Follow-up written evidence submitted by the Department of Health and Social Care and the Ministry of Justice (MHB110)

5 December 2022

Dear Baroness Buscombe,

Thank you for your letter of 25 November and for the opportunity to provide oral evidence to you and other Joint Committee members on 23 November.

The reforms we have brought forward through the draft Mental Health Bill present a once in a generation opportunity to ensure the Mental Health Act is fit for modern life. It is therefore vital that we get it right if we are going to truly deliver against the strength of our shared ambition. We continue to welcome the scrutiny and thorough work undertaken by the Joint Committee to ensure that the draft Bill to delivers on the shared aim of improving patient experiences of the Mental Health Act.

Please find attached the Government's responses to your latest questions in the attached annex.

We look forward to receiving the Joint Committee's report and recommendations in due course.

Kind regards,

MARIA CAULFIELD MP

DAMIAN HINDS MP

<u>Annex</u>

1. **Following up Dr Poulter's question about why the Government has decided to have different detention standards for Part II and Part III, what assessment have you made of:**
    a. **the possibility that this may lead patients to be diverted into the criminal justice system?**

The grounds for detention under Part 2 and Part 3 of the Act have always been different and the draft Bill does not seek to change this. It is well established that detentions under Part 3 have different requirements. The need to protect the public from those who have been accused or convicted of serious offences remains at the forefront of decisions concerning Part 3 patients and must be carefully balanced with the patient's autonomy and need to ensure care and treatment is appropriate.

Wherever possible, we have ensured patients subject to the criminal justice system will benefit from the reforms, however sometimes it has been necessary to take a different approach for these patients as a consequence of them being subject to the criminal justice system and the Justice Secretary's responsibilities towards

public protection. While we are extending the therapeutic benefit element of the new criteria to Part 3 and the discharge criteria will be the same under both Parts of the Act, it would be inappropriate to extend the new risk criteria for detention to Part 3 patients as risk in this context is a matter of discretion for the courts and, in the case of prison transfers, the Justice Secretary.

We recognise Dr Poulter's concern however, in that a person who does not meet the revised detention criteria in Part 2 will often instead need to receive appropriate care and support in the community. The Government believes that people should be supported in the community rather than in hospital where possible. It is important therefore to consider the draft Bill within the wider context of the Government and NHS England's strategy to invest, improve and expand community services for people with severe mental illness, as is set out in the NHS Long-Term Plan.

Clinicians must consider alternatives to detention, and in keeping with the principle of least restriction, where a person does not meet the criteria for detention, they should be supported by community mental health services, which are currently in a process of substantial expansion.

Where people come into contact with the criminal justice system, there are also opportunities for diverting people from this system, particularly via NHS liaison and diversion services. Well-functioning crisis services should involve multi-agency collaboration to ensure that people in need are getting the right support, including diversion from the criminal justice system where appropriate.

b. **the implications for professionals working with two different sets of rules, often with the same person at different times in their life?**

There are already significant differences in how the Act applies to people under Part 2 and Part 3, and good reasons for the rules to differ under each Part. Part 3 serves a different purpose to Part 2 and so it is right that there will be different considerations to professional decision making depending on different circumstances – and the Government believes that this position is well established and understood.

We will be publishing the new Code of Practice after the passage of the Bill with detailed guidance for all staff groups, including third sector roles such as IMHAs. The Department will work with NHS England, Social Work England and other partners to develop appropriate training for staff on the reforms before they are implemented.

2. **We would like to hear more about how the Government intends to prevent individuals with learning disabilities and autism who would previously have been detained under the Part 2 Section 3, being detained under Part 3 of the Act. Aside from community care and existing provisions in the draft Bill, could you provide us a detailed response to each of the following questions:**
    a. **What specific legislative changes could be made to Part 3 of the Act to mitigate this risk?**

