Witness Name: William Vineall
Statement No.: 1
Exhibits: 55
Dated: 24 March 2025

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF WILLIAM VINEALL

I, William Vineall, Director, NHS Quality, Safety, Investigations, at the Department of Health and Social Care, 39 Victoria St, Westminster, London SW1H OEU, will say as follows.

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 Lampard Inquiry, dated 20 January 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. I have worked in DHSC since 1998 (including a spell in 2006 on the policy work underpinning the reform of mental health legislation in 2006; and the passage of the Mental Health (Approval Functions) Act 2012). There are a limited number of senior officials who are able to act as the corporate witness from the DHSC and owing to various conflicts of interest amongst colleagues who have or have had policy responsibility for mental health, I have been directed to this role. I have therefore rescinded my previous responsibilities as the senior sponsor, a role I have had since 2021, in order to assist the Inquiry with the evidence on behalf of the Department. In doing so I am very aware of the need for full transparency between the two departmental roles, and my contact with the sponsoring team on any matters relating to the Lampard inquiry has now ceased. The Department has separately provided confirmation to the Inquiry of the new senior sponsor.

3. I would like to take this opportunity to extend the Department's deepest sympathy to all those who have suffered as a result of their treatment at the NHS Trusts in Essex or by bereavement, pain and injury to their loved ones. As the Government Department with responsibility for the health service and oversight of NHS England, the Department of Health and Social Care is fully committed to assisting and cooperating with the Inquiry in any way requested to enable it to fulfil its terms of reference and consider its provisional list of issues.

4. By way of overview, I address within this statement:
   a. The role of the Department and its day-to-day responsibilities over the period - paras 9-30
   b. An overview of the different bodies that the Department oversees in England - paras 31-39
   c. Other organisations or departments which DHSC has worked with in relation to mental health services and mental health inpatient safety – para 40
   d. National mental health services and inpatient safety related policies, programmes, information, DHSC commissioned reviews and recommendations – paras 41-68
   e. Monitoring of compliance, concerns and failings at a national level – paras 69-76
   f. A reflective overview of lessons learned – paras 77-91

5. As this corporate statement is made on behalf of the Department, it necessarily and very largely covers matters that are not within my personal knowledge or recollection. This statement has therefore been prepared by officials within the Department and its legal advisors. To ensure that the information provided is as comprehensive and accurate as possible and to avoid needless duplication of work, where relevant use has been deliberately made use of information provided to other recent inquiries, updated as appropriate. This statement is true to the best of my knowledge and belief. The statement is accurate and complete at the time of signing.

6. Officials within the Department have been preparing for this Rule 9 request in advance of its receipt and have tried to anticipate the types of questions with which the Inquiry will require the Department's assistance. Accordingly, the more generic material had been obtained in advance of the request being made. However, notwithstanding that earlier preparation, the request itself with a month turnaround has presented a significant challenge in relation to the Department's ability to obtain all of the information requested. We have therefore prefaced the response to indicate where we consider the Department has been able to trace much of the relevant material and where we consider that the Department may be in a position to provide further detail on relevant issues.

7. The events falling within the Terms of Reference of this Inquiry concern mental health services and inpatient safety within England and so that forms the primary focus of the material set out below, unless otherwise stated. Health and social care is largely devolved to the Welsh and Scottish Governments and the Northern Ireland Executive.

8. I would also like to highlight the statement the Secretary of State made to the House of Commons on 13 March 2025, in which he announced that NHS England, and its functions, will be brought into the Department over the next two years. I will provide further updates to the Inquiry as the plans develop.

The role of the Department and its day-to-day responsibilities over the period

9. The Department of Health and Social Care (or Department of Health until it changed its name in 2018) was (and remains) responsible for the key 'department of state' functions with respect to the health service, including:

- Securing resources for the NHS within Government.

- Overseeing and where necessary seeking to amend (with Parliamentary approval) the legislative framework for the NHS.

- Representing the views and interests of the NHS within Government (e.g. the NHS as a major employer).

- Developing and supporting strategy and policy for the NHS (see next section for how this has varied over time).

- Being accountable to Parliament for the NHS (through Parliamentary Questions, debates, Select Committees). The issues for which the Department is accountable can be both general matters of policy and strategy and quite specific matters (and at certain times some but not all of that accountability has been shared with NHS England and other organisations). This would include significant failures in care.

10. The Department's role is to support and advise the Government's health and social care Ministers by shaping policy, assisting in the setting of the strategic direction for the health and care system and implementing agreed policy, often through oversight of our operational Arms Length Bodies (ALBs). This includes the three main functions that the Department oversees in England: the National Health Service ('NHS'), public health, and adult social care.

11. The Department remains ultimately accountable for the NHS, via the direct Ministerial accountability to Parliament, but the model of oversight in the NHS has evolved over time.

12. The Department's responsibilities in relation to, and its relationship with, NHS bodies are underpinned by a legal framework. That framework has evolved over time, most notably due to the Health and Social Care Act 2001, the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022.

13. The Department is responsible for overall health policy. NHS England (NHSE) has day-to-day responsibility for the NHS in England. NHSE supports and oversees the commissioning of health services and, since its merger with NHS Improvement ('NHSI'), also has responsibility for specific oversight of healthcare providers.

14. For completeness, I exhibit to this statement, five examples of the Department's published Departmental Reports and Annual Reports and Accounts for the relevant period:
    - 2000/01 (WV/1)
    - 2007/08 (WV/2)
    - 2012/13 (WV/3)
    - 2017/18 (WV/4)
    - 2023/24 (WV/5)

15. All the reports are publicly available and they help demonstrate and provide evidence of the changes that have taken place. These documents set out in further detail the Department's role, purpose, structure and funding, as well as performance against key priorities for each reporting year since 2000 (the start of the Inquiry's time period).

16. The Department also supports the Secretary of State for Health in the discharge of his duties. The Secretary of State has a wide range of powers and duties as a result of various Acts of Parliament and secondary legislation. He is accountable to Parliament for these responsibilities. I do not set out a comprehensive list of all those responsibilities, however I have set out below some of those which I believe are most relevant to the Inquiry, alongside the legislation that they relate to.

Health and Social Care Act 2001 ('the 2001 Act')

17. In July 2000, the Government published 'The NHS Plan: A plan for investment, a plan for reform' and 'The NHS Plan: the Government's response to the Royal Commission on Long Term Care'. The 2001 Act was intended to deliver many of the aspects of 'The NHS Plan' and the parts of the Government's response to the Royal Commission on Long Term Care that required changes to primary legislation.

18. Section 2 of the 2001 Act enabled the Secretary of State to increase a Health Authority's financial allocation where it had demonstrated achievement against objectives and performed well against performance criteria, whilst Section 3 provided for the Secretary of State to make supplementary payments to NHS Trusts and Primary Care Trusts.

19. Section 4 amended the National Health Service 1977 (c.49) and provided the Secretary of State with the statutory power to form NHS Trusts.

20. Section 13 of the Act provided the Secretary of State with new intervention powers to deal with cases of persistent failure, enabling the Secretary of State to intervene in an NHS body where there were concerns regarding management or performance of functions.

21. All the above sections were repealed on 1st March 2007 by the National Health Service (Consequential Provisions) Act 2006.

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

22. Section 1 of the 2006 Act imposes a duty on the Secretary of State to continue 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. This includes the continuous improvement in outcomes (s.1A(2)), in particular, in the efficacy and safety of the services provided and the quality of the individual's experience. Section 1 was substituted on 1st October 2012 providing 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), save in relation to public health functions. Section 1H of the 2006 Act as amended created NHS England ("NHSE") and made it subject to a concurrent duty to promote a comprehensive health service in England

under s.1(1). In relation to this duty, NHSE has responsibility for arranging the provision of services for the purposes of the health service in England (see s.1H of the 2006 Act) and for securing their provision through (since 1 July 2022) Integrated Care Boards ("ICBs"). For the avoidance of doubt, neither the Secretary of State, nor the Department, are responsible for directly commissioning any NHS services.

23. 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. The s.1D duty was revoked as of 1 July 2022 by s.73 of the Health and Care Act 2022 as part of a suite of measures designed to promote collaborative working between NHSE and system partners.

24. Prior to the commencement of relevant sections of the Health and Care Act 2022 on 1 July 2022, there was no general power for the Secretary of State to issue Directions to NHSE about the exercise of its functions other than in an emergency scenario. In such circumstance such Directions could be issued under s.253 of the 2006 Act. The Health and Care Act 2022 introduced a general power to direct NHSE in the exercise of its functions (s.13ZC of the 2006 Act, which came into force on 1 July 2022), subject to some specified exemptions (s.1 3ZD of the 2006 Act).

Health and Social Care Act 2012

25. 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. Responsibility for NHS commissioning passed to the newly created NHS Commissioning Board and Clinical Commissioning Groups ('CCGs'). CCGs commissioned most NHS services and were supported by, and were accountable to, the NHS Commissioning Board (which came to be known as NHS England). CCGs were clinically led groups made up of GP practices and other clinicians within defined geographical boundaries which covered the whole of England. CCGs were the appropriate 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. The new s.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 NHS Act to promote a comprehensive health service.

26. The changes were predominantly to establish a more clearly ‘rules-based' system, with individual NHS bodies' day-to-day operations being more clearly separated from the strategic role of Ministers. To formalise this relationship, a system of assurance and assessment of NHS bodies was also introduced. By s.13A of the 2006 Act (as amended by the Health and Social Care Act 2012), the Secretary of State was required to publish and lay before Parliament a document known as 'the mandate’ to set strategic direction as well as capital resource and spending limits. The content of the mandate was subject to collective Government agreement and the objectives in the mandate were reflected in NHS England's operational guidance. As originally enacted, the mandate was directed to the NHS Commissioning Board. From 2019 to 2022, the mandate was addressed to both NHSE and NHSI, and their joint operational guidance was addressed to both CCGs and NHS providers.

27. 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.

28. I exhibit to this statement, the mandates for the relevant period:
    - 2013/2015 (WV/6)
    - 2014/15 (WV/7)
    - 2015/16 (WV/8)
    - 2016/17 (WV/9)
    - 2017/18 (WV/10)
    - 2018/19 (WV/11)
    - 2019/20 (WV/12)
    - 2020/21 (WV/13)
    - 2021/22 (WV/14)
    - 2023 (WV/15)

29. By s.1(2) of the 2006 Act (as amended in 2012), the functions of commissioning services and the provision of services were no longer delegated by the Secretary of State, but instead directly conferred on the organisations responsible for providing them. NHSE and

CCGs would be responsible for arranging services (that is for their commissioning and not for their provision).

30. The Health and Social Care Act 2012 made clear that Secretary of State's responsibility primarily lay in ensuring that the functions of commissioning services and the provision of services were being carried out effectively, through the power to set objectives for NHSE (via the mandate already mentioned), by overseeing the effective operation of the health service and through the power to intervene in the event of significant failure (under the new s.1 3Z2 of the 2006 Act).

An overview of the different bodies that the Department oversees in England

31. I would now like to provide an overview of the different bodies the Department has overseen over the relevant period, including general methods and principles of oversight.

32. The Department's Arm's Length Bodies or 'public bodies' can be variously considered to include:
    - Non-Departmental Public Bodies (NDPBs)
    - Arm's Length Bodies (ALBs)
    - Executive Agencies
    - Special Health Authorities (SpHAs)
    - Public Corporations
    - Advisory Committees

33. In the health and social care landscape and across Government, many bodies have changed over time. Not only have bodies been formed, merged, or abolished, many have changed classification as well. **Annex A** provides a timeline and brief outline of the roles and function of the key ALBs, which are of particular relevance to the matter during the relevant period, including NHSI, setting out the key changes over that time. **Annex B** provides a more complete list of departmental ALBs over this time. Those marked with an * may have information of particular relevance to the matters the Inquiry is investigating.

34. As set out in the Department's 2023-24 annual report and accounts (WV/5), I would like to assure the Inquiry that the Department prioritises building strong and effective working relationships with each of its ALBs via Departmental sponsorship teams. These teams, in

line with the Cabinet Office 'ALB Sponsorship Code of Good Practice', work collaboratively, and in line with the *Code*, to ensure accountable, efficient and effective health and care services are provided to the public.

35. In response to the Inquiry's particular interest in NHSI, we have sourced and submitted an internal guide that was prepared for Departmental staff in 2017 (WV/16), which sets out and explains the role and responsibilities of NHSI, and how the Department sponsored NHSI and held it to account at that time. The Inquiry may also be interested in the Framework Agreement between DHSC and NHSI, which was published in October 2018 (WV/17). This document set out arrangements for the Department to monitor and scrutinise NHSI's strategy, performance and delivery.

36. NHS Improvement was the operational name for an organisation that brought together Monitor, the NHS Trust Development Agency, Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and Intensive Support Teams. It was established on 1 April 2016. Prior to this, on 9 March 2016, Monitor and the NHS Trust Development Authority published the "Learning from Mistakes League" to encourage openness and transparency in the NHS (WV/18).

37. The league table was drawn together by scoring providers based on: the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their Trust. The supporting data, drawn from the 2015 NHS Staff Survey and from the National Reporting and Learning System was published alongside (WV/19). NHS Trusts in Essex featured in the league table. South Essex Partnership University NHS Foundation Trust was ranked 20th (out of 230 trusts), Mid Essex Hospital Services NHS Trust was 189th, and North Essex Partnership University NHS Foundation Trust was 218th.

38. In 2018, NHSE and NHSI began working more closely together and sharing posts and functions. From 1 April 2019 they worked together as a single organisation. A full merger, under the name of NHS England, followed with passage of the Health and Care Act 2022. As such DHSC does not have access to NHSI record repositories. The Department will check what records it may hold relating to 'Learning from Mistakes League', and other analysis NHSI may have undertaken in relation to NHS Trusts in Essex. The Department will undertake further searches to consider if we hold any relevant materials.

39. As of 2025, in addition to those above, expectations of both the Department and its ALBs also include:

- Publication of a Framework Document, to be updated every three years, outlining the relationship between the Department and the ALB, and the governance and accountability arrangements that should be in place.

- Publication of a Remit or Chair's Letter, to be updated annually, outlining the key areas of focus the Department wishes the ALB to focus on in each financial year. For NHS England, this takes the form of a 'Mandate' from the Secretary of State (as set out above).

- The holding of regular meetings between the Department and ALBs. These are generally quarterly, chaired by the Senior Sponsor or a Senior Civil Servant within their team, and attended by the Chief Executive and/or Chair of the ALB.

Other organisations or departments DHSC worked with in relation to mental health services and mental health inpatient safety

40. In addition to formal ALBs and public bodies, over the relevant period, the Department has worked and continues to work very closely and collaboratively at a national level with a wide range of other organisations, including other Government Departments, on mental health services and inpatient safety matters. Please find below a list of some of the key organisations with whom the Department has had involvement. This is not exhaustive, as it has not been possible to capture every point of relevant engagement the Department might have had over the time period in the time permitted.

