

Health and Social Care Committee

Oral evidence: Community Mental Health Services, HC 566

Wednesday 10 September 2025

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Watch the meeting

Members present: Danny Beales; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Joe Robertson.

In the absence of the Chair, Paulette Hamilton took the Chair.

Questions 244-338

Witnesses

I: Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health, Department of Health and Social Care, Caroline Allnutt, Deputy Director for Serious Mental Illness and Offender Health, Department of Health and Social Care, and Gareth Harry, Director of Delivery, Mental Health, Learning Disability and Autism, NHS England.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Baroness Merron, Caroline Allnutt and Gareth Harry.

Q244 Chair: Welcome to the fifth and final evidence session of our inquiry into community mental health services. We are joined by the Minister, Baroness Merron, and officials from both the Department of Health and Social Care and NHS England.

Before I begin, I would like to acknowledge that today is World Suicide Prevention Day. The theme this year is "Changing the narrative on suicide". It is important that we have more compassionate conversations about suicide.

Improving access to care in the community, ensuring that those in crisis get the support they need and reducing stigma are ways we can prioritise mental health and suicide prevention, which are themes that we have been exploring throughout this inquiry. With that, I ask the witnesses to introduce themselves. Baroness Merron.

Baroness Merron: Thank you. I am Baroness Gillian Merron, the Minister for women's health and mental health.

Caroline Allnutt: I am Caroline Allnutt, Deputy Director for Serious Mental Illness and Offender Health at the Department of Health and Social Care.

Gareth Harry: I am Gareth Harry, national Director of Delivery for Mental Health, Learning Disability and Autism in NHS England.

Q245 Chair: My first question is quite an easy one about neighbourhood mental health centres and the way they have been designed. What role do you envisage they will play in supporting individuals with severe and enduring mental health needs? I would like you to look at how they will complement specialists, multidisciplinary teams and long-term care that other services currently deliver.

Baroness Merron: Thank you for the warm welcome. It is extremely appropriate that we are meeting on World Suicide Prevention Day. In view of the informal conversation earlier, the Committee might be interested to know that for that reason we have brought forward by a day the launch of e-learning on suicide prevention, which will be widely available to staff in the NHS, to charities and across the board. That will be a huge contribution, so I am glad we have done that today.

For me and the Government, the move to neighbourhood provision is key. It builds on the framework that was launched in 2018. I am sure that my colleagues, with their long experience, will comment on that. It very much comes out of the Darzi review and the 10-year plan. I know the Committee is familiar with the three shifts. The one we are particularly talking about here is hospital to community, as well as analogue to digital. There is also the move from sickness to prevention. They all come together in the neighbourhood centres.



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If I had to say why I am so passionate about them, it would be because of what they bring together. Chair, you made a good list of all the areas they will bring together under one roof. It is also key that the centres are 24/7 and people can access them without referral. There has been a huge amount of enthusiasm that they are being piloted, so that we can evaluate the strengths and any issues we need to resolve. I note, for example, that in addition to the big welcome to the pilot areas, several areas have put themselves forward to be associate areas, such is the enthusiasm, but also the wisdom of what this is about.

I would say it can be transformative. It will vary greatly, I think, because it will mean that those who need support, treatment and care can access it, but it will also mean that we bring together crisis, home resolution and treatment teams.

Q246 Chair: These 24/7 centres will offer wide-ranging services and people will be able to just walk in. Are you worried that staff may be overwhelmed by the numbers going to the centres? What plans have you put in place to ensure that the risks are managed?

Baroness Merron: That is part of the pilot. We want to encourage people to seek support and treatment. That is important when we are talking about access, because we know that a number of people do not access the care they need, including in mental health, so we want to encourage that, and the centres will be properly staffed.

More generally, Chair, I refer to our commitment, on which we are making big progress, to recruiting 8,500 extra mental health workers. The strength of this approach is also a multidisciplinary team. It is not just about what people might regard as straight mental health support; people might need help in terms of employment support or with housing and so on—

Q247 Chair: I don't mean to stop you mid-flow, but I am asking about the risks. I absolutely agree with you that these centres are needed, but we need to understand whether you looked at the risks and how they will be managed if too many people come to the door.

Baroness Merron: It might be helpful to bring in colleagues, because we have looked into that.

Gareth Harry: It is really early days for the pilots, and I should emphasise that it is about continuing existing services. It brings together in one site, in one place, sometimes in a high street location and sometimes in a place close to a community, the range of services that already exists.

In the early days of the pilots, we are not getting feedback that we are seeing the sort of overwhelm you are worried about. We know that there is a treatment gap, so you are right as a Committee to be concerned and to be thinking about that risk. The pilots are in their very early days, but we are not seeing that sort of flow into the centres yet. Of course, that is why we want to pilot this new way of working.



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I want to emphasise the continuity of services that already exist in the form of crisis and community mental health teams, and in early intervention in psychosis teams. It is about bringing them together into a single multidisciplinary team in a place and venue that is readily accessible to the community that needs it.

Chair: Does anyone want to add anything before I move on?

Caroline Allnutt: Only to say that I know the Committee has been to visit the model in Trieste, and we have seen from the international models that that overwhelm does not appear to happen. As Baroness Merron and Gareth have said, it is about the fact that you have a whole range of support for people's needs. We know that, at the moment, people are waiting a long time for clinical care, but actually it might be that they could be handed back to talking therapies or benefit from peer support or employment support, as well as clinical intervention. Our being able to access people's needs more quickly will be really beneficial in potentially preventing them from coming back to services with a high level of need.

Q248 **Chair:** This is my final point, Baroness Merron. You have got these pilot sites. You will have these hubs in certain areas, but in places that are not able to access them, how will you ensure that residents are not getting a two-tier system, because one area, or one constituency, can absolutely access them and others cannot?

Baroness Merron: I understand that point. We are making other improvements in the meantime, but it is a fact of how it will be that we do need to do a pilot to evaluate and to make sure it is right before extending it further. I am sure that every constituency MP would like to see provision in their area, and rightly so, in my view. I think I would say to colleagues that our intent in rolling it out is to make it broadly available, but we want to make that sure that we get it right. I should say on the modern service framework—I am sure we will come on to this—

Q249 **Chair:** We will come on to all that. I just need to understand where the centres are going to be placed and what risks there are. For me, the bigger thing is the areas that do not get them. You have highlighted that it is a pilot. How long will the pilot last for?

Gareth Harry: The transformation funding to support the pilots is for a year, but that is a year of them operating, so there has been some set-up time before the pilots have started. We are learning lessons from them continuously through the process, but we expect those to last a year.

Q250 **Chair:** Once the pilot sites have proved to be successful or not successful, when will this then be rolled out? After a year? After 18 months?

Gareth Harry: We have got the other systems, which are not part of the formal pilot, that are already starting to adopt and adapt the model, so it is within the gift of local systems and local providers to start to work along this model, even without the transformation funding that we have been able to deploy to support the pilots themselves. I guess with the allocations and the planning round that the NHS is coming through at the



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moment in terms of the three-year spending review that the pace at which we can expand will depend on decisions that are made around that.

Chair: Thank you for that. I will stop there because I have got some more questions later.

Q251 Joe Robertson: I want to pick up on the Chair's question about the timeline and criteria for scaling up the pilots. You say that it is dependent on the three-year spending review. How does it tie in with the neighbourhood health centres generally that are referred to in the 10-year plan? I think the figure in that is for 50 centres. Presumably these will be embedded within the neighbourhood health centres, rather than being something separate from them.

Gareth Harry: They will be closely connected with them. Within that wider neighbourhood model, this specific neighbourhood approach and a centre approach for people with severe mental illness will be part of that wider neighbourhood approach, but a separate service.

Q252 Joe Robertson: In the 10-year plan, there is a plan—indeed, it was one of the main planks that the Government were promoting—for 50, I think, neighbourhood health centres to be set up across the country, starting with need first. There are then pilots for neighbourhood mental health centres, and at the moment we have no figure for how many will be rolled out, say, in this Parliament. Surely, they are one and the same thing. Surely, you will not have different sites for mental health in a neighbourhood from the general neighbourhood health centre. Or are these completely different projects?

Gareth Harry: There will be connections and there will be the ability to refer in between the different approaches. The neighbourhood health model is essentially about looking at wraparound care for those people who are most in need of it, and in many systems, they are looking at the frail older community—people with multiple long-term conditions—and trying to look at community interventions in a way that avoids hospital admissions.

Between that community and population that require intense wraparound support and the community with severe mental illness, there is a small overlap, but it is not massive. That is why we are looking at a separate service, connected, and the key connection will be primary care—primary care as a key component of the wider physical healthcare neighbourhood model, and primary care in terms of input into the neighbourhood model to ensure that people are getting the physical healthcare that they need. So the relationship at a local level with primary care networks and with GP practices is absolutely crucial in the model.

Q253 Joe Robertson: May I suggest that if 50 neighbourhood health centres are rolled out according to the 10-year plan, we must expect at least 50 neighbourhood mental health centres, because it would be bizarre to have a situation where you have a neighbourhood health centre that does not cater for mental health?



Baroness Merron: We have to ensure that the provision is right for local areas. The Committee will know how keen we have been to empower local areas to get the services right, and how the modern service framework will ensure that the level of care is right, while allowing for individual difficulties. It might help if I mention something about the pilot schemes: I would not want the Committee to think that we are starting from absolute scratch, with no idea. Certainly—I am sure the Committee saw it in Trieste—international models have shown us that the outcomes are so much more positive, such as reduced admissions and length of stay and quality of care. I wouldn't want the Committee to think we are starting from nothing—we are not at all.

Q254 **Joe Robertson:** Putting to one side for the moment the questions around timescales, is it the Government's intention that at some point everyone will have access to a neighbourhood mental health centre?

