House of Lords
House of Commons

Joint Committee on Human Rights

Legislative scrutiny: Mental Health Bill: Government Response

Third Special Report of Session 2024–25 HC 1217

Joint Committee on Human Rights

The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases); proposals for remedial orders, draft remedial orders and remedial orders. The Joint Committee has a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

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Publication

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Third Special Report

The Joint Committee on Human Rights published its Third Report of Session 2024–25, Legislative Scrutiny: Mental Health Bill (HC 6HC 601 / HL Paper 126), on 19 May 2025. The Government response was received on 8 July 2025 and is appended below.

Appendix: Government Response

Thank you for your Committee's report following its scrutiny of the provisions of the Mental Health Bill ("the Bill"). We are pleased that the Committee welcomes the direction of travel of the Bill's reforms and notes that this legislation represents a 'very welcome attempt to bring the legal framework up to date'. We also welcome the Committee's constructive challenge, and note the proposed amendments. The Government has carefully considered the Committee's findings and our response is set out below:

Background to the Mental Health Bill and the JCHR's scrutiny

Committee View

It is crucial that any process of reform to mental health law hears from individuals with direct, personal experience. We welcome the Bill's proposal to introduce a requirement to offer de-briefing to mental health patients after they have left hospital, so that personal experience can be learned from in future.

We urge the Government to support the retention of this amendment as the Bill progresses through the House of Commons.

Government Response

We agree that the voices and experiences of people who have come into contact with the Mental Health Act (MHA), either directly or through a relative or friend, must be at the heart of the reform process. This has been the approach taken throughout.

However, we do not feel that there is a need for an additional legislative mechanism for gathering the views of people who have been in hospital after they have been discharged, as proposed by the amendment. There are already a range of feedback systems, both locally and nationally, aimed at monitoring patient experience and supporting service improvements. Whilst some of these feedback mechanisms may not always be working as effectively as they could, we would prefer to focus on improving on what we currently have, rather than creating something new and risk causing confusion.

We also have concerns about the practicalities of delivering this amendment. Independent Mental Health Advocates currently have no formal role in relation to people who have been discharged from the MHA and are living in the community (not including those who are subject to a community treatment order). Therefore, arranging to consult with individuals post discharge would require new systems to be put in place and significant additional resource. Advocates have also warned that a potential unintended consequence of this amendment is that patients no longer consider advocacy services to be truly independent and impartial, as they are effectively acting on behalf of the hospital to collect feedback. The amendment could therefore negatively impact the advocate's ability to perform their core role, which is to represent and support patients whilst they are subject to the MHA. Trusted relationships between patients and advocates are critical for this to be effective. For these reasons we are rejecting the Committee's recommendation to keep the amendment in the Bill.

We recognise that a key objective of this amendment is, not only to provide feedback on inpatient services, but to create a space for the person to reflect on their detention such that they can heal from a potentially traumatic experience. Where a person has past experience of detention or admission as a voluntary patient we would expect this to form a key part of the process of making an Advance Choice Document, with the facilitation of an appropriately qualified professional. However, we think that this should be user-led and not mandated by the supporting health or care professional, as many individuals may find it traumatic to reflect on their past experiences.

We do not consider Advance Choice Documents as the only opportunity for people to reflect on their experiences following their discharge. As set out in the Community Mental Health Framework, every person receiving support, care, and treatment in the community should have a co-produced and personalised care plan that takes into account all of their needs, as well as their rights under the Care Act and Section 117 of the Mental Health Act, where applicable. The care plan should include agreed timescales for review, discussed collaboratively at the outset. Reflective discussions between the individual and clinician are essential to understand what is working well and to ensure care remains responsive and personalised.

We think that these forums provide a more therapeutic space for reflecting on past, potentially traumatic experiences, rather than coupling it with a feedback mechanism for making inpatient service improvements.

Detaining autistic people and people with a learning disability under the Mental Health Act

Committee View

There is an inherent lack of justification for detaining a person for treatment based only on their learning disability or autism, giving rise to clear concerns over compatibility with Article 5 European Convention on Human Rights (ECHR). We welcome the Bill's attempts to remove autistic people and people with learning disabilities from the scope of detention for treatment under the MHA. We recognise that the change in the law would leave open a possibility of these groups being detained on other grounds.