Allied Health Professions Federation
Anna Freud National Centre for Children and Families
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Bipolar UK
Boarders Mental Health Trust
British Psychological Society
British Association of Social Workers
Cabinet Office

Care Services Improvement Partnership
Centre for Mental Health
Children and Young People's Mental Health Coalition
Coroner’s Office
Crisis Care Concordat
Crown Prosecution Service
Equality 2025
Equality and Human Rights Commission
Department of Education
Department of Work and Pensions
Faculty of Old Age Psychiatry
Faculty of Public Health
Healthwatch
HM Courts and Tribunal Service
HM Prison and Probation Service
HM Treasury
Home Office
Independent Mental Health Services Alliance
International Initiative for Mental Health Leadership (IIMHL) & International Initiative for Disability Leadership (IIDL)
INQUEST
Law Society
Local Government Association
MENCAP
Mental Health First Aid in England (MHFA)
Mental Health Foundation
MIND
Ministry of Housing, Communities and Local Government (was DCLG)
Ministry of Justice
NHS Confederation
National Institute for Mental Health
NSUN
Office of National Statistics (ONS)
Place2Be

Public Health England (OHID)
Race Equality Foundation
Rethink
Royal College of GPs
Royal College of Nursing
Royal College of Psychiatrists
Samaritans
Time to Change
Turning Point
YoungMinds
Zero Suicide Alliance

National mental health services and inpatient safety related policies, programmes, information, DHSC and recommendations

41. I would now like to provide an overview of the Department's role and interests in national mental health and inpatient safety policies. Due to the overlapping nature of the policies, programmes, recommendations and information that the Department communicated, I have set these out in chronological order to show the evolution of the work.

42. The Department had a very active policy agenda on mental health during this time. This included the establishment and roll out of key interventions that continue today including Talking Therapies (formerly Improving Access to Psychological 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.

43. For the purposes of this statement, I have set out policies related to mental health and drawn out where they touch on areas most relevant to the Inquiry's terms of reference, namely inpatient settings, severe mental illness, discharge from inpatient settings, learning and review and involvement of patients and carers in decision making and planning.

Chronology of national policies

44. I have set out a chronology of key policies and documents below. Further detail of the specific content of these policies and documents can be found in **Annexes C and D**. I

have focussed this summary on overarching policy and programmes that set national direction and priorities for local areas during this time, which the Department has either developed or convened others to develop. This is not an exhaustive list due to time constraints. The Department would be happy to seek further detail in areas of particular interest to the Inquiry if it would be of assistance.

45. The Mental Health Act 1983 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 others, supported by a statutory 'Code of Practice' (2015 - WV/20). The Government, last revised the Act in 2007, and has most recently, proposed revisions to the Act and these are currently being considered by Parliament (as at February 2025).

46. There are also two policy documents that are just outside the timescales of the Inquiry but which are important to show the strategic context for policies that followed – the new NHS White Paper published in 1998, and the 'National Service Framework for Mental Health', published in 1999. The new NHS White Paper set out a range of measures to drive up quality and reduce unacceptable variations, with services responsive to individual needs, regardless of age, gender, race, culture, religion, disability, or sexual orientation. A First Class Service (WV/21) explained how NHS standards would be: set by the National Institute for Clinical Excellence and National Service Frameworks; delivered by clinical governance, underpinned by professional self-regulation and lifelong learning; and monitored by the Commission for Health Improvement, using the new National Performance Assessment Framework, and the National Survey of Patients.

47. **1999:** The Government published the first 'National Service Framework (NSF) for Mental Health' (for adults up to 65 - WV/22) with advice from an external expert group that it convened. 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 ensure that everyone received a high quality of care, regardless of where they live, by tackling variations in access and service delivery across the country. The 'NSF for Mental Health' set out 7 standards the NHS were expected to meet for mental health including health promotion, primary care, access to services, severe mental illness, supporting carers and suicide prevention. The framework was intended to set the standards for ten years, with a specific three-year programme to achieve specific national and local targets until 2002, underpinned by £700m of funding.

Examples of specific indicators introduced relating to patient safety and mental health include the availability of Section 12 doctors and social workers, eliminating mixed sex wards, adherence to clinical guidelines on prescribing antipsychotics, antidepressants and benzodiazepines, the national suicide rate and training for staff on risk management every three years. As I have set out at para 46, progress on the standards in the NSF was monitored by the Commission for Health Improvement, and the aims and standards were reflected in wider priorities and policies issued by the Department, for example, the Modernising Health and Social Services National Priorities Guidance 1999/00 (WV/23) and the covering Health Services Circular (WV/24).

48. **2000:** 'The NHS Plan: A plan for investment, a plan for reform' set out overall priorities and commitments for the NHS (WV/25). The Plan was introduced because of the lack of national standards across the NHS, barriers between services, and a lack of clear incentives. It was intended to be a long-term vision for the NHS and set national priorities. Mental health was identified as one of these priority areas and specific commitments included the reduction of avoidable emergency readmissions for people with mental health problems, new graduate mental health workers in primary care and new mental health teams for immediate crisis response. The Modernisation Agency, was formed by the Department, in April 2001 to support the NHS make the changes required to implement the overall Plan.

49. **2002:** The first 'National Suicide Prevention Strategy for England' was published by the Department (WV/26). This was to support the White Paper Saving Lives: Our Healthier Nation (published by the Department in 1999), which was a Government plan focused on the main killers: cancer, coronary heart disease and stroke, accidents, and mental illness. The target was to reduce death rate from suicides by at least 20% by 2010. This set out suicide as a major public health issue. It set out six key goals to support suicide prevention. The National Institute of Mental Health in England, which was part of the Modernisation Agency, oversaw the implementation of the Strategy, including supporting local mental health services to implement the "t*welve points to a safer service".*

50. **2007***:* The Mental Health Act was last revised in 2007, with changes including: revised criteria for detention; introduction of Independent Mental Health Advocates; Age-appropriate services; and requiring hospital managers to ensure that patients under 18 admitted to hospital for mental disorder are accommodated in an environment suitable for their age. It also introduced supervised community treatment (in the form of Community

Treatment Orders) for patients following detention in hospital. This provision aimed to stop the 'revolving door' whereby patients leave hospital, do not continue with their treatment and see a deterioration in their health and require detention again.

51. **2011:** 'No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages' was published by the Coalition Government (WV/27). 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 changes were top-down in direction, with more emphasis on structures and processes than outcomes. The strategy noted that progress was uneven between different areas and conditions and not all groups benefitted equally. 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, and with recognition that tackling wider objectives such as improving education and reducing drugs and alcohol consumption cannot be achieved without improvements in mental 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, along with indicators and areas for action for each. Outcomes were related to prevention, treatment and recovery, physical health, positive experience of care, reducing avoidable harm, reducing stigma and discrimination. Oversight of implementation was the responsibility of the Government Cabinet Sub-committee on Public Health. This was accompanied by a plan to expand access to Improving Access to Psychological Therapies for four years from April 2011, which offer National Institute for Health and Clinical Excellence (NICE) approved treatments for depression and anxiety. The number of people accessing IAPT has grown each year since 2008. It now sees over 1 million people each year. The latest data show the average wait to be seen is 19 days. Approximately, 7 of every 10 people (67%) who have a course of treatment (two or more sessions) show reliable and substantial reductions in their anxiety/depression. Around 5 in every 10 (51%) improve so much they are classified as recovered.

52. **2012:** A new ten-year national 'Suicide Prevention Strategy for England' (WV/28), published by the Department, set out the Government's objectives to reduce the suicide rate in the general population in England and provide better support for those bereaved or affected by suicide. It addressed new challenges and areas of concern including greater

support for families and more explicit reference to the importance of primary care in preventing suicide. It set out what Departments across Government would do to contribute. It identified high-risk groups who are priorities for prevention: young and middle-aged men, people in the care of mental health services (including inpatients), people with a history of self-harm or in contact with the justice system and specific occupation groups such as doctors and agricultural workers. In relation to patient safety, the Strategy identified inpatients as a priority group for action. It also highlighted the approaches identified by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) which can contribute to a reduction in suicide rates including improved care pathways, risk assessment and management training for front-line staff working with high-risk groups and the regular assessments of ward areas to identify and remove potential risks i.e. ligatures and ligature points.

53. **2014:** 'Closing the Gap: Priorities for essential change in mental health' was published by the Department (WV/29). This set out shorter term priorities to achieve the longer term vision outlined in the 2011 Mental Health Strategy (WV/27). It set out 25 areas for changes in local service planning and delivery in the next 2-3 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 Care Quality Commission (CQC) models for regulating mental health services and specialist community perinatal mental health teams.

54. **2014:** 'Achieving better access to Mental Health Services by 2020' (WV/30) was published by the Department and NHS England, following structural changes I have set out previously. 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:
    - 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% treated within 18 weeks of referral.
    - More than 50% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.

55. It was also accompanied by £30m targeted investment on effective models of liaison psychiatry in more acute hospitals. Availability of liaison psychiatry informed CQC inspections and therefore contributed to ratings.

56. **2015:** "Future in Mind" (WV/31). was developed by the Children and Young People's Mental Health Taskforce (convened by the Department) and published jointly between the Department and NHS England. It emphasised the NHS, public health, Local Authorities, social care, schools and youth justice sectors working together on building resilience, promoting good mental health, prevention and early intervention; simplifying structures and improving access; delivering a clear joined up approach; harnessing the power of information to drive improvements in the delivery of care and standards of performance; sustaining a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience; and making the right investments to be clear about how resources are being used in each area. The report acknowledged there were variations in access to appropriate or age-appropriate inpatient care close to home and availability when needed for children and young people. It described a model to address gaps in provision, addressing the role of pre-crisis, crisis, and 'step-down' services alongside inpatient provision. The aim was for commissioners to make better decisions about what inpatient capacity was required.

57. **2016:** 'Implementing the Five Year Forward View for Mental Health'(WV/32). In response to recommendations from the Mental Health Taskforce, which was commissioned by Simon Stevens, Chief Executive of NHS England, on behalf of the NHS, set out an implementation programme to deliver many of the recommendations. It 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. It included an objective to eliminate inappropriate placements (in terms of inappropriate settings and locations) for in-patient beds for children and young people by 2020/21, alongside new models of care, funding for crisis resolution and home treatment services and an expectation that commissioners develop plans to align in-patient beds to meet local need.

58. **2018**: 'Mental Health Units (Use of Force) Act 2018'. In 2017, a Private Member's Bill was introduced known as 'Seni's Law' and was debated in Parliament. It aimed to reduce unnecessary and inappropriate use of restraint in mental health hospitals. After public

consultation, accompanying statutory guidance was published. Three sections are due to be commenced during 2025, and significant work to reduce restraint in mental health settings is already in place on the ground.

59. **2019:** 'The NHS Long Term Plan' (WV/33) 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.

60. **2019**: 'NHS Mental Health Implementation Plan' (WV/34). This set trajectories and plans for delivering the remaining 'Five Year Forward View for Mental Health' commitments and building on these to deliver '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 and care closer to home (rather than inpatient settings) and 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.

61. **2021**: The 'COVID-19 mental health and wellbeing recovery action plan' (WV/35) 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.

62. 2023: NHSE launched the 'Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme' (WV/36) 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, and supporting local oversight and support arrangements.

63. **2023**: 'Major Conditions Strategy: case for change and our strategic framework' (WV/37). This paper, published by DHSC, focuses on six groups of conditions that are collectively the greatest contributors to ill-health and early mortality, including mental ill health.

64. **2023**: 'The Suicide Prevention Strategy for England' (WV/38) replaced the 2012 strategy and sets out priority areas for action to reduce suicides. Mental health patients are identified as a priority group and effective crisis support is identified as a priority area for action across the NHS and wider organisations.

65. **2024**: 'Mental Health Bill'. Following an Independent Review into the Mental Health Act chaired by Sir Simon Wessely, the Government published a White Paper, Reforming the Mental Health Act (WV/39), in January 2021 which accepted the vast majority of the review's recommendations. After a public consultation on the proposed reforms, a draft bill was published in 2022 (WV/40). The Mental Health Bill was introduced to the UK Parliament on 6 November 2024 and is currently undergoing detailed parliamentary scrutiny.

<u>Key themes and consistent policies from 2000- 2023</u>

66. There are particular policies that may be of interest to the inquiry and that have remained consistent through this timeframe. These include, but are not limited to:

- **Reducing inappropriate out of area placements (OAPs).** This policy was first introduced in the 'National Service Framework for Mental Health' in 1999 and remained a core aim in the 2019 'NHS Long Term Plan' (LTP) and in the NHSE 2024/25 'Priorities and Operational Planning Guidance'. The LTP in 2019 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 LTP sought to bring the typical length of stay in outliers to the national average of 32 days, which was expected to contribute to ending OAPs.

- **Ensuring timely follow up after someone is discharged from inpatient facilities.** A standard expectation that patients would receive follow up support within 7 days 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 7 days was included as an indicator of success. This standard later became more specific and ambitious. The '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. This effectively ended when, following consultation, NHS England stopped publishing data on this metric in April 2021. This decision was made due to the impact of the COVID-19 pandemic on data collection.

- **Assessing the physical environment to remove means of suicide.** This was introduced as a standard in the 1999 NSF and has continued subsequently. Removal of ligature points specifically is identified in the 2002 suicide prevention strategy and has continued throughout multiple policy documents and programmes subsequently, including in the 2012 and 2023 national suicide prevention strategies. Between 2010 and 2020, there was a 35% fall in the number of suicides in inpatient settings in England, when taking into account the number of admissions. The 'NHS Long Term Plan' also set out that reducing suicides would remain an NHS priority over the next decade.

- **Risk management for suicide and self-harm.** In the first part of this period, the focus was on ensuring that staff received training for risk management for suicide to be updated every 3 years. This built on the commitment in the 'National Service Framework for Mental Health', to ensure that staff are competent to assess the risk of suicide among individuals at greatest risk. Later policy documents from both the Department and NHSE encouraged compliance with NICE guidelines from 2003 and most recently updated in 2022 which includes guidelines on risk formulation and management, including avoiding the use of risk stratification tools and putting in place high quality safety plans and support. More recently, the 2023 national suicide prevention strategy notes that to continue to build on progress, mental health trusts and providers of NHS-funded mental healthcare should identify and implement actions to further prevent suicides in inpatient settings. This includes reviewing and implement evidence-informed recommendations such as those outlined in NCISH annual reports.

- **Ensuring that patients, carers and families are included in decision making, planning and information sharing.** '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 highlighted the importance of including patients in discharge planning, including those in child and adolescent mental health services (CAMHS). In 2000, 'The NHS Plan' placed emphasis on building on patient advocacy services in mental health and learning disability and autism services. The 12 points to a safer service guidance, from the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (NCISH) report 'Safety First' (WV/41) (which the 2002 suicide prevention strategy encouraged services to implement) set out the importance of sharing information with families during reviews of suicides. 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.** 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 in this time period, including the Mental Health Act 1983. 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 MHA under review. The 2015 revision of the statutory 'Code of Practice', which supports the Mental Health Act 1983, asserted that the principle of choosing the least restrictive option should always be considered when making decisions in relation to care, support and treatment. 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.