Baroness Merron: We focus on that 24/7 approach, but it is important to refer back to earlier comments, that that could be delivered in a whole range of ways. What we might do in a city is obviously very different from what we might do in a rural area. That is why it is so important that those local decisions are made. But the principle is the right one—to be available. I am sure it is a point the Committee will make—the importance of ensuring that the provision is available, but tailored to what is needed.

Caroline Allnutt: Many of the principles that we are talking about in the 10-year plan around mental health have been tested and recognised in mental health for a very long time. Particularly for people with severe and enduring mental illness, the principle that they should have continuity of care, that they should not have to tell their story several times to different professionals, and the importance of wider support for their lives, including education, employment, housing, is just so apparent in mental health. Lots of areas have already been looking at those principles and how they can put them into practice. Last year, I went to Somerset to see their Open Mental Health model, which is deeply impressive. One of the things they were most proud of was their utilisation of local voluntary partners, and the fact that it was completely rooted in people's communities, delivering what people needed as close to home as possible.

Q255 **Joe Robertson:** I understand the need and the desire not to replicate good services that have been provided in particular localities. What work is being done to identify where services are lacking, so that when the time comes, I hope, to scale up neighbourhood mental health services, there is a priority list of areas where Government will look to start doing that?

Caroline Allnutt: We are not there yet. One of the things we are doing through the pilots—Gareth may wish to say more about it—is understanding more about barriers to implementation and the key factors that need to exist for successful implementation. Those include digital operability, good governance, clear leadership and accountability for outcomes. All those things will be really important. We drew up a list of factors that areas might wish to assess themselves against to understand



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how ready they are for that. I don't know whether Gareth wants to add anything.

Gareth Harry: I think you have covered it.

Q256 **Joe Robertson:** Presumably, that work is under way if pilots have been set up to assess how good the model could be and any ways it could be improved. Presumably, the work is already under way to identify the areas that could benefit from new mental health centres. Otherwise, you will have a model that might be ready to go, but you have not even begun the work on working out where it would be most beneficial.

Baroness Merron: It is important, as Caroline said, that things are in place such as good governance—I use that as one example—and so on, to make the centres successful. We will also look at places where they can actually happen initially. It is important to stress the point about the number of areas that have chosen, without the back-up of the transformation fund, to come forward—"We want to do this anyway because it makes sense"—and they are getting on with it and recognising that funding is not the only point at all, and that this is a better service. They have the other bits—building blocks—in place, and they can get on. We are encouraging that, too. We are not holding back—unusually; we are enabling local areas to come forward and make that change now.

Gareth Harry: We went through a process to select the six pilots, and we had a high level of interest from providers and local systems in deciding on those six. We wanted to test the model in a range of settings; we wanted to look at ultra-urban areas and rural-urban combined areas, and I am pleased that we are also testing the model in a coastal town. Having the 16 or 17 associates to the pilot shows that people are ready to come forward and roll this out just through good will, because they can see the potential benefits of working in a very different way.

Q257 **Joe Robertson:** Presumably, there are some objective criteria around assessments. No matter how keen an area is to implement the model, sadly the areas where it might not be happening so well are those where the leadership is lacking, and they are not coming forward to you—"We have a problem. We would like to explore this." I want to ensure that it is not first come, first served—whoever pushes to the front of the queue—

Baroness Merron: Absolutely not.

Joe Robertson: And there are some objective criteria to assess the need rather than the willingness.

Q258 **Jen Craft:** My question is on co-production. All the evidence we have heard on the services is that they are most successful when they are co-produced with people with lived experience. What kind of plans are in place to co-produce not only the services, but how outcomes are measured? We have heard fairly constantly that quite often things like access and waiting times are measured in evaluation, but recovery, preventing relapse and helping people to stay well do not always play into that. How is co-production taking place?



Gareth Harry: Co-production has been at the heart of everything we have been doing around the development of a model. Experts, by experience, and stakeholders from across the country have been involved in developing the model and developing the very approach that we take into the piloting and evaluation. Even the principles on which the 24/7 centres are operating have been co-designed and co-produced with experts by experience. It is at the very heart.

Both through the 24/7 model and the work we want to continue to do in community services across the board, we are trying everything we can to make it as easy as possible for clinicians and patients to report their own outcomes as a routine collection within neighbourhood and community services. It is so important to us. It is important for individuals in being able to look at their own care, and it is important to look at the progress people are making and what therapeutic benefit they are getting from services. It is important as a building block for local commissioning decisions and resource allocation.

Q259 **Jen Craft:** How does that work in practice? How are people—and patients—able to measure their outcomes in real time?

Gareth Harry: Ordinarily, when someone is entering a service, a clinician will undertake an assessment. At that first point, there will be a clinical assessment of need and a scoring mechanism—there are a number of tools that clinicians use to score people when they are entering a service. At the same time—sometimes in the same assessment—there will be a patient-reported self-survey of how they are feeling at that point in time. Then, through the course of the treatment, the patient might be asked to complete that self-assessment survey again, and the same when people leave the service or their treatment ends. That comparison of how someone was feeling entering the service with how they feel at the end of the service is your outcome improvement.

Q260 **Jen Craft:** Are those outcomes dictated by the patient, and is the patient able to articulate what they want out of it? For instance, the survey that gives a rank on the famous Edinburgh scale for normal levels of human despair would not always be applicable to what someone might be looking to achieve, so can that be fed in?

Gareth Harry: What we are trying to do at the same time—this is slightly different from the collection of patient-reported outcome measures—is look at the personalised care framework, to replace the care programme approach. We are expecting to be able to publish the new approach in the coming months. That approach, which is what you are talking about, where at the outset everybody has a plan that they own—one that is their plan, as part of that assessment—is absolutely crucial and is one of the building blocks of the personalised care framework.

Q261 **Jen Craft:** That is really helpful. I just want to clarify, because I think it would be helpful for people watching this to understand: can you be crystal clear about who can access this service? How will people find out about it? How will they know they can just turn up to a walk-in centre, and



when they can access it? Is it for people who are in a mental health crisis? Is it for people with an SMI whose condition is currently in a period where their symptoms are very obvious? A lot of experts by experience who came and gave us evidence told us that quite often they would go through a period of crisis, they would get support, they would recover and they would be discharged, but then, because they have this experience, they could see months out that they were going into crisis again, but could not access support until they were in that moment where things had reached a pinch point. Is this a service that someone with that experience who might be thinking, "I'm not sleeping as well; I'm not eating as well; I'm starting to have intrusive thoughts," is able to access at the earliest opportunity, or is it a crisis service?

Gareth Harry: No, it is all that. It is open access, 24/7. That is exactly what we are trying to address through the new approach. The feedback that we get from experts by experience is that one of the key sources of anxiety can be: "I've been discharged. How do I get back into a service when I need to access it?" This would provide the answer. At those early signs, you would be able to go to the 24/7 centre and see somebody.

Baroness Merron: We also want to make sure that it is one door, so that somebody does not have to think, "Do I go there, or do I go there? Do I wait?" They can just go and report, and they will be seen and dealt with. They may be referred elsewhere or whatever, but it is the door that is important. As the 10-year plan identifies, there is so much confusion, and people therefore do not come forward or they get dispirited just by the system, and we cannot have that. This is a classic example of where we are wrapping the service around the patient, not the other way around.

Q262 **Alex McIntyre:** Just to build on that last question, in terms of healthcare being out in the community, you said you wanted this to be a one-door, wraparound service. One of the most successful aspects of the community mental health hubs programme that we saw on our visit to Trieste was the fact that it was not just contained within a building. Outreach—going and finding people quickly—was a key part of that work and, I thought, probably the most important. What work is the Department doing to make sure that this is not just about a patient pushing a door into a building, but that we are going out to where the patient is?

Baroness Merron: If I may mention a few, I am sure colleagues will add to them. For me, one of the important areas is improving assertive outreach care and treatment so that, going back to the earlier discussion, we have 100% national coverage. That is particularly for those with more severe mental illness who are not coming forward. In other words—going back to the door-pushing—we are not even waiting for people to push the door; we are going to them. That is absolutely crucial; otherwise, we are just being reactive, and that won't work.

The other point, to which Gareth referred earlier, is about digital support. I think about the use of the NHS app, which will make sure that people can access digital interventions, and access them when it suits them, in ways that suit them. That is really key.



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Another thing that has been a great success is the talking therapies service—I am mentioning only three areas initially. For me, there is huge strength there, with self-referral and little waiting list. It does vary, but generally it is one of our better services, and it has the ability to signpost people. For example, for somebody in work who is struggling at work, as well as with their mental health, employment advisers are available. The cross-departmental work between us and the DWP, for example, is really strong in that area. That is just one example.

Q263 Alex McIntyre: Thank you—that is very comprehensive. To come back to the point that you made about waiting times, in 2022 NHS England consulted on waiting times standards for community mental health. Nothing seems to have happened since that consultation, so will those waiting times standards be implemented by services? If so, when?

Baroness Merron: We know that waiting times are too long; I have to agree completely with that. Although there are not specifics about the standards at the moment, on mental health there is a real drive to get down the waiting lists in the way that we are describing. It might be helpful to hear from colleagues who will have been involved in the work that you refer to.

Gareth Harry: Although we do not have a target for mental health waiting times, we have started to use those clinical standards to report. We report regularly and publish data on the length of time that people are waiting and the performance against the four-week clinical standard that was set out. Going back to your wider point about the open door, and relying on people coming forward, I will take the opportunity to say that although there is a centre approach, this is not the end of domiciliary services and mental health being provided in people's own homes when they need to be seen in their own homes. This is somewhere people can go, but community mental health teams will continue to work in people's homes. Of course, as the Minister said, assertive and intensive treatment will be a crucial part of the model.

