Summary of evidence of the
Department of Health and Social Care

1. This is a summary of the evidence provided to the Inquiry by the Department of Health and Social Care (DHSC). That evidence has already been disclosed to Core Participants.

2. It should be noted that this summary will not cover the totality of the evidence provided.

Background and Role

3. The evidence submitted to the Inquiry on behalf of the DHSC thus far is in the form of a written statement, signed by William Vineall, Director of NHS Quality, Safety and Investigations, and dated 24 March 2025 **[Core Bundle Index item 23, page 370]**. With it, Mr Vineall disclosed a number of exhibits.

4. The DHSC, known as the Department of Health until 2018, is responsible for key functions in respect of the health service. Those functions include securing resources for the National Health Service (NHS) within Government; overseeing and, where necessary, seeking to amend the legislative framework for the NHS; representing the views and interests of the NHS within Government; developing and supporting strategy and policy; and being accountable to Parliament for the NHS.

5. The DHSC's role is to support and advise the Government's health and social care Ministers, and it oversees three main functions: the NHS, public health, and adult social care. It is responsible for overall health policy, whilst NHS England (NHSE) has day to day responsibility for the NHS and arranging and securing the provision of services through (since 1 July 2022) Integrated Care Boards (ICBs). Neither the Secretary of State nor the DHSC are responsible for directly commissioning NHS services.

6. The DHSC supports the Secretary of State in the discharge of their duties. The Secretary of State had powers of intervention to deal with cases of persistent failure until they were repealed in 2007. The National Health Service Act 2006 placed a duty on the Secretary to promote a comprehensive health service designed to secure improvement in the physical and mental health of people in England, and in the prevention, diagnosis and treatment of physical and mental illness.

7. The Health and Social Care Act 2012 made significant amendments to the 2006 Act and gave effect to a wide range of structural changes to the NHS. For example, Primary Care Trusts (PCTs) and Strategic Health Authorities were abolished, and commissioning responsibilities were passed to a newly created NHS Commissioning Board (which would later become known as NHSE) and Clinical Commissioning Groups (CCGs). The Act made clear that the Secretary of State's responsibility lay primarily in ensuring that the functions of commissioning services and the provision of services were being carried out effectively. The changes established a more 'rules-based' system, with NHS bodies' day to day operations being more clearly separated from the strategic role of Ministers.

8. With the 2012 Act, the Secretary of State was required to publish and lay before Parliament a mandate to set strategic direction; the content was subject to Government agreement and any objectives were reflected in NHSE operational guidance. The mandates for relevant years are exhibited in DHSC's statement **[Exhibits Bundle, Exhibits WV/10 – WV/15, pages 3892 – 4016]**.

9. The DHSC prioritises building strong and effective working relationships with each of its Arm's Length Bodies (ALBs) or 'public bodies' via sponsorship teams. These teams work collaboratively to ensure accountable, efficient and effective healthcare services.

10. NHS Improvement (NHSI) was a key ALB that operated during the Relevant Period. It was established on 1 April 2016 and merged with NHSE following the passage of the Health and Care Act 2022, although was working together with NHSE from 1 April 2019 as a single organisation. DHSC's role in respect of NHSI was to scrutinise its strategy, performance and delivery.

11. The DHSC has provided to the Inquiry an internal guide that was prepared for Departmental staff, which sets out the roles and responsibilities of NHSI, and how the Department held it to account during the time it was in operation **[Exhibit WV/16, page 4017]**. The Framework Agreement between the DHSC and NHSI that was published in 2018 has also been supplied **[Exhibit WV/17, page 4040]**.

12. NHSI brought together Monitor, the NHS Trust Development Agency, Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and Intensive Support Teams. Prior to this, on 9 March 2016, Monitor and the NHS Trust Development Authority

published a 'Learning from Mistakes League' to encourage openness and transparency in the NHS **[Exhibit WV/18, page 4066]**.

