remains on services to engage with these patients.

NHSE actions to improve community based mental health support

281. NHSE has taken actions designed to strengthen the quality and safety of care for people with SMI who may pose a risk of harm to others when unwell. These are largely set out in a letter by Claire Murdoch, National Director of Mental Health and Learning Disabilities and Autism for NHSE from 30 September 2024 (**WV1/71 - DHSC0000094**), Guidance on intensive and assertive community mental health treatment (**WV1/173 - DHSC0000163**) and Guidance to ICBs on intensive and assertive community mental health care from July 2024 (**WV1/174 - WITN0155047**); (**WV1/94 - DHSC0000101**).

282. These actions include:

- a. **Enhanced Local Oversight:** NHSE has reinforced system-wide oversight to ensure individuals with SMI receive appropriate, timely support and care that reduces the risk of relapse and associated harm.
- b. **Planning and Operational Requirements:** As part of the 2024/25 NHS Priorities and Operational Planning Guidance, NHSE required all ICBs to complete a review of their community mental health services by Q2 2024/25. The aim was to ensure that systems have robust policies and practices in place to support individuals with serious mental illness who require intensive community treatment and follow-up, particularly where engagement may be challenging. All 42 ICBs have now completed these reviews, identifying examples of good practice as well as areas requiring further development to improve local services. NHSE asked each ICB to discuss the outcomes of their reviews and present a local action plan at public board meetings. These plans aim to address any identified gaps in provision and ensure accountability and transparency at a local level.
- c. **Ongoing Assurance:** To support delivery and accountability, NHSE will formally assure ICB progress against these action plans through dedicated review points in July 2025 and January 2026. These reviews will assess the implementation of improvements and identify any further support needed.

283. The Department is scrutinising progress against all actions from the CQC s.48 reviews as well as the Independent Homicide Review and receives regular reports on progress on behalf of the Secretary of State. As mentioned previously, the most recent update was received on 7 August 2025 and is being provided as an exhibit. To note, the Department will seek a further update from NHSE in November 2025 to continue to track progress and will subsequently request routine updates from NHSE, likely every 3 to 6 months.

Assertive Outreach

284. CQC's s. 48 review flagged concerns around practice in Nottinghamshire regarding case management and made a recommendation that NHSE "*ensures every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis who typical services struggle to engage and who present with high risk.*" More broadly, CQC suggested further action is needed to support adults with SMI who struggle to engage with services, especially where they pose a potential risk to themselves or others.

285. Following the publication of the CQC review, department officials provided advice to the Secretary of State recommending actions to take forward work on AO (**WV1/92 - WITN0155014**) and supported the production of guidance on AO discussed at paragraph 153 above.

Fit For the Future: 10 Year Health Plan

286. The Department recognises the importance of ensuring the necessary capacity and resilience in the system to keep both patients and the public safe.

287. As announced in the Department's 2025 10 Year Health Plan, the Department will invest up to £120 million to bring the number of mental health emergency departments to around 85, meaning there will be one co-located (or very close to) 50% of existing type 1 A&E units (**WV1/1 - DHSC0000096**), A&E units which provide a consultant-led 24-hour service which account for the majority of attendances.

288. The 10 Year Health Plan also shared plans for the Neighbourhood Health Service, bringing care into local communities, and convening professionals into patient-centred teams. This seeks to provide predictive and preventative care that anticipates needs, rather than just reacting to them. The Plan also commits to begin to expand NICE's technology appraisal process from April 2026, which includes mandated funding by the NHS, to cover some devices, diagnostics and digital products. This will focus on those that meet the NHS's most urgent needs, for instance digital behavioural therapy for adolescents to support those on long Children and Adolescent Mental Health Service waiting lists. As part of the 10 Year Health Plan's Commitment to reform the National Quality Board ('NQB'), the Department will task the NQB with developing a new quality strategy and the development of modern service frameworks, including mental health.