Q264 Alex McIntyre: I am relying on colleagues' expertise but talking therapies are not available for many people with SMIs. Bipolar and schizophrenia, for example, are often excluded from them. If we are relying on things like talking therapies, how do we broaden the access to them? Is it even appropriate to do so?

Gareth Harry: The evidence base for talking therapies is on a specific number of conditions. The interventions that are undertaken in talking therapies are closely evidence-based. It is a very high-performing service: 90% of people get seen within six weeks. I would go as far as to say that it is the best-performing service in the NHS. It is a high-performing service, with rapid access, and good outcome measures—people are getting good outcomes from it. That is slightly different from the population with severe mental illness, how they access and how they get the support and care that they need from community mental health services, which of course are secondary care services that just happen to



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be provided in the community, whereas in a physical healthcare setting they would normally be provided in a hospital.

Q265 Alex McIntyre: Going back to the point you made about waiting times, if we are measuring them and publishing them, why can't we have a standard for community mental health waiting times?

Baroness Merron: That is a challenge that I will take on. I would be interested to see what the Committee reports on that. I do take the point.

Q266 Alex McIntyre: It strikes me that if we want to have parity of esteem with physical health, it would seem an obvious step to indicate that to patients by giving them a standard that they should expect their service to perform to.

What impact do you expect the modern service framework to have on community mental health services for people with SMI, and what practical difference do you expect the framework to make?

Baroness Merron: I will make some general comments. Again, this is very helpful, because it is going to support consistent, high-quality and high-value care for those with severe mental illness. It is part of a wider programme, following the 10-year health plan, about improving outcomes and reducing—I referred to this earlier—what I would call unwarranted variation. Obviously, services are not going to be exactly provided everywhere, but that should be because they are better providing for what is needed locally. It will also align provider payments with the provision of high-quality care. For me—I invite colleagues to add their personal and professional experience—the modern service framework moves us on and elevates the importance of proper services for those with severe mental illness.

Q267 Alex McIntyre: Taking this back to my constituents over the weekend, what impact will they see in practical terms as a result of the framework?

Baroness Merron: The framework will identify the best-evidenced interventions—in other words, what will actually make a difference to your constituents on an individual basis. It will set the standards about those interventions—that, again, is a reassurance to individuals. Importantly, it will identify areas where greater innovation is needed; in other words, it is not a static thing. It will also define long-term goals. I realise that, for an individual constituent, that is quite hard to articulate—I am doing my best in this setting, and I am sure that we could put all that in different words. I am also pleased that this is clinically led. We are developing it.

Q268 Alex McIntyre: When do we expect it to be published?

Baroness Merron: Next year.

Alex McIntyre: Early next year? Late next year?

Baroness Merron: Oh, come on!

Alex McIntyre: It was worth a try.



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Baroness Merron: In the Chamber—soon. No, it is not a “soon”. I am being realistic because it is in the process of being developed. If I was in the Chamber, I would say that I would be very pleased to update the noble Lord on the timetable when it is clearer. I do genuinely mean that. In terms of the Committee, we would be very pleased to keep the Committee up to date on this area.

Chair: I know that Josh wants to ask an additional question.

Q269 **Josh Fenton-Glynn:** We were talking about mental health waiting lists. Gareth just referred to it as a very well working service. There are places in this country where the only way you can get access to talking therapies is if you are sectioned—my colleague from Congleton raised that. Do you think that the mental health service is currently working well?

Gareth Harry: I wonder whether we are talking about slightly different things. The talking therapies service is very much a primary care service for common mental illness, like anxiety and depression. It is available on self-referral or via a professional referral, but mainly it is accessed via self-referral. Waiting times are extremely short: 90% of people are seen within six weeks. In the area of the country that you are talking about, Congleton, the service will be operating in the same way. We have a consistent, universal offer across the country for talking therapies.

I wonder whether the case you refer to is around access to secondary care psychological therapy services, in which case, we know that the waits for some of those therapeutic interventions are very long. It should not be happening that somebody needs to be admitted in order to access that sort of therapeutic intervention.

Baroness Merron: It is not the right one, either. Talking therapies is not the right one, if somebody is going to be sectioned. That is not what talking therapies is. If MPs have individual areas they want to raise, they are very welcome to raise them with me.

Q270 **Dr Cooper:** Thanks for coming this morning. I would like to move on to the community mental health transformation programme. My first question is: given that we now have an ambitious 10-year health plan, are we continuing with the community mental health framework in its current guise, or will we see changes or even replacements?

Baroness Merron: The framework has been very helpful in leading us to the place we have got to. I believe it was published in 2018. It has been helpful because its focus has been on neighbourhoods, so you can see why we have got to where we have. I will ask colleagues about their experience of it over the years, and its applicability, but I see it as—launchpad is not the right word—a solid base from which we are working.

Q271 **Dr Cooper:** I just want to be clear about my question, although I take your points, Baroness—well made. As we have now got to the 2025 point and we have this 10-year health plan, will we continue with the framework as it is, or see changes and/or replacements? Perhaps Gareth or Caroline could talk to that.



Caroline Allnutt: Our understanding of what good looks like in mental health is ever evolving. We are not departing from the community mental health framework by any means. We are not saying that that is no longer applicable. We are moving forward using the learning from the framework and applying it particularly through the 24/7 pilots. My assessment would be that the community mental health framework has taken us a huge way forward since 2018. There were some very big issues that it was designed to fix, particularly around integration between primary, secondary and patient services—a more personalised approach, not seeing people as a diagnosis, but looking at the totality of their needs. I do not think we have come all the way with all those things, so we need to move further forwards, but we are definitely not ditching it, as it were.

Q272 Dr Cooper: Great. I take both your points about the historical success of this. That is absolutely great—not in question. Now that we are in this place, I just want to be clear that we are going to keep this framework and see it move forward—that there will not be a significant change. Is that right?

Gareth Harry: Well, the significant change is the testing and, hopefully, roll-out of the 24/7 neighbourhood model. You take the basis of the framework—you will have picked up from your evidence that the application of the framework has varied around the country. There have been particular digital barriers to full integration and multidisciplinary working at a local level across organisations, but all the basic principles of community mental health teams—working with the voluntary sector locally, with the local authority sat around the table, and with primary care as a key partner—go into the new approach, in terms of the new neighbourhood model. It is definitely not a moving away from the content or the principles of the framework.

Q273 Dr Cooper: Great. That is completely clear—thank you so much. It was, as you say, implemented in 2018 or 2019, so it has been going for a good few years. As all good health professionals would, I am going to ask you whether we will see an evaluation of the framework. If you have plans to undertake that, that would be really useful. Are there plans to undertake an evaluation of what has gone before?

Baroness Merron: Sorry, I am hesitating. It is not an exact answer to your question, I freely admit, but our action since has shown what our experience has taught us, which is that this is the right approach. It is interesting—I was looking back, and the framework that was established in 2018 was very much what we are still talking about now, which is a “no wrong door” approach and a needs-led approach. As for formal evaluation over the years, there will have been consideration, but Caroline might comment on that.

Caroline Allnutt: If I am correct, this started out with pilots, as the 24/7 model is doing, and there was evaluation in those early stages to ensure that it was being implemented in the most effective way. I do not think we have plans for a wholesale formal evaluation at this point. What we are looking at is drawing in the evidence about what we know works best,

particularly looking at those international models and then, through the pilots, to think about how this can be best taken forward.

Gareth Harry: We have been constantly sharing learning throughout the roll-out of the framework. Although it was published in 2018, it did not kick in into the long-term plan until 2020, and we know what happened in 2020, so it took two or three years. It was always part of a three-year roll-out of the framework across the country and the investment that went with it.

Q274 **Dr Cooper:** Lovely. Thank you. I have a gentle challenge about evaluation. You have worked in the healthcare system for a considerable amount of time, I am sure, and there are always pilots going on. In our first evidence session, Rethink Mental Illness reflected on the call for a national evaluation of the framework, through the CQC and others. It said: "This is always what holds mental health back. When there is no evaluation, commissioners cannot keep proving to their financial directors that this is what they should be investing in. Then everything falters and stutters, and attention goes elsewhere." Doubtless this has been a good framework and there have been learnings, but we heard during our evidence session that there is a large call for evaluation from various organisations. That is a gentle challenge to you.

Baroness Merron: It is a fair and gentle challenge. My view is that the question on evaluation is: "What will it give us that we haven't got already? Are we just drawing a line now?" Actually, what we are trying to convey, as the Committee has heard, is more of a continuum. There is a downside to saying, "Line drawn. Evaluate. Start all over again," which is also a real challenge in Government. That tends to have been traditional, and my feeling in this role is that this is a mature way forward, because we are not dissing a previous framework; we are building on it and getting on with it.

Dr Cooper: That is absolutely heard and fully respected; I am just giving you the challenge from the organisations.

Baroness Merron: It is fair.

Dr Cooper: And I understand that in health, we always have to make the case for allocation of resources—there are limited resources.

Baroness Merron: Absolutely right.

Q275 **Dr Cooper:** I have one final question about the implementation of the framework. We have heard from various people during our sessions, including the Royal College of Psychiatrists—Gareth, you alluded to this—which described the implementation of the framework as "patchy at best, but mostly inadequate". You may or may not think that that is harsh—I will leave that to you—but what lessons have you learned from the implementation to date that will enable the vision of neighbourhood care to become a reality, to assuage some of those concerns about the implementation of the framework?



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Gareth Harry: Digital and data has definitely played a key role. If you bring people from other organisations in, you have to find ways in which you can collect the information about the service they are taking and collate it in a way that enables reporting and understanding of the service. That has been difficult, in terms of getting access to an electronic patient record in a provider from voluntary sector and other partners. That has undoubtedly been an issue.