NHS

LEARNING FROM MISTAKES LEAGUE

The rankings are as follows:

1 – **outstanding levels** of openness and transparency

2 – **good** levels of openness and transparency

3 – **significant concerns** about openness and transparency

4 – **poor reporting culture**

13. The league table scored providers based on factors including near misses and incidents, and the fairness and effectiveness of procedures for reporting errors. Essex NHS Trusts featured in the table. The South Essex Partnership University NHS Foundation Trust was ranked 20th out of 230 Trusts, the Mid Essex Hospital Services NHS Trust was 189th, and the North Essex Partnership University NHS Foundation Trust was 218th. Supporting data from the 2015 NHS Staff Survey and National Reporting and Learning System was published alongside the table **[Exhibit WV/19, exhibit 4078]**.

14. As of 2025, the DHSC is expected to publish a Framework Document outlining its relationship with each ALB, governance and accountability arrangements; a Remit or Chair's Letter outlining key areas for the ALBs to focus on each year (this being the mandate from the Secretary of State for NHSE); and to hold regular meetings with its ALBs.

15. The DHSC works closely with a range of other organisations including other Government Departments on mental health services and inpatient safety matters. These organisations include (but are not limited to) Bipolar UK, the British Psychological Society, INQUEST, MIND, the National Institute for Mental Health, the Office of National Statistics, and the Zero Suicide Alliance.

Involvement with mental health services

16. The DHSC had an active policy agenda in relation to mental health during the Relevant Period, which included the establishment and roll out of interventions such as Talking Therapies, Early Intervention in Psychosis services, shifting care from hospital to the community, reforms to the Mental Health Act, improving crisis care access, mental health support in schools and suicide prevention.

17. The Mental Health Act 1983 sets the legal framework to authorise detention and compulsory treatment of people with a mental health disorder. It is supported by a Code of Practice. Revisions have recently been proposed and are currently under consideration by Parliament.

18. The DHSC notes, for context, the NHS White Paper published in 1988 and the 'National Service Framework for Mental Health' published in 1999. Mention is also made of other another publication, 'A First Class Service' **[Exhibit WV/21, page 4103]**, which explained how NHS standards would be set by the National Institute for Clinical Excellence and National Service Frameworks (NSFs), delivered by clinical governance and monitored by the Commission for Health Improvement, amongst other things. NSFs were intended to improve the quality and consistency of healthcare by setting national

standards for specific areas of health and social care, identifying key interventions, and establishing strategies to tackle variations in access and service delivery across the country. The first NSF, published din 1999, set out seven standards the NHS were expected to meet for mental health including access to services and suicide prevention. The aims and standards were reflected in wider policies by the DHSC, for example the Health Services Circular **[Exhibit WV/24, page 4190]**.

19. The 'The NHS Plan: A plan for investment, a plan for reform' in 2000 set out overall priorities and commitments for the NHS **[Exhibit WV/25, page 4194]**. It was intended to be a long-term vision for the NHS and to set national priorities, of which mental health was one.

20. The first 'National Suicide Prevention Strategy for England' **[Exhibit WV/26, page 4341]** was published by the DHSC in 2002.

This supported the White Paper 'Saving Lives: Our Healthier Nation', published by the Department in 1999, which was a Government plan focused on the main killers, including mental illness. The target was to reduce death rate from suicides by at least 20% by 2010. The National Institute of Mental Health in England oversaw its implementation.

21. In 2011, the 'No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages' **[Exhibit WV/27, page 4385]** was published. The strategy asserted that the quality of mental health care had improved in recent years but that more emphasis had to be placed on structures and processes rather than outcomes. The DHSC worked with several partner organisations to agree six shared objectives and six shared outcome indicators. The outcomes related to prevention, treatment and recovery, physical health, positive experiences of care and reducing avoidable harm.

22. A new ten-year national 'Suicide Prevention Strategy for England' **[Exhibit WV/28, page 4488]** was published by the DHSC in 2012. It addressed new challenges and concerns and identified inpatients as a priority group for action. In 2014, the DHSC then published 'Closing the Gap: Priorities for essential change in mental health' **[Exhibit WV/29, page 4548]**. This set out shorter term priorities to achieve the longer-term vision. Its goals included increased access to services and improving the life of those with mental ill health. 'Achieving better access to Mental Health Services by 2020' **[Exhibit WV/30, page 4588**] was also published in 2014 by the DHSC and NHSE. It detailed three phases to change mental health services, including increasing capacity and introducing waiting time standards to improve access, and aimed to achieve parity between physical and mental health services.

