The Lampard Inquiry: an overview of NHS structures, policy, legislation, regulation and accountability

SLIDE 1 – title slide

My name is Helen Gilburt, and I am a Fellow in the Policy Team at The King's Fund where I lead our work on mental health. I joined the Fund in 2013, and my background has involved conducting research and analysis as well as supporting the delivery of advice and information on mental health care and policy for more than 20 years.

SLIDE 2 – About The King's Fund

The King's Fund is an independent charity working to improve health and care in England.

We do this through:

- Conducting research and analysis to support policy makers and those planning and delivering services
- Supporting and developing leadership within health and care organisations through leadership development course, and organisational development support
- Bringing people together to share ideas and thinking on new ways of delivering health and care
- Supporting people to understand how health and care services work through sense-making content.

Our work on mental health has included understanding the changing nature of care through deinstitutionalisation and the local-led transformation of services; exploring factors influencing the delivery of mental health care, such as workforce and funding; and bringing together national data and insight to support and share wider understanding about the delivery of mental health services.

The breadth of our work and focus on mental health policy alongside an understanding of the wider structures and systems which frame the delivery of care – supports our ability to provide a national overview of that care over time.

SLIDE 3 – What this covers

This seminar has been put together to provide the Inquiry team with an overview of the key legislation, policies and guidance which frame mental health care between 2000 and January 2023. It aims to provide a national picture, rather than covering policies, structures and arrangements at a local level.

It is important to note that the content is not exhaustive – rather we have identified key policies, often with a focus on timepoints at which policies were first implemented, or when there was a notable change in requirements or direction. In addition, there is a focus on policies relevant to the content of the Inquiry, in particular on inpatient services. Content for this seminar was informed by the input of clinical and practice experts, alongside members of the Inquiry team.

The seminar and slides are structured to cover the following content:

- Structure of the NHS
- Key mental health policies and plans
- Legislation
- Regulation and accountability
- Data and funding

SLIDE 4 – The structure of the NHS

First we will look at the structure of the NHS, role of government and arms-length bodies

SLIDE 5 – Key legislation

During the period covered by the Inquiry, there have been 3 key pieces of legislation which have led to restructures of the NHS. These are important because they define the various bodies, their functions and roles.

The following slides outline how the wider NHS structures have changed over that time.

SLIDE 6 – NHS commissioners and providers

Firstly we are going to look at the NHS organisational structures for commissioning and providing healthcare.

The slides show changes over time. Rather than a hierarchy, the structures from top to bottom on the slides can be seen as serving different functions, operating at a national level, regional and local level.

In 2000, the start of the Inquiry time period:

- The NHS Executive which was part of Department of Health, was responsible for national strategy and policy.

- Health Authorities received allocations for commissioning health services at a regional level, off which Primary Care Groups ran as subcommittees, commissioning services for local populations and monitoring delivery.
- NHS Trusts, alongside independent sector providers and the voluntary sector, then delivered that care.

In 2002, the NHS Reform and Healthcare Professions Act led to a restructure of the NHS:

- Health Authorities were replaced by Strategic Health Authorities – managing performance and implementing national policy at a regional level.
- Primary Care Groups came together to form Primary Care Trusts. They commissioned all local services including specialised services such as forensic inpatient and children and young people's inpatient care.
- NHS Trusts are able to apply to become NHS Foundation Trusts. Foundation Trusts have greater managerial and financial autonomy compared with NHS trusts. To apply Trusts had to meet requirements related to governance and financial sustainability. Over time the majority of Trusts became Foundation Trusts, providing care alongside independent sector providers and the voluntary and community sector.

From 2007, a national body was set up to take responsibility for commissioning specialised services, with primary care trusts now focused on the commissioning of local services.

In 2012, the Health and Social Care Act, led to another restructure of the NHS.

- Strategic Health Authorities and Primary Care Trusts were abolished.
- The NHS Commissioning Board (known as NHS England) was set up. It set policy and guidance for healthcare and picks up the national role for commissioning specialised services.
- Clinical Commissioning Groups were formed to commission all local services.

From 2015 there was a move towards greater collaboration across local areas, supported by a planning framework for NHS services. Sustainability and Transformation Partnerships were formed which brought together NHS organisations and local authorities to develop plans for providing care for local populations. Although they were not statutory bodies, policy during this period orientates around them.

From 2020, NHS England supports the development of NHS Provider Collaboratives in mental health. These are groups of Trusts and healthcare providers who NHS England delegates budget and responsibility for commissioning of specialised services to at a local level.