Similarly, the allocation of key workers across a multidisciplinary team, where the key worker might not be part of the close clinical team, has been problematic in some in some teams. I return to one of the key things the Public Accounts Committee, along with the NAO, identified when it looked in detail at the programme: overall, it considered it a well-led and run programme, but made recommendations around the routine outcomes collection, which I mentioned earlier. Dr Cooper, if you have wider concerns that the service without an evaluation is not able to compete in local decision making, then the routine collection of outcome information and building what it would cost and deliver for a local population is a key mechanism where we can start to get some parity in local decision making. I do not necessarily agree with the Royal College of Psychiatrists on that point, but it is welcome to its view. We have examples of really good practice and successful implementation in Midlands Partnership—across Staffordshire and Shropshire—and Sheffield Health and Social Care. It is learnings such as those that we have been sharing with other systems and providers over the last three years.

Baroness Merron: We know that there are challenges in implementation. It is not universal across the country; it would be quite wrong to say that. One thing is good relationships between the key partners is key, and those vary.

Q276 **Dr Cooper:** I am sure that people listening will be glad to hear that, thank you.

Finally, when Rethink Mental Illness came to see the Committee, it said that it had sought to plug the implementation gap and had established a dedicated community mental health unit supporting the roll-out of the framework in 13 ICS areas across England—something that you may or may not know about. It is good that you have acknowledged that the situation is not perfect and can differ from one area to another. As you move forward to plug any gaps, would you please engage with those organisations that have given their time to this inquiry and provided valuable information?

Caroline Allnutt: We work closely with Rethink. It provides a massively valuable contribution. I have mentioned the Somerset example, where it is the lead voluntary sector provider and is absolutely brilliant. In terms of consistency, it is a key theme in the 10-year health plan. As well as the issues that Gareth described on local improvement and integration, an emphasis on transparency and improved outcomes data and the importance of streamlined regulation will be important as well.

Dr Cooper: That sounds like ongoing evaluation to me.

Q277 **Jen Craft:** Turning to the Mental Health Bill, I was on the Bill Committee, along with my Select Committee colleague Gregory Stafford, who unfortunately is not here now. There were some interesting discussions, and I will pick up on a couple of bits, which we will split into two halves. The Local Government Association and the Association of Directors of Adult Social Services, among others, have warned that the impact of the Bill—getting people out of hospital and into communities—will not come into effect if community mental health services are not sufficiently funded or reformed at the point of implementation. Focusing on that, what kind of assurances can the Department and NHS England provide that community mental health services will have the resources and capacity to support delivery of the Bill when it comes into force?

Baroness Merron: I was pleased and proud to take the Bill through. I know we have not quite completed it, but we have done most of it. Thanks to you and your colleagues for your work with my colleague Stephen Kinnock in the Commons. When taking the Bill through the Lords, there was huge discussion about that; you will not be surprised as it was the case in the Commons, too. Good legislation must make a difference, and you must be able to implement it. It is true; as part of implementation, we will continue to improve community support. As we have just been talking about, there have to be strong community services in place, particularly to support those with a learning disability.

Q278 **Jen Craft:** I was hoping that we could talk about that separately. If we look at the wider SMI population—if we can call people that—what kind of assurances are there in place that, when the Bill is implemented and comes into force, community mental health teams will not be overwhelmed?

Baroness Merron: If we look at the timeline, for example, we expect the Mental Health Bill to get Royal Assent by the end of the year—if you will allow me, I will mention a few of these points, because I think they tie in. Then we need to draw up secondary legislation and revise the code of practice. Then we need time to train the existing workforce on the new Act, regulations and the code, which is likely to be in 2027.

I am trying to get the point on record that we are not going to flick a switch. We will commence some clauses, like supervised discharge, a few months after Royal Assent. The first major reforms are expected to come in in 2028. All this timing allows for the development of the code, which will take at least a year. For me, the code is absolutely crucial; that will make it workable in the way that the LGA and others, rightly—as I do—want it to be. We need to consult on the draft code and lay it before Parliament again—quite correctly in my view—before final publication.

When we talk about later phases, timelines are necessarily less concrete, clearly. That allows us time to train the workforce and improve community provision. We have to increase the frequency of mental health tribunals as well. Those timelines I mentioned are all indicative. I hope we will keep



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the Committee and Parliament informed on them as we can nail future timelines. The point the LGA makes is absolutely right, and it was explored massively in the course of the Bill. We have clearly said that there are many aspects of the Bill that just cannot happen without the right services in place. I want to emphasise that we have the timelines to get those things in place.

Q279 Jen Craft: If we turn to learning disability and autism, one aspect of the Bill that the sector has strongly welcomed is removing the criteria for detention based solely on someone having a diagnosis of autism or a learning disability. However, that particular clause does not come into effect until the Secretary of State thinks that community mental health services—and not just those, but community services—are in place to support them. That has caused a concern that this aspect of the Bill—which is crucial in righting what people have said is like something out of the Victorian era: the sight of people with learning disabilities being detained purely for having a learning disability—may never come into effect. There is nothing in the Bill that articulates what good looks like, what the aim is, and what people can expect. What are the criteria where we can turn round and say, “Now people are sufficiently supported”? What does good look like?

Baroness Merron: I will go back to the point you made, and perhaps turn to Caroline—I work very closely with her and her team on the Bill. I understand people’s concerns. They were raised and explored at some considerable length through the parliamentary stages of the Bill, and rightly so. I really would like to put this on record, and I know this was not being suggested in your comments: there is absolutely no intent to evade any of the responsibilities. We are totally committed.

As a Government, we have revised an Act that was more than 40 years old and had long been wanting. We did that in the full knowledge that there will be change and improvement with strong community services in place. We need to be judged by results, obviously, but our intent and commitment also have to be considered. This is a bit of a road, this one, but Caroline has a real handle on the practicalities.

Caroline Allnutt: You have covered it all in terms of where we are going next with implementation, which is a big piece of work for us. We have committed to providing an annual report to Parliament on implementation, which I would envisage does not just talk about the provisions surrounding in-patient care, but talks about how things are going in the community, both for people with SMI and for people with learning disabilities and autistic people. There is an ongoing programme of work to support autistic people and people with learning disabilities to leave hospital and be better cared for in the community. The planning guidance last year talked about achieving a 10% reduction in that population.

The Bill has some provisions that support our aims in this regard. For example, the introduction of dynamic support registers and placing care, education and treatment reviews on a statutory footing very much speaks to the idea that there should be proactive shared endeavours at a local



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level to take steps for people who are at risk of detention or for people who are in detention, and think about how they can be better treated and supported closer to home.

Q280 Jen Craft: That is really positive. The concern is that we are in an era of lots of competing priorities in healthcare, particularly in this space and in adult social care. We have just concluded our adult social care inquiry, and we saw how incredibly stretched that area is. For people with a learning disability or autism to be supported in the community, that relies on a robust adult social care sector that often does not exist. Placing an onus on people to identify the need to maintain dynamic risk registers is fantastic, but the real concern that people in this space have is that in an area of competing priorities, quite often those with a learning disability are very much low down on those lists of priorities. The scandal is where people are detained in an environment that is completely unsuitable for them. That is completely the antithesis to recovery and to care. But when they are there, they are out of sight, out of mind. The Bill looks to redress that situation.

We can all agree that it is appalling to detain people purely for having a learning disability or autism. To withhold the ability for it to be switched on until services are in place creates such a worry for people. It is such a worry that that priority is never going to surface sufficiently, that that bit of the Bill that we all think is something that is long overdue, that has to happen, will not actually come into force. I hear what you say about looking at the intent, but there is a very famous thing about the road to hell being paved with good intentions.

Baroness Merron: That is fairly put. However, as the responsible Minister, I have to say that the whole area of learning disability and autism is absolutely key and is one of the big motivations for us as a Government to update the Act, which we have done in a way that is not just fit for now, but for the future. This is not a static situation.

You are correct to highlight that it is totally unacceptable that people are in places they should not be because they have a learning disability or autism. This is a situation as shocking to me as it is, I am sure, to the Committee. As Caroline said, we are not waiting for a switch to be flicked; we are already progressing that work. That is the thing I want to get over to the Committee: the situation, which you described so well, is one that we know needs to be dealt with. The current situation, where people are in the wrong place and not getting therapeutic support, is not right.

Q281 Jen Craft: Would an implementation date in the Bill help? Would it almost put a rocket up having those community services ready?

Baroness Merron: We have to be realistic. My view on legislation is that good legislation is legislation that delivers the change you want and is achievable. Again, this was a debate we had, and that is why we accepted the amendment—I was keen to accept it—about the annual report to Parliament, not least for transparency, because I do think there is a lot in being transparent to give confidence, but also to show where there are problems. I hope that people have seen that, as a Government, we have

not been shy to acknowledge where there have been problems, and then say what we are going to do about them.

Q282 Jen Craft: On this point, I think that the concern people have is competing priorities. What does good look like? What is the point at which the Secretary of State can look and think, "Community services are sufficient. We can switch this on"? And when do you think we will reach it? When do you personally think we will get there?

Chair: Can we have a succinct answer? Then we are moving on.

Caroline Allnutt: I cannot at this point answer your second point about when we will reach it, but as part of our implementation work, one of the key things we want to do is to work with people with learning disabilities and autistic people and groups representing them, to understand what good looks like and to co-produce that. I think that is really important.

Q283 Jen Craft: Does our not knowing when we will get there not leave the situation continuing in perpetuity?

Baroness Merron: No, because I think we are going to be constantly—and correctly—judged and assessed the whole way along. What I am trying to do is tread a line that says we will be open about dates; we will be open about where we are and where the difficulties are. We will be open about what the dates are looking like. I am just reluctant, sitting here—

Q284 Chair: I am going to stop you there. Thank you, Jen, and thank you, panel. We are going to move swiftly on. Before we do the next bit, because this is on the legislation, I had a family visit me last week. It was Dianne and Cyril from Oxford, and they have been campaigning for reform of the Mental Health Bill, as their son Leon committed suicide. The couple have argued his death was preventable and due to failings in care. The question I would like to ask you is this. What do you feel is the role of parents, and how should you measure success for the Mental Health Bill?