289. This will be backed up by an increase in workforce and funding. To better help those with mental ill health, the Government is boosting access to support. As of June 2025, we had recruited more than 6,700 extra mental health workers since July 2024, marking a significant milestone towards the manifesto commitment of 8,500 mental health staff by the end of this Parliament.

290. For 2025-26, mental health spending is forecast to amount to £5.6 billion. This represents a significant uplift in real terms spending on mental health of £320 million compared to the previous financial year. The Department has committed to the mental health investment standard in 2025-26 and expects all ICBs to meet this standard in 2025-26.

Responses to previous Inquiry recommendations, current policies, and opportunities

Overview

291. Firstly, it is important to address the numerous existing recommendations in reports arising from recent reviews and investigations, such as the CQC Section 48 Review (**WV1/155 - WITN0155030**); (**WV1/158 - WITN0155033**) and the Theemis Independent Investigation (**WV1/160 - WITN0155034**) discussed at paragraphs 253 to 266 above. The Department has monitored, and continues to monitor, the implementation of the recommendations made in these reviews, through three

- separate updates sought from NHSE between October 2024 and August 2025, and through an update which will be sought in November 2025. In line with recommendations made by Dr Penny Dash in the Review into Patient Safety Across the Health and Care Landscape (**WV1/42 - DHSC0000084**), the 10 Year Health Plan (**WV1/1 - DHSC0000096**) commits to reform the NQB so that it provides a single and authoritative determination of quality. As part of this, the NQB has been tasked with developing a new quality strategy in 2026. In addition the NQB is starting work on developing a set of recommendations principles, and guidance and processes to support the prioritisation and oversight of recommendations.
292. Additionally, SMI is associated with a variety of factors, such as inadequate housing, financial matters, employment, and social circumstances, as well as biological factors. A recognition of the holistic factors which worsen a person's SMI and potentially trigger crisis is a critical part of delivering effective care and treatment. The Government's mission-led Plan for Change (2024) is providing a vehicle for cross-government action to address these risk factors, some of which sit outside the policy responsibility of DHSC, whether that is breaking down barriers to opportunity, promoting safer streets or kickstarting economic growth (**WV1/175 - DHSC0000164**).
293. Finally, it is important to consider the necessary balance between more restrictive approaches to be taken as necessary, and the importance of a longer-term engaging and relational approach to supporting people with severe and enduring mental illness. An overly restrictive response could risk reduced engagement between patient and services, when engagement and contact are critical to safety. A range of services designed to support people with severe mental illness must be in place to reduce the risk of serious violence, or homicide, by mental health patients. The Department considers that services should be designed and provided which the people proactively want to use, with the intention of building trusting relationships between patients and staff. The best way to keep patients and the public safe is for people with severe mental illness to want to positively engage with services and seek help when required.
294. The 10 Year Health Plan has presented an opportunity to review what steps can be taken to improve access to and quality of services, especially in relation to

supporting neighbourhood mental health services. This statement breaks these down into several key themes: proactive and early engagement, improved join-up and accountability, and data sharing. The Department is keen to work with the Inquiry to consider these findings and recommendations.

Proactive and Early Engagement

Assertive Outreach

295. The CQC Section 48 Review highlighted the need for services to engage more effectively with patients suffering from severe mental illnesses, so patients do not 'fall through the gaps', especially those patients who most struggle to engage in their treatment (**WV1/176 - DHSC0000165**). As discussed at paragraph 156 to 158, the Department believes AO services will play an important role in ensuring this engagement, especially for patients who do not have insight into their own condition and for those with complex needs.

296. There is a commitment in the 10 Year Health Plan to improve AO care and treatment to ensure 100% national coverage in the next decade. To support this roll-out, further work may be required to understand the evidence and provide guidance to support effective AO models. This will support the national policy, as recently reiterated by the NHSE National Director for Mental Health, that patients with a severe mental illness should not be discharged back to their GP without any follow-up if they fail to attend their appointments (**WV1/173 - DHSC0000163**); (**WV1/1 - DHSC0000096**).