In 2022, the Health and Care Act creates a final restructure of the NHS.

- Clinical Commissioning groups are abolished.
- Integrated Care Systems are formed. These built on Sustainability and Transformation Partnerships to become statutory bodies. They comprise of the Integrated Care System, which brings together organisations to plan for the health of their population, and an Integrated Care Board which are responsible for commissioning healthcare.

SLIDE 7 – NHS policy and oversight bodies (pre-2012)

Legislative changes have also influenced the NHS organisations which develop policy and hold organisations to account for the care they provide.

In 2000, policy making was led by the NHS Executive within the Department of Health, with regional offices which fed into Health Authorities, alongside individual policy departments in Department of Health, including mental health.

Following reorganisation of the NHS in 2002, functions of the NHS Executive were absorbed into Department of Health, and alongside it's policy department, it set national strategy and policy.

In 2002, the National Institute for Mental Health in England was established. It was responsible for overseeing guidance and implementation of government policy.

Alongside it sat the National Institute for Clinical Excellence, which develops national clinical guidance, and the National Patient Safety Agency, which was responsible for monitoring patient safety in NHS-funded care settings.

The Commission for Health Improvement inspected health care provided by NHS providers, and the National Care Standards Commission inspected and regulated care provided by independent sector providers.

In 2004 – Monitor was established to licence and regulate newly formed NHS Foundation Trusts.

Some of these bodies have evolved or were reorganised over time –

- Notably, the National Institute for Mental Health in England became part of the Care Service Improvement Partnership, and later was replaced by the National Mental Health Development Unit.
- The Commission for Health Improvement was replaced by the Commission for Healthcare Audit and Inspection, which also took on the role of regulating independent sector provision. This body was subsequently replaced by the Care Quality Commission.

At the bottom, you will see are the Strategic Health Authorities. While they were not responsible for making policy, their work was key for implementation of national policy at a regional level and managing performance.

So as an overview during this period - policy was set by Department of Health and the National Institute for Mental Health in England (and its successors) which also supported implementation and improvement. The National Institute for Clinical Excellence (NICE) contributed to this by setting clinical standards through its guidance. The Commission for Health Improvement and its successors monitored if providers met regulations and standards; but only the Care Quality Commission had the power to enforce changes across both NHS and independent sector providers. Monitor also acted as a regulator for the finances and governance of foundation trusts, while the National Patient Safety Agency aimed to provide a coordinated mechanism for capturing and learning from patient safety incidents.

SLIDE 8 – NHS policy and oversight bodies (post-2012)

The Health and Social Care Act 2012 saw the establishment of a number of new bodies. As you will have seen – the NHS Commissioning Board (known as NHS England) – was initially responsible for commissioning specialised services. It also oversees funding, planning, and delivery of transformation and performance of NHS healthcare in England.

The Health and Social Care Information Centre was established to provide information and data for the day-to-day management of healthcare.

Health Education England was established to provide leadership for education, training and workforce development in the health sector.

And Public Health England was established to improve the public's health and reduce health inequalities. It did this by delivering specialist public health support functions, such as information and intelligence, providing leadership for public health and supporting the development of the public health workforce. It played a key role in policy on suicide prevention.

Over time there has been a rationalisation of national bodies – as you can see, with the organisations and their functions being incorporated into the structure of NHS England.

SLIDE 9 – Key mental health policies and guidance

We are now going to look at the strategies which frame delivery of mental healthcare.

SLIDE 10 – National strategies and plans

This is an overview of the high-level strategies which frame delivery of mental health care during the period the Inquiry covers.

The National Service Framework for Mental Health was published in 1999 and set out a 10-year plan for the development and delivery of services for working age adults based on 7 quality standards, including suicide prevention, access to services, and services for people with severe mental illness.

The National Service Framework, alongside new guidance on care planning – revised the existing approach to implementing what was known as Care Programme Approach (or CPA). CPA aimed to ensure that there was a full assessment of a patient's needs, that a care-coordinator would see that care was delivered, and there would be regular review of the care plan. Patients were designated under standard or enhanced CPA dependent on their level of needs or complexity.

The subsequent NHS plan outlined wider plans for modernising the NHS and included funding to fast-track implementation of the National Service Framework for mental health.

The National Institute for Mental Health oversaw implementation of the National Service Framework, developing a series of policy implementation guides, and supported at a local level by the establishment of Local Implementation Teams.