Caroline Allnutt: Specifically on the Mental Health Bill, there are lots of things that the Bill does that we think strengthen and reinforce family involvement. For one thing, we have at the moment—I will try not to get into too much detail—a rather archaic provision called "nearest relative". In relation to the person who is appointed to represent someone's issues once they have been detained, there is an automatic hierarchy and it may not be the person that they would have appointed, so we are looking to change that to give people choice about whom they can appoint. That person will be called the nominated person.

We are also placing a huge amount of emphasis on care planning and re-emphasising that the clinician needs to take into account both the patient's views and those of anybody that they designate either at the time or in advance, through an advance choice document, as somebody that should be involved in decisions about their care.

Looking more widely at the 24/7 model and what we want to do in community mental health services, I think better involvement of family,



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friends and loved ones is absolutely something that we should be reinforcing. I cannot remember which of the pilots it is, but I think there are case studies where people are able to access their own medical records and to give access to other people as well. When we know that it is sometimes difficult for people with severe and enduring mental illness to attend appointments when they should or to engage effectively, having supporting them somebody who has access in the same way to that information and can contact health professionals on their behalf is hugely important.

Q285 Chair: This is for a family who are watching on television and who are very distressed by what they have gone through. The next part of the question I would like to ask is, will you be assessing whether there has been a reduction in the number of suicides of people discharged into community care? Will you actually be assessing this?

Baroness Merron: First of all, I express my sincere condolences on behalf of us all to your constituents.

Q286 Chair: To be fair, the constituent is from Oxford; they are one of the constituents of the substantive Chair. But I actually met them, and it was heartbreaking to hear their story.

Baroness Merron: It would be. It cannot be any other way but heartbreaking, and I am sure that they appreciated your listening in such a difficult situation. Today is World Suicide Prevention Day, and it is important to say that every suicide is an absolute tragedy and that we recall that point. What was the question you asked? Forgive me.

Q287 Chair: The question was about assessing whether there has been a reduction in the number of suicides of people discharged into community care.

Caroline Allnutt: We do have data on that. Over the last 10 years or so, if I am right, I think the percentage of people who died by suicide who had been discharged within the last three months is about 13%, so it is a considerable number. We know that that time is a big risk.

Q288 Chair: You have highlighted 10 years. Is there a chart or anything that can be sent to the Committee so that we can see how the numbers have gone down over the years?

Caroline Allnutt: Yes, we can certainly write. We will probably draw on data from the national confidential inquiry into suicide as well.

Q289 Chair: As it is World Suicide Prevention Day, the last point I want to make, because I want to do the family justice, is will the Department be monitoring and reviewing cases of those who have fallen through the safeguarding gaps? Will you be doing any monitoring? How will you know that things have improved if there is no monitoring and if there is nothing going on to say, "This is what we have done to improve it"?

Caroline Allnutt: We have suicide data at a macro level, and we are improving that all the time. We now have near-to-real-time surveillance



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data on that, which has much improved our understanding because previously there has been quite a time lag in data being available. From the Department's perspective, we also have the prevention of future deaths reports that are provided by coroners after an inquest. They provide some very difficult and distressing but hugely important information about the reasons why people may have fallen through the gaps and what should be improved.

Q290 Chair: Just so that you know, and then I am going to hand over to Joe, the issue for this family, especially Dianne, who is listening now, was their son died, and from the day he died, everybody—all the medical professionals, everybody—seems to have just moved on. The family feel that they do not want this to happen to another family. We need to show that we are doing the extensive monitoring so that, first, we know what is going on; secondly, if it is going to happen it will happen; and thirdly, as much as possible, we are doing that preventive work. That is all I am asking.

Caroline Allnutt: I do send my very best wishes and thanks to the family for their ongoing commitment to make things better for other people in the light of their loss. We are absolutely looking at this, and as we have been discussing previously, I do think continuity of care within community services and then with specialist and in-patient services is absolutely vital in getting the right handovers of care and being very clear about who is responsible for people's care and who is doing the follow-up. I do not know the specifics.

Q291 Chair: I do not want you to. I am just saying that this is how families are feeling. I am just going on the back of what Jen is saying. They want to know that things will improve for the future.

Baroness Merron: Just yesterday, I had a meeting with a working group at NHSE, and one of its members is a father who lost his son. I have also met him personally to discuss exactly the areas that you are referring to, Chair—about how we drive down suicide rates, which is one of our commitments that I am very keen we work on—and the working group is actively looking at ways of working in all sorts of areas. The point raised about people being lost in the system is crucial. There are some very serious cases—as every one of these is—where the system perhaps did not always support, so there are some individual issues—

Chair: The system failed them; let's say it as it is.

Baroness Merron: Yes, indeed.

Chair: But, in the future, we want the system to have the mechanisms in place to ensure that these families are supported, so that they do not lose their loved ones. I have to move on, because that was an additional question—

Baroness Merron: Can I just say that those points are extremely well made, and that I share the views that are being expressed? I wanted to

say that because of those who I know are watching and looking for that from us.

Chair: Thank you. I will hand swiftly over to Joe.

Q292 **Joe Robertson:** How are you monitoring the impact of the end to the service development funding for community mental health services?

Gareth Harry: The money did not end; it got built into system allocations. All of the expansions of mental health services that were funded via that SDF moneys went into system baseline allocations last year, with some very small exceptions, such as the money this year for the expansion of talking therapies and of individual placement and support services to support people with severe mental illness in the workplace. So it was not that the SDF moneys stopped; they were built into baseline allocations. That was part of the wider approach to having less ringfenced moneys and for local systems to make local commissioning decisions.

Q293 **Joe Robertson:** So you would not accept any concerns that its ending could jeopardise progress in transforming community mental health services?

Gareth Harry: This comes back to the devolution of decision making to local systems, and their ability to make those local choices about where they choose to spend their allocations. There are still key levers available nationally, through things such as the planning guidance, for things that we expect local systems to deliver with their allocations. It has been a progressive set of decisions, over the last two to three years, to provide local ICBs with more ability to make decisions around their allocations and progressively fewer ringfenced budgets like SDF. However, the planning guidance still sets out key expectations for each system in terms of performance and delivery. That includes system transformation, such as—although this is not an example of what you are looking at today—mental health support teams in schools.

Q294 **Joe Robertson:** Given that it will now be local decision making on how to allocate and spend this money, there could be areas where the end to service development funding is exactly that, because of local decision making about how equivalent money is spent. Are you monitoring the impact at all, regarding local differences?

Gareth Harry: Local plans are all assured and agreed by the regional offices of NHS England. Any decommissioning decisions that might be made by local systems would be part of that annual planning process. Obviously, there would be a view given by an NHS England regional team to a system if it was seeking to make a decommissioning decision that did not make complete sense in terms of the overall transformation agenda. That sort of confirm-and-challenge and assurance process is a natural and well-established part of the agreement of local plans.

Q295 **Joe Robertson:** How do you deal with the wider issue that, in devolving decision making, you open up the possibility of a postcode lottery and a very uneven provision of services across the country?



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Baroness Merron: I understand the concern. I would suggest that it is a concern that has been there for many years. As an overall comment, what we are seeking is for standards to be provided for, but we in Government have to understand that it is local areas that need to be empowered because they are the ones that understand their local communities, and one size does not fit all. If the service was exactly the same everywhere, the areas of the country that are more disadvantaged than others would remain disadvantaged. I know that is not a case that you are making, but to me that is how it will all shake out.

In the Darzi review, Lord Darzi found that the health service was struggling with the fact that, often, where there was a problem, a target would be set. The fact that the target was never met, but created huge amounts of pressure, did not seem to figure. We have drawn that back. That is why the planning guidance that exists now is more streamlined, more reasonable and more enabling—that is the word I would use—so that local areas can actually serve their local populations. We have talked a bit about the modern service framework. That is for severe mental illness, but also other things such as sepsis, cancer and so on. So there are often other levers that can be used.

I want to emphasise that we are taking a very particular direction because of the evidence, because of Lord Darzi's review and because we need to ensure that the more disadvantaged areas and groups are more advantaged than they are currently. I understand the concern, but all the evidence points to making the change that we have made.

Q296 **Joe Robertson:** Can you confirm that local health systems will still be required to meet the mental health investment standard after this financial year?

Baroness Merron: I can tell you that, as I am sure the Committee realises, mental health is a priority for the NHS. The mental health investment standard continues in '25-26. I know that the Committee would not expect me to make a comment on financial matters in any area beyond that.

Q297 **Joe Robertson:** So there is no confirmation that local health systems will still be required to meet that standard? It is a concern if the Government cannot confirm that.

Baroness Merron: I understand that, but, again, I am speaking of the reality that the mental health investment standard is absolutely in place. We committed to that, and rightly so. But it is just a fact in all areas that funding arrangements are not finalised beyond '25-26. It is way above my pay grade to comment on that. I am not commenting on MHIS itself; I am just commenting more generally on financing.

Q298 **Joe Robertson:** It sounds as if devolution is also deregulation because targets disappear, and it is targets by which you measure success or lack thereof for local systems. If things such as the mental health investment standard are not being mandated to local health systems, that looks to me like devolution is also deregulation, which opens the possibility of an



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increasing mismatch in the quality of care across different localities.

Baroness Merron: That is why I feel that we need to look at the community mental health framework as a mechanism, to give just one example. I appreciate the view that is being put across. It not one that I or the Government share. If we look at the facts and figures—colleagues would be able to elaborate on this if required, or maybe we are going on to funding; I do not know—we will see that local spend on community mental health services alone increased to £3.3 billion in 2025-26, compared with £1.8 billion in 2018-19. That gives an example.