- **Improving access to services and reducing waiting times.** Between 1999 and 2000, there was more focus on reducing bed occupancy, reviewing bed pressures and increasing medium secure beds. For example, ‘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. Starting with the NSF, the aspiration was to shift care and increase capacity in community services (including crisis services), in part to reduce the need for inappropriate stays in hospital and/or inappropriate out of area placements. For example, ‘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 commission improved access to 24/7 crisis resolution and liaison mental health services which are appropriate for children and young people.

- **Crisis care, including liaison teams in A&E to** support people with severe mental illness and to reduce inappropriate hospital care and out of area placements (the ‘Five Year Forward View’ set the goal for all acute hospitals to have "all-age" liaison mental health services available in their emergency departments and inpatient wards by 2020/21). The importance of good access to crisis care features in the majority of policy documents, starting with the NSF, as well as the role of crisis alternatives and community crisis care in reducing inappropriate hospital stays and out of area placements. ‘The NHS Plan’ 2000, for instance, 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. 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. In later years (2016, 2019) there were more dedicated programmes for rolling out crisis care and ensuring a wider provision of psychiatric liaison teams in emergency departments. For example, the implementation of the ‘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.

- **Addressing inequalities, stigma and culture of care.** This is not always specific to inpatient care and often the principles are intended to apply to a wide range of mental health services and activity, including upstream and prevention activity. This includes

the need to tackle socially excluded and deprived groups in health improvement programmes from 1999 and to adhere to the new Public Sector Equalities Duties from 2010. 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. The plan outlined intended actions to achieve this through a combination of specific health policies and broader government policies, including expanding Sure Start and increasing and improving primary care services in deprived areas. Later, the '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. Specifically in relation to racial disparities, in response to an independent inquiry into the death of David Bennett (WV/42) in 2003, the Government published 'Delivering race equality in mental health care: An action plan for reform inside and outside services' (WV/43) 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 Independent Review of the MHA (WV/44) in 2018 highlighted high rates of detention, racial disparities in detentions and community treatment orders, poor patient experience and the particular disadvantages experienced by people with a learning disability and autistic people.

67. Throughout this time, there were also relevant supporting plans and policies across the Department - for example workforce and financial planning, and estates planning. For example, the ambition to reduce same sex wards was set out in 'The NHS Plan', Suicide Prevention Strategy 2012 and 'Closing the Gap'.

68. In addition to policies and strategies published, the Department also shared information with NHS organisations and Local Authorities through circulars and updates: Chief Inspector, Social Services Inspectorate updates and Local Authority Circulars; Chief Medical Officer updates; Health Service Circulars; and Health Service Guidelines (issued by the NHS Executive from the Department.

Monitoring of compliance, concerns and failings at a national level

69. I would now like to provide an overview of how compliance against the policy and programmes landscape was monitored at a national level.

70. While 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, most day-to-day operational management in the NHS, including mental health services, takes place at arm's length from the Department. This approach empowers front-line professionals, whilst maintaining Ministerial accountability, and DHSC's involvement in operational decision-making. With the exception of SpHAs, all organisations in the NHS have their own statutory functions conferred by legislation, rather than by delegation from the Secretary of State.

71. The Department has a consistent approach through its sponsorship arrangements for holding ALBs to account and gaining assurance that they are carrying out their functions properly, including those on to mental health. This is underpinned by the duty to keep their performance under review. Each of the ALBs has a Senior Departmental Sponsor (SDS), supported by a dedicated sponsor team, which provides the principal day-to-day liaison. The SDS is responsible for ensuring each organisation is sponsored effectively and in line with the Department's sponsorship standards. DHSC's levers include:

- Power for the Secretary of State to appoint and remove chairs and non-executive board members.

- Accountability from the Accounting Officer of each ALB, who holds the primary responsibility for ensuring that the organisation discharges its responsibilities properly and uses its resources in accordance with the requirements of Managing Public Money. This includes preparing the governance statement, which forms part of the ALB's annual report and accounts. Accounting Officers are appointed by the Principal Accounting Officer, except for the Accounting Officer of NHS England, appointed directly by legislation; and the Accounting Officer of the Medicines and Healthcare Regulatory Agency; appointed by HM Treasury because of its Trading Fund status. The names of Accounting Officers can be found in the Department's Estimates, which are regularly published.

- Framework agreements between the Department and each ALB, setting out the relationship between the sponsored body and the Department, lines of accountability, the way in which the ALB will provide assurance to the Department on its performance, the core financial requirements with which the ALB must comply, and the relationships between the ALB and other bodies in the system. The framework agreements set out how the Department holds the ALB to account for the delivery of its objectives and outcomes and for the use of public money.

- Annual business plans and performance reporting against these plans. Each ALB must produce an annual business plan, which has to be agreed with the Department, demonstrating how its objectives will be achieved and forecasting its financial performance. Most SDSs conduct quarterly accountability reviews with their ALBs to provide assurance that the ALB is delivering against its objectives, managing its finances, identifying and managing risks and working well with partner organisations. A formal accountability review takes place each year to review the past year's performance against objectives and to look forward to the next year. The annual reports and accounts of executive agencies, SpHAs and executive NDPBs must be laid before Parliament.

- A programme of reviews, coordinated by the Cabinet Office, that look at individual ALBs. This programme, which ends in March 2025, ensures that each ALB is reviewed every few years. The Department tailors reviews to ensure that they focus on the areas that will add value and not duplicate other work. The review team work closely with the ALBs involved to ensure the process is relevant and supports effective delivery.

72. The Secretary of State retains formal powers to intervene in the event of significant failure, including where an ALB is not acting consistently with what the Secretary of State considers to be the interests of the health service. These failure powers apply to non-departmental public bodies established or amended by the Health and Social Care Act 2012 and the Care Act 2014 (they are not needed for executive agencies or SpHAs, where Ministers are able to exert direct control). As a first step, the Secretary of State can issue a direction to the body. If the organisation fails to comply with the direction, then the Department may discharge the functions to which the direction relates or make arrangements for another organisation to do so. In all cases, the Secretary of State must publish the reasons for his intervention.

73. In order to safeguard the independence of the regulators, and avoid any perception of political interference, Ministers' intervention powers will not allow them to intervene in specific cases being dealt with by Monitor or Care Quality Commission (CQC). Ministerial powers are limited to situations of significant failure, as set out within the Health and Social Care Act 2012 and the Care Act 2014.

74. This approach is set out in the Department's Accounting Officer System Statement, which sets out all of the key accountability relationships and processes within the Department, making clear who is accountable for what at all levels of the health and social care system. The latest edition was published in 2018, with earlier editions published in 2017, and 2012, the latter of which also describes what the accountability arrangements were planned for April 2013 onwards, following the introduction of the 2012 Act.

75. I also wanted to provide more details about the role of the CQC, 'the Commission'. From 1st April 2009, the CQC took responsibility for monitoring and inspecting the quality of services. The CQC also had a particular role in monitoring the way the Mental Health Act was used and Healthwatch England was set up (as a committee hosted by CQC) 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 specialist mental health services. The CQC provided advice to the Secretary of State and the NHS Commissioning Board and its responsibilities included powers to suggest investigations by the CQC of poor services. Section 53 Health and Social Care Act 2008 requires the Commission 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 and section 82 provides for circumstances where the Secretary of State can intervene and issue a direction The section also enables the Secretary of State to carry out functions of the Commission or arrange for a third party to do so if the Commission fails to comply with the direction. This power has/has not been exercised since the inception of the commission.

76. Although this sits outside of the relevant period of the Inquiry, the Inquiry should also be aware of the review into the operational effectiveness of the CQC, which Dr Penny Dash conducted on behalf of the Department, with the full findings published in October 2024.

A reflective overview of lessons learned

77. Finally, I would like to share the Department's initial reflections on what lessons have been learnt over the relevant period, including from the investigations and inquiries commissioned by the Department. Evidence from various sources including reports and reviews commissioned by the Department and the findings of those commissioned by other bodies, point to key supportive factors for patient safety, most recently underlined by the HSSIB reports as described below (para 88).

78. In terms of independent reviews, audits, or investigations commissioned by the Department specifically and related to these matters during the relevant period, I have set these out in **Annex E** including more details on the scope, findings and actions taken as a result.

79. There have been many independent reviews, reports and inquiries that were not directly commissioned by the Department, but which led to important learning and government action in relation to mental health inpatient safety. Although not Departmentally commissioned reviews, some of these are referenced below, and I would be happy to provide more information for the Inquiry on reviews that had implications for Government policy on mental health inpatient care.

80. I will start by setting out some specific examples over the relevant period of the Inquiry where learning has been used by the Department to take action. 'An organisation with a memory' (2000 - WV/45) was commissioned by the Department to understand what was known about the scale and nature of serious failures in the NHS and make recommendations to improve patient safety, including mental health inpatient safety. 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.

81. The report also highlighted a particularly important point for Government, in relation to the need for swifter action on recommendations. For example, the vulnerability of suicide by hanging among mental health inpatients had been highlighted nearly 30 years earlier but had still remained an issue. The Department responded to this issue with 'Building a safer NHS' (WV/46) which included a new national target to reduce to zero the number of suicides by mental health patients as result of hanging from non-collapsible bed or shower

curtain rails on wards by 2002. To strengthen the response to improving patient safety, The report also set out plans to establish the National Patient Safety Agency and a new mandatory national reporting scheme extending to mental health inpatient services (National Reporting and Learning System). These actions were likely to have contributed to the reduction in inpatient suicides during the time period as outlined in further detail below. The report also found there to be little clarity about the circumstances under which some form of external investigation or inquiry is appropriate following an adverse event. In 2005 the Department published guidance "Independent investigation of adverse events in mental health services" (WV/47) to provide clarity on this specifically for mental health.

82. There have also been independent reviews, reports and inquiries that were not directly commissioned by the Department but nevertheless led to important learning and government action. As an example, the independent inquiry into the death of David Bennett in 2003 (WV/42) highlighted issues with relation to institutional racism in mental health inpatient settings and inappropriate use of physical restraint. The Independent Inquiry was commissioned by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority after consultation with the Department. Recognising the importance of these issues, at the Department's request, the Inquiry also examined some broader mental health issues, which helped to inform the developing black and minority ethnic mental health strategy. In response to the inquiry, the Government published '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' (WV/43). This includes government 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.

83. The Department has also learnt from serious incidents and failings in care, such as the death of Olaseni (Seni) Lewis, a young Black man who lost his life following the disproportionate and inappropriate use of force in a mental health unit, which highlighted that more was needed to address the inappropriate use of force in mental health inpatient units. In 2017, a Private Member's Bill was introduced known as 'Seni's Law' and was debated in Parliament, which aimed to reduce unnecessary and inappropriate use of restraint in mental health hospitals. In 2018, The Bill received Royal Assent as the 'Mental Health Units (Use of Force) Act. After public consultation, accompanying statutory guidance (WV/48) was published. The Act and accompanying guidance aims to ensure

there is better oversight and management of the appropriate use of force (including physical restraint, use of isolation, and chemical restraint) in relation to people in inpatient mental health units.

84. In 2018, an Independent Review of the Mental Health Act (WV/44) identified that the current legislation was out of step with a modern-day mental health service and that significant reform was needed. In particular it highlighted rising rates of detention, racial disparities in detentions and community treatment orders, poor patient experience and the particular disadvantages felt by people with a learning disability and autistic people. In response to the review, the Government published a White Paper, 'Reforming the Mental Health Act' (WV/39), in January 2021. which accepted the vast majority of the review's recommendations. After a public consultation on the proposed draft bill (WV/40) was published in 2022. The Mental Health Bill was introduced to the UK Parliament on 6 November, 2024 and is currently undergoing detailed parliamentary scrutiny.

85. After a series of high-profile patient safety incidents and abuse of patients, in 2023, the DHSC commissioned an independent 'rapid review' into mental health inpatient safety (WV/49), chaired by Dr Geraldine Strathdee. The purpose of the review was 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 recommended that the Department and NHS need to ensure we are measuring the most important and impactful metrics in terms of mental health patient safety and therapeutic care, to make the best use of the data and information we have whilst reduce unnecessary burden on staff where possible, and better utilise feedback and insights from patient, carers and staff. In March 2024, DHSC published the Government's response to the rapid review into data on mental health inpatient settings (WV/50) and set up a Ministerial-chaired steering group and a mortality data working group to take work forward actions. The Government has relaunched the mortality data working group and the next meeting is being arranged. Previous steering group members will also be receiving regular written updates on progress towards implementation.

86. In June 2023 when the 'rapid review' report was published, the SofS also announced that the Essex Inquiry would be made statutory. This decision was made as a non-statutory inquiry into patient safety issues at Essex had limitations in terms of ensuring engagement from staff to undertake a thorough investigation. It was also identified that a more wide-

ranging investigation was needed that would look at mental health patient safety issues more broadly, rather than a specific Trust.

87. The Government therefore commissioned the Healthcare Safety Investigation Branch (which became The Health Services Safety Investigations Body (HSSIB) on 1 October 2023 as an independent arm's length body of the Department) to undertake a series of national investigations into of mental health inpatient services to cover 4 priority area where more evidence was needed: 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.
88. In January 2025, HSSIB concluded their investigations into mental health inpatient settings. HSSIB's findings have been published in a series of reports since September 2024 that are available on the HSSIB website (WV/51). The investigations identify ways we can improve mental health care, protect patients and the public and create a safe working environment for staff and HSSIB has engaged with patients, families and carers, as well as local and national healthcare organisations, as part of these investigations. HSSIB have also taken the decision to undertake further work in 2025 which will be published in May 2025. DHSC will be formally responding to all the recommendations for the Department made within the reports in due course.

89. Over the period covered by the inquiry, action has been taken at national level and progress made, as set out in the sections on policy and investigations above. Much of this has been based on learning from reviews commissioned by the Department or others, academic or clinical evidence or input from health care and other professionals working in frontline services, and people with experience of being or caring for mental health inpatients. Examples of this include but are not limited to:

- Between 2010 and 2020, there was a 35% fall in the number of suicides in inpatient settings in England (according to NCISH 2023 Annual report) and the number of suicides by patients within 3 months of discharge fell over the report period - the average for 2010-14 being 255, and for 2016-20 being 185. It is likely that policies to reduce ligature points on wards and the focus on 7 day and later 72 hour follow up post discharge outlined above contributed to this reduction.

- The reduction in use of police cells as a place of safety for people experiencing mental health crises, including as a result of collaboration between DHSC, police, health and

mental health charities as part of 'The Mental Health Crisis Care Concordat' (launched in 2014 - WV/52). Data suggests that uses of police stations as places of safety in England has reduced - from around 8,000 in 2012/13 to 320 in 2023/24.

- Developing new legislation and statutory guidance to improve care by listening to and working in partnership with professionals and experts by experience. This includes the current Mental Health Bill, founded on the Independent Review of the Mental Health Act (see para 84). The new Bill, which was introduced to the UK Parliament on 6 November 2024 and is currently undergoing detailed parliamentary scrutiny included a number of changes to give people greater control over their treatment and help ensure they receive the dignity and respect they deserve.