Although government published a further vision for mental health in 2009, the next strategy in 2011 reflected a move away from the national specification of services and a drive towards

improving care based on outcomes. These would be measured through the use of national outcomes frameworks that commissioners and national bodies could use to assess progress.

In 2014 the government set out actions and additional investment over the next two years to introduce access and waiting time standards in some community-based services by 2020.

The government subsequently set out a vision for improving children and young people's mental health. The vision includes a number of ambitions which are described as cost-neutral and could be taken forward, while others required funding and implementation was subject to subsequent government spending reviews.

The final two national policies reflect a further shift in approach.

The Five Year Forward aimed to deliver rapid improvements in outcomes by focusing on a number of priority areas.

Similarly, the NHS Long Term Plan focuses on a smaller number of service areas, in addition to supporting large scale transformation of community mental health services guided by the Community Mental Health Framework. This describes how community mental health services can better meet the needs of people with severe mental illness. The NHS Long Term Plan also sees the end of Care Programme Approach, with the exception of use in perinatal mental health, adult eating disorder services and adult secure services.

Both of these plans were supported by implementation plans which outlined targets for the expansion of access, funding allocation and workforce requirements. At a national level, funding for the Five Year Forward View was predicated on the basis that investments would generate significant savings and efficiencies.

SLIDE 11 – Wider mental health system policies

National strategies and plans have been accompanied by mental health policy related to specific populations.

The was particularly notable during the period of the National Service Framework – and included national policy on care for people with a diagnosis of personality disorder – which set an expectation that trusts should develop appropriate services, but with no explicit requirements around the provision of inpatient care.

The same year, guidance was issued on meeting the needs of women within mental health settings. The guidance outlines specific expectations around the delivery of single-sex accommodation, provision of peri-natal mental health care, and actions to address patient safety, privacy and dignity.

The National Service Framework extended existing work – and set an expectation that young people under the age of 18 should have access to 'age-appropriate' services.

Finally, Delivering Race Equality in Mental Health Care – is the first guidance within the timeframe which focuses on racial inequalities in care and outlines training requirements for staff working in mental health services, including clinicians and managers.

Best Practice in Managing Risk was published to support services to adopt a more systemic approach to risk assessment and management, and to embed risk management in day-to-day

practice, including as part of Care Programme Approach. The guidance provides best practice points alongside tools to support implementation.

The next policy of notable relevance is Transforming Care – this is the start of a programme of work to review the care of people with learning disabilities and autism within hospital settings, with the aims of providing appropriate support for people in the community wherever possible.

The final policy to flag is the Advancing Mental Health Equalities strategy – one of the core components is the Patient and Race Equality Framework – which aims to embed anti-racism as part of day-to-day practice of mental health care. In addition, there is a focus on the collection and use of data and diversity and representation in the workforce.

SLIDE 12 – Policies and guidance related to quality of care

In this slide I want to draw attention to some of the policies and guidance which frames delivery of inpatient care.

First are the clinical guidelines issued by the National Institute for Clinical Excellence. Many guidelines cover best practice in relation to care in relation to specific conditions. Expectations of care within inpatient settings often forms a component of this. In addition, there are specific guidance which relates to the experience of mental health care and to transitions of care between inpatient and community settings and care homes.

Guidance is also issued in response to legislative changes – for example this is the statutory guidance that was published in relation to the Mental Health Units (Use of Force) Act.

Health Building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Again, this is just one of several examples.

Some guidance sets out national specifications for inpatient care – again, another example is on addressing requirements around single-sex accommodation.

The Royal College of Psychiatrists has run a national accreditation programme for inpatient mental health settings. As part of this they issue standards which aim to provide staff with clear and comprehensive description of best practice. The first standards for adult inpatient settings were published in 2006 with the guidance updated on a regular basis since.

Finally, I want to draw attention to the Acute Care Declaration. The declaration outlines expectations of good quality acute mental health care and seeks to champion the development of high-quality acute care services. The declaration was signed by a number of organisations including the National Mental Health Development Unit, The NHS Confederation Mental Health Network which represents most mental health trusts and the Royal College of Psychiatrists.

SLIDE 13 – Key themes in inpatient policy and guidance

There are also a number of themes which frame policy and guidance across this time period. These themes are reflected both within national plans, and subsequently through specific guidance and planning documents.

One of those themes is on the elimination of mixed-sex accommodation.

Below is an example of policies and guidance issued over time which reflect the aims of eliminating mixed-sex accommodation, and providing safety, dignity and privacy.