Early Identification

297. Early identification could be key in preventing future incidents; no matter what arrangements are in place, these are only as good as the system's ability to identify potential risks early. It is important to clearly distinguish between identifying risks of violence that do not relate to mental illness and identifying early signs of SMI.

298. I now turn to the early recognition of symptoms of SMI, which for some disorders may entail auditory hallucinations, bizarre delusions, and disrupted speech. It is

important that these symptoms are identified as early as possible and that care and treatment are offered before the point of crisis. Early identification and treatment of psychotic illness is associated with better clinical outcomes and reduced risk of harm. In addition, we could consider whether services which are likely to come into contact with those likely to exhibit early indicators of SMI, such as colleges and universities, could be supported to identify these symptoms and signpost support as an earlier intervention. This bears particular relevance to VC, whose health deteriorated at university.

Continuity of Care

299. One of the key shifts as part of the 10 Year Health Plan is the progression from analogue to digitalisation. The 10 Year Health Plan sets out a vision for a single patient record - this should give patients a single, secure and authoritative account of their data, enabling more co-ordinated, personalised and predictive care. This is especially important in the case of people with an SMI whose needs are often complex and they present to a range of different services, possibly in multiple different geographical areas. For example, a person with an SMI might be accessing support from community mental health services in one area but experience a crisis and be admitted to hospital somewhere else. They may also be placed out of area, possibly in an independent sector hospital. This can cause difficulties in terms of continuity of care and fragmentation of record keeping. The Single Patient Record will support continuity of care for people with complex needs by bringing all a patient's medical records into one place, making sure patients get seamless care no matter where they are in the NHS (**WV1/1 - DHSC0000096**). The 10 Year Health Plan commits to harnessing the power of new digital technologies to improve continuity of care, including through the new Single Patient Record.

Neighbourhood health service model

300. The 10 Year Health Plan also commits to rolling out a neighbourhood health service model which will break down the siloes between primary care, community care, hospitals, social care providers and other types of health and social care provision. The neighbourhood health service will bring care into local communities;

convene professionals into patient-centred teams; end fragmentation and abolish the NHS default of 'one size fits all' care. It will transform access to general practice and prevent unnecessary hospital admissions. People with complex needs will be offered a care plan and supported to personalise their care.

301. The 10 Year Health Plan commits to training thousands more GPs and freeing up GP capacity by cutting bureaucracy and red tape. This will mean more appointments, at more convenient times, and better continuity of care for those with complex needs.

302. In mental health services, the vision for a neighbourhood health service is supported by the 24/7 neighbourhood mental health model, which is currently being piloted in six areas. Anyone with severe mental illness can drop into a centre to receive support from mental health professionals, psychiatrists, social workers, voluntary sector workers and peer support workers. As part of this model, there will be one team responsible for managing patient care, bringing all other services into one place, which results in better continuity of care.

303. The six areas where pilots are running are:

- a. Whitehaven, run by Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust.
- b. York, run by York Mental Health Partnership.
- c. Birmingham East Central, run by Birmingham and Solihull NHS Foundation Trust.
- d. Tower Hamlets, run by East London Foundation Trust.
- e. Lewisham, run by South London and Maudsley NHS Foundation Trust.
- f. Sheffield, run by Sheffield Health and Social Care NHS FT.

304. These pilots will report by Summer 2026, and the Department will give serious consideration to the learning from these six pilots.

Improved join-up and accountability

Join-Up Across Different Services and Settings

305. Within the context of the Neighbourhood Health Service at the core of the 10 Year Health Plan, there is an opportunity for better join-up locally across different services and settings. Without effective planning and collaboration between inpatient and community-based teams, discharge from inpatient settings can be a cliff edge for patients if they do not have the right care in place in the community. We know that the weeks after discharge from hospital are particularly high-risk for self-harm and suicide. The aforementioned reforms in the Bill and the statutory guidance on discharge from mental health inpatient settings aim to promote safe and effective discharge. Finally, there may be lessons to be learned from forensic mental health services on how to take a more proactive, joined up approach as people move through the system and how risk is managed during that journey.