- Non-legislative action recommended by the Independent Review of the Mental Health Act, including the £400m programme (announced in 2020) to replace dormitory accommodation in inpatient mental health wards. As at March 2024, Since the programme started in 2020/21, 43 projects have been completed, eradicating roughly 700 dormitory beds to date, allowing services to provide more therapeutic arrangements for people in inpatient units.

90. However, it remains the case that too many people experience poor quality care and sadly people lose their lives in inpatient mental health hospitals. This requires the Department to reflect and consider what the Department and the health system as a whole could and should have done differently over the period to improve the level of patient care. Some of these issues were the focus of the most recent reports from the HSSIB. Some policies also did not achieve their intention or led to unintended outcomes. Some examples of these reflections include:
    (i) Could the Department have done more to encourage a shift away from commissioning practices and models of care that the evidence suggests increase the risk of poor treatment and outcomes, for example the use of 'out of area placements' which are still too common despite a national focus on reducing them? (see para 66 above)
    (ii) With the focus on improving access to care for common mental illnesses from around 2008 to 2015, did the Department retain enough of a focus on serious mental illness and the quality of inpatient care?
    (iii) The focus of the 'Five Year Forward View for Mental Health' (see para 57 above), whilst leading to improvements in access to perinatal and early intervention in

psychosis services also had the unintended consequence of attracting staff and attention away from wider community mental health teams responsible for people with serious mental illness.

(iv) Whilst there has been a significant amount of work to develop policies using feedback from people with experience of services, such as via the Independent Review of the Mental Health, there has clearly been a gap in the ability to identify themes, and absorb and act upon feedback from correspondence and Coroners' Preventing Future Death Reports (PfDs) into the Department's work on a routine basis. The HSSIB report (WV/53) 'Mental health inpatient settings: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge' underlines that the Department and others could do more to learn from deaths and/or when issues are identified in mental health reviews as part of the Patient Safety Incident Response Framework.

91. To prevent unacceptable care and tragic losses occurring in the future, it is vital that the Department learns both from what has gone well in the past, and from where the Department could have done more. The HSSIB reports have highlighted that more needs to be done to improve mental health patient safety and therapeutic care in mental health inpatient settings, and the Department will be responding to the reports in due course, with specific action plans to address the concerns in the reports.

Statement of Truth

I believe that 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:

[I/S]

Name: William Vineall

Date: 24 March 2025

Annex A: Timeline of key ALBs during the relevant period

The Department's ALB landscape is complex and there have been many changes over the last 25 years. This table provides an overview of the most relevant ALBs, and how they have changed, during the relevant period.

Time Period	Body	Narrative
Post-merger of NHS England and NHS Improvement	**NHS England**	In 2023, NHS Digital and Health Education England were merged with NHS England, combining their functions and staff. A number of elements of NHS England's new role, branding, and powers were facilitated by the Health and Social Care Act 2022. As of February 2025, NHS England delivered the functions of a range of legacy bodies, including: • NHS Improvement • NHS Digital • Health Education England • Monitor • NHS Trust Development Agency • National Patient Safety Agency • NHS Commissioning Board
	NHS Digital	NHS Digital was formed in April 2016 as the successor of the Health and Social Care Information Centre. It was an executive non-departmental body of DHSC.

		It was the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. Its work included: • publishing more than 260 statistical publications per year • providing a range of specialist data services • managing informatics projects and programmes, and developing and assuring national systems against appropriate contractual, clinical safety and information standards NHS Digital became part of NHS England in February 2023.
	Health Education England	Health Education England (HEE) was an executive non-departmental public body (NDPB) of the Department. Its function was to provide national leadership and coordination for education and training within the health and public health workforce in England. It was introduced as part of the NHS reforms of April 2012, and was originally established as a Special Health Authority, becoming an NDPB in 2015. It began operations in June 2012, and merged with NHS England in April 2023.
	Health Services Safety Investigations Body	The Healthcare Safety Investigation Branch (HSIB) was established by legal direction in 2016 and became operational in 2017.

		During this time HSIB was funded by the Department and hosted by the Trust Development Authority, then NHS Improvement and finally NHS England (due to mergers). The organisation gained full statutory independence in the Health and Care Act 2022, and went through a period of transformation to become the Health Services Safety Investigations Body (HSSIB) on 1 October 2023. It investigates patient safety concerns across the NHS in England and in independent healthcare settings where safety learning could also help to improve NHS care. The maternity investigation programme that was part of HSIB is now known as the Maternity and Newborn Safety Investigations (MNSI) programme and is hosted by the Care Quality Commission.
Pre-merger of NHS England and NHS Improvement	**NHS Improvement (Successor Body)**	NHS Improvement was the operational name for an organisation that brought together Monitor, the NHS Trust Development Agency, Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and Intensive Support Teams. It was establishment on 1 April 2016. NHS Improvement and NHS England worked together as a single organisation from 1 April 2019, formally moving to a joint working arrangement in a new corporate directorate structure and undertaking joint management and reporting of internal budgets and expenditure. The NHS accountability framework 2019 to 2020 (WV/12), and the mandates for 2020-21 and 2021-22 (WV/13 and WV/14)

		set out the Department's expectations for the objectives and budgets for NHS England and NHS Improvement.
Pre-creation of NHS Improvement	**Health and Social Care Information Centre**	The HSCIC was created as a Special Health Authority on 1 April 2005 by a merger of the National Programme for IT, part of the Department, the NHS Information Authority, and the Prescribing Support Unit.
	NHS Trust Development Authority	The NHS Trust Development Authority (NHSTDA) was an executive non-departmental public body of the Department. The NHSTDA existed to manage the process of NHS trusts becoming foundation trusts and to performance manage those hospital trusts that remained directly accountable to the NHS. In 2015 the Chief Executive post of both Monitor and the Authority were merged.
	Monitor	Monitor was an executive non-departmental public body of the Department, responsible between 2004 and 2016 for ensuring healthcare provided by NHS England was financially effective. The body was established on 5 January 2004 under the Health and Social Care (Community Health and Standards) Act 2003, and was formally called The Independent Regulator for Foundation Trusts. The legislation made it responsible for authorising, monitoring and regulating NHS foundation trusts. It took on the brand name Monitor from August 2004.

		The Health and Social Care Act 2012 formally changed the organisation's name to Monitor and gave it additional duties. In addition to assessing NHS trusts for foundation trust status and ensuring that foundation trusts are well led, in terms of quality and finances, Monitor had a duty to: • set prices for NHS-funded care in partnership with NHS England • enable integrated care • safeguard patient choice and prevent anti-competitive behaviour which is against the interests of patients • support commissioners to protect essential health care services for patients if a provider gets into financial difficulties Monitor's main tool for carrying out these functions was the NHS provider licence, which contains obligations for providers of NHS services. The 2012 Act requires everyone who provides an NHS health care service to hold a licence unless they are exempt under regulations made by the Department. Foundation trusts were licensed from 1 April 2013, and all other non-exempt providers were required to apply for a licence from April 2014. It was announced in June 2015 that the chief executive posts at Monitor and the NHS Trust Development Authority were to be merged, although there would not be a complete merger of the organisations.

		In April 2016 both organisations became part of NHS Improvement which subsequently operationally merged with NHS England from September 2018 and was formally abolished by the Health and Care Act 2022.
	NHS Improvement (Original Body)	NHS Improvement was established in April 2008 to drive clinical service improvement. It was merged with NHS Improving Quality in 2013 following the Health and Social Care Act reforms.
	National Patient Safety Agency	The National Patient Safety Agency (NPSA) was a Special Health Authority of the National Health Service (NHS) in England. It was established in 2001 to monitor patient safety incidents, including medication and prescribing error reporting, in the NHS. Between 2005 and April 2012 it hosted the National Clinical Assessment Service that aims to help in resolving concerns about the performance of individual doctors and dentists. Finally, it also managed the contracts with the three confidential enquiries: National Confidential Enquiry into Patient Outcome and Death; Confidential Enquiry into Maternal Deaths in the UK; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. This responsibility was transferred from the National Institute for Health and Clinical Excellence.

		On 1 June 2012, the key functions of the NPSA were transferred to the NHS Commissioning Board Special Health Authority, later known as NHS England. In April 2016, the patient safety function was transferred from NHS England to the newly established NHS Improvement.
	Mental Health Act Commission	The Mental Health Act Commission was an NHS Special Health Authority that provided a safeguard for people detained in hospital under the powers of the Mental Health Act 1983 in England and Wales. The Commission consisted of some 100 members (Commissioners), including laypersons, lawyers, doctors, nurses, social workers, psychologists and other specialists. The Health and Social Care Act 2008 replaced the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission with a single, integrated regulator for health and adult social care - the Care Quality Commission. The Commission was abolished on 31 March 2009. The Care Quality Commission began operating on 1 April 2009 as a non-departmental public body.

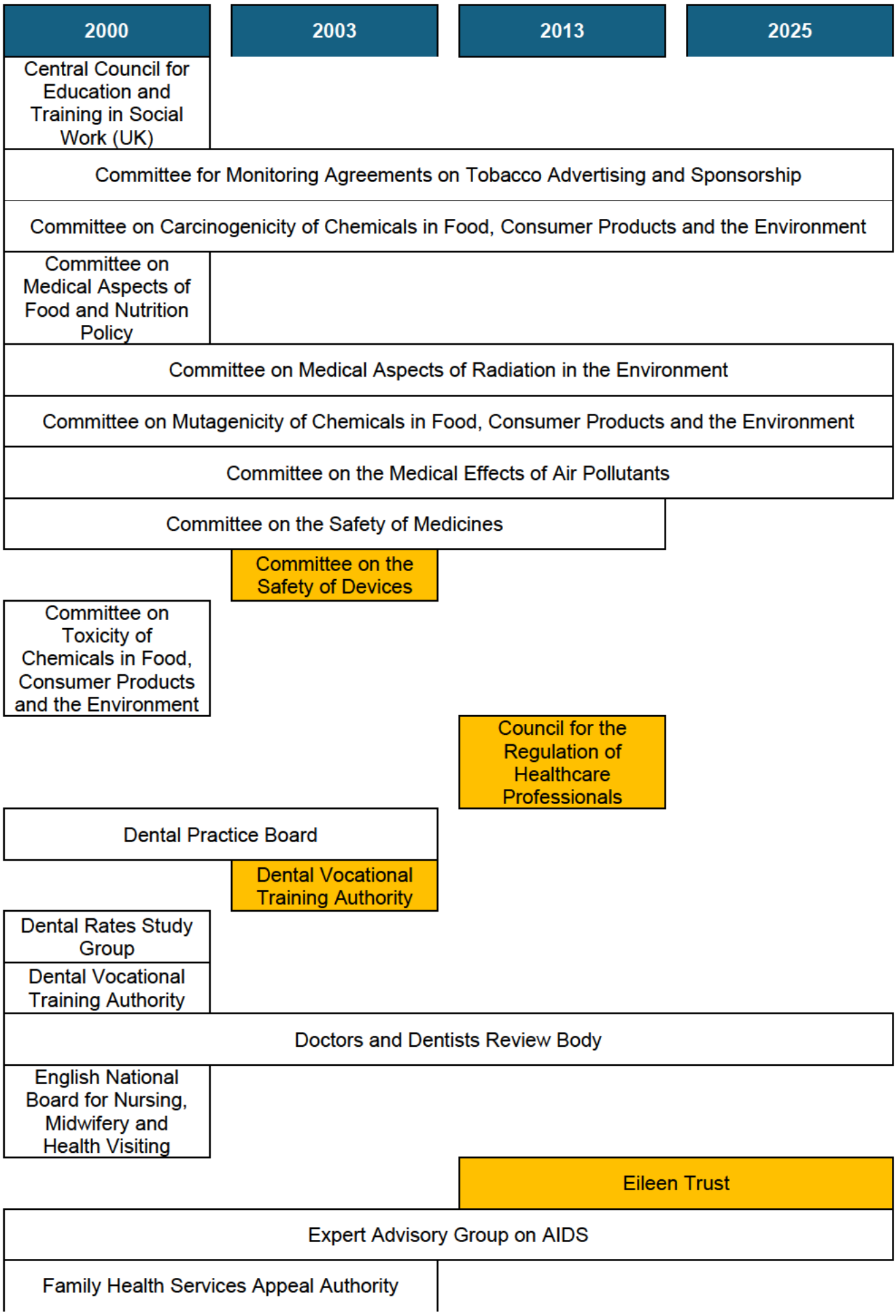
	Care Quality Commission	The Care Quality Commission (CQC) is an executive non-departmental public body of the Department. It was established in 2009 to regulate and inspect health and social care providers in England. It was formed from three predecessor organisations: • the Healthcare Commission • the Commission for Social Care Inspection • the Mental Health Act Commission Until 31 March 2009, regulation of health and adult social care in England was carried out by the Healthcare Commission and the Commission for Social Care Inspection, and the Mental Health Act Commission had monitoring functions with regard to the operation of the Mental Health Act 1983. The Care Quality Commission was established as an integrated regulator for England's health and adult social care services by the Health and Social Care Act 2008 to replace these three bodies. The commission was created in shadow form on 1 October 2008 and began operating on 1 April 2009.