As such relevant themes are reflected in new guidance, the ambition is extended, and some guidance is updated as the nature of an issue changes.

SLIDE 14 - Key themes in inpatient policy and guidance

A second theme is around the removal of ligature points.

Again, there is a similar pattern of policy and guidance evolving over time. So the aim to manage ligature risks to ensure the safety of patients is reflected in early policy, later guidance such as that issued through Patient Safety Alerts highlight the identification of new risks that providers must respond to. In more recent policy, is associated with national support for improvement.

SLIDE 15 - Key themes in inpatient policy and guidance

A third theme is reducing the need for restrictive interventions. Here you can see that restrictive practice is a key feature of more NICE guidelines around delivery of inpatient care, and there is associated guidance on reducing restrictive practice. Commissioning for Quality and Innovation is a framework which links key national targets to additional payments – so you can see this scheme being used to incentivise work to reduce the use of restrictive practices, and similarly, requirements to implement mechanisms to reduce restrictive practice as part of the Mental Health Units of Force legislation are reflected within the NHS Standard contract, which outlines priorities for providers.

SLIDE 16 – Policy and guidance during COVID-19 (2020)

As the COVID-19 pandemic falls within the Inquiries timeline – we've also pulled out some of the policy and guidance relevant to inpatient care in particular.

As you can see, the guidance was issued at pace, and many of these documents were updated in a short space of time as needs and the situation changed.

The guidance focuses on operational management of inpatient environment, contact of patients recently discharged, improving pathways of care with a focus on ensuring discharge and support in the community, visiting on wards and communication with patients, family and carers.

These policies primarily relate to the operational running of mental health and particularly inpatient services during the first year of the pandemic. This includes organisation of wards to separate patients with and without COVID-19, and to monitor the physical health of these patients with appropriate arrangements for transfer to acute hospitals if their condition deteriorated.

During this period, hospitals sought to discharge as many people as possible. Subsequent guidance seeks to guide discharge processes, as well as following up and ensuring there is appropriate support for those who are discharged or deemed to be at high risk in the community.

Finally, there is guidance to reinforce guidance more widely on visiting for hospitals.

SLIDE 17 – Suicide prevention policy

We've pulled out some of the key documents – although major strategies and plan often include suicide prevention, there have also been dedicated suicide prevention strategies.

In 2000 – national policy set an ambition to reduce rates of suicide by 1/5th. At the same time, the National Service Framework for Mental Health made suicide prevention one of its core standards.

This was followed by a national suicide prevention strategy in 2002. One of the core elements of the strategy was putting learning from the National Confidential Inquiry into Suicide and Homicide in Mental Health into practice. NCISH had identified 12 points to a safer service which influence how safe an inpatient service is and actions that can be taken to reduce the risk. This document has been updated over time – but remains a core resource for reducing risk of suicide.

The next suicide prevention plan was published in 2012 – this looks at actions across government but again focuses on reducing risk of suicide within inpatient settings (identified as a high-risk group) and for local areas to develop suicide prevention plans.

The next key point is the National mental health strategy – the Five Year Forward View, which sets a new target, to reduce the number of people taking their own lives by 10%.

This is followed in 2018 by an announcement by the Secretary of State for Health of a zero-suicide ambition for mental health inpatient services. Each mental health trust was required to develop a plan to implement the ambition of zero suicides, and funding was made available for staff training and to develop a model to better learn from suicides. In the same year, NHS England announced that NCISH would be working with all Sustainability and Transformation Partnerships to improve the quality and safety within mental health services.

Finally, we have a new suicide prevention strategy in 2023 – again there is focus on inpatient settings, and the need to follow up with people within 72 hrs of discharge to reduce the risk of suicide.

Once again, it's worth noting that there is an overlap between suicide prevention and policy focus in inpatient care – such as on removal of ligature points and efforts to reduce people who go absent without leave.

The National Confidential Inquiry into Suicide and Homicide has collected data on deaths by suicide to identify trends and disseminate learning since 1997. Their analysis shows that there has been a fall in the rate of patient suicides (that is people in contact with mental health services in the 12 months prior to death) between 2000 and 2010, and from 2011 until 2021 taking into account the overall number of patients (which has increased). However, there has been little change in the trend in recent years.

There is a similar picture with inpatient suicides – showing a long-term downward trend in the rate of inpatient suicide, taking into account numbers of patients.

SLIDE 18 - Legislation

We are now going to look at legislation which underpins the delivery of care and that defines roles and requirements in relation to regulation and accountability.