23. The DHSC and NHSE jointly published 'Future in Mind' **[Exhibit WV/31, page 4611]** in 2015, which emphasised the NHS, public health, Local Authorities and other organisations working together to build resilience, promoting good mental health and prevention and early

intervention, and more. The aim was for commissioners to make better decisions about what inpatient capacity was needed.

24. In 2016, NHSE commissioned the paper 'Implementing the Five Year Forward View for Mental Health' **[Exhibit WV/32, page 4687]**. It set out an implementation programme to deliver recommendations from a Mental Health Taskforce and a number of key commitments.

25. In 2018, the Mental Health Units (Use of Force) Act was introduced with the aim of reducing unnecessary and inappropriate uses of restraint in mental health hospitals.

26. In 2019, 'The NHS Long Term Plan' set out ten-year priorities for the NHS. The plan included priorities for inpatient mental health settings including eliminating inappropriate out of area placements, reducing the average length of stay, and reducing suicides for mental health inpatients. Also in 2019 was the publication of the 'NHS Mental Health Implementation Plan' **[Exhibit WV/34, page 4737]**, which detailed plans for delivering the remaining commitments under the Five Year Forward View and how these would be built on to deliver those under the NHS Long Term Plan.

27. The 'COVID-19 mental health and wellbeing recovery action plan' **[Exhibit WV/35, page 4794]** in 2021 outlined the Government's plans to mitigate and respond to the mental health impact of the pandemic. It aimed to provide additional funding to keep the Long-Term Plan and Mental Health Act reforms on track.

28. In 2023, the NHSE launched the 'Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme' **[Exhibit WV/36, page 4849]** to support cultural change across inpatient

services. The DHSC published another paper titled 'Major Conditions Strategy: case for change and our strategic framework' **[Exhibit WV/37, page 4854]**, identifying the six key groups of conditions contributing to ill health, one of which was mental ill health. An additional paper, 'The Suicide Prevention Strategy for England' **[Exhibit WV/38, page 4925]**, was also published in 2023. This replaced the 2012 strategy and set out priority areas for action, including the need for effective crisis support, to reduce suicide.

29. Finally, in 2024 the Mental Health Bill was introduced. After an Independent Review into the Mental Health Act, the Government published a White Paper, Reforming the Mental Health Act **[Exhibit WV/39, page 4992]** which accepted most of the review's recommendations. The Bill is now undergoing parliamentary scrutiny.

30. There are several relevant policies cited by the DHSC. The first, on reducing inappropriate out of area placements, was introduced in 1999 and remained a core aim in the 2019 NHS Long Term Plan. The Plan set out aims to eliminate out of area placements by 2023/24, although this was not achieved, the DHSC states, 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 did not necessarily lead to better outcomes for patients.

31. There was a policy on ensuring timely follow up after someone is discharged from inpatient facilities. The standard expectation was that patients would receive follow up support within seven days. The aim was then for inpatients to receive a follow up within 72 hours of discharge. This was abandoned when NHSE stopped publishing data on this metric in April 2021.

32. A policy on assessing the physical environment to remove means of suicide was introduced in 1999. Removal of ligature points was also identified in the 2002 suicide prevention strategy, and in multiple policy documents published since. There was a 35% fall in the number of inpatient suicides between 2010-2020; and improvements on this number remains a key aim.

33. As to policies around risk management for suicide and self-harm, the focus during the first part of the Relevant Period was on staff training for risk management and suicide being updated every three years. Later policy documents from the DHSC and NHSE encouraged compliance with NICE guidelines on risk formulation and management. The 2023 National Prevention Strategy notes that trusts and providers should go further to identify and implement actions to prevent suicides in inpatient settings.

34. The DHSC issued a policy around ensuring that patients, carers and families are included in decision making, planning and information sharing. To that end, the 12 points to a safer service guidance set out in the Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness **[WV/41, page 5178]** emphasised the importance of sharing information with families during reviews of suicides, as well as risk management training for staff, and other factors. 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 co-production of services with people with lived experience, their families and carers, was emphasised further in the Five Year Forward View and associated implementation plan.

35. The principle of providing therapeutic care in the least restrictive environment is consistent throughout many policies in the Relevant Period, from the NHS Plan in 2000 to Government announcements in 2020 detailing investments in greater privacy in mental health facilities.