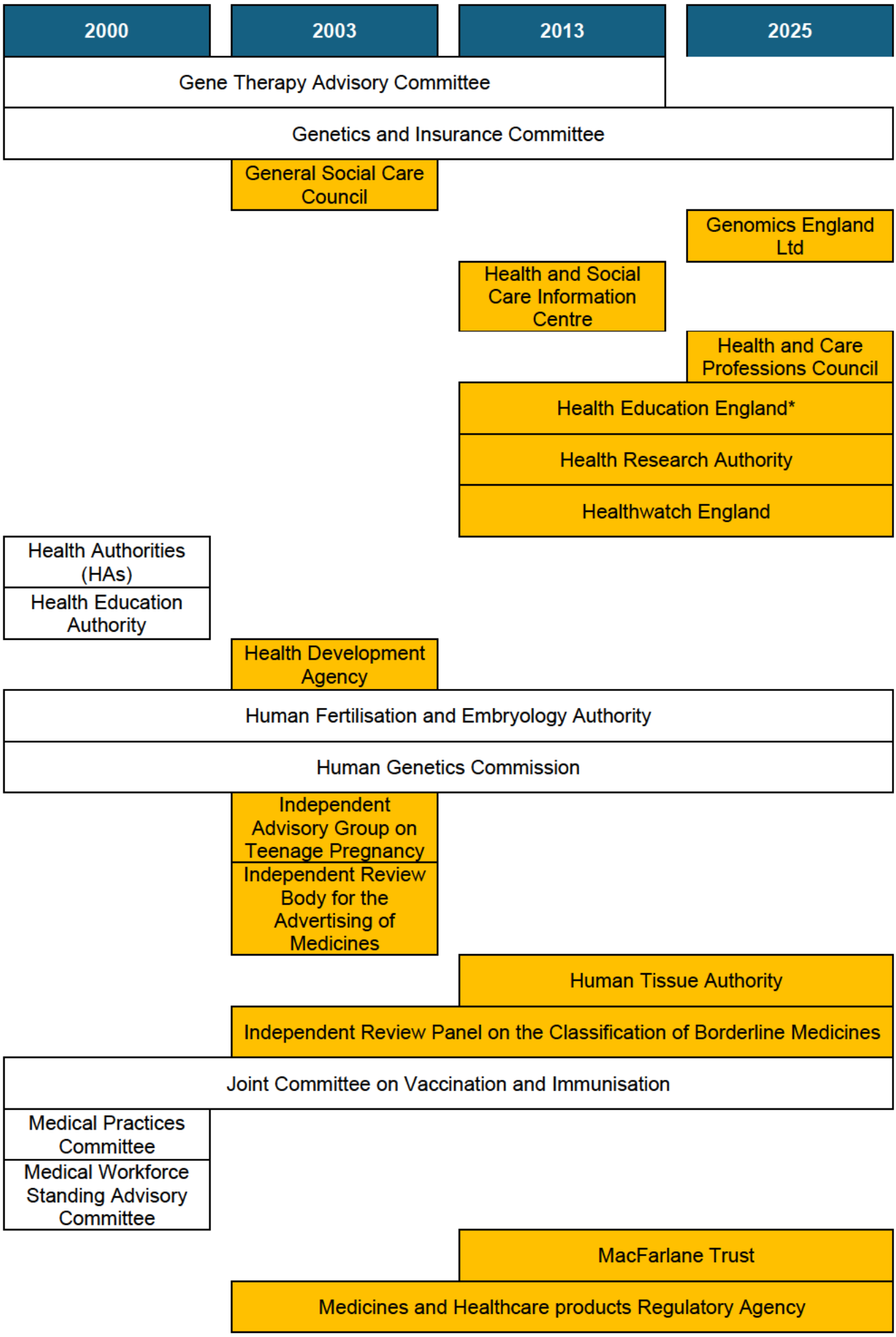
Annex B: More complete list of departmental ALBs - snapshot covering key points in the Inquiry's timeframe

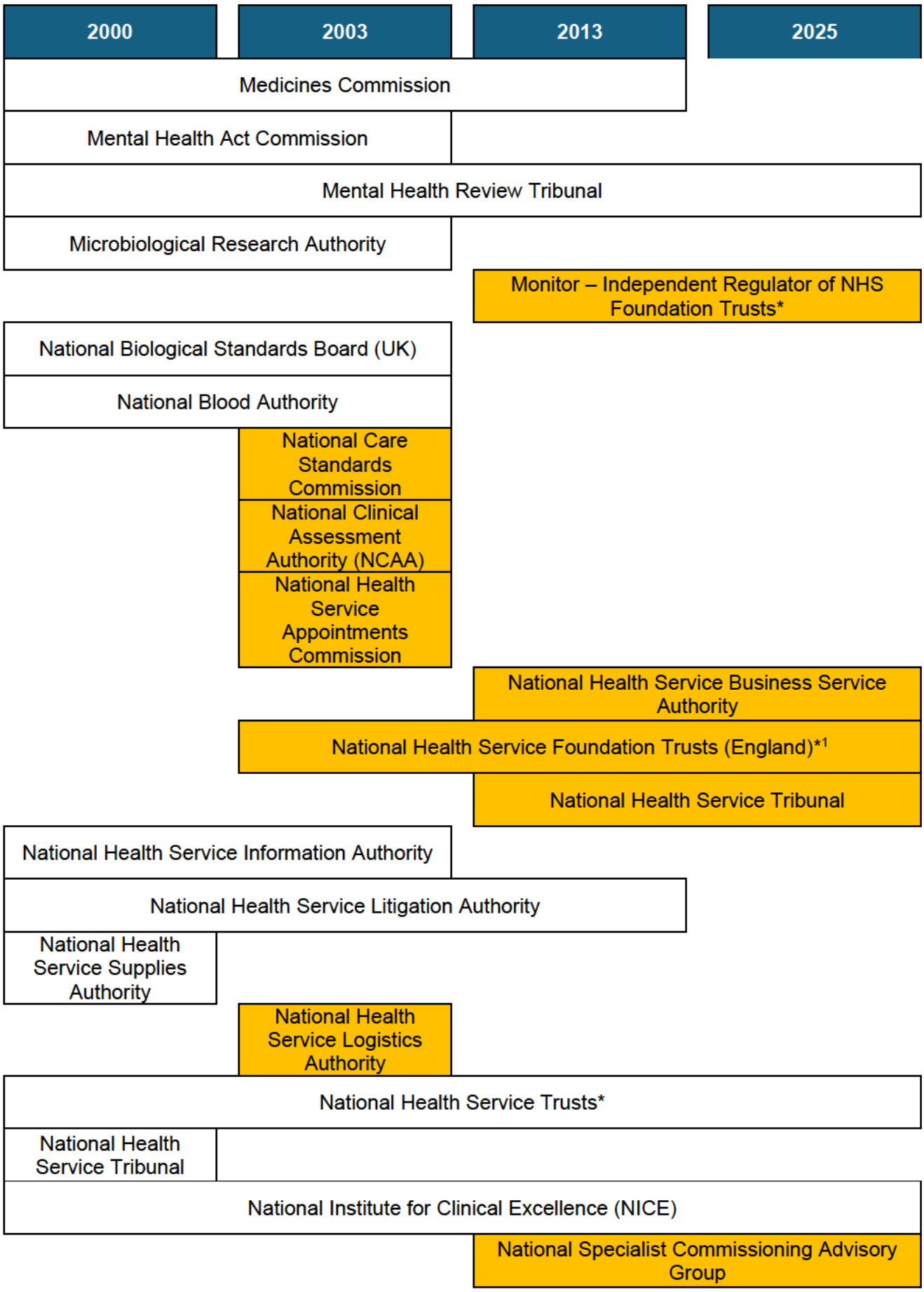
Key:

	Indicates new body that was not included in the preceding time period
*	Indicates that the body may have information of particular relevance to the matters the Inquiry is investigating

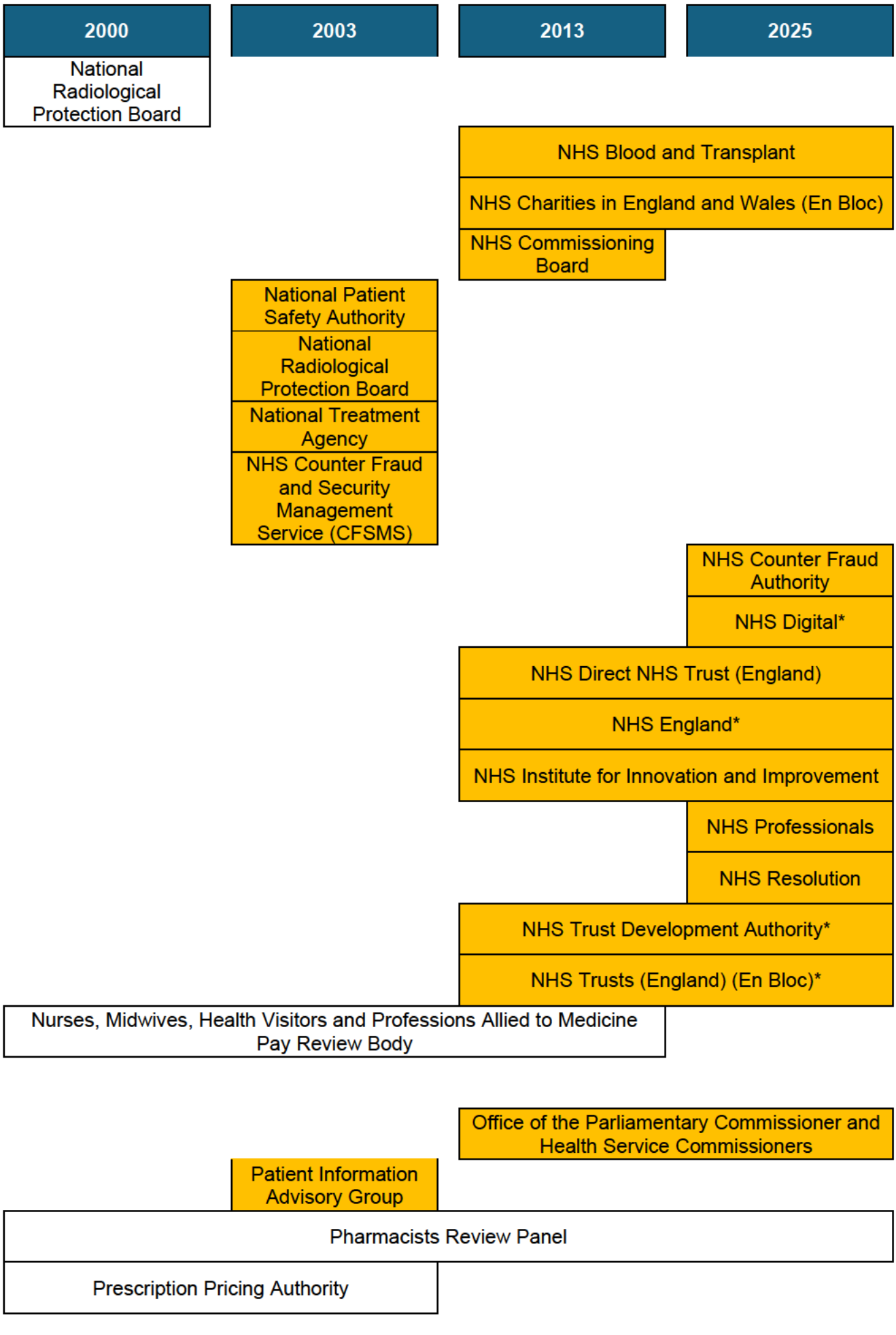
2000	2003	2013	2025
Administration of Radioactive Substances Advisory Committee			
Advisory Board on the Registration of Homeopathic Products			
Advisory Committee on Borderline Substances			
Advisory Committee on Dangerous Pathogens*			
Advisory Committee on Distinction Awards			
Advisory Committee on NHS Drugs			
Advisory Committee on the Micro-biological Safety of Food			
Advisory Group on Hepatitis			
Appeal Body (Dental Vocational Training Authority)			
Ashworth Hospital Authority			
British Pharmacopeia Commission			
Broadmoor Hospital Authority			
	Care Standards Tribunal		
	Commission for Health Improvement*		
		Care Quality Commission*	
		Clinical Commissioning Groups (En Bloc)	

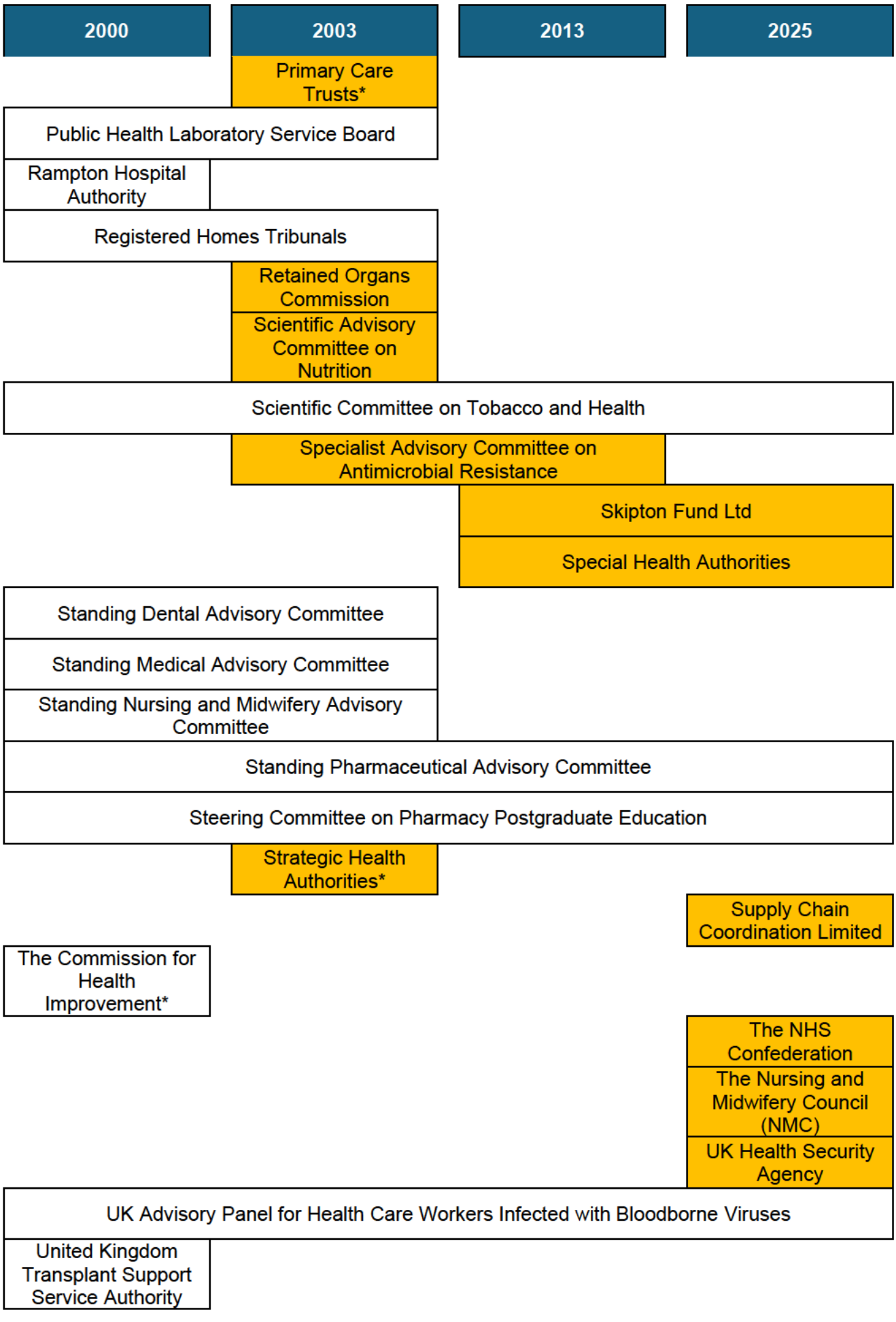

2000
2003
2013
2025
Central Council for Education and Training in Social Work (UK)
Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship
Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment
Committee on Medical Aspects of Food and Nutrition Policy
Committee on Medical Aspects of Radiation in the Environment
Committee on Mutagenicity of Chemicals in Food, Consumer Products and the Environment
Committee on the Medical Effects of Air Pollutants
Committee on the Safety of Medicines
Committee on the Safety of Devices
Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment
Council for the Regulation of Healthcare Professionals
Dental Practice Board
Dental Vocational Training Authority
Dental Rates Study Group
Dental Vocational Training Authority
Doctors and Dentists Review Body
English National Board for Nursing, Midwifery and Health Visiting
Eileen Trust
Expert Advisory Group on AIDS
Family Health Services Appeal Authority