If I had to answer the point generically, I would say there is no attempt through the back door to do anything other than support mental health services. But we are seeking—and we talked about the word “transformation”—to transform the way in which they are delivered.

I should also say that the Government are keen—there has been, in many Governments, a huge focus on inputs of cash without looking at the results and whether those were producing what people needed; the fact is that we have seen they have not—and very concerned to measure what comes out of service provision. In other words, that is the difference it makes to all your constituents.

Q299 **Joe Robertson:** I hope the Government can take away, and be aware of, your wider point that freeing up local decision making to get things right for their area also gives freedom to get it wrong. When they do get it wrong, the Government, NHS England and the Department do not have the degree of control they once had to ensure that standards are met and, in some cases, this standard has been done away with altogether.

Baroness Merron: I would not accept that scenario, for the reasons we discussed earlier about what is expected and about service standards. At the outset I talked about enabling standards while allowing local areas to better provide.

My experience is that not just this Government, but certainly the last Labour Government over a number of years, and most Governments in the end—I know you did not exactly say this, Joe—find that to have, yes, a steering hand, but to run things from Whitehall has not been the way to provide for local areas. We are seeing the results now in what we are dealing with.

Caroline Allnutt: If you think about the levers for change—

Chair: We will have to leave it there, if you do not mind.

Q300 **Dr Cooper:** Hopefully this is a relatively short question around short-term commissioning cycles. Could you outline how you will or are supporting integrated care boards to move away from short-term commissioning cycles—which I hope we all agree are fairly damaging for long-term strategic planning across any health service—to multi-year contracts for VCSE organisations supporting the delivery of community mental health services? Could you also let us know what guidance has been issued to



facilitate that shift, which I hope is happening?

Caroline Allnutt: Absolutely. That is a really important point, particularly with the VCS and those local organisations that are so integral to providing mental health support and supporting the NHS, picking up a lot of the demand that the NHS cannot meet. We absolutely need to support them to plan ahead and maintain a financially sustainable position. That is something we want to think about as part of the 10-year healthcare delivery plan, in terms of a more sustainable commissioning structure—not just for mental health, but more broadly in the round. Gareth, do you want to say something?

Q301 **Dr Cooper:** Apologies, Caroline, but on the specifics—I appreciate that ICBs are moving to strategic commissioning, full stop—you are moving to multi-year commissioning for mental health services and VCS.

Gareth Harry: The planning round will require plans from systems for three years in terms of the finance element, and in terms of the delivery of the 10-year plan, a five-year plan. Local commissioning and contracting decisions will continue to be made by ICBs, but you would expect that knowing your allocations as a local system three years in advance would allow for that—

Dr Cooper: Multi-year commissioning.

Gareth Harry: Absolutely.

Q302 **Dr Cooper:** Perhaps, playing devil's advocate slightly, and I am reasonably sure that this will not happen, but if you had a rogue ICB that thought it was going to continue with the single-year funding commissioning—perhaps its books are not looking terribly good—what recourse would you have to step in and say that you were not doing that any more? How does that work?

Gareth Harry: That would come down to the plans that were being made by ICBs and submitted to regional teams, and the assurance of those plans.

Q303 **Dr Cooper:** So regional teams could say, "We are not signing that off—thanks very much."

Gareth Harry: There is still the ability to be able to do that—yes.

Q304 **Dr Cooper:** So there are some checks and balances, but hopefully they will not be needed. Following on from that, is the guidance that has been issued to facilitate this shift, and how you are supporting the ICBs, part of the broader strategic commissioning shift for ICBs?

Gareth Harry: It is part of that, but there has also been a recently published planning framework that has gone out to systems and providers. We expect there to be some sort of planning document that goes out to systems and providers—at the moment, we are expecting a date to be confirmed in early October—where the clear expectations about what providers need to be planning for over that three to five-year period will be set out.



Q305 Dr Cooper: That is helpful. Very quickly, how do you plan to resource the voluntary sector to participate in the development of neighbourhood mental health care? That is probably a large question, but just a couple of points would be great.

Gareth Harry: It goes back to previous answers, in that through the community framework investment, which was £900 million over the three years of that expansion—a significant expansion in community mental health teams—we saw local systems and providers funding voluntary sector partners through that approach and bringing those voluntary sector organisations into the multidisciplinary approach. At the same time, an awful lot of our crisis services are provided through the voluntary sector, commissioned by local commissioners. What we would see through the 24/7 model would be a continuation of that; those existing relationships and existing service models would be provided in the new way of working. That would be the plan.

From a commissioning perspective, we are continuing to encourage local systems—like Northamptonshire, for example, which has pulled together a mental health alliance whereby a single provider, in this instance the mental health trust, has the mental health budget local spend devolved to them—to then have an alliance arrangement. That is an agreement with voluntary sector partners and others at that local level about how they are going to jointly plan, commit resource and deliver services within the alliance framework. The devolution of local commissioning budgets to groups of providers where there is a partnership with the voluntary sector is something that we want to continue. I think that mitigates the risk that you talked about earlier on, Dr Cooper, in terms of the commissioning decisions being made by providers working together.

Caroline Allnutt: I know from talking to lots of local charities that the alliance model is very attractive, because it enables them to work more collaboratively. Instead of competing for small contracts, they can actually decide who is best placed to deliver what aspect of the total service. I should think that is much more effective for them and the patient.

Q306 Dr Cooper: Okay; that is aspirational, and it makes sense.

Gareth Harry: It is happening now in practice. It is happening in Northamptonshire and has been for three to four years, and it is happening elsewhere.

Q307 Dr Cooper: It is great for Northamptonshire. Coming from Sussex, it is definitely patchy, but I look forward to seeing it.

Gareth Harry: Understood. It is a model that we want to see encouraged—we want to encourage it.

Q308 Danny Beales: Good morning. Digital integration, digital interoperability and the sharing of patient data have been key challenges that we have heard about in our inquiry, and something that you have touched on already in terms of issues and learnings from some of the pilots. I want to press further on some of the specifics of what can happen in this space.

The 10-year health plan has committed to improvements in the shift from analogue to digital, the single patient record—as you have talked about—and a greater continuity of care. What specific improvements will we see in community mental health services in terms of digital integration and the interoperability of digital platforms between providers?

Baroness Merron: I will turn to Gareth to give the details to the Committee, but NHS England has been working with clinicians and service users—which I think is really important to do—to develop a new currency model. That model is referred to as the mental health and neurodevelopmental resource groups. It will help providers and systems plan, fund and improve their services in a more evidence-based way. I know that that is important in terms of data, and that there is more work going on around data submissions. We absolutely believe that we need to improve mental health data services and what is available to us, not least because of our focus on evidence-based interventions.

Q309 Danny Beales: Some of this is quite basic. We have heard about the multidisciplinary nature of mental health work. What you envisage from the community mental health hubs is going to be quite multidisciplinary. You have touched on some of that already. We have heard, for example, that 70% of social workers have basic, poor IT; there is an issue with the ability to access the internet for some professionals working in these systems. What, in practice, will get us to a digitally integrated community mental health service?

Gareth Harry: It will depend on local systems. Already, many local systems have been working around models of shared care records so that information within existing electronic patient records can be pooled and information shared at an individual patient level. That work is progressing and some areas are making really strong progress on it. That helps with some of that. In terms of basic access to IT, for colleagues around a multidisciplinary team, it will depend on local investment decisions about supporting it.

Q310 Danny Beales: There is no funding or guidance centrally to enable that for community mental health services.

Gareth Harry: There is certainly advice and guidance on how local community teams might be able to have workarounds and make best use of local electronic patient records for people who are not working for that organisation. Lots of organisations, for example, provide an honorary contract to people in other organisations so that the information governance works properly and people can have access to enter information—not only on a read-only basis, but by being able to input directly into electronic patient records.

Q311 Danny Beales: Is that looking at the voluntary sector as well? You talked about the local authority in terms of honorary contracts, but we have heard about the voluntary sector, which—as you have touched on already—is a crucial element in Somerset. Even in Somerset, this issue has come up as a major challenge. Open Mental Health in Somerset states that digital integration “is often a sizeable barrier” in many cases, and for



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smaller VCS organisations in particular.

Gareth Harry: There are two elements to that issue. You are absolutely right about Somerset. We have been working with Somerset quite closely to try to find ways of making it work. Some of the issue is around the access to records, which is what I referred to earlier. Some of it is the collection of information about the work that the voluntary sector is undertaking. In those instances, there is a role for local mental health providers to take on some sort of lead provider role, both for what I was talking about earlier on—alliance working—and by being responsible for the collection of data from the system.

Q312 Danny Beales: We have heard that, as you touched on regarding the local authority having a separate system, the voluntary sector will also have a separate IT system that is potentially quite underdeveloped and under-resourced. It will not have any permissions or ability to access NHS data because of those guardian-based issues. If they are a part of the healthcare system, they are not able to see continuity of care information, or access and upload patient information. As you say, if they are not recording, it is not counting—their activity and what they are doing—and the impact of it is not being valued in the system. There are a number of challenges that the voluntary sector have given to us. In these pilots, and in the Somerset example, are you looking at how to overcome that? It seems quite a crucial barrier to this community-based mental health model.

Gareth Harry: It is certainly being looked at in the neighbourhood model through the testing around that. How can the various providers involved collect that information in an easier way? There are workarounds but they are very clunky, and I accept that.

Baroness Merron: The observations that you make are absolutely right: when it comes down to basics, people who are not IT literate will not be able to be part of the system and support people, but if we are to get the efficiencies through teams and partners working together around the patients and shared patient records, it has to be on a digital basis, absolutely. One of the things that we all know people complain about, and rightly so, is that they have to tell their stories over and over, either for themselves or for the person they care for. It is not acceptable. Not just that, but it reduces the quality of care.