Multi-Agency Accountability

306. The question of responsibility between different services is critical; ultimately, each organisation in health and social care must be confident about its role in the management of risk. The Department will re-examine existing guidance about who holds responsibility for risk in each part of the system and how partners can work together to take a collective approach to mitigating risk. This should ensure every part of the system has the necessary clarity, as well as providing a key opportunity to reflect on future delivery models for people with severe mental illness.

Modern Service Frameworks

307. The reformed NQB will oversee the development of new 'Modern Service Frameworks for a range of conditions', with severe mental illness an early priority. We would anticipate that the Modern Service Framework for severe mental illness will take into account work already set in train to improve the quality and safety of services and be based on learning and evidence about what brings most benefit to

patients, as well as providing an opportunity to reflect on future delivery models for people with severe mental illness.

Data sharing

308. The Department understands that individuals and organisations providing health and care services are not always confident about when they can and should share data. The Department understands that the different IT systems across the NHS and partner organisations - which often cannot easily share information between each other - and confusion around the law may inhibit sharing.

309. We are therefore taking a number of steps to support better data access for individual care, while embedding privacy by design. Most prominently, these include:

- a. The development of a Single Patient Record, announced in the 10 Year Health Plan, to enable more co-ordinated, personalised and predictive care.
- b. Legislative reform to support the implementation of the Single Patient Record and the effective and safe use of data for individual care. Reform to legislation will additionally better enable the use of data for other purposes such as NHS service planning and research into life-saving treatments and medications.
- c. A review of the exclusion of health bodies from part 5 of the Digital Economy Act, which permits data sharing for a number of specific purposes, including public service delivery which could, subject to public consultation and legal consideration, be used in the future to facilitate such sharing.
- d. Measures in the recently passed Data Use and Access Act (See s. 121 of and Schedule 15 to the Data Use and Access Act 2025 and paragraphs 44-45, 921-922 and 1224-1251 of the Act's Explanatory Notes) to extend the application of mandatory information standards to include those involved in supplying IT products and services used in connection with the provision of health or adult social care in, or in relation to, England. The interoperability enabled by these changes would make it easier for people delivering care to access accurate and complete information when they need it, thereby

facilitating improved clinical outcomes for patients, improved patient safety, and improved clinical decision making.

Conclusion

310. The Department acknowledges that this Inquiry will examine areas of significant public interest and importance. DHSC will fully support the Inquiry to respond to any requests it makes regarding the events leading up to 13 June 2023 and strive to ensure there is no repetition of these terrible events.

Statement of Truth

I believe the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed

GRO-B

Name: William Vineall

Date: 21/11/2025

IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

UK NOTTINGHAM INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE
Final Exhibits of William Vineall

Number	URN	Title of Document	Para
1	DHSC0000096	Policy document, Re: Fit for the future: 10 Year Health Plan for England - executive summary (accessible version), by DHSC and Prime Minister's Office 10 Downing Street.	4, 143, 287, 291, 296, 299
2	WITN0155002	NHS England Medium term planning framework delivering change together 2026/27 to 2028/29	4
3	DHSC0000075	Report, dated 28/01/2021, compiled by DHSC. Re: Department of Health and Social Care Annual Report and Accounts 2019-20 (For the period ended 31 March 2020).	15a
4	DHSC0000076	Report, dated 31/01/2022, compiled by DHSC. Re: Department of Health and Social Care Annual Report and Accounts 2020-21 (For the period ended 31 March 2021).	15b
5	DHSC0000077	Report, dated 26/01/2023, compiled by DHSC. Re: Department of Health and Social Care Annual Report and Accounts 2021-22 (For the period ended 31 March 2022).	15c
6	DHSC0000078	Report, dated 25/01/2024, compiled by DHSC. Re: Department of Health and Social Care Annual Report and Accounts 2021-22 (For the period ended 31 March 2023).	15d
7	DHSC0000001	Report, dated 17/12/2024, compiled by DHSC. RE: Department of Health and Social Care Annual Report and Accounts 2023-24 (For the period ended 31 March 2024).	15e
8	DHSC0000079	Guidance, Re: The NHS Constitution for England by DHSC.	28, 28e
9	DHSC0000109	Guidance, Re: Handbook to the NHS Constitution for England.	28