SLIDE 19 – Legislation – delivery of care

The Mental Health Act 1983, covers the assessment, treatment and rights of people with a mental disorder. It is the legal framework for detention of people with a mental disorder in hospital.

In 2003, the Delayed Discharges Order for mental health care placed a new requirement on NHS bodies to notify local authorities of patients likely to need community care on discharge – which sought to speed up discharge from hospital and ensure people received appropriate support in the community.

The Mental Capacity Act was introduced in 2005 – and provides a framework for decision-making on behalf people who may lack the mental capacity to make their own decisions.

The Mental Health Act was updated in 2007 – with key changes included a simplified definition of mental disorder and a new 'appropriate medical treatment' test which limits the ability to detain someone unless medical treatment appropriate to the person's medical disorder is available. Other changes include the introduction of community treatment orders, allowing patients to be discharged under supervision subject to conditions and subsequent recall to hospital; and the introduction of deprivation of liberty safeguards for people who lack capacity to consent to treatment or care while in hospital.

The Care Act in 2014 – amended section 117 of the Mental Health Act 1983, which pertains to the rights to aftercare services following detention in hospital for mental health treatment. The changes extended those rights to support which went beyond that relevant to the disorder for which someone was admitted.

The next piece of legislation makes further amendments to the Mental Health Act, reducing the maximum length of time a person can be detained under section 136, which allows the police to take a person to a place of safety for assessment, from 72 hrs to 24 hrs;

The final Act in this section was introduced with the aims of reducing the use of force and ensure accountability and transparency about the use of restraint and seclusion. The Act requires mental health units to identify a responsible person who ensures the organisation complies with the requirement of the act, have appropriate policies in place and publishing data on how and when physical force is used.

SLIDE 20 – Legislation – regulation and accountability

This second slide pulls together key legislation which impacts on accountability.

The first is the Coroner's Act, which provides a legal framework for when the coroner should be involved and their role. This was subsequently updated in 2009, which includes a legal duty to investigate deaths of people who were detained under the Mental Health Act.

In 2012 – case law clarified that the duty of NHS trusts to protect voluntary mental health patients from risk of suicide also applies to those who are admitted to hospital on a voluntary basis.

In 2014 regulations established a new set of fundamental standards relating to the quality and safety of care that all providers must meet. And which would be used as the basis for regulation by CQC.

This was further updated a year later to include a requirement that registered providers provide care in a safe way that avoids reasonable harm. It also included new measures to ensure appropriate information sharing to support the delivery of direct care.

The final piece of legislation I want to draw attention to are regulations which require medical practitioners to notify the coroner of a death where a doctor suspects it was due to drugs, medication, treatment, trauma, self-harm, neglect, otherwise unnatural causes and during state detention.

SLIDE 21 – Regulation and accountability

In this next section we're going to talk more about regulation and accountability.

SLIDE 22 – NHS regulatory and investigatory bodies

There are a number of arm's length bodies who play a key role in regulating NHS organisations and holding them to account.

The Mental Health Act Commission existed between 2000 and 2008 – its role was focused on reviewing use of the Mental Health Act. The Commission investigates complaints made by detained patients about matters that occurred whilst detained and complaints about use of the Act in respect of a detained patient. In general, it reviews complaints that have are subject to local resolution, as a basis to use its own investigatory powers proceeding only when it is likely to uncover new evidence. The commission also has visiting powers which it uses when potentially serious issues have been identified through complaints. The Commission receives notifications of deaths of detained patients. Unnatural deaths and natural deaths where practice issues are identified are the subject of a review, to understand whether good practice as defined by the MHA was followed, and ensure lessons are learned.

Inspection and regulation of healthcare providers has changed over the years. In 2000 – The Commission for Health Improvement inspected healthcare providers and could offer recommendations for improvement, while the National Care Standards Commission was responsible for regulating independent providers according to a set of National Care Standards.

In 2004 these functions merged to form the Commission for Healthcare Audit and Inspection. However, the Commissions role remained to inspect NHS providers and make recommendations, while regulating independent providers.

In 2009 the Care Quality Commission was established – it took on the roles of Commission for Healthcare Audit and Inspection, in addition to the Mental Health Act Commission. CQC has additional powers which enable it to issue warning notices and set out improvements in care a provider must make; it can place a provider in special measures and closely supervise the quality of care; and it can hold providers to account for failings by issuing fines and prosecuting cases where people are harmed or placed in danger of harm. In 2014 CQC became responsible for regulating new requirements around duty of candour; and ensure that directors meet requirements such that they are fit and proper for their role.