We have consulted extensively on our proposal to keep learning disabilities and autism as grounds for detention under Part 3 of the Act whilst removing this option for civil patients unless the individual has a co-occurring mental health condition. Following a lack of consensus during the White Paper consultation, an Expert Group was convened to explore the options further and make a recommendation to the Justice Secretary. The Expert Group concluded that it would be preferable to continue to allow those with learning disabilities and autistic people in the criminal justice system to be diverted, where appropriate, from prison to hospital to access the specialist support they need in a more therapeutic environment. It would be incorrect to assume that all patients with learning disabilities and autistic people who would have been previously detained under Part 2 Section 3 of the Mental Health Act will display behaviour that meets the threshold for arrest, charge and remand under the criminal justice system, and will therefore be detained under Part 3 of the Act. It is important to note that an individual detained under Section 2 cannot then be moved to detention under Part 3. For Part 3 of the Act to be an option for detention an individual will have needed to have been in contact with the Criminal Justice System.

The draft Mental Health Bill contains several important provisions to ensure that detention only takes place where appropriate and that there must be a therapeutic benefit for the patient. A key element of our proposals is to give patients more of a voice in their care and treatment, and more frequent rights of appeal. The Bill is also underpinned by NHS England's Long-Term Plan, which will ensure that individuals with learning disabilities and autistic people have the right support in the community to minimise the risk of contact with the criminal justice system.

In our view these changes, when combined with the existing legislative and operational regime, provide appropriate and meaningful safeguards with those with learning disabilities and autism. That said, we will consider carefully any further recommendations the Committee has for how to prevent patients with learning disabilities and autism from being detained under Part 3 of the Mental Health Act except where truly necessary.

b. What specific legislative changes could be made to other parts of the Act to mitigate this risk?

The draft Bill includes sufficient provisions to mitigate this risk. For example, the provision regarding the holding of Care (Education) and Treatment Reviews (C(E)TRs) in respect of patients with learning disabilities and autistic patients who are detained under certain provisions in the Act, including section 2. Responsible clinicians and Integrated Care Boards will be legally required to have regard to recommendations from those C(E)TRs.

The draft Bill also legally requires Integrated Care Boards to establish and maintain a register of people they consider have a learning disability or are autistic and have risk factors for detention. The intention is that the Secretary of State will make regulations requiring that that recommendations from the above C(E)TR are to be included on an

individual's risk register entry. Crucially, Integrated Care Boards and Local Authorities will legally be required to have regard to risk registers when commissioning services.

These measures will work together to help ensure people with a learning disability and autistic people can be supported in the community, rather than requiring hospital treatment. In our view, increased community services are also likely to benefit those who may have otherwise been admitted via Part 3 of the Act, by reducing the risk of an individual reaching a crisis point which could lead to them coming into contact with the Criminal Justice System.

We are continuing to work with relevant stakeholders to ensure that the planned regulations – the content of which has not yet been settled, in order to allow for further consideration - will properly support the implementation of these reforms.

c. **What changes will you make to the MHA Code of Practice to mitigate this risk?**

We expect to publish an updated version of the draft Code of Practice following Royal Assent of the Mental Health Bill, and in advance of the commencement of provisions included within the Bill. The Code of Practice will sit alongside the guidance the Secretary of State must issue under what will be section 125F of the Act, which will give guidance regarding the CETR and risk register provisions, and the regulations they may issue under section125D(3), to ensure professionals involved in the care of people with a learning disability and autistic people understand how to discharge their duties under the Act. The forthcoming revision of the Code of Practice will provide an opportunity for the Government to articulate that the intention of the reforms is to ensure that the needs of individuals can be met in the community, as opposed to people needing to de detained under the Act. In updating the Code of Practice, we will draw on the expertise and experience of experts and people with lived experience to ensure their input is reflected.

There are particular areas of the Code of Practice we will need to amend, for example sections 20.7-20.28 in light of the reformed detention criteria. However, there are some sections we may choose to retain and build upon, such as section 20.28 which sets out that autistic people should only be detained where necessary and for the shortest time possible. This is a key principle on which our reforms in relation to people with a learning disability and autistic people are based.

d. **What changes will you make to wider guidance for police services to mitigate this risk?**

It is important that the Police receive the training they need to be able to meet the individual, complex and varying needs of individuals that come into contact with them. The College of Policing provide guidance for the Police on the Mental Health Act which is updated when necessary to do so. We will work closely with them on considering the implementation requirements for the Bill and to ensure this is reflected in their guidance.