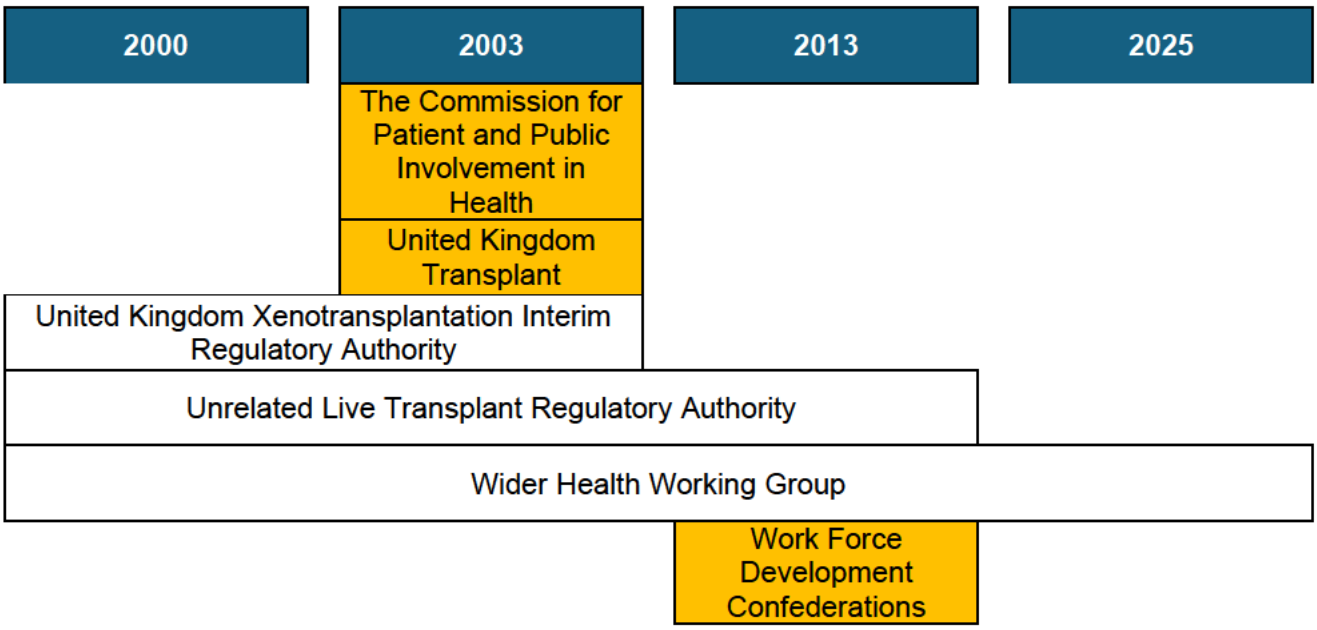

2000
2003
2013
2025
Gene Therapy Advisory Committee
Genetics and Insurance Committee
General Social Care Council
Genomics England Ltd
Health and Social Care Information Centre
Health and Care Professions Council
Health Education England*
Health Research Authority
Healthwatch England
Health Authorities (HAs)
Health Education Authority
Health Development Agency
Human Fertilisation and Embryology Authority
Human Genetics Commission
Independent Advisory Group on Teenage Pregnancy
Independent Review Body for the Advertising of Medicines
Human Tissue Authority
Independent Review Panel on the Classification of Borderline Medicines
Joint Committee on Vaccination and Immunisation
Medical Practices Committee
Medical Workforce Standing Advisory Committee
MacFarlane Trust
Medicines and Healthcare products Regulatory Agency



[1] NHS Foundation Trusts were established through the Health and Social Care (Community Health and Standards) Act 2003 and further defined in Schedule 7 of the National Health Service Act 2006.


2000
2003
2013
2025
National Radiological Protection Board
NHS Blood and Transplant
NHS Charities in England and Wales (En Bloc)
NHS Commissioning Board
National Patient Safety Authority
National Radiological Protection Board
National Treatment Agency
NHS Counter Fraud and Security Management Service (CFSMS)
NHS Counter Fraud Authority
NHS Digital*
NHS Direct NHS Trust (England)
NHS England*
NHS Institute for Innovation and Improvement
NHS Professionals
NHS Resolution
NHS Trust Development Authority*
NHS Trusts (England) (En Bloc)*
Nurses, Midwives, Health Visitors and Professions Allied to Medicine Pay Review Body
Office of the Parliamentary Commissioner and Health Service Commissioners
Patient Information Advisory Group
Pharmacists Review Panel
Prescription Pricing Authority


2000
2003
2013
2025
Primary Care Trusts*
Public Health Laboratory Service Board
Rampton Hospital Authority
Registered Homes Tribunals
Retained Organs Commission
Scientific Advisory Committee on Nutrition
Scientific Committee on Tobacco and Health
Specialist Advisory Committee on Antimicrobial Resistance
Skipton Fund Ltd
Special Health Authorities
Standing Dental Advisory Committee
Standing Medical Advisory Committee
Standing Nursing and Midwifery Advisory Committee
Standing Pharmaceutical Advisory Committee
Steering Committee on Pharmacy Postgraduate Education
Strategic Health Authorities*
Supply Chain Coordination Limited
The Commission for Health Improvement*
The NHS Confederation
The Nursing and Midwifery Council (NMC)
UK Health Security Agency
UK Advisory Panel for Health Care Workers Infected with Bloodborne Viruses
United Kingdom Transplant Support Service Authority



Sources – all published and publicly available

Cabinet Office Public Bodies Document Collection and Annual Public Bodies Data

Department of Health Annual Reports

The NAO's Releasing resources to the frontline: the Department of Health's Review of its Arm's Length Bodies

ONS Statistical Data, Public sector classification guide and forward work plan

We have drawn on publicly available datasets and sources to create this table. We have endeavoured to provide only information that can be referenced. There are limitations to this data. It provides a snapshot over four time periods rather than a comprehensive year-by-year timeline of when different bodies existed.

Annex C – National Mental Health, including Patient Safety related, Policies and recommendations between 1 January 2000 and 31 December 2023

Title: Mental Health Act 1983

Brief summary of the policy:

The Mental Health Act 1983 (MHA) provides a 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 or others. It covers the assessment, treatment, and rights of people when detained or liable to be detained under the Act.

Part 2 of the MHA deals with patients who are detained in hospital and have no criminal proceedings against them or have criminal proceedings against them not related to their mental health. These are generally referred to as civil patients.

Part 3 of the MHA is concerned with the care and treatment of offenders with severe mental health needs who are involved in criminal proceedings or under sentence.

The Mental Health Act was last revised in 2007, with changes including:

- New criteria for detention.
- Independent Mental Health Advocates.
- Age-appropriate services: requiring hospital managers to ensure that patients under 18 admitted to hospital for mental disorder are accommodated in an environment suitable for their age.
- The introduction of supervised community treatment for patients following detention in hospital. This aims to stop the 'revolving door' whereby patients leave hospital, do not continue with their treatment and see a deterioration in their health and require detention again.

The Mental Health Act 1983 is supported by a statutory Code of Practice, last revised in 2015 (WV/20), which sets out further detail on how the Mental Health Act should be applied in practice. Changes to the Code of Practice include:

- Involving the patient and, where appropriate, their families and carers in discussions about the patient's care at every stage.
- Providing personalised care.
- Further guidance on how to support children and young people, and those with a learning disability or autism.

DHSC's role in its creation: DHSC leads on all elements of the act apart from Part 3 which is the responsibility of the Ministry of Justice.
Was the policy made a change to previous policy or was an entirely new policy? Previous legislation was the Mental Health Act of 1959. 1983 Act introduced the issue of consent to treatment/detainment and established limits to medical discretion.
Please explain why the change was made or why was it created: The need for greater balancing of the rights of people with mental ill-health with the need to protect the public.
Date implemented or came into force: 30 September 1983.

Title: National Service Framework for Mental Health 1999 (WV/22)

Brief summary of the policy:

The 'National Service Framework for Mental Health' set quality standards for mental health services. The scope was for mental health needs of working age adults up to 65. It set national standards for promoting mental health and treating mental illness; put in place underpinning programmes to support local delivery; established milestones with national targets for outcomes and inputs, as well as local milestones for all areas. It also set out performance indicators against which progress within agreed time-scales will be measured.

It was also intended as a guide for investment of the £700 million Government funding for reshaping mental health services.

It set standards in the following areas: Mental health promotion; primary care; access to services; effective services for people with severe mental illness; caring about carers and preventing suicide.

The specific standards were:

- **Standard 1:** promote mental health for all, working with individuals and communities and combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.
- **Standard 2:** Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.
- **Standard 3:** Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care and be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services
- **Standard 4:** All mental health service users on CPA (Care Programme Approach) should: receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk AND have a copy of a written care plan which includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator, advises their GP how they should respond if the

service user needs additional help, is regularly reviewed by their care co-ordinator, be able to access services 24 hours a day, 365 days a year.

- **Standard 5:** Each service user who is assessed as requiring a period of care away from their home should have: timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public, as close to home as possible. They should also have a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.
- **Standard 6:** All individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis AND have their own written care plan which is given to them and implemented in discussion with them.
- **Standard 7:** Local health and social care communities should prevent suicides by implementing standard 1 to 6; support local prison staff in preventing suicides among prisoners; ensure that staff are competent to assess the risk of suicide among individuals at greatest risk; develop local systems for suicide audit to learn lessons and take any necessary action.

The framework set out evidence and good practice in terms of service models and interventions that may support achieving each standards.

Targets and milestones were set including reiteration of previous national targets, introduction of new national targets and local milestones to be achieved (some at set timescales, and some according to local readiness). Examples included:

- reduction in the suicide rate by at least one fifth by 2010.
- by the year 2002, 95% of health authorities should have removed mixed sex accommodation.
- by 2000, Service users with severe mental illness have an integrated assessment, care plan and care co-ordinator.
- duty doctor, Section 12 approved, and approved social worker always available for mental health emergencies.
- using clinical guidelines, all service users should be assessed for and receive new antipsychotics where indicated.

- carers involved in service review and development.
- training for staff in specialist mental health services in risk assessment and management is a priority, and is updated at least every three years.
- safety on wards is improved to reduce access to the means of suicide.
- follow-up for people recently discharged from hospital is a priority and steps are taken to improve the continuity of care and the transfer of information between hospital and community staff; Care plans for those with severe mental illness include an urgent follow-up within one week of discharge.

It also set out 20 recommended outcome indicators for people with severe mental illness.

National support was set out including finance, capital, estates, workforce planning and education, research and development, clinical decision support systems and information.

Timelines for local areas to submit funding plans and development of regional mental health plans.

DHSC's role in its creation:

The Department developed and published the standards, with advice from an External Reference Group.

It also set up a national implementation group to oversee implementation of the standards. The group was led by the head of mental health policy in the Department, an assistant chief inspector from a social care region, and a director from a regional office of the NHS Executive. Its role was to monitor high level milestones, synthesise regional monitoring, commission further work and maintain the national service framework.

A national implementation team was also set up and led by an experienced mental health services chief executive to support the implementation group – specifically understanding readiness across England, supporting regions and providing challenge to actions plans, sharing good practice and raising concerns to the implementation group. Local areas were asked to set up local implementation teams as part of the standards framework and to identify priorities for service development to meet the standards in the framework.

Previous documents had set out that:

- NHS standards would be set by the National Institute for Clinical Excellence and National Service Frameworks.
- delivered by clinical governance, underpinned by professional self-regulation and lifelong learning.
- monitored by the Commission for Health Improvement, the new National Performance Assessment Framework, and the National Survey of Patients.

Progress was to be measured through a small number of high-level performance indicators within the NHS and Social Services Performance Assessment Frameworks and complemented by the programme of systematic service reviews undertaken by the Commission for Health Improvement and the Social Services Inspectorate, working with the Audit Commission.

Was the policy made a change to previous policy or was an entirely new policy?

New policy.

Please explain why the change was made or why was it created:

Purpose was to drive up quality and reduce unacceptable variations, with services responsive to individual needs, regardless of age, gender, race, culture, religion, disability, or sexual orientation. Was used to set out priorities and areas for investment**.**

Date implemented or came into force:

Published in 1999 and intended to cover a 10 year period, with specific funding and milestones for 3 years (until 2001/2002).

Title: The NHS Plan: A plan for investment, a plan for reform 2000 (WV/25)

Brief summary of the policy:

The NHS Plan (published in 2000 outlined plans for sustained increases in funding for the NHS alongside systemic reform, with the overall aim of ensuring the NHS is a health service fit for purpose in the 21st century and is designed around the needs of its patients.

Key aspects of investment across the NHS estate (not just mental health) included;

- 7,000 extra hospital beds.
- Over 100 new hospitals by 2010, 500 new one-stop primary care centres, the modernisation of over 3,000 GP premises and 250 new scanner.
- 7,500 more consultants, 2,000 more GPs, 20,000 extra nurses and 6,500 extra therapists.

Key aspects of reform included:

- A new system of earned autonomy, which would devolve power from the Government to local health services by enabling local NHS organisations that perform well for patients to get more freedom to run their own affairs.
- Patients having influence over the way the NHS works, with patient advocates being established in every hospital, patient surveys and forums and the ability for patients to choose another date for operation within 28 days in the event of cancellation.
- Staffing investments including ensuring all support staff have Individual Learning Accounts and a new Leadership Centre to develop a new generation of managerial and clinical leaders.
- A concordat with private providers of healthcare to enable the NHS to make better use of facilities in private hospitals – where this provided value for money and maintained standards of patient care.

Reforms/investment outlined in the plan related to mental health included:

- The establishment of 335 crisis resolution teams over the next 3 years, so that people in contact with specialist mental health services can access crisis services at any time.

- 1,000 new primary care mental health workers, trained in therapy techniques to treat common mental health problems.
- The establishment of new Care Trusts integrating health and social care social care.

Please note: this is a small selection of the actions outlined in the policy. All not summarised due to brevity.

DHSC's role in its creation:

This was a key policy document about the NHS that was presented to Parliament by the Secretary of State for Health, and the Department lead its development.

Was the policy made a change to previous policy or was an entirely new policy?

Yes – it set out steps which aimed to transform the health service through substantial investment in the NHS, the introduction of private sector providers, a reduction in inequality and redesigning services around the needs of patients.

Please explain why the change was made or why was it created:

The Plan outlined that a change was needed due to the NHS's lack of national standard, old-fashioned demarcations between staff, barriers between services, lack of clear incentives, over-centralisations and disempowerment of patients. To quote "the NHS is a 1940s system operating in a 21st century world".

Date implemented or came into force:

2000.

Title: 2002 National Suicide Prevention Strategy (WV/26)

Brief summary of the policy:

This strategy aimed to support the *Saving Lives: Our Healthier Nation* target of reducing the death rate from suicide by at least 20% by 2010. It was intended to be an on-going, co-ordinated set of activities which are comprehensive, based on evidence, specific and subject to evaluation - which would evolve over several years.