10	DHSC0000085	World's largest quango scrapped under reforms to put patients first, DHSC Press Release.	31, 102
11	DHSC0000002	Policy Document. Re: The Government's revised mandate to NHS England for 2018-19, DHSC.	40a
12	DHSC0000049	Policy Document. Re: The Government's revised 2019-20 Accountability Framework with NHS England and NHS Improvement, DHSC.	40b
13	DHSC0000003	Policy Document Re: The Government's revised 2020-21 mandate to NHS England and NHS Improvement, DHSC.	40c
14	DHSC0000004	Policy document, Re: The Government's revised 2021-22 mandate to NHS England and NHS Improvement, DHSC.	40d
15	DHSC0000110	Policy document, Re: The government's 2022 to 2023 mandate to NHS England, DHSC.	40e, 47
16	DHSC0000005	Policy Document, Re: The government's 2023 mandate to NHS England, 15/06/2023.	40f, 48
17	DHSC0000111	Policy Document, Re: Road to recovery_ the government's 2025 mandate to NHS England, 30/01/2025.	40g, 49
18	WITN0155003	Department of Health, The Mandate, A mandate from the Government to the NHS Commissioning Board: April 2023 to March 2015	42
19	DHSC0000112	Policy Document, Re: The Mandate - A mandate from the Government to NHS England, 21/12/2015.	43
20	DHSC0000113	Guidance, Re: Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis, 18/02/2014.	43,195,196
21	DHSC0000114	Policy Document, Re: The Government's mandate to NHS England for 2016-17, 17/12/2015.	45
22	DHSC0000062	Policy Document. Re: List of the prescribed specialised services directly commissioned by NHS England as at April 2023.	50
23	DHSC0000061	Policy Document. Re: Framework Agreement between the Department of Health and NHS England.	53
24	DHSC0000080	New reforms and independent commission to transform social care, DHSC Press Release, Stephen Kinnock MP and Wes Streeting MP.	65
25	DHSC0000081	Guidance, Re: An Introduction to our assessments of local authorities, by Care Quality Commission.	69
26	DHSC0000063	Policy Guidance. Re: What are integrated care systems? NHS England.	71
27	DHSC0000064	Policy Document. Re: Psychosis and schizophrenia in adults Quality standard, NICE.	81
28	DHSC0000065	Policy Guidance. Re: Psychosis and schizophrenia in adults: prevention and management Clinical guideline, NICE.	81
29	DHSC0000066	Policy Document. Re: Transition between inpatient mental health settings and community or care home settings Quality standard, NICE.	81
30	DHSC0000067	Policy Document. Re: Violent and aggressive behaviours in people with mental health problems Quality standard.	81
31	DHSC0000082	Guidance, Re: What is Good medical practice by GMC.	82
32	DHSC0000068	Policy Guidance. Re: Guidance on supporting information for revalidation guide, GMC.	82