e. **What are your plans to support police forces and other crisis care providers in preventing this risk, for example, through mandatory police training in learning disabilities and autism?**

As noted above, Police training, as well as other forms of support, is primarily a matter for the Home Office through the College of Policing. However, this is important in ensuring the draft Bill and the wider work on system wide reform has the impact that we intend. More widely, DHSC already works closely with partners across the crisis care system, including Home Office, NPCC and College of Policing. Crisis care works best when services work well in partnership, whether that is through Liaison and Diversion services or through police officers consulting AMHPs before exercising their section 136 powers to detain. We are considering how we can improve multi-agency working on crisis via changes to the Code of Practice, for example on handover processes between police and health services.

The Ministry of Justice (MoJ) has also established a Cross Government Working Group of Senior Officials and an Operational Group of the relevant agencies in recognition of the need for a cross system effort to improve provision for neurodivergent people at all stages of the criminal justice system. To ensure we are able to develop and implement system wide improvements, the Cross Government Working Group and the Operational Group will consider each of the key stages of the criminal justice system including an individual's first contact with police, Liaison and Diversion services, courts and sentencing, probation supervision, prison and, lastly, resettlement back into the community.

f. **Are you intending to develop alternative crisis care options for people in crisis who are at risk of detention under Part 3?**

Yes. As set out in the Building the Right Support Action Plan we are investing £90 million in community services, including improvements to the capacity and capability of 7-day specialist multidisciplinary and crisis support in 2022/23.

There will also be additional investment in community services for people with a learning disability and autistic people under the NHS Long Term Plan in 2023/24.

As set out above, the draft Bill does introduce legally binding duties on Commissioners to take into account relevant risk information supplied to them by Integrated Care Boards and to seek to ensure an adequate supply of community services for those at risk of admission under Part 2 of the Act. These duties will help to ensure that people with a learning disability and autistic people can be supported in their community, avoiding the need for hospital admission as far as possible. We expect the improved community support will help people avoid reaching a crisis point which could lead to them committing a crime or being admitted to hospital.

Detention under Part 3 is a diversion from prison to hospital after a person has been convicted of an imprisonable offence. It would therefore not be appropriate for local commissioners to make assessments of an individual's risk of detention under Part 3 as this would involve making predictions around forensic risk and the decision-making of criminal justice professionals (e.g. the Crown Prosecution Service and the judiciary) which have a

significant amount of discretion. However, increased community services which meet individuals’ needs and reduce the risk of crisis are likely to benefit those who may have otherwise been admitted via the Criminal Justice System and who will present with similar needs to those who may have been admitted through the civil route.

3. **In the hearing you mentioned programmes that were being developed to support people with learning disabilities and autism detained in prison settings. Could you please expand on these programmes mentioned, and any others that are relevant, and provide detailed timelines for their implementation?**

The MoJ is committed to providing support for neurodivergent people coming to prison. On 30 June the MoJ published a cross-government Action Plan in response to the Justice Inspectorates’ Evidence Review on Neurodiversity in the CJS. As part of our response, we are exploring ways in which to ensure greater consistency of screening across criminal justice agencies and to ensure that reasonable adjustments are made to address the needs of neurodivergent people in prison.

As the Action Plan shows, significant progress has already been made to improve support across the prison estate. Neurodiversity Support Managers have been introduced in 49 prisons, and we are on track to roll this across all prisons in England by 2025. These roles are already playing a vital role in improving processes to identify and support prisoners with neurodivergent needs, including ensuring neurodivergent prisoners can access the education, skills and work opportunities within the prison.

Specialist wings have also been established in some prisons, including HMP Parc and HMP Wakefield. These wings are designed to cater for the needs of neurodivergent individuals.

An update on the progress made against each of our commitments in the Action Plan will be published shortly.

4. **Evidence provided to the Committee expressed concern that those subject to guardianship orders diagnosed with learning disability or autism, may end up being transferred to hospital under section 19 of the Mental Health Act. What safeguards will be in place to prevent unwarranted transfer to detention in hospital under those provisions?**

It is not the intention of the Government for guardianships to function as a potential 'back door' into section 3 detention.