We are pleased to see that the Government has committed to monitoring the number of autistic people and people with learning disabilities who are detained under the Mental Capacity Act. The Government should report these numbers to Parliament within a year of the relevant clauses of the Bill coming into force, and stick to their commitment to take action if they indicate that the Mental Capacity Act is being used inappropriately.

Government Response

The Department has been clear that we do not want to see people detained in hospital through alternative legislative routes, where this is not appropriate. We therefore do accept this recommendation in part. Through

the national Assuring Transformation dataset, NHS England currently collect data on the number of people with a learning disability and autistic people in inpatient settings under different legal frameworks.

As the Committee has noted, the Government has committed that ahead of the changes to Part 2, Section 3 we will monitor and publish data on the number of detentions of people with a learning disability and autistic people under the Mental Capacity Act and will include a line on this in our standard publications. As part of standard practice to avoid risk of disclosure of personal information, any figures below five would be suppressed in publications (represented with an asterisk). Should detentions rise to five or more in future, we will publish the number rounded to nearest five.

If there is evidence of inappropriate use of the Mental Capacity Act, action will be taken. This must be tailored to and informed by the data and intelligence from local areas.

Committee View

While the evidence we have received supports the view that rushing implementation of the Bill could undermine efforts to improve the treatment of autistic people and people with learning disabilities, we also note that the implementation of other substantial changes in the law in this area have suffered from excessive delays. Most obviously, the Mental Capacity (Amendment) Act 2019, which provides for the replacement of Deprivation of Liberty Safeguards (DoLs) with Liberty Protection Safeguards, has still not been brought into force. An uncertain target of implementation "where there are strong community services in place" provides little reassurance. Those affected have already waited a long time for this reform and the Bill must not be allowed to lie fallow.

We therefore welcome the Government's commitment to provide a Written Ministerial Statement to both Houses of Parliament on an annual basis, updating on progress on implementation.

Government Response

We are pleased that the Committee welcomes our commitment to report annually on the implementation of the Bill post Royal Assent, until such a time that the Bill is fully implemented. This annual report will include details of the work done over the preceding 12 months to implement this legislation, and plans for how we will implement the next phases of the MHA going forward.

Implementation plans will need to be carefully considered alongside future Spending Review decisions and wider related reforms. The Department will engage with expert stakeholders to inform implementation planning, including in respect of development of strong community services.

Committee View

The detention of autistic people and people with learning disabilities under the MHA is a significant human rights concern. Detention in the absence of individualised, therapeutic treatment risks violating the Article 5 ECHR right to liberty and may even result in degrading treatment contrary to Article 3 ECHR. We welcome the Bill's change in the threshold for detention, which should make detention less likely for everyone, including those who are autistic or have learning disabilities. We also share in the general welcome given in the evidence we received to clause 3 of the Bill, which would prevent autistic people and people with learning disabilities from being detained under section 3 of the MHA on the basis of their autism or learning disabilities. However, this change will be of limited benefit unless the Government also commits to invest in community services for autistic people and those with learning disabilities– both in respect of care and housing.

Government Response

While we cannot pre-empt future funding decisions that are subject to the ongoing Spending Review process, we recognise the importance of strong community services to support people with a learning disability and autistic people.

The Bill introduces a package of measures to help improve community support for people with a learning disability and autistic people which includes putting Care (Education) and Treatment Reviews (C(E)TRs) and Dynamic Support Registers (DSRs) on a statutory footing and placing duties on Integrated Care Boards (ICBs) and local authorities when exercising existing commissioning duties. C(E)TRs make recommendations about the patient's needs for social care, special educational provision where relevant, and medical treatment. Relevant bodies must have regard to these recommendations, which means they must be considered and given appropriate weight in decision making. DSRs enable commissioners to identify adults, children and young people with a learning disability, autism or both who have risk factors for detention. They must then have regard to information on the register when exercising relevant commissioning duties and seek to ensure the needs of these groups of people can be met without detaining them.

For the 2025/2026 financial year, there is continued NHS funding within ICB financial allocations for people with a learning disability and autistic people. NHS England has said that ICBs should continue to invest in reducing reliance on inpatient care for people with a learning disability and autistic people in line with the 2025/26 NHS Operational Planning Guidance.