33	DHSC0000069	Policy Document. Re: Standards of conduct, performance and ethics, HCPC.	83
34	DHSC0000070	Policy Document. Re: Professional standards, Social Work England.	84
35	WITN0155004	Letter from Department of Health and Social Care to Amanda Pritchard regarding the Community Services Data Set (Amendment) Directions 2024 dated 11 March 2024	91
36	DHSC0000071	Report, dated 12/07/2018, compiled by Department of Health and Social Care. Re: Accounting Officer System Statement.	93
37	DHSC0000072	Report, dated 18/07/2017, compiled by Department of Health. Re: Accounting Officer System Statement.	93
38	DHSC0000036	Report, dated 01/01/2012, compiled by Department of Health. Re: Accounting Officer system statement.	93
39	DHSC0000073	Policy Document. Re: NHS Oversight Framework 2025/26, NHS England.	95b
40	DHSC0000074	Policy Document. Re: Annual assessment of integrated care boards 2024/25 – supporting guidance, NHS England.	96
41	DHSC0000083	Guidance, Re: Review of patient safety across the health and care landscape: terms of reference, by DHSC	99
42	DHSC0000084	Report, dated 07/07/2025, compiled by DHSC, Re: Review of patient safety across the health and care landscape.	99, 291
43	DHSC0000086	Guidance, Re: Change NHS: help build a health service fit for the future - initial surveys by DHSC.	101,104
44	WITN0155005	Joint executive team to be set up across DHSC and NHS England - GOV.UK dated 18 September 2025	103
45	WITN0155006	Letter from the Department of Health and Social Care to Sir Geoffrey Clifton-Brown regarding DHSC-NHSE Transformation dated 4 July 2025	104f
46	WITN0155007	The proposed future DHSC senior structure table	105
47	DHSC0000007	Policy Document, Re: Mental Health Act 1983: Code of Practise, Department of Health.	112, 169, 191
48	DHSC0000087	Report Re: The independent review of the Mental Health Act Interim report, dated 01/05/2018, compiled by DHSC	118
49	WITN0155008	Modernising the Mental Health Act Final Report of the Independent Review of the Mental Health Act 1983	118, 216
50	DHSC0000020	Policy Document. Re: Reforming the Mental Health Act (White Paper), Secretary of State for Health and Social Care, the Secretary of State for Justice and Lord Chancellor.	119
51	DHSC0000021	Policy Document. Re: Draft Mental Health Bill, Secretary of State for Health and Social Care.	119
52	DHSC0000116	Report dated 23/03/2024, Monitoring the Mental Health Act in 2022/23, by Care Quality Commission.	122
53	DHSC0000041	Policy Document. Re: No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, HM Government.	125, 127

54	WITN0155009	Cabinet Committee System	125g
55	DHSC0000106	Report dated 10/08/2025, compiled by NHS Re: Talking Therapies Monthly Statistics Including Employment Advisors, Performance May 2025.	126
56	DHSC0000011	Policy Document. Re: Closing the Gap: Priorities for essential change in mental health. Department of Health.	127
57	DHSC0000012	Policy Document dated 08/10/2024, Re: Achieving Better Access to Mental Health Services by 2020.	127a, 127b, 128
58	DHSC0000088	Report dated 31/03/2025 by NHS England, Re: Intervention in Psychosis: Recording and reporting on NICE-recommended interventions using SNOMED CT codes.	127c
59	DHSC0000015	Policy Document. Re: Implementing the Five Year Forward View for Mental Health, NHS.	129
60	DHSC0000028	Policy Document. Re: Mental Health Units (Use of Force) Act 2018 - Statutory guidance for NHS organisations in England, and police forces in England and Wales, DHSC	130
61	DHSC0000090	Guidance, Re: National Quality Board National Guidance on Learning from Deaths, by National Quality Board.	131, 230
62	DHSC0000091	Guidance, Re: Health matters: reducing health inequalities in mental illness, by Public Health England.	132
63	DHSC0000013	Policy Document. Re: The NHS Long Term Plan, NHS.	133, 145, 197
64	DHSC0000016	Policy document. Re: NHS Mental Health Implementation Plan 2019/20 – 2023/24, NHS.	134
65	DHSC0000092	Guidance, Re: The Community Mental Health Framework for Adults and Older Adults, by NHSE, NHSI & National Collaborating Central for Mental Health.	135
66	DHSC0000017	Policy Document. Re: COVID-19 mental health and wellbeing recovery action plan, HM Government.	136
67	DHSC0000059	Report, dated 17/05/2023, compiled by DHSC. Re: Call for evidence outcome Mental health and wellbeing plan: discussion paper and call for evidence - results.	137
68	DHSC0000018	Policy Document. Re: Major conditions strategy: case for change and our strategic framework. DHSC.	137, 140
69	DHSC0000093	Policy Document, Re: Suicide prevention in England 5-year cross-sector strategy by DHSC.	137
69A	DHSC0000010	Policy Document. Re: Preventing suicide in England. A cross-government outcomes strategy to save lives, HM Government.	138
70	DHSC0000117	Policy Document by DHSC, Re: Preventing suicide in England - A cross-government outcomes strategy to save lives.	138
71	DHSC0000094	Guidance, Re: Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme, by NHS England.	139, 281
72	DHSC0000095	Guidance, Re: Commissioning framework for mental health inpatient services.	139
73	WITN0155010	NHS Planning Guidance Homepage, links to Previous Planning Guidance	141
74	WITN0155011	Discharge from mental health inpatient settings Gov.UK dated 26 January 2024	142, 201
75	DHSC0000097	Guidance, Re: National Service Framework for Mental Health, by NHS and Secretary of State.	145, 153
76	DHSC0000098	Guidance, Re: 2024/25 priorities and operational planning guidance by NHS England.	145