Under the current Act, the process for transferring people from a guardianship to hospital is detailed in the section 8(2) of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008[1], and the Government’s Reference Guide to the MHA[2]. These specify that a person can in practice only be transferred from a guardianship to a section 3

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[1] The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (legislation.gov.uk)
[2] Microsoft Word - with covers etc - Complete reference guide 23 March - JRA.docx (publishing.service.gov.uk). In particular, page 118.

detention with a section 3 application, meaning that, if someone does not satisfy the section 3 criteria, section 19 does not allow a means of detaining them.

We will review the regulations in order to ensure that they continue to achieve the intended effect in light of our proposed changes to the detention criteria. As part of that review we will consider whether any revisions to the regulations would be necessary.

5. **Your response said that you had decided not to take forward an emergency detention power within Emergency Departments. We note that the provisions of the Mental Capacity Act would not apply where patients have capacity. We note the concerns of NHS England, but also the evidence we have heard that this is already happening without a statutory provision:**
    a. **If there are situations where patients pose a risk of serious harm unless immediately restrained for a short period, what is the rationale for allowing this for in-patients and those without capacity, but not for others?**

We recognise that currently, in many cases, a person cannot be detained in A&E whilst they are waiting for a Mental Health Act assessment. For example, it may not always be possible to detain a person with capacity or who doesn't have capacity and where common law powers of necessity are not available.

We are also aware that a new emergency detention power designed to clarify the position could involve the creation of a new power and might well extend the powers of the state to detain people beyond those currently available. If that analysis is correct, this would be a significant step and would require a clear justification. Whilst we are sympathetic to the view that the lack of a specifically-targeted statutory detention power on the statute book that deals specifically with detention in A&E may mean some lack of clarity for decision-making clinicians, there is no clear consensus that a new power is necessary and or that it would be proportionate.

b. **Has the Government considered an approach similar to the Emergency Detention Certificate under the Mental Health (Care and Treatment) (Scotland) Act 2003?**

Yes. We have worked closely with stakeholders to understand what, a new holding power under the Act could look like if it was required. The model in Scotland formed a key part of these considerations and elements of the Certificate were consulted on in our White Paper, including the detention period of 72 hours under the Emergency Detention Certificate. However, respondents to the White Paper who expressed significant concern with applying section 5 in an A&E setting noted the 72-hour time limit as a primary reason for their objection.

6. **In your response to our last letter, you said you would not be taking forward the proposal to allow Tribunals to review treatment decisions due to concerns raised during the consultation process:**

a. **What led you to give those concerns greater weight than the views of the Independent Review?**
b. **Has the Government considered a pilot scheme, to establish how valid those concerns are in practice?**

The Review's recommendation to create a new appeal route for treatment decisions did not command majority support from stakeholders during consultation and a number of significant concerns were raised. In particular, there were concerns about the potential risk to patient safety as a consequence of the single judge intervening in their current treatment by directing that the responsible clinician stops or reconsiders the treatment in question.

It is our view that meeting the ambitions of the Independent Review for greater choice and patient self-determination is not contingent on creating a new appeal route. We have looked very closely at this recommendation, including the adequacy of current routes, the effectiveness of non-legislative alternatives and operational consequences of proceeding with such a recommendation. When we re-examined the desired impact of the proposal, we concluded that this had already been achieved through the other measures within the Bill that seek to protect and strengthen the patient's choice and autonomy

As discussed in our previous letter, some of these measures include:

- the 'clinical checklist' (clause 9), which requires responsible clinicians to follow a number of steps to ensure that treatment decisions are patient-led.
- the 'compelling reason' criteria (clause 11), which limits the use of compulsory medication, where it is in conflict with a valid refusal (either in advance or at the time), to exceptional circumstances.
- increased oversight by the Second Opinion Appointed Doctors' (SOAD) service, meaning in the case of a valid refusal, certification must be secured *before* compulsory treatment can be given, as opposed to 3 months after it began.

For all these reasons, we are not considering a new pilot because we do not agree a new appeal right is required.