36. There have been policies on improving access to services and reducing waiting times, and on crisis care. As to improving access, there was a commitment to increasing the number of beds in the implementation plan for the Five Year Forward View, for example. On crisis care, there was a focus on liaison teams in A&E supporting people with severe mental illness to reduce inappropriate hospital care and out of area placements. The Long-Term Plan set out an intention for mental health liaison services to be available in all acute hospital A&E departments and inpatient wards in 2023/24.

37. Finally, there have been policies on addressing inequality, stigma and encouraging a culture of care. A national inequalities target was first introduced in 2000, to reinforce local targets for reducing inequality. In 2018, the Independent Review of the Mental Health Act **[Exhibit WV/44, page 5353]** highlighted racial disparities in the rate of detention. Within this policy, it is noted that the Government consulted on the White Paper proposals issued in response to the Independent Review. A response was published in 2021 **[Exhibit WV/54, page 5989]**. A draft Bill was also issued in 2022, and the Joint Pre-Legislative Scrutiny Committee produced a report and recommendations in March 2024 **[Exhibit WV/55, page 6124]**.

Monitoring of compliance, concerns and failings at a national level

38. The Secretary of State has responsibility to Parliament for the provision of the health service and the DHSC is responsible for the health and care legislative framework. Most operational management in the NHS, including mental health services, takes place at arm's length from the Department. The DHSC holds ALBs accountable through its sponsorship arrangements and each ALB has a Senior Departmental Sponsor. The DHSC's levers include the power for the Secretary of State to appoint and remove chairs; accountability from the Accounting Officer of each ALB; framework agreements between the DHSC and the ALB; annual business plans and performance reporting against these plans; and a programme of reviews.

39. The Secretary of State retains formal powers to intervene in the event of significant failure by a non-departmental public body. As a first step, the Secretary of State can issue a direction to the ALB and, if the organisation fails to comply, the DHSC may discharge the functions to which the direction relates or make arrangements for another organisation to do so. In all cases, reasons for an intervention by the Secretary of State must be published.

40. To safeguard the independence of regulators, ministers are prevented from intervening in specific cases dealt with by Monitor or the Care Quality Commission (CQC). Ministerial powers are limited to situations of significant failure.

41. The CQC took over responsibility for monitoring and inspecting the quality of services in 2009. The Health and Social Care Act 2008 requires the CQC to keep the Secretary of State informed about the provision of NHS health care services, and the Secretary of State may

intervene and issue directions. The Secretary of State can also carry out the functions of the CQC or arrange for a third party to do so if the CQC fails to comply. That power has not been exercised since the creation of the CQC.

42. At Annex E to the witness statement, there is a summary of investigations, independent reviews and audits commissioned by the DHSC over the Relevant Period.

43. Evidence from reviews and reports commissioned by the DHSC points to factors supportive of patient safety. There were many independent reviews, reports and inquiries, not all directly commissioned by the DHSC, which led to important learning and Government action in relation to inpatient safety. One example is the 'An organisation with a memory' report, commissioned to learn about the scale and nature of serious failures in the NHS and to make requisite recommendations. The report, although not specific to mental health, found that a blame culture and the lack of a national system for sharing lessons learnt were key barriers to identifying and then reducing the number of patient safety incidents. It also highlighted the need for the Government to act on recommendations quicker.

44. The DHSC responded with 'Building a safer NHS'. This set out plans to establish the National Patient Safety Agency and a mandatory reporting scheme extending to mental health inpatient services. The report found there was a lack of clarity as to when external investigation was required after an incident, and in 2005 the DHSC published guidance titled 'Independent investigation of adverse events in mental health services' **[Exhibit WV/47, page 5675]**.

Independent investigation of adverse events in mental health services

It is essential that all adverse health care events are reviewed in such a way that lessons can be learnt (*An Organisation with a Memory* and *Building a Safer NHS*).

45. The DHSC learnt from serious incidents and failings in care, such as the death of Olaseni (Seni) Lewis, who lost his life following the disproportionate and inappropriate use of force in a mental health unit. A Private Member's Bill titled Seni's Law was introduced to Parliament in 2017 and aimed to reduce the use of restraint in hospitals. It received Royal Assent in 2018 as the Mental Health Units (Use of Force) Act. Accompanying statutory guidance was published after public consultation **[Exhibit WV/48, page 5680]**.