Committee View

To help ensure that mental health needs are properly identified before they reach crisis point, we recommend that the Government considers introducing an English equivalent to the right to a mental health assessment that appears in the Mental Health (Wales) Measure 2010.

Government Response

Support in the community is crucial, but we do not agree that a new dedicated right is the best approach to achieve this. We are concerned that introducing a statutory right would bring practical and delivery complications, with the NHS already being free at the point of use.

The right to healthcare already exists – it is in the NHS Constitution, which is clear that the NHS is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It provides people with the right to access NHS services, to receive care and treatment that meets their needs and reflects their preferences, and to expect the NHS to commission and plan the services to meet health needs as considered necessary.

We are piloting neighbourhood mental health centres to improve access to timely and appropriate care. These pilots will co-locate services and assign a named professional to oversee each person's care. This will provide 24/7 open access and direct referral routes, reducing the need to navigate complex pathways. Staff will provide immediate support and connect individuals to the right care without unnecessary delays. Joint clinical management and neighbourhood-based oversight will ensure care is continuous, accountable, and responsive to individual needs.

Committee View

We recognise the risk that permitting detention on the basis of autism or learning disabilities under Part 3 of the MHA whilst prohibiting it under Part 2 amounts to a difference in treatment falling under the prohibition on discrimination in Article 14 ECHR. Nevertheless, we share the views expressed to the Committee that, currently, given the alternative for these patients is likely to be detention in prison, this difference in treatment

appears justified. This is not, however, an adequate long–term solution. Once again, greater support to autistic people or learning disabilities in the community is needed to divert them away from the criminal justice system.

Government Response

We welcome the Committee's agreement with the government's approach and recognise the concerns expressed. For a person with a learning disability or an autistic person in the criminal justice system, hospital may be a more appropriate environment to ensure that offenders and defendants are able to access the specialist support they need. Where admission to a mental health hospital is necessary to meet the person's needs, their care must be person-centred and high quality.

For those who are detained under Part 3, the Ministry of Justice and the Department of Health and Social Care are committed to working together to ensure the prison estate meets the needs of people with a learning disability and autistic people, and that knowledge of best practice is shared amongst staff.

However, we also recognise the importance of avoiding inappropriate detentions for anyone with a learning disability and autistic people and expect local systems to continue to build on the work they have undertaken over the last decade to improve community crisis services and community forensic support for people with a learning disability and autistic people, alongside wider measures in the Bill itself and as we plan for implementation.

Interface between the Mental Health Act and Mental Capacity Act

Committee View

It is disappointing that the Mental Health Bill has not taken the opportunity to provide greater clarity to the interface between the Mental Health Act and the Mental Capacity Act and to make clear when detention and treatment under one or the other should be authorised. In a legislative scrutiny inquiry like this one, we are not in a position to conclude which of the possible alternative approaches to the interface between the Mental Health Act and Mental Capacity Act would best provide the necessary human rights protection.

The Government should, however, carry out an urgent review of the interface between the Mental Health Act and Mental Capacity Act and take prompt action to provide the clarity that is currently lacking.

Government Response

Both the Mental Health Act and Mental Capacity Act provide appropriate procedural safeguards to ensure that the individuals Article 5 human right to liberty and security is protected during their detention. The nature of the safeguards provided under the two Acts are however different.

We note the concerns raised regarding the complex nature of the interface between the Mental Health Act and Mental Capacity Act and recognise that in some cases, this may present challenges for decision makers.

We will provide guidance on this in the Mental Health Act Code of Practice. We will engage with stakeholders to understand what support and guidance could help clinicians when deciding which of the two Acts must be used or where there is a choice, is most appropriate for individual patients as part of our consultation on the new Code of Practice.

We have committed to keep the interface and the matter of fusion legislation under review.

Children

Committee View

While the recent Government amendment to the Bill, introducing a review of notification requirements in respect of children on adult wards represents a welcome acknowledgement that the status quo may not be satisfactory, it does not guarantee the prompt protection for children's rights that we have heard is needed.