In 2000 NHS Trusts were accountable to the Secretary of State for Health, via Health Authorities and then Strategic Health Authorities. With the development of NHS Foundation Trusts came greater financial autonomy and Monitor was established regulate foundation trusts. NHS Foundation Trusts were licensed by Monitor, and regulation particularly focused on governance and finances. The role of licensing NHS trusts, Foundation Trusts and Independent Providers is now held by NHS England.

Finally there are arm's length bodies who play a role in safety and investigatory functions. The National Patient Safety Agency monitored patient safety events in NHS-funded care and with the aim of learning about adverse incidents. It did this through collecting and analysing information on adverse incidents, sharing learning and working towards targets around specific risks. The function merged into NHS England in 2012.

Finally, the Health and Safety Investigation Branch was set up in 2017 to conduct independent investigations into patient safety concerns in NHS-funded care. The organisation was succeeded by the Health Services Safety Investigations Body. Both organisations conducted national investigations with the aim to identify contributory factors and make recommendations to reduce risk and improve safety.

SLIDE 23 – Non-NHS regulatory and investigatory bodies

The following organisation are all non-NHS organisations but play a key role in regulation and accountability of health and care.

- The General Medical Council, Nursing and Midwifery Council, and the Health and Care Professionals Council are all regulators of professionals. They set standards of competence and conduct, check the quality of education and training, maintain a register of professionals, and investigate complaints and where there are concerns of misconduct or competence among other grounds. Concerns which are subject to Fitness to Practice proceedings involve a formal investigation and are adjudicated by a tribunal or panel set up by the regulator.

- The Health and Safety Executive enforces the law on health and safety and has the power to bring criminal prosecutions. There is an agreement between CQC and HSE about who prosecutes in relation to health and hospitals.

- The Parliamentary and Health Service Ombudsman investigates complaints against NHS authorities or trusts when people have exhausted all other routes of complaint.

- The Coroners Service investigates deaths which have occurred as a result of violence or unnatural circumstances, or that have occurred in custody. From 2009 this included people detained under the Mental Health Act.

SLIDE 24 – Policies and guidance for accountability (1)

The final slides in this section covers some of the key policies and guidance related to accountability and regulation.

I want to start by first bringing to attention the two codes of practice. These are statutory guidance which accompanies the associated legislation and provide guidance for professionals on applications of the Acts in practice. They have been updated at regular intervals to reflect updates to the legislation, policy, case law and professional practice.

Within these slides there are number of tools which government and NHS bodies use to define what providers of NHS-funded care should prioritise. One of these is the operating framework which sets out the planning, performance and financial requirements for NHS organisations.

In 2007, the operating framework requires trusts to comply with policy on addressing issues with mixed-sex accommodation (issued in 1999). It also requires Primary Care Trusts (commissioning care) to ensure implementation of the of the commitment. This is picked up again in the operating framework for 2010/11 – but moves towards the elimination of mixed-sex accommodation.

Another route of guidance has been through the National Patient Safety Agency. In 2009, the Never Events framework, which sets out serious events which are deemed to be preventable, included suicide using non-collapsible ligature points as a never event. It required trusts to monitor their incidence and trusts were provided with advice to reduce the risk.

The following year the National Patient Safety Agency published a national framework for reporting and learning from serious incidents requiring investigation. This aims to ensure consistency in definitions, roles and responsibilities in relation to reporting and to clarity legal and regulatory requirements.

In the same year registered providers were required to notify CQC about any events which could be perceived as a risk to compliance with registration of requirements. This included reports about serious incidents and deaths.

The Operating Framework in that year also reflected an expectation that NHS organisations eliminate mixed-sex accommodation.

SLIDE 25 - Policies and guidance for accountability (2)

Further guidance was issued in 2012 which requires all NHS trusts providing specialist mental health services to report all apparent or actual suicides of people who are currently in their care at the time of death.

In 2015 the Department of Health also issues guidance to ensure that the NHS is compliant with Article 2 of the European Convention on Human Rights. The guidance states, NHS

organisations should consider an investigation to examine the causation of a serious incident or multiple serious incidents that could indicate systemic failures to protect life.

In the same year, following changes in the legislations, regulatory issued guidance on professional duty of candour. This is done through joint guidance for the General Medical Council and Nursing and Midwifery Council, and through a revision of professional standards for professionals registered with the Health and Care Professionals Council.