77	WITN0155012	NHS England » NHS Standard Contract webpage	146
78	DHSC0000129	The NHS Plan, the Plan for Investment and plan for reform, dated July 2000	147, 166
79	DHSC0000022	Policy Document. Re: Safety First - Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. National Confidential Inquiry and University of Manchester.	147
80	WITN0155013	New Mental Health Act code of practice - GOV.UK dated 15 January 2015	149
81	DHSC0000119	Monitoring the Mental Health Act in 2022/23, Restrictive practices - Care Quality Commission	150
82	DHSC0000099	Report, Department of Health, The National Service Framework for Long-Term Conditions	151
83	DHSC0000120	Report, A National Service Framework for Mental Health	151
84	DHSC0000121	Report, Department of Health, The Government's Expenditure Plans 2001-2002 to 2003-2004 and Main estimates 2001-2002	153
85	DHSC0000122	The REACT study randomised evaluation of assertive community treatment in North London	154
86	DHSC0000123	The impact of assertive outreach teams on hospital admissions for psychosis_ a time series analysis - PubMed	154
87	DHSC0000505	Processes of disengagement and engagement in assertive outreach patients: qualitative study	154
88	DHSC0000125	Does assertive community outreach improve social support? Results from the Lambeth Study of early-episode psychosis - PubMed	154
89	DHSC0000126	Intensive case management for severe mental illness – PMC Paper	154
90	DHSC0000127	Fifteen-month follow up of an assertive community treatment program for chronic patients with mental illness BMC Health Services Research	154
91	DHSC0000128	The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness. A Meta-Analysis American Journal of Psychiatry	154
92	WITN0155014	Submission, Assertive Outreach for Adults with severe mental illness in the community dated 18 April 2024	156, 285
93	DHSC0000024	Policy Document. Re: Modernising the Mental Health Act Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983.	169
94	DHSC0000101	NHS England » Guidance to integrated care boards on intensive and assertive community mental health care	156,157, 281
95	DHSC0000102	Report, Fair Society, Healthy Lives, Marmot Review	165
96	DHSC0000103	Webpage, What is changing Futures? Changing Futures Sussex,	167
97	DHSC0000023	Report, The Independent Inquiry into the death of David Bennett, December 2003	169

98	DHSC0000104	Report, Department of Health, Delivering race equality in mental health care, an action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett.	169
99	DHSC0000105	NHS England » Patient and carer race equality framework	170
100	WITN0155015	Evidence briefing on the drivers of racial disparities in the Mental Health Act	171
101	DHSC0000130	Report dated 12/09/2024, Compiled by NHSE, Re: Mental Health Act Statistics, Annual Figures, 2023-24	171a, 171b,171c
102	DHSC0000131	Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 - NHS England Digital	171b
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104	DHSC0000132	Webpage, Wellbeing and mental health Applying All Our Health - GOV.UK	174
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