Q313 Danny Beales: Definitely. Localism is important, but there is also efficiency—I think that was the word I just heard. If you find ways that work, you do not necessarily need to see 100 ways of working around the digital barriers that might be present, particularly when you are piloting something that demonstrates to the system the way forward for the roll-out of community mental health services in every area, rather than asking them to solve the problem again and again for the sake of localism, as the NHS often does.

Baroness Merron: We would rather deal with it. Perhaps I can also throw in the word “productivity”. That is hugely important. The requirement in

the planning guidance is to improve productivity by 4%. Part of that is absolutely about digital optimisation. It cannot be done without it.

Q314 Danny Beales: Would you say that you are confident that the pilots will be able to show a way forward for digital integration and interoperability for the roll-out? Are you confident that the learnings from the pilot will quite clearly demonstrate how, on roll-out, we will solve these problems?

Baroness Merron: Let me put it in my language. I think that, without that, it is not going to be possible to deliver what we have talked about delivering in a neighbourhood way, or around the patient. In other words, it is so fundamental that it is not a matter of “keep patching up”. Yes, that is being dealt with.

Caroline Allnutt: We have six pilots, but we also have 15 associate sites, so we are developing a strong community of practice that can share ideas and hopefully, as we move to evaluation and then roll-out, share solutions as well.

Q315 Danny Beales: Digital and data will be a key part of that evaluation piece, in terms of the pilots and the associate sites.

Caroline Allnutt: Yes.

Baroness Merron: Also, I mentioned at the beginning how we brought forward today the availability of e-learning for suicide prevention. That is a digital training solution that goes beyond just those in mental health services, on the basis that most people who take their lives are not in contact with mental health services.

Q316 Danny Beales: That is really welcome, Minister. I have met with Samaritans, who highlighted that many frontline workers and emergency services workers do not have mandatory training around suicide prevention and dealing with suicide. I have met paramedics and Metropolitan police staff who have had no training in how to deal with suicide and suicide prevention—fortunately, they have prevented suicides, but they had no training. It is welcome that the Government are rolling that out. I hope that it will be available to all frontline emergency and blue light services. Is that the case?

Baroness Merron: It is, but it actually goes beyond that. The fact that it is e-learning makes that possible. It is also for third sector organisations and other workers who are not necessarily the frontline workers to whom you refer.

Q317 Danny Beales: That is welcome. I hope that the Government will provide some guidance to public sector organisations to enable staff to have the time to do that.

Last, I have a slightly different question about data; it is about the quality of data. I recently met an organisation to discuss people in the health and mental health system who are homeless. Particularly in regard to mental health, many people are in insecure accommodation or homelessness situations of different sorts. The organisation pointed out that there is



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currently no consistent recording of people's homelessness status in the health and mental health system, although there is now an agreed definition in the NHS data dictionary and codes associated with homelessness. The inconsistent collection of this data from patients at mental health trusts and acute trusts is preventing us from understanding the full nature of the problems in readmissions, discharge issues and ultimately the very poor outcomes, such as premature death, that these individuals face. I think one mental health trust is potentially implementing this. Do you think there is a case for the consistent application and recording of homelessness for patients in mental health settings? If you are not sure, perhaps you can take it away and consider it.

Baroness Merron: That is a very relevant factor. In fact, I was just thinking about a visit that I made when I talked about that. I am sure that Committee members are familiar with the South London and Maudsley Trust and its work. It had what I would call a multidisciplinary team that worked with those who were homeless, because it also recognised that it is not just about mental health services.

Danny Beales: One of the Pathway teams is there.

Baroness Merron: I was deeply impressed by that and, from talking to those who had used that service, by the impact it had made. You are absolutely right that being homeless is a major factor, and it must be recorded.

Q318 **Danny Beales:** Those Pathway teams have a major impact, but one of the challenges in the health system is that there just is not consistent recording of whether individuals in settings are homeless or not.

Caroline Allnutt: It is not an issue that I have come across, but I will definitely look into it.

Baroness Merron: We will find out.

Q319 **Danny Beales:** You might consider how we might collect that data in mental health services. As we all know, if people are not counted, they are not taken into account when it comes to service decisions. Whether or not those Pathway teams get recommissioned is crucial.

Baroness Merron: You are absolutely right. We will dig into this a bit more and come back to you.

Gareth Harry: The wider point you make about data quality and the completeness of information is absolutely crucial to the future of mental health services.

Chair: Before we go any further, we are running a little bit late—the questions have been very rich today. So that my last two colleagues are not cut short, can you stay for 10 minutes over?

Baroness Merron: Of course; I hope that the answers are as rich as the questions.



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Q320 Andrew George: I hope we will have some rich answers; I do not know about the questions now. On the theme of lessons learned, and on the back of an earlier question from the Chair, we can learn lessons from successes like Trieste and the pilots, but we can also learn from the not-so-good examples, the failures and where things go wrong.

On that theme, I also want to talk about a tragic case. In my constituency, Sally Poynton was murdered by her schizophrenic son in 2021, after three years of pleading for help for him. Since that time, the family has wanted not to scapegoat or point fingers at individuals but to learn lessons, or to make sure that lessons are learned from where things went wrong in that case, so that the service is improved. Although the coroner's report was very clear on the matter, the family has been met with heavily redacted reports and obfuscation, and the severe incident reports have not been as clear and open as they perhaps should be, particularly given that the duty of candour should be applied to the NHS.

First, I seek your support in cases where the families want information. One understands that patient confidentiality and data protection mean that things cannot go into the public, but surely the direct family can have such information, even if it has been redacted from the public. Is that not right? Can we not acknowledge that families are entitled to learn lessons from very tragic cases such as this?

Baroness Merron: First of all, I offer my condolences to Sally's family. Sadly, this is not a lone case, as we know. The lessons learned point is absolutely crucial. I very much understand the need to support and inform families who are affected by a situation such as the one you just described, which is a complete tragedy. I hope the Committee is aware that this Government are very committed to the duty of candour. The issue about confidentiality makes it difficult for me to comment on the specific case, but you are very welcome to raise the details with me to look into, Andrew, because there is a whole range of things.

My main point is that in tragic situations such as that, there are many angles, and the family must not be overlooked—indeed, they should be very much part of how the situation is dealt with. I know that has not always been the case, but they all vary. Sometimes, information is withheld for reasons of confidentiality, perhaps about staff. I am talking very generally, but I would be pleased to look into the specific case.

Caroline Allnutt: I would not add much more, except obviously to extend my condolences for that very sad case. There are very tricky legal issues around confidentiality, which are very specific to each case. What is really important is that mental health trusts should be open to discussing this with families and should play a really important ongoing role. That is partly in terms of that restitution process—helping the families come to terms with what has happened in some small way—but also, incredibly importantly, helping where people want to see change and to protect others from having to go through what they have. From the trust leadership down, there definitely needs to be a culture where people are not afraid that those kinds of discussions might leave them open to risk or

anything like that. That is hugely important in the way that they conduct their services and embed learning in what they do.

Q321 Andrew George: Thank you for that response—that is much appreciated. Maybe we could take this up, Minister, separately outside this meeting.

Moving on to the workforce, you mentioned earlier the 8,500 additional mental health workers coming into the system. There is a severe shortage of staff within community mental health services. That is evident and has been very clearly documented—probably in that sector more so than elsewhere within the NHS. Rather than waiting for the publication, I think next year, of the revised workforce plan, can you say any more about what you are doing now? Presumably, there is nothing that you are going to say next year in the workforce plan that you cannot say now about how you are going to fill the enormous gaps and vacancies in the service?

Gareth Harry: Certainly, in terms of retention of staff, providers are doing an awful lot of work, with support from NHS England and from systems working together around improving working lives and making retention a key priority. That will certainly help with vacancy rates. The wider financial pressure that many systems and providers are under this year is resulting in quite significant cost improvement programmes, in which vacancy management may play a part. Expansion of workforce may be being impacted by those cost improvement programmes that providers are having to implement. That is the issue of vacancies.

Of course, in many mental health services we have really quite vigorous and rigorous minimum staffing levels, such as on in-patient wards, where there is a very clear expectation about the number of people you have in a particular ward.

Q322 Andrew George: Safe staffing ratios, you mean?

Gareth Harry: Well, minimum numbers of qualified staff on an in-patient ward. In mental health services, that is set out.

Baroness Merron: It is probably worth saying that, although you are absolutely right about the challenges, there has been some progress. It might be helpful if Caroline makes some reference to that for you.

Caroline Allnutt: In recent years, we have seen quite a big rise in the number of mental health FT workers. At the end of March this year, 160,000 people were working across core NHS organisations. That does not account for wider voluntary sector workers, for example, who play a hugely important role.

Q323 Andrew George: And what is the target number?

Caroline Allnutt: We do not have the target at the moment, but I think there is about a 15% vacancy rate in community mental health services. That is significant.

Q324 Andrew George: So if you had a target, it would be something in the region of another 15% on top of that number. Have I got that wrong?

Baroness Merron: You are tempting us to set a number. We will resist, but thank you.

Gareth Harry: This comes back to our other challenge across the NHS system in terms of productivity and it being less about the number of people you have than freeing up the ability of clinicians to be as patient-facing as they possibly can and investing in technology to enable different ways in which people can receive services. There is also the use of AI to support the collection of records to free up clinical time to face patients. It is not a measure of success to have a massive future growth of workforce; we want more people to be seen and to get the treatment they need.

Baroness Merron: Capacity, productivity and delivery are what matter. I am not avoiding the need, but we are keen to release people to do their jobs. A number of people struggle with that currently, as you will well know.

Caroline Allnutt: At the risk of sounding aspirational again, I do think that the 24/7 pilots offer a real opportunity for staff to enjoy what they are doing and to do the job that they wanted to do. Hopefully, we are cutting down on the number of handovers and internal referrals, working more with patients in a holistic setting and not having to be gatekeepers all the time, which is very soul-destroying for people.