In 2016, the National Quality Board published its first Shared Commitment to Quality. This provides a nationally agreed definition of quality which is held across all national bodies. It is intended as a guide for professionals leading work to improve care and includes safety, effectiveness, positive experience of those receiving care, well-led and that use of resources is sustainable and equitable for all.

Similar to the operating framework – the Clinical Commissioning Group Improvement and Assessment Framework forms a tool indicating areas for prioritisation by commissioners and is used as part of monitoring of performance. In 2016 the framework includes an indicator on out of area placement for acute mental health care.

SLIDE 26 - Policies and guidance for accountability (3)

In 2017 there are two pieces of policy and guidance I want to draw your attention to. The first is a written statement to the House of Commons by the Parliamentary Under-Secretary of State for Health which outlines the expectation that all deaths of patients under the care of Tier 4 inpatient Child and Adolescent Mental Health services (which is inpatient services) would be reported to Ministers, providing a line of visibility and accountability.

At the same time, the national guidance on learning from deaths framework was updated with a requirement that trusts develop and publish a policy on how it responds to and learns from deaths of patients who die under its management and care. This includes requirements around governance and processes, staff skills to effectively review and investigate deaths, and policies for engaging with bereaved families and carers. In addition, trusts were required to collect and publish data on deaths.

A further tool – the NHS oversight framework describes how oversight of NHS trusts, foundation trusts and integrated care boards will be monitored on performance. In 2019, this included an explicit focus on mental health out of area placements, and quality of data submitted at a national level, with regional NHS England teams reviewing performance and providing support where needed.

Finally, we jump to 2022 with the publication of a Patient Safety Incident Response Framework which requires all provides of NHS-funded care to create a policy that describes systems in place to learn and improve following a patient safety incident.

In addition, the NHS Standard Contract, which is issued each year to NHS providers, introduces a national quality requirement that 80% of service users under mental illness specialities are followed up within 72 hours of discharge from inpatient care. This does not apply to specialised mental health services commissioned by NHS England.

SLIDE 27 – Policy on leadership

The final slide I'm going to cover in this section is around policy on leadership because this outlines expectations and is part of regulation.

The first Leadership Framework was published in 2002. The framework provides a consistent approach to leadership development, focusing on values and behaviours. This is updated over the years to include clinical and managerial staff – and focusing on core competencies of staff.

In 2014 – CQC and Monitor both started to use frameworks to assess leadership and governance of providers. In CQC this was the Well-led framework. CQC use a number of 'key lines of inquiry to guide their inspection process. The Well-led framework had 5 key lines of inquiry including vision and strategy, governance arrangements, leadership and culture, patient and staff experiences and continuous learning and improvement. At the same time Monitor adopted an aligned approach as part of supporting and assessing trusts applying to become a foundation trust.

This was updated in 2017 – and aligns between regulators. It's also expanded to cover 8 key lines of Inquiry. It also forms part of the oversight process for trusts and foundation trusts – which are required to conduct developmental reviews of leadership and governance and report on their findings.

In 2019 there are two new requirements. The first recognises the importance of diversity and representation of minoritised groups within senior NHS leadership. This includes use of the Workforce Race Equality Standards to support improvement.

The second is Freedom to Speak Up – the policy includes structures and roles which aim to improve the ability of staff to speak up about concerns about patient care.

In 2021 – new guidance focuses on the role of Integrated Care Systems (ICS) – and the need for distributed leadership across systems. ICS are required to agree a local plan for clinical and care professional leadership across all ICS partners.

Finally, in 2022 NHS England issued a code of governance for NHS provider trusts. The code applies to both NHS trusts and Foundation Trusts and are required to comply with each of the provisions of the code.

SLIDE 28 – Data and funding

This final section picks up some additional areas, including mental health data and funding.

SLIDE 29 – National mental health data

This slide takes us through the availability and development of data during this time period.

In 2000, there was a basic data set on mental health and learning disabilities. In addition, data was captured on the number of people detained under the Mental Health Act. Both data sets were managed by the Department for Health.

In 2003, following the set-up of a minimum data set, it was mandatory for all providers to submit data.

Another notable data set was the Count Me In Census which captured all patients in a psychiatric unit at one time point. The data included ethnicity so comparisons could be made. It also included all NHS and independent mental health services. This ceased in 2011.

In 2009, the NHS workforce statistics data set was established. This captures numbers of NHS hospital and community health services staff working in NHS Trusts.