We agree with submissions made to us that the Mental Health Bill could and should do more to protect against children being placed on adult wards. The Bill should be amended to include a requirement that a child should not be placed on an adult ward unless that placement is demonstrably in the child's best interests. We propose an amendment to this effect (see Appendix). The Bill should also go further than a review of current notification requirements. It should require the provider to notify the CQC within 24 hours of any child being placed on an adult ward.

Government Response

The MHA already includes provisions regarding placing children on adult wards. It is clear that hospital managers must ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). These circumstances require careful consideration and nuance. Further guidance, will be set out in the revised Code of Practice (subject to consultation), and this will include guidance on how to determine the circumstances in which it is in a young persons' best interest to be treated in an adult ward. It is important that the legislation retains sufficient flexibility for individual circumstances, and emergency situations.

Currently, it is a legislative requirement to notify the CQC if a child is placed on an adult ward for longer than 48 hours. As the Committee are aware, in the House of Lords, we amended the Bill to introduce a statutory commitment to review whether regulations should be extended to require notification to CQC in relation to other incidents where a child in hospital is being treated or assessed in relation to mental disorder, and whether the 48-hour time period remains appropriate. A report of findings will be published in Parliament within two years of the Bill being passed. Whilst we welcome the Committee's view, we think it is important that we test options with a range of stakeholders.

Committee View

We recognise the special importance of advocacy services for children, who may face particular difficulties in understanding and enforcing their legal rights when separated from their families. Independent advocates represent an important method of ensuring the child's right to be heard, guaranteed by Article 12 UNCRC, is respected.

We welcome the introduction of an "opt–out" system in respect of independent advocacy but call on the Government to ensure that this system extends to children who are informal patients as well as those who are compulsory patients.

Government Response

We appreciate that many mental health inpatients under 18 are informal patients and that advocacy plays a vital role in supporting choice and the person as an individual. The Bill already extends the right to an independent mental health advocate to informal patients, and this includes children and young people. It also places a new duty on hospital managers to inform them of this right. This means that hospital managers will be expected to

proactively approach all patients, including children and young people, and others such as their parents or carers, to make sure they know that they are entitled to an advocate and help them to appoint one. Extending the opt-out model to informal children and young people who are in hospital informally would have cost and capacity implications. We have prioritised this for compulsory patients who are under greater restrictions and so are likely to need higher levels of support from advocates.

As independent mental health advocacy services for informal patients will be a new requirement, we will also be describing in the revised Mental Health Act Code of Practice the new role for these advocates in relation to informal patients. This will include in relation to vulnerable inpatient groups such as children and young people, people from ethnic minority backgrounds, and people with a learning disability or autistic people.

Committee View

We agree with witnesses that children under 16 may be denied the opportunity to benefit from the rights provided by the Bill if their ability to make decisions for themselves is not properly assessed. Clarity in such assessments is therefore important.

We support the call from the Joint Committee on the Draft Mental Health Bill for the Government to consult on the introduction of a statutory test for competency, or "child capacity", for children aged under 16.

Government Response

It is our assessment that any legislative change which sought to introduce a statutory test in under the MHA, could have unintended consequences for how competence is assessed in other settings, in particular mental health settings more broadly, including informal inpatients, and other linked areas of decision making. Introducing a statutory test for under-16s solely under the MHA risks creating additional confusion within wider mental health settings and other settings. This could lead to the creation of two different tests depending on whether or not an under-16 was detained under the MHA. It also risks undermining the principles of Gillick competence, which apply broadly across health and social care contexts—including reproductive health and children's services—and could impact the wider legislative framework relating to children. Fundamentally, we are concerned that in seeking to provide clarity, the creation of two different competence tests is likely to cause further confusion and uncertainty on the ground for decision makers and children, and, have negative unintended consequences on the ability of children to exercise choice and autonomy over their care and treatment.

The MHA Code of Practice already offers guidance on assessing competence in under-16s. We will consult on updating this guidance in the revised Code to improve the practical application of Gillick and assessment of competency.

Race Discrimination

Committee View

One of the most significant factors that prompted the process of reform that has resulted in this Mental Health Bill was the disproportionate use of compulsory detention and treatment under the MHA on people from minority ethnic backgrounds, particularly black people. Unequal treatment on the basis of race, especially in respect of the coercive powers of the state, is, of course, a significant human rights issue.