7. **The Independent Review recommended that Tribunals should have the power to change or remove the conditions of a Community Treatment Order: why has the Government not followed that recommendation?**

The Government has followed this recommendation and landed on a broadly similar approach to that proposed by the Independent Review. The draft Bill therefore provides for a new power for the Mental Health Tribunal (MHT) to recommend that the Responsible Clinician (RC) reconsiders whether a particular CTO condition is necessary, in cases where the MHT has decided not to discharge a patient from a CTO.

Rather than giving the MHT the power to change or remove the conditions, we consider that this provides a better balance between the MHT's role in scrutinising how the RC is applying the statutory framework whilst ensuring that responsibility for clinical decision-making remains with the RC.

The RC is best placed to manage, and remain principally accountable for, a patient's CTO conditions as they have a better understanding of the patient's history and needs, both past and present. For example, if a condition requires that the patient abstains from alcohol, it would not be for the MHT to know whether this would be clinically appropriate for the individual.

8. **You indicated on Wednesday that Community Treatment Orders needed to be reviewed after the Bill was passed, to determine whether they should be retained or abolished. Is there any reason why the Bill should not include a review mechanism to ensure that happens?**

We expect the extensive reforms we are seeking to make to CTOs will ensure they are used more appropriately. Once the Bill is enacted, at the appropriate stage, we will of course review and evaluate its implementation, including our reforms to Community Treatment Orders (CTOs).

I re-iterated our commitment to do this to the Committee on 23 November and it is not necessary to provide for this in legislation. We do not believe it is necessary for the draft Bill to make statutory provision to review this specific policy.

We have already begun to consider what steps we should take to facilitate how we review the implementation of CTOs, such as exploring what data we will need ahead of implementation to ensure that sufficient baseline information is available to identify impacts. This work includes looking to commission feasibility studies for how we can collect systematic data on patient and carer experiences. As part of this, we are specifically considering how we monitor inequalities, particularly racial disparities, and will work with stakeholders to make sure the data is available to monitor these issues.

9. **In your response to our legal questions 1 and 2 in our last letter you outlined the Government's understanding of the law. Could you please explain why the Government has decided not to legislate to cover what could be potentially life-threatening situations?**
    a. **On question 1, why should it be necessary for clinicians to go to the courts?**

In our view, it is right that clinicians should in the future go to the Court of Protection for a decision to further detain a patient who is already detained under the MHA. This is because these cases raise significant and complex ethical and legal issues, and the Court of Protection has longstanding experience of considering similar issues. leading issues. Also, such patients are in a particularly vulnerable position given that they have already been deprived of their liberty through detention under the Act.

This also reflects the current approach of the Court of Protection under the MCA. Already, there are other serious cases where only the Court of Protection can make the decision and

not clinicians on the ground (e.g. sterilisation, withdrawal of life sustaining treatment, forced move to a care home) and this falls into a similar category.

b. **On question 2, why should it be necessary for clinicians, often dealing with an emergency, to have to consider range of potential options? These options – calling in the police using section 136 or processing applications faster or use of the common law – may not be available, suitable, or reliable in many situations.**

As we noted above, there is not a unified position amongst stakeholders and the evidence is not compelling to warrant further provision in the Bill.

The options currently available to clinicians each have a specific, distinct purpose. Therefore, clinicians should use their professional judgement to consider which option is best for the patient on the basis of their individual circumstances. We will continue to work closely with stakeholders to consider how we can provide clarity on the existing legal framework for clinicians where possible, to ensure that health professionals in A&E and those involved in crisis care understand what powers are available to them (and which powers are not available) in these circumstances.

10. **You will be aware of the recent high-profile cases of abuse in mental health settings. One proposal that might help is a better complaints mechanism. What is the Government's view on the Parliamentary and Health Service Ombudsman's recommendations for streamlining the complaints system set out in their written evidence to the Committee?**

Of course, it is imperative that there is a functioning and effective complaints process in place for patients and those they choose to represent them, to raise concerns about their experiences. We are deeply disappointed that, in some instances, patients have not been able to use this mechanism effectively.

That is why we are already working closely with the CQC and other delivery partners to consider what more we need to do to ensure complaints can be made, are investigated fully and where necessary, action is taken.