It has 6 key goals: to reduce risk in key high-risk groups, to promote mental well-being in the wider population, to reduce the availability and lethality of suicide methods, to improve reporting of suicidal behaviour in the media, to promote research on suicide and suicide prevention and to improve monitoring of progress towards the target to reduce suicide.

The implementation plan of the strategy was the responsibility of the National Institute for Mental Health in England (NIMHE), which sat within the Modernisation Agency, which in turn was formed in April 2001 by the Department to support the NHS to make the radical and sustainable changes required to achieve 'The NHS Plan' 2000.

Actions related to mental ill-health patients included:

- Local mental health services to be supported by NIMHE to implement the '*Twelve points to a safer service'* such as; staff training in risk management every 3 years; all patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care under the Care Programme Approach; in-patient wards to remove or cover all likely ligature points.

DHSC's role in its creation:

The Department led the drafting and development of the strategy.

The Department had a range of actions in the strategy, including;

- Disseminating a toolkit to support primary care staff in promoting mental health and guidelines on meeting the physical needs of people with mental ill health.

- Working alongside NIMHE and Primary Care Trusts to explore the benefits of promoting the safe disposal of unwanted medicines by the public and the recalling of unused prescribed antidepressants by clinicians.

Please note: this is a small selection of the actions outlined in the policy. We have not summarised all the content due to brevity.

Was the policy made a change to previous policy or was an entirely new policy?

The strategy supported the target outlined in Government's White Paper *Saving Lives: Our Healthier Nation* to reduce the death rate from suicide by at least 20%. The strategy was the first specific national suicide prevention strategy.

Please explain why the change was made or why was it created:

At the time of creation, as stated in the strategy, suicide was a major public health issue. In the previous 20 years, suicide rates amongst older people had fallen but risen amongst young men with the economic and psychological impacts being felt on an individual and societal level.

Date implemented or came into force:

2002 – 2012.

Title: No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages (WV/27)

Brief summary of the policy:

Published in 2011, this policy was the mental health strategy of the Coalition government. It set out the ambition to mainstream mental health and establish parity of esteem between services for people with mental and physical ill health. It looked to communities, as well as the state, to promote independence and choice; demonstrating the Government's localised approach.

The underlying objectives of the strategy were; improved mental health and recovery rates for all, ensuring individuals with mental ill-health will have good physical health, increasing positive experiences of care and support and reducing avoidable harms, stigma and discrimination.

Indicators listed in the policy as being useful in assessing whether or not progress was made on improving mental health outcomes included;

- the proportion of people discharged from inpatient care who are followed up within 7 days.
- community survival time from inpatient discharge to readmission in mental health services.
- the mortality rate of people with mental illness.
- the suicide rate.

Please note: this is a just a selection of indicators included in the policy. All not summarised due to brevity.

DHSC's role in its creation:

The Department worked with a wide range of partner organisations, including user and carer representatives, providers, local government and other Government Departments, to agree the 6 shared objectives underpinning the strategy (outlined above).

The Department also had a role in the implementation of the strategy including pre-existing/new actions to;

- to launch a set of ‘recovery’ pilots to test the key features of organisational practice to support the recovery of those using mental health services.
- funding a programme to support services to improve the experience of young people who are moving from CAMHS to adult services.
- reconvening the Ministerial Advisory Group on equality in mental health, where the leading organisations in the field would be invited to work with the Minister of State for Care Services on progress.

Was the policy made a change to previous policy or was an entirely new policy?

New approach – the Government committed to achieving change by putting more power in the hands of local areas, in recognition that better mental health outcomes will occur if people and communities are able to take more responsibility for their own wellbeing.

Please explain why the change was made or why was it created:

The strategy states that wider objectives to improve education, employment, training, safety and crime reduction, reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health.

It also notes that at the time of development, the quality of mental health care in recent years such as the improved access to psychological therapies and development of community-based services. However, changes were top-down in direction, with more emphasis on structures and processes than outcomes with little done to promote mental health and wellbeing. Progress was uneven between different areas and conditions and not all groups benefitted equally. This strategy aimed to address this by putting more power in the hands of local areas and increasing focus on outcomes.

Date implemented or came into force:

February 2011.

Title: 2012 National Suicide Prevention Strategy (WV/28)

Brief summary of the policy:

Published in 2012, the national Suicide Prevention Strategy set out the Government's objectives to reduce the suicide rate in the general population in England and provide better support for those bereaved or affected by suicide.

It set out key areas for action; states what Government Departments would do to contribute; and brought together knowledge about groups at higher risk, effective interventions and resources to support local action. The strategy identified six key areas for action to support delivery of these objectives:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approached to suicide and suicidal behaviour
6. Support research, data collection and monitoring

It also identified the following high-risk groups who are priorities for prevention: young and middle-aged men, people in the care of mental health services (including inpatients), people with a history of self-harm or in contact with the justice system and specific occupational groups such as doctors and agricultural workers.

In relation to inpatients, the strategy identified people in the care of mental health services as a priority group for action. It also highlighted the approaches identified by The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness which can contribute to a reduction in suicide rates for those in the care of mental health services, including; improved care pathways, risk assessment and management training for front-line staff working with high-risk groups and the regular assessments of ward areas to identify and remove potential risks i.e. ligatures and ligature points.

DHSC's role in its creation:

The Department led the drafting and development of the strategy.

Was the policy made a change to previous policy or was an entirely new policy? The 2012 National Suicide Prevention Strategy worked alongside the Coalition Government's mental health strategy published in 2011 – *No health without mental health.* It also built upon the 2002 National Suicide Prevention Strategy.
Please explain why the change was made or why was it created: The 2012 strategy addressed new challenges/areas of concern including greater support for families and more explicit reference to the importance of primary care in preventing suicide.
Date implemented or came into force: 2012 (intended as 10-year strategy, replaced by new strategy in 2023 – see below).

Title: Closing the Gap: Priorities for essential change in mental health (2014) (WV/29)

Brief summary of the policy:

The 2011 mental health strategy – *No health without mental health* – set out long-term ambitions for the transformation of mental health care built around six objectives. *Closing the gap* aimed to bridge the gap between this longer-term ambition and shorter-term action. It set out 25 areas for change in local service planning and delivery 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.

Of particular relevance to inpatient safety, the policy noted the following actions as being delivered/to be delivered:

- CQC to develop a new model for monitoring, inspecting and regulating mental health providers that will ensure poor quality services or gaps in provision are identified sooner.
- To a new set of measures for care quality, new rating systems for mental health services and a new inspection process for mental heath NHS trusts, which will put patient opinions and experiences at its heart.
- Specialist community perinatal mental health teams and if necessary, admission to specialist mother and baby units for the minority of new mothers with more serious mental health problems that cannot be effectively managed by extended primary care teams.

Please note: this is a small selection of the actions outlined in the policy.

DHSC's role in its creation:

DHSC lead on development and drafting.

Was the policy made a change to previous policy or was an entirely new policy?

Built on the long-term ambitions for the transformation of mental health set out in *No health without mental health*. It set out 25 areas for short-term action to achieve these longer-term ambitions.

Please explain why the change was made or why was it created:

Follow on from the mental health strategy of the Coalition government's, *No Health Without Mental Health (2011)*. It outlined that further action is needed in the short-term achieve the longer-term ambitions in that strategy.
Date implemented or came into force: January 2014.

Title: Future in Mind (2015) Promoting, protecting and improving our children and young people's mental health and wellbeing (WV/31)

Brief summary of the policy:

The NHS, public health, local authorities, social care, schools and youth justice sectors working together to:

- Place the emphasis on building resilience, promoting good mental health, prevention and early intervention.
- Simplify structures and improve access: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service.
- Deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable so people do not fall between gaps.
- Harness the power of information: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.
- Sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience.
- Make the right investments: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment.

DHSC's role in its creation:

DHSC and NHSE jointly chaired taskforce to create the strategy, and joint publication.

Was the policy made a change to previous policy or was an entirely new policy? Built on previous policy direction but recognition a multi-agency approach is needed. The forewords included from DH Minister, NHSE Chief Executive, and DfE Minister.
Please explain why the change was made or why was it created: The Taskforce considered ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided. Set out a cross-Government approach - the NHS, public health, local authorities, social care, schools and youth justice sectors working together.
Date implemented or came into force: Taskforce 2015, actions for 2015/16 with aspirations up to 2020.

Title: NHS Long Term Plan (WV/33).

Brief summary of the policy:

Set out ten-year priorities for the NHS including, with five-year funding packages for specific programmes of work. Priorities were set in the following areas

- Moving to new joined up service models.
- Strengthening NHS contribution to prevention and health inequalities (Severe mental illness highlighted as a key health inequality given premature mortality of 15-20 years).
- Care quality and outcome improvements (building on the 'Five Year Forward View for Mental Health' focus).
- Tackling workforce pressures and supporting staff.
- Upgrade technology and digitally enabled care.
- Putting the NHS back on a sustainable financial path.
- Next steps for implementation.

There were specific policy and plans for mental health including prevention, renewed commitment to grow investment in mental health services for each of the next five years, supporting physical health needs and community services amongst others.

Specific policy and priorities for inpatient mental health services and patient safety included:

- A new universal smoking cessation to be available as part of specialist mental health services.
- Eliminating inappropriate out of area placements for non-specialist acute care by 2021 (as per the 'Five Year Forward View for Mental Health' commitments)
- An improved therapeutic offer in inpatient mental health services by increased investment in interventions and activities.
- NHSE to work with those units with a long length of stay and look to bring the typical length of stay in these units to the national average of 32 days.
- Capital investment from the forthcoming Spending Review to upgrade the physical environment for inpatient psychiatric care.

- Dedicated quality improvement programme to implement the findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (which was already in place).
- Reducing suicides over the next decade. The current suicide prevention programme to cover every local area in the country.
- NHSE to design a new Mental Health Safety Improvement Programme with a focus on suicide prevention and reduction for mental health inpatients.

DHSC's role in its creation:

NHS England-led with the Department would have had a key role in the development

Was the policy made a change to previous policy or was an entirely new policy?

Mixture: Reiterated commitments in the 'Five Year Forward View for Mental Health' and set out next steps/ additional policy.

Please explain why the change was made or why was it created:

Part of overarching long-term priorities and direction setting for the NHS.

Date implemented or came into force:

Published August 2019, with five-year funding commitment and 10-year anticipated timeframe.

Title: COVID-19 mental health and wellbeing recovery action plan (WV/35)

Brief summary of the policy:

The document outlined the Government's plans to prevent, mitigate and respond to the mental health impacts of the COVID-19 pandemic. The cross-government objectives were to: support the general population to take action and look after their mental wellbeing, prevent the onset of mental health difficulties by taking action to address contributing factors and to support services to expand and transform to meet the needs of people requiring specialist support.

The plan committed to additional investment from the Government, to ensure that new pressures brought by the pandemic were addressed and so that delivery of the 'NHS Long Term Plan' and Mental Health Act reforms remained on track.

Areas receiving additional funding included:

- NHSE Talking Therapies receiving an additional £38 million to support 1.6 million people access services in 2021/22.
- £58 million for the expansion of community mental health services.
- £19 million to alleviate pressures on crisis services and inpatient facilities, and help to prevent suicide.

Please note: this is a small selection of the actions outlined in the policy.

DHSC's role in its creation:

DHSC led on development and drafting with Cabinet Office.

Was the policy made a change to previous policy or was an entirely new policy?

New in regard to outlining to response to the COVID-19 pandemic and committing to additional investment, but it also outlined commitments to previously announced policies/programmes and supported LTP commitment delivery.

Please explain why the change was made or why was it created:

Response to the COVID-19 Pandemic and to ensure longer-term commitments remain on track for delivery.

Date implemented or came into force:

2021 – 2022.

Title: Major conditions strategy: case for change and our strategic framework WV/37)

Brief summary of the policy:

The strategy was a framework for change, primarily concerned with assessing how our approach to health and care delivery can evolve to improve outcomes and better meet the needs of our population which is becoming older and living with multimorbidity.

The strategy focused on 6 groups of conditions that are collectively the greatest contributors to ill-health and early mortality: cancers, cardiovascular disease, musculoskeletal disorders, mental ill health, dementia and chronic respiratory disease. Within each of these conditions the strategy set out approaches for primary prevention, secondary prevention, early diagnosis, long-term treatment and prompt and urgent care.

The strategy sought to prioritise change in 5 areas to have the greatest impact:

- Proactive prevention by managing personalised risk factors
- Embedding early diagnosis and treatment in the community
- Managing multiple condition through aligning generalism and specialism
- Better integration between physical and MH services
- Giving people more choice and control over their care

DHSC's role in its creation:

DHSC led on the development and publication of the document.

Within the strategy, DHSC committed to a variety of actions including;

- Investing £100 million in NIHR policy research units for cancer, dementia and neurodegeneration and mental health
- Bringing forward a 'mental health and wellbeing impact assessment tool', to support policymakers to consider the mental health and wellbeing impacts of all policies
- To work with NHSE look at how best to implement the mental health waiting times standards set out in the Clinical Review of Standards

Please note: this is a small selection of the actions outlined in the policy.

Was the policy made a change to previous policy or was an entirely new policy? Yes - move from single condition approach to a multi-conditions approach
Please explain why the change was made or why was it created: The strategy was a recognition of demographic change and the changing burden of disease that reshaped society and the health and care system. It outlined that the population was spending a greater proportion of their lives with a limiting condition, with more people having multiple long-term conditions. This burden of disease has enormous implications for people's lives, their families, the economy and for the future of the health and care system with a change in approach needed to address this.
Date implemented or came into force: August 2023.

Title: 2023 Suicide Prevention Strategy 2023-2028 (WV/38)

Brief summary of the policy:

Published in 2023, the National Suicide Prevention Strategy set out the Government's ambitions over the next 5 years to: reduce suicide rates, improve support for people who have self-harmed and improved support for people bereaved by suicide. The strategy includes over 100 actions for a range of government departments, NHSE, local government, voluntary, community and social enterprise sectors and employers to achieve these ambitions. Several priority groups and areas for action are included in the strategy such as;

- Improving data and evidence.
- Providing tailored and targeted support for priority groups (e.g. middle-aged men, autistic people, children and young people, individuals in financial difficulty or in contact with the justice system and victims/perpetrators of domestic abuse).
- Addressing common risk factors to provide early intervention and tailored support.
- Promoting online safety.
- Providing effective crisis support across sectors.
- Reducing access to means and methods of suicide.
- Providing effective bereavement support to those affected by suicide.
- Making suicide everybody's business.

Specific actions for inpatient mental health services and patient safety include:

- NHSE taking steps to ensure that patients receive good-quality (in line with NICE guidelines) follow-up support within 72 hours of being discharged from inpatient MH settings – this includes developing effective integrated pathways.
- NHSE will convene a safety planning working group of experts and people with lived experience to identify opportunity to improve the quality and culture of inpatient services, including risk management of suicide and self-harm across different settings.

DHSC's role in its creation:

DHSC led the co-ordination and development of the strategy.