Q325 **Andrew George:** You mentioned 15 associate pilots. Do we know where those are? Can you provide us with a list?

Baroness Merron: We will happily provide a list, of course.

Q326 **Andrew George:** That would be really helpful.

Finally, social workers were not included in the workforce plan, yet they are clearly essential in the workforce that you require. What are you going to say about them? First, will you make sure that social workers are included in the workforce plan? Secondly, what plans do you have to ensure that there are enough of them and that they are properly supported?

Caroline Allnutt: That is a really good point. In some of the pilot sites that I visited, mental health social workers are part of the multidisciplinary team; it is excellent that they have direct access there. In our plans to reform the Mental Health Act, the role of the mental health social worker is really key. They have very important statutory duties but also a really key role in thinking about prevention of detention and what happens to people when they come out. As part of our overall workforce planning, we absolutely need to think about the role of mental health social workers as well.

Chair: Let us go straight over to Josh. Jen, if you are still here you can do your statement after that. Over to you, Josh.

Q327 **Josh Fenton-Glynn:** I am going to talk about the integration of mental health services, which is key to making this work. The LGA and ADASS submission says that "the Community Mental Health framework has



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identified what is needed—locally based, co-located services that are accessible to all at a point in their journey that is right for them.” We saw that in Trieste. What are we doing to provide that? Is that part of the 24/7 neighbourhood pilots?

Baroness Merron: If I understand the question correctly—please correct me if I do not—that is exactly what the neighbourhood health provision, the centres that we have been talking about, are providing. That is the way we are going. Also, the 10-year plan has been clear that a neighbourhood health service generally is a new preventative principle and also a new principle of how we better provide care. The whole thrust of the NHS is that way, but we have a specific working example, as we have been discussing.

Q328 Josh Fenton-Glynn: We are aware that prevention is key to our future plans, and that is what we are looking for. We are aware that we must ensure that access to services, which is less likely for people with SMI, is supported. We also know that people with severe mental illness have five times higher rates of liver disease, 4.7 times higher rates of respiratory disease, 3.3 times higher rates of cardiovascular disease and two times higher rates of cancer. Thinking about the shift to prevention from cure, my question is: why was the decision taken to remove the targets for physical health checks for people with severe mental health illnesses in the 2025-26 planning guidance?

Baroness Merron: I go back to my earlier comments about the planning guidance as a result of Lord Darzi’s review. He found that there were too many requirements within the planning guidance—too many targets, often not being met. What matters more is what I would call the results. I feel that the area to which you refer is really important, but my question, not to you—I am just throwing it out there—is whether having it in the planning guidance made a difference. It seems that it did not, so we would do better incorporating it in a different way.

When we talk about people with severe mental illness, there is also the issue of whether they are in contact and whether they are presenting. Joined-up services will certainly help, but the question is whether just having it in the planning guidance would deliver the result, and as I said, it does not seem so. That is not a comment on how important the point is.

Q329 Josh Fenton-Glynn: I take that on board. When I was in local government, we co-located some of our wound clinic work with our drug outreach, so a lot of these things make sense. I just worry that we seem to be saying that the last Government missed a lot of targets so, to solve that, we are not going to have them.

Baroness Merron: If I am sounding like that, that is not what I wish to sound like. However, if there is a problem, the answer is not necessarily just to set a target, because we know how many targets were not achieved. That is my point.

Q330 Josh Fenton-Glynn: I get that, but I also think that we have targets to hold ourselves accountable. How will you hold yourself accountable to



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make sure we are picking up the other co-morbidities?

Baroness Merron: You are absolutely right. Gareth, do you want to comment on how we do that?

Gareth Harry: On the point of targets, in general when the mental health sector has been a target historically, it has done very well against it. We can look at our performance—

Q331 **Josh Fenton-Glynn:** So why are we getting rid of them?

Gareth Harry: As the Minister said, the decisions that were made around agreements with primary care about what was reasonable, in terms of the targets on primary care and the range of primary care targets that GP practices were having to meet, were obviously something that primary care and GP practices were very concerned about at the time, and they were listened to.

In terms of the wider, new approach to making sure people are getting the physical healthcare that they need, there are two or three things that we need to be doing. The first is ensuring that access to primary care is absolutely part of the neighbourhood model, and that the relationships are really strong between local primary care networks, local practices and the new centres, just as they should be and must be with the existing community framework.

Secondly—this is a similar case for people with a learning disability and autistic people—it is about making sure reasonable adjustments take place in physical healthcare to take account of people's needs at the point at which they need physical healthcare, whether that is through accessing emergency departments or planned care when they need it.

Q332 **Josh Fenton-Glynn:** You have demonstrated the need. I am still not entirely sure what our mechanism will be for ensuring that the need is met, and how we will hold that service accountable to that.

Caroline Allnutt: One observation: we have these modern service frameworks for physical health, and one of the key tasks of my team responsible for mental health is to work with people producing those, to think about how the interventions that they express can incorporate the needs of people with SMI, people with a learning disability, and autistic people. I do think that that provides a good opportunity and, as Gareth says, I completely agree about the neighbourhood mental health model providing a mechanism by which mental health is everybody's business. Mental health practitioners should be thinking about the physical health of the people they see, because we know that there is so much interdependency between those two things.

Q333 **Josh Fenton-Glynn:** The word that makes me anxious in what you just said is "should"—you did not say how we "will" do these things.

Baroness Merron: I do not know whether it will provide any reassurance, but as Caroline was saying and I mentioned, the development of the modern service framework for certain areas, including for severe mental



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illness, is a very strong opportunity to do, I would hope, what you are talking about. Yes, the point is very well made about what is lacking, and what we have to do, as well as adapting to individuals with particular needs—who could come in all shapes and sizes, obviously—is also to embed it. My guess from what you are saying is, it needs to be embedded—that joint look at somebody. I would totally agree, and that is how the service will develop, but it is not in that place now. The point is right. I will ensure, as they are developing the framework, that we look at this point very much. I will be very pleased if you would like me to come back to you; of course I will.

Q334 Josh Fenton-Glynn: In 2018, the Department for Health and Social Care said that two in three deaths of people with SMIs from physical illnesses could be prevented. Are we going to do an exercise to try and get that number again? That was 2018, the last period we have numbers for. At what point do you expect that number to reduce?

Baroness Merron: I can't give a specific on by when it will reduce; but I can say that, by linking up the services in the way we have described, it will reduce. The problem is people being in one bit of the system but not in another, and that is exactly not the way we want the NHS to be—in fact, the opposite. We know that that approach delivers improvement, in the way we have talked about. Whilst I cannot give you an exact figure—I understand why you seek it, by the way—I can tell you that the whole direction, as I hope we have demonstrated, is to improve the situation that you refer to and, as I said earlier, this is about seeing the patient as the whole patient. If we are to achieve parity on mental health, that does mean including physical health in the care, treatment and support.

Chair: Jen will ask the last question.

Q335 Jen Craft: Earlier, we were discussing the Mental Health Bill and the provisions around learning disability and autism. There are currently—this is happening today—people with a learning disability, such as Down's syndrome or autism, that are being detained, sometimes for years on end, in mental health units that are unsuitable, purely because of their disability. It is completely unacceptable—mainly because we have completely failed them as a society. Can we confirm to the families of these people, and these people themselves, that by the end of this Parliament those provisions in the Bill will be switched on, so that they have some hope and have some light at the end of the tunnel?

Baroness Merron: I understand the reason for the question. Regarding the families you are referring to, Jen, for me, it is about not just the Mental Health Bill; it is about what we are doing now and what we can do now.

Gareth Harry: You are right. In the meantime, we are continuing to do everything we can to support local systems and providers around reducing length of stay, particularly for people with learning disabilities and autism who are clinically ready for discharge, and for whom staying in the hospital is currently not offering any therapeutic benefit. There are some people



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who will be getting therapeutic benefit from being in a hospital setting, but there a high number of people who are not. We are continuing to work with systems and providers to get people discharged and get community packages in place to support them, including capital to build permanent homes for people.

Q336 Jen Craft: This is great. It is just that the provisions in the Bill are there for a reason. They are there because we think it is completely immoral that someone with a learning disability can be detained purely because of that. Will we end it by the end of this Parliament? Will it be illegal as well as immoral?

Baroness Merron: That is exactly what the Mental Health Bill does: it puts an end to that.

Jen Craft: But that will not be switched on until things are ready.

Caroline Allnutt: Until it is safe to do so.

Baroness Merron: I want to add another concern that I have, which is why I was thinking about ongoing work. There is a group of people who are already in a situation where their individual circumstances need to be assessed as to whether they are in the right place. In other words, that should not need to wait for the Bill. That is what we are talking about now.

Q337 Chair: Baroness Merron, I am going to intervene, because we are over time. Is it yes or no? Will it be switched on or not?

Jen Craft: Will the provisions in the Bill be switched on by the end of this Parliament?

Baroness Merron: When the community services are in place.

Q338 Jen Craft: Will that be by the end of this Parliament?

Baroness Merron: Thank you, because you have given me the opportunity to say this. I was talking earlier about indicative timelines, and I was being open with the Committee about how we will update Parliament regularly about timelines, progress, what needs to be done and so on. Sitting here at this moment, it would be wrong of me to give something exact, but I am trying to give reassurance about the situation you refer to.

Chair: We are happy for you to write to the Committee with an answer to that question, so we know whether the provisions that are in the Bill already will be switched on. To be fair on Jen, this is something she is really passionate about.

Baroness Merron: It is key and absolutely right.

Chair: On that note, we will have to end today's session. I thank you all so much, not just for coming, but for staying over for the community mental health services inquiry. This is our last session, and it has been really full and fruitful.