46. After a series of high-profile patient safety incidents and abuse of patients, the DHSC commissioned a rapid review into mental health inpatient safety in 2023 **[Exhibit WV/49, page 5738]**.

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Independent report

Rapid review into data on mental health inpatient settings: final report and recommendations

Updated 21 March 2024

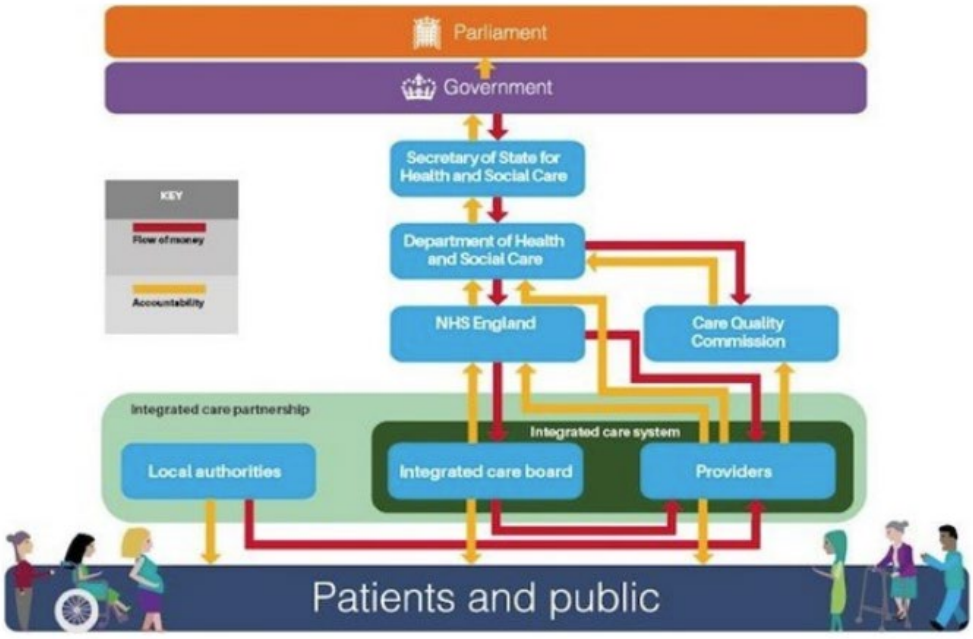
The review recommended that the DHSC and the NHS needed to ensure that the most important and impactful metrics were being measured regarding mental health patient safety and therapeutic care. In March 2024, the DHSC published the Government's response to the rapid review and set up a steering group and a mortality working group to act on the recommendations.

47. The Government then commissioned the Healthcare Safety Investigation Branch (now the Healthcare Services Safety Investigations Body (HSSIB)) to undertake a series of national investigations into mental health inpatient services to cover four priority areas: how out of area placements are handled; supporting transition to adult inpatient settings for children and young people; creating conditions for delivery of safe and therapeutic care; and learning from deaths. In January 2025, the HSSIB concluded their investigations and the findings have been published in a series of reports available on the HSSIB website **[Exhibit WV/51, page 5821]**. As part of this the DSSIB took the decision to undertake further work, the results of which are due to be published this month (May 2025). The DHSC will be formally responding to all of the HSSIB's recommendations in due course.

48. Action has been taken at a national level and progress made, one example being the reduction in the use of police cells as a place of safety for people in mental health crisis including as a result of collaboration between the DHSC, police, health and mental health charities as part of 'The Mental Health Crisis Care Concordat' **[Exhibit WV/52, page 5834]**. Another example is the action recommended by the Independent Review of the Mental Health Act to replace

dormitory accommodation on inpatient wards; 43 projects have been completed to this end.

49. The DHSC notes, however, that it remains the case that too many people experience poor quality care and lose their lives in inpatient mental health settings. The HSSIB's report 'Mental health inpatient settings: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge' **[Exhibit WV/53, page 5888]** includes a diagram detailing the flow of accountability from Parliament all the way to patients and the public **[page 5951]**.



The HSSIB report underlines that the DHSC and others could do more to learn from deaths and/or issues identified in reviews.

13 May 2025

Counsel to the Inquiry