Was the policy made a change to previous policy or was an entirely new policy? Built/went further on the previous national Suicide Prevention Strategy published in 2012. NHSE actions on inpatient care and patient safety were reiterations of existing previously announced policies.
Please explain why the change was made or why was it created: The previous national Suicide Prevention Strategy was published in 2012. This strategy provided a more up to date strategy to set direction and priorities for suicide prevention across England.
Date implemented or came into force: Published 2023 (five-year strategy).

Annex D – National Mental Health, including Patient Safety related, Programmes between 1 January 2000 and 31 December 2023

Title: Achieving Better Access to Mental Health Services by 2020 (WV/30)
Dates they were in effect: Published 2014
Brief summary of the programme: The programme set out three phases which could, with sustained commitment, delivery change in NHS MH services by 2020. Phase one aimed to lay the groundwork for further improvement in later years by building capacity to enable the NHS to meet tough access and waiting time standards. Phase two aimed to introduce access and waiting time standards in key areas of mental health services, with an investment of £80 million to drive progress. This aimed to ensure that people with common mental health problems get faster access to the most effective evidence-based treatment. Phase three aimed for continuous staged roll out of new access and waiting time standards across the whole of mental health services in England to ensure parity of esteem between mental and physical health. Related to inpatient care: • Phase one aimed for NHSE to invite £7 million in 50 new inpatient beds and better case management for Children and Young People • Phase three aimed for all in-patients to have a thorough assessment of their physical health needs on admission. This would overtime extend beyond inpatient care to community patients and primary care
Rationale for the why the programme was necessary to implement: This programme complemented the actions included in *Closing the Gap*, and set out the areas necessary to take action on to progress the Government's aim of parity of esteem for mental health services by 2020. It did not commit or obligate subsequent

Government's into following the programme as spending decisions were the prerogative of the subsequent Governments.
If changes were made to programmes, please explain why those changes were made: Unknown – we have been unable to acquire this information.

Title: Implementing the Five Year Forward View for Mental Health (WV/32)
Dates they were in effect: 2016 – 2020/21
Brief summary of the programme: This document outlines the NHS's implementation plans for the recommendations of the 'Five Year Forward View for Mental Health' to 2020/21. It was directed at commissioners and providers to support and influence their local plans and sets out in detail where and when additional funding will become available. The plan aimed to deliver improved access to high-quality care, more integrated services, earlier access and to build capacity within community-based services to reduce demand on the acute sector and in-patient beds; whilst also moving the commissioning model for in-patient beds in mental health towards a more 'place-based' approach so that pathways and incentives are better aligned and efficiencies more readily realised.
Rationale for the why the programme was necessary to implement: It set out an implementation plan in response to recommendations from the Mental Health Taskforce, which was commissioned by Simon Stevens on behalf of the NHS.
If changes were made to programmes, please explain why those changes were made: Unknown – we have been unable to acquire this information.

Title: NHS Mental Health Implementation Plan (WV/34)

Dates they were in effect:

2019/2020 – 2023/24

Brief summary of the programme:

- Set trajectories for implementation to meet 'Five Year Forward View' and LTP mental health commitments
- Gave local systems flexibility to tailor local pathways, staffing mix etc. to their local needs
- All systems were expected to achieve the same end point by 2023/24 and to provide a local year-on-year phasing for delivery in their 5-year plan
- Provided indicative workforce profile by programme area and staffing group
- Set out national programmes to address inequalities e.g. Patient and Carer Race Equality Framework (PCREF) with the goal of improving access, experience and outcomes for black and minority ethnic people

Some areas were fixed (set national access or coverage with year-on-year trajectories) and some were flexible (all systems had to have in place by 2023/24 but had more flexibility over delivery approach).

Examples of fixed:

- Maintain ambition to eliminate all inappropriate adult acute out of area placements by 2020/21.
  - Included local plans to improve system/bed capacity management and unwarranted variation in Length of Stay (LoS).
- 100% of mental health providers to achieve and maintain a score of 95%, or above, in the MHSDS Data Quality Maturity Index from 2020/21.

Examples of flexible:

- Improved therapeutic offer to improve patient outcomes and experience of inpatient care, and reduce average length of stay in all in adult acute inpatient mental health settings to the current average of 32 days (or fewer) by 2023/24.

- New funding secured to increase the level and mix of staff on acute inpatient wards.

- All appropriate specialised mental health services, and learning disability and autism services, to be managed through NHS-led provider collaboratives.
  - Starting with adult low and medium secure services, children and young people's mental health inpatient services (CAMHS Tier 4) and adult eating disorder specialised services & then expanding to other services as appropriate.
  - Information on the proposed commissioning model and requirements for NHS-led Provider Collaboratives has been provided as part of the provider selection process.
- Systems are utilising digital clinical decision-making tools.
- Systems are improving data quality.
  - Supported by incentives e.g. Mental Health Data Quality CQUIN, CCG Improvement and Assessment Framework.

Example of targeted (e.g. ringfenced funding for):

- Localised suicide reduction programme rolled-out across all STPs/ICSs by 2023/24.
  - Support materials included National Confidential Inquiry into Suicide and Safety in Mental Health: 10 ways to improve safety.

Local expectations:

- Review their current staffing levels and mix.
- Review their current average length of stay.
- Support national work to define optimal therapeutic staffing models.
- Identify key local staffing gaps/challenges which may result in above optimal LoS in hospital.
- Plan how they will incrementally improve the staffing levels and mix as the funding in CCG baselines increases to address identified gaps.
- Improve the experience of patients who need to transition from CYPMH inpatient to adult inpatient services.
- Review plans and include more trajectories to reduce average length of stay by 2023/24 if needed.

Rationale for the why the programme was necessary to implement: Provided a new framework to ensure we delivered on 'NHS Long Term Plan' commitments at the local level, following engagement programme run by NHSE/I.
If changes were made to programmes, please explain why those changes were made: Unknown – we have been unable to acquire this information.

Title: NHSE's Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme (WV/36)

Dates they were in effect:

Launched February 2023.

Brief summary of the programme:

The aim of the programme is to support cultural change and introduce a bold, radical, reimagined model of care for the future across all NHS-funded mental health, learning disability and autism in patient settings. To achieve this aim, the programme has the following objectives:

1. To localise and redesign inpatient services – to ensure care models focus on being delivered close to home, least restrictive models of inpatient care are used which promote the therapeutic relationship through continuity of care. Steps to achieve this include;
    a. Systems co-producing a strategic plan to localise and realign mental health inpatient services over a 3-year period in line with a Commissioning Framework (as outlined in NHS 2023/24 Planning Guidance).
    b. A Commissioning Framework for inpatient services and associated baselining tools have been produced to support ICBs with this task. The guidance provides a clear and shared understanding of 'what good looks like' and pays particular attention to models of inpatient care where people are in hospital for years at a time, such as inpatient rehabilitation.

2. To improve the culture within inpatient services and support people and staff to flourish, and enable the least coercive care through reducing restrictive practices.

3. To support systems and providers facing immediate challenges and make oversight and support arrangements fit for the sector – to ensure that while transformation is underway, focus is given to people and families who are at risk of being care for in unsafe and poor-quality setting now. Steps to achieve this include;

a. Supporting regions and systems to identify units most at risk of developing a closed culture through the development of a tool aligned to inherent risk factors and drawing upon CQC ratings.
b. Making available a range of quality recovery offers to complement existing improvement offers, which systems and regions can draw upon as needed.

Rationale for the why the programme was necessary to implement:

Recent inquiries and rapid reviews into mental health inpatient services, including those specifically for people with a learning disability and autistic people, identified particular 'setting conditions' and/or characteristics of service models which negatively contribute to the delivery of high quality, person-centred care. Additionally, following the care scandal at the Edenfield Centre in Greater Manchester, NHSE considered the actions required to improve the quality and safety of mental health inpatient services and best enable the care people receive to be close to home, less restrictive and focused on therapeutic benefit.

As a result, NHS England wrote to all Mental Health providers requesting that each organisation urgently review safeguarding of care, recognising the inherent risk factors of certain bed-based provision. All providers have since published their review and subsequent actions they are taking. The action plans published by each provider informed the scope of the Quality Transformation programme.

If changes were made to programmes, please explain why those changes were made:

Unknown – we have been unable to acquire this information.

Annex E – Mental Health, including Patient Safety related, independent reviews, audits or investigations commissioned by DHSC between 1 January 2000 and 31 December 2023

Title: An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer (WV/45)
Date: Published in 2000.
Scope: The report, commissioned by the Department, set out to understand what was known about the scale and nature of serious failures in the United Kingdom's National Health Service system, examine how the NHS might learn from those failures, and recommend methods to minimise future failures.
Summary of the findings: 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. The report estimated that one in ten patients admitted to NHS hospitals are unintentionally harmed, costing the NHS around £2 billion a year in extra bed days and some £400 million in settled clinical negligence claims. Around 50% of incidents could be avoided if lessons from previous incidents had been learnt In terms of mental health patient safety specifically, the report found that implementation of recommendations can take too long. For example, suicide by hanging among mental health inpatients was an issue which had been first highlighted 30 years before but was still a prominent problem in the NHS. The report recommended that there should be an explicit focus on identifying and addressing very specific serious categories of recurring serious adverse event. For example, hanging from non-collapsible bed or shower curtain rails are the commonest method of suicide on mental health inpatient wards. The report set out an aim that by 2005, we would reduce to zero the number of suicides by mental health inpatients as a result of hanging from these structures on wards. In addition, the report found that there is very little clarity about the circumstances under which some form of external investigation or inquiry is appropriate following

an adverse event. The need for specific work to address this issue for mental health inquiries was recognised and specific work undertaken.

Summary of the resulting actions:

In response, the Department published 'Building a safer NHS for patients' (WV/46), which set out the Government's plans, timetable and targets to promote patient safety, including establishing the National Patient Safety Agency. The Agency's objectives were to develop a mandatory national reporting scheme by December 2001 for incidents and near misses, assimilate other safety-related information from a variety of existing systems, learn lessons and develop solutions. For mental health services specifically, 'Building a safer NHS' also set out the target to 'reduce to zero the number of suicides by mental health patients as a result of hanging from non-collapsible bed or shower curtain rails on wards by 2002'.

In relation to about there being little clarity about the circumstances under which some form of external investigation or inquiry is appropriate following an adverse event, the Department published guidance in 2004 on this specifically to mental health 'Independent investigation of adverse events in mental health services' (WV/47). This set out a clear process for investigating incidents, and the criteria to be met for an independent investigation to be undertaken. The guidance set out that Strategic Health Authorities were responsible for commissioning independent investigations, and that investigations should be focussed on openness, learning lessons and creating change.

Title: Modernising the Mental Health Act – final report from the independent review (WV/44)

Date:

Commissioned in 2017 / published in 2018.

Scope:

The review was set up to look at how the Mental Health Act is used and how practice could improve. The purpose of the review was to understand the reasons for rising rates of detention under the Act; the disproportionate number of people from black and minority ethnic groups detained under the Act and processes that are out of step with a modern mental health care system.

Summary of the findings:

The review identified that the current MHA is out of step with a modern-day mental health service and is in significant need of reform to make it work better for everyone. The reforms the review recommended were driven by the following problems:

- rising rates of detention
- racial disparities in detentions and community treatment orders
- poor patient experience
- the particular disadvantages felt by people with a learning disability and autistic people

Summary of the resulting actions:

In response to the Independent Review, the Government published a White Paper (WV/39) in January 2021, which accepted the vast majority of the review's recommendations and sought views on the impact of these recommendations and how best to implement them in practice.

The Government consulted on the white paper proposals from January to April 2021 and published its response to the consultation (WV/54) in July 2021. Respondents were broadly supportive of the proposals. The Government said it would continue to work with stakeholders to refine the proposals, to make final policy decisions and develop a draft bill.

A draft bill was published in 2022 (WV/40), setting out planned changes to the MHA. This underwent pre-legislative scrutiny (PLS) by a joint committee of both houses. The Joint PLS Committee produced a report and recommendations, to which the Government responded in March 2024 (WV/55).

Title: Rapid review into data on mental health inpatient settings: final report and recommendations (WV/49)

Date:

Commissioned in January 2023 / published June 2023

Scope:

The purpose of the rapid review was 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 all providers of NHS-funded care, including Trust and Independent Sector providers.

The review considered:

- The available evidence about factors which contribute to patient safety risks.
- The data collected by CQC, NHS England, providers, ICBs and non-statutory bodies and how this is used to inform monitoring.

The report includes a set of recommendations about how to improve data collection and the use and reporting of data to help identify mental health inpatient settings at risk of developing patient safety issues, or a poor culture of care, and how providers and others can improve the way they use data.

Summary of the findings:

Some of the key findings from the Review include:

- Safe care is therapeutic care: To reduce the risk of patient safety incidents, mental health staff and leaders need to focus not just on where things go wrong, but on what is needed for things to go right, such as providing safe, therapeutic, compassionate environments and functioning pathways.
- Mental health inpatient services need a greater focus on 'measuring what matters' for safe, therapeutic care.
- Patient, carer and staff voice must be heard at all levels to help identify where things are going wrong and how to improve care.
- Frontline clinical staff spend too much time entering data and don't get enough value from the data they enter.

- Data is often not available in real time or used consistently for benchmarking between similar providers.
- Data on its own isn't enough – people need to act on it and make improvements.

The review set out 13 recommendations to improve how data and information is used in relation to mental health patient safety.

Summary of the resulting actions:

In March 2024, the Government published its response to the 13 recommendations, agreed with NHSE and CQC (WV/50).

To oversee implementation, DHSC set up a Ministerial-chaired steering group and a mortality data working group to take work forward actions. Since the new Government, the mortality data working group has been re-launched and the next meeting will take place soon, and the previous steering group members will also be receiving regular written updates on progress towards implementation.

Title: The Health Services Safety Investigations Body (HSSIB) Investigations into mental health inpatient settings

Date:

The Secretary of State gave an Oral Statement to the House of Commons on 28 June 2023 which included the announcement of HSSIB's investigation into mental health inpatient settings, as well as the publication of the rapid review into mental health patient safety and making the Essex Inquiry statutory.

HSSIB's findings have been published in a series of reports since September 2024 and January 2025 and are available on the HSSIB website (WV/51).

Scope:

The terms of reference for the HSSIB investigations were then published in January 2024 and can be found on HSSIB's website.

The aims of the investigation included:

- learning from inpatient mental health deaths.
- improving patient safety.
- helping to provide safe care during transition from children and young people to adults in mental health services.
- creating conditions for staff to deliver safe and therapeutic care.

Summary of the findings:

In January 2025 the HSSIB concluded their series of investigations into mental health inpatient settings.

These investigations identified ways to improve mental health care, protect patients and the public and create a safe working environment for staff and HSSIB has engaged with patients, families and carers, as well as local and national healthcare organisations.

As part of these investigations. HSSIB have also taken the decision to undertake further work into mental health inpatient care which is scheduled to be published in May 2025.

Summary of the resulting actions:

The Department will formally respond to all the recommendations for DHSC made within the HSSIB reports in due course.