The next isn't a data set as such, but to note that the Health and Social Care Act 2012 provides the Health and Social Care Information Centre (which collects data for the NHS) with statutory powers to require data from providers of health and care services as part of their contract.

If we jump down to the bottom row – in 2013 the Mental Health Dashboard is established as part of the Five Year Forward View for Mental Health. The dashboard brings together a series of published measures to monitor progress against current strategic policy objectives. It also includes data on funding.

In 2014 the national minimum data set is expanded to include people with learning disabilities.

This data set is subsequently replaced with the Mental Health Services Data Set – which also replaces KP90 – data on people detained under the MHA. The data allows for more detailed analysis to support service improvement and monitor performance. It was also designed to support implementation of access and waiting time standards.

In 2018, NHS England developed a dashboard of quality metrics for specialised services which aims to provide assurance on quality of care.

Finally, in 2019 the NHS Long Term implementation plan, sets out requirements for all mental health providers to improve the quality of data submitted, to be measured through a data quality maturity index.

SLIDE 30 – Funding mechanisms

There has been no consistent data set which tracks funding for mental health care, as a result it is hard to give a pattern of funding over the time period for which the Inquiry spans.

Instead, the following two slides outline some of the key mechanisms for funding in health care including mental health, and key points of investment – with a focus on inpatient services.

I want to draw attention to three funding components which have existed over the length of the Inquiry period. The first is national funding – often for programmes of work which are then either allocated to providers of care, or via commissioning bodies.

Mental Health services have traditionally been funded through a block contract. This is a payment made to a provider to deliver a specific, usually broadly defined service. How block contracts are calculated varies and can be set through a measure of patient need, or based on historical spend.

NHS organisations are set efficiency targets on an annual basis. Cost improvement programmes set out how each organisation is going to save money while maintaining the quality of services it provides.

There have been a number of additional components and changes over time.

The first in 2009 is the introduction of Commissioning for Quality and Innovation (or CQUIN) is a payment framework which enables commissioners to reward NHS providers by linking a proportion of the providers income to achievement of a set of quality indicators. The indicators include national goals which focus on key priorities, and local goals to be agreed with the commissioner.

In 2012 – the NHS brought in a new mechanism which aimed to support the development of a payment by results approach in mental health, and supporting a move away from block contracts.

This was closely followed by the introduction of new payment approaches which have developed over time, but largely offer a wider range of options for procurement.

In 2016 – the Mental Health Investment Standard was introduced. The standard aims to increase investment in mental health services across England. The investment standard required all clinical commissioning groups to increase investment in mental health services in line with their overall increase in allocation each year. Commissioners are audited on their achievement of the standard.

Finally, as mentioned previously, NHSE started to delegate budgetary responsibility for commissioning some specialised services from 2021 which included low and medium secure mental health services, children and young people's inpatient services, and adult eating disorder services.

SLIDE 31 – Funding for inpatient care

Often national strategy and policy comes with additional investment. Those policies direct where funding can be invested and to what purpose. This slide highlights funding which has been targeted towards improving access and quality of care in inpatient services.

The NHS Plan and National Service Framework in early 2000's came with significant investment a proportion of which included expansion of bed capacity in specific services. In addition, there was investment to remove dormitory accommodation from inpatient care. In 2014, investment supported expansions of bed capacity for children and young people.

The Five Year Forward View 2 years later also expanded capacity – but specifically for perinatal mental health in the form of mother and baby units. This ensured that capacity was available across the country.

In 2019, the NHS long term plan provided additional investment in activities and interventions on inpatient wards to improve the therapeutic officer and for expansion of the workforce in mother and baby units.

In 2020 there was additional investment in replacing dormitory accommodation, and as part of the Suicide Prevention Strategy to develop local suicide prevention plans. However, in addition the Covid-19 pandemic led to additional measures to manage the changing picture of care during this period. There was an uplift in the block contract value of mental health providers, and systems were instructed to recognise additional costs incurred in responding to the Covid-19 pandemic. Finally, additional funding was made available to support post-discharge support for mental health patients during winter.

In 2021 – the government announced additional funding to expand mental health services as part of the recovery from the Covid-19 pandemic which included further funding to provide enhanced discharge support from inpatient mental health care.

Finally, it's worth noting that the Commissioning for Quality and Innovation payment framework has been used consistently since 2016 to improve quality of care in inpatient settings.

SLIDE 32 – final slide

That concludes the content of this presentation in the seminar. I hope we've provided you with a better understanding of the context for the delivery of mental health care over the last 24 years. Thank you for listening.