We recognise that some of the changes proposed in the Bill could help to reduce racial inequity in the application of the MHA. We also recognise that the causes of differences of treatment and particularly outcomes between people of different races can be varied and complex, and that addressing them may require wider systemic and societal change beyond the scope of this or any legislation. Nevertheless, we were surprised that the Mental Health Bill contains no measures directly addressing racial and ethnic inequalities in the application of the MHA and we agree with many witnesses that the Bill could go further.

We share the view of witnesses including the Care Quality Commission that the inclusion of an additional guiding principle of equity in the Bill would be beneficial. While by no means a complete answer, this would emphasise the key need for equitable treatment under the MHA. We propose an amendment to the Bill to add this additional guiding principle.

Government Response

We recognise the need to tackle inequalities under the MHA but believe we already have the necessary legal framework to do this - the Equality Act 2010 is the legal framework which protects people from discrimination, to which all those carrying out functions under the MHA must already adhere. The requirement to comply with these legal duties will be emphasised in the Code of Practice and the NHS Patient Carer Race Equality Framework (PCREF). At its core the PCREF is an organisational competency framework that values the voices of ethnic minority groups. The aim of the PCREF is to support NHS mental health providers to advance race equalities and race

equity across all mental health care pathways in collaboration with their partners, in order to improve access, experience and outcomes for ethnic minority groups.

We do not believe adding Equity as a fifth principle to the other guiding principles recommended by the Independent Review is appropriate because it is already encompassed by 'The person as an individual' principle. Whilst the Committee's proposed amendment seeks to achieve equality of outcomes between patients, adding an extra principle is not the appropriate way to achieve this. We will consult on how the principles should be interpreted and applied most appropriately in specific circumstances when we come to revise the Code of Practice. This will include guidance on how any person's race, cultural background and/or disability should be considered by decision makers to ensure that decisions taken about their care and treatment are tailored to each individual and their needs.

The Government will work closely with the wider mental health system to support the effective implementation of the provisions in the Bill, to reduce racial disparities in decision making under the MHA. Updating the Code of Practice will be a key way to achieve this, and we intend to work closely with the sector and in consideration of expert advice to ensure the Code is appropriately clear on the actions that can be taken to avoid and address racial disparities in the application of the MHA.

Committee View

The Government should carry out a review of the use of Community Treatment Orders (CTOs), which a black person is seven times more likely to receive than a white person.

Government Response

The Government is committed to monitoring and reviewing reformed CTOs as we implement changes. We will work closely with the system to ensure the Bill's provisions, including reforms to CTOs, are effectively implemented, aiming to reduce racial disparities in decision-making under the MHA. We are developing a monitoring and evaluation strategy for the reforms, which we expect will be a long-term staged exercise to look at the process of implementing changes, understanding patient experiences, and monitoring data relating to processes and outcomes, including consideration of changes to CTOs. We are working with NHS England and system partners to understand what data is available and what additional data it would be helpful to collect for monitoring and evaluation purposes.

Committee View

We look forward to the results of the evaluation of two culturally appropriate advocacy pilot schemes, which the Government should expand if the results are positive.

Government Response

We are pleased that the Committee welcomes the culturally appropriate advocacy pilots which DHSC has funded. These pilots aim to improve provision of advocacy for ethnic minority groups who we know are not well served by the current advocacy provision. We are awaiting the evaluation of the pilots so that we can consider options going forward.

Other issues

Committee View

The Human Rights Act provides legal protection against, and redress for, human rights violations in the UK. Recent case law has highlighted a gap in that human rights protection for mental health patients in state commissioned but privately provided care.

The Mental Health Bill should be amended to ensure that the Human Rights Act, and the protection it provides, applies whenever people receive publicly funded mental health treatment or after–care, or are deprived of their liberty on mental health grounds. This protection should not depend on whether or not the provider itself is public or private. The Government should also consider carrying out a wider review of the scope of the terms "public authority" and "functions of a public nature" in section 6 HRA to address any other similar and unjustified human rights protection gaps that may exist.

Government Response

We agree that this should be remedied and committed in the previous house to continue work on this issue. The Government tabled an amendment at Commons Committee, which seeks to address issues with the variations in the application of the Human Rights Act (HRA). The amendment, in line with the committee's view, sets out that where inpatient care for mental disorder and Section 117 after care (and its equivalent in Scotland) is arranged and paid for by a public authority, private providers will be considered public

authorities under section 6 of the Human Rights Act. The amendment focuses on the provision of care and treatment for mental disorder in line with the scope of the Bill.

More broadly, the Human Rights Act applies to public authorities, which includes any person certain of whose functions are functions of a public nature. The scope of "public authority" in Section 6 of the Human Rights Act was intended to be broad and flexible. The application of the Human Rights Act to outsourced services has developed via both case law and legislation since the Act came into force to reflect changes in how public functions are delivered. In this specific case under the Mental Health Act, we are seeking to fix a specific issue in relation to Human Rights Act coverage in mental health care, whilst maintaining the flexibility of the current position in the Human Rights Act. There are ongoing questions about how human rights are protected when public authorities are outsourcing their functions and we are alive to stakeholder interest in this.

Committee View

It is crucial that prisoners experiencing serious mental health crises are promptly moved to a hospital environment where they can receive the treatment they need. Delays in such moves risk exposing individuals to inhuman or degrading treatment in breach of Article 3 ECHR. The Bill's introduction of a statutory 28 day time frame for hospital transfers represents, therefore, a welcome development.

Monitoring compliance with this standard is important. Data on hospital transfers should be gathered centrally and made available to the public.

Government Response

We agree that monitoring and oversight of the transfer process will be crucial to the successful implementation of the statutory time-limit. A Mental Health and Justice Strategic Advisory Group has recently been established which will bring together key partners across health and justice agencies to scrutinise data and intelligence on transfer timeliness and identify and deliver solutions to address the common causes of delays. The group will provide quarterly progress updates to Ministers in both the Ministry of Justice and Department of Health and Social Care on progress.

We have committed to report annually on the implementation of the Bill post Royal Assent, until such a time that the Bill is fully implemented which will include providing updates on progress and data relating to transfer timeliness, when it is ready for publication.

Committee View

We can see that in narrow circumstances, where the need to ensure the safety of the public makes deprivation of liberty in the community the least restrictive option available, being able to impose conditions on the discharge of a restricted patient that amount to a deprivation of liberty may be beneficial and compatible with Article 5 ECHR. However, we agree with evidence we received that effective safeguards against abuse of the power to impose such conditions are crucial.

The Bill should be amended to ensure that conditions depriving a restricted patient of their liberty are reviewed by the Mental Health Tribunal promptly and regularly In particular, the Secretary of State should refer the restricted patient's case to the tribunal after 6 months (unless the case has already been considered) and every restricted patient subject to deprivation of liberty conditions should have their case reviewed every 12 months.

A proposed amendment to achieve this is set out in the Appendix. The Government must also ensure that full and detailed guidance is issued on the use of conditions that amount to a deprivation of liberty.

Government Response

We agree with the Committee that this power must only be used when necessary due to the level of restriction imposed on the individual, and the extent of supervision these patients may be subject to. Therefore, this cohort of patients will have more safeguards in place compared to other restricted patients, which include more frequent access and automatic referral to the Mental Health Tribunal.

However, we are not accepting the recommendation for the following reasons. In reaching the appropriate frequency of tribunal access, careful consideration has been given to finding the correct balance between providing scrutiny on this restrictive form of discharge, and the clinical needs of this cohort. Many of these patients are unlikely to be suitable for absolute discharge, owing to the enduring nature of their mental disorders and their associated risk profiles. Therefore, increasing the frequency of Tribunal reviews further could risk causing distress and negatively impact on the clinical stability and wellbeing of this cohort.

We fully agree with the Committee on the importance of full and detailed guidance and that's why we're taking several measures to deliver this. The Mental Health Casework Section, who discharge the Justice Secretary's functions under Part 3 of the MHA, are producing detailed guidance setting out the circumstances in which the Justice Secretary will make use of this power, and will monitor its use after the power has commenced. His

Majesty's Court and Tribunal Service are also preparing complementary guidance and training to ensure the Mental Health Tribunal are prepared to hear these patients' cases. The Justice Secretary also has the power to direct patients to the Mental Health Tribunal to provide further independent scrutiny on an ad hoc basis in addition to regular automatic referrals which will ensure that any patient that does not apply to the Tribunal still has their case heard.