The draft Bill includes improvements to the Act's complaints provisions. It seeks to create statutory obligations for Hospital Managers to supply patients and their nominated person with information about complaints (clause 35). This duty will extend to patients in the community (clause 36). We are sympathetic to the Parliamentary and Health Service Ombudsman's recommendation to clearly define the roles of the bodies responsible for complaints, however legislation is not required to do this. This clarity can be achieved through wider work to support the implementation of clauses 35 and 36.

11. **We have heard evidence that there should be greater requirements and consistency for data collection on ethnic inequalities. Did the Government consider including a clause on requirements to record and publish data on ethnic disparities, similar to that seen in the Mental Health Units (Use of Force) Act 2018?**

Improving access to high quality mental health data is an essential enabler of the reforms to the draft Bill and the non-legislative measures that sit alongside it.

There are a number of non-legislative initiatives are being taken forward currently to improve the collection of ethnicity data specifically. This includes the publication earlier this year of NHS guidance for improving the quality of data collected on protected characteristics and for other vulnerable groups. NHS England is piloting the Patient and Carer Race Equality Framework (PCREF) which includes a specific focus on the collection and consideration of ethnicity data by NHS providers in the context of existing statutory duties. NHS England and NHS Digital are also leading broader data collection and quality improvement plans, for example targeted engagement with NHS providers who return lower quality data – including where demographic information, including on ethnicity, is not provided. This builds on the specific data requirements legislated for in the Use of Force Act, which we expect to be used to underpin broader system improvements, including in addressing racial disparities.

Given these non-legislative plans already in place to improve how ethnicity data is collected and used going forwards, it is our view that it would not be appropriate to introduce a legislative requirement around this specific issue at this stage.

12. **Many of the proposals to address inequalities rely on non-legislative programmes, mainly within the NHS. How will the Government show that these are on track to be completed alongside the draft Bill? How will we know if these changes are supporting the draft Bill in achieving its aims?**

We are committed to continuously monitoring the impact of our non-legislative programmes on the experience and outcomes of people subject to the Act. For example, we are currently planning our second phase of culturally appropriate advocacy pilots which will be underpinned by independent evaluation. NHS England's Patient and Carer Race Equality Framework (PCREF) is now being piloted in ten NHS mental health trusts across the country, with a roll-out of guidance and broader support at national-level planned shortly. We expect the PCREF to play a particularly important role in supporting systems to understand, and target action to address, racial inequalities in how the Act is being applied going forwards. We will continue to monitor the implementation of these two pilots, as well as for other initiatives, such as the broader NHS Workforce Race Equality Standard, and take action to further support delivery if and where required.

Our aim is to assess the impact of our reforms in the round, both legislative and non-legislative. To support this, we intend to commission an independent evaluation of the first phase of our reforms, as set out in our Impact Assessment, through the National Institute for Health and Care Research. This would provide rigorous academic evaluation of the impact of both legislative and non-legislative reforms that take effect in the first phase of implementation.

13. **The Metropolitan Police have asked whether section 135 of the Act can be amended to allow those other than "*any constable*" to execute a warrant, such as by allowing "*any authorised individual*" to do so, thus allowing flexibility in cases**

where police involvement is not most appropriate. What are your views on their proposals?

The draft Bill does not amend section 135 in the way proposed by the Metropolitan Police because the compulsory power to enter private premises is a fundamental question of civil liberties. It is a well-established principle that only the police can be granted this power via a warrant from a Court.

Whilst we acknowledge the police may not need to play an active role in every case, nonetheless they are important within crisis care and other professions rely on the police's powers of entry when exercising section 135.

However, we do intention to take steps that will make those handovers quicker so they can return to their other duties more swiftly.

14. **The Independent Review recommended that there should be support for those compiling advance choice documents – what support does the Government envisage will be available?**

It is our intention that, as far as possible, people at risk of detention under the Act should be informed of their ability to set out what they want and don't want in advance. They should also be supported to do this at a point when they are well enough to make decisions affecting their future care and treatment. NHS community mental health teams and the voluntary and community sector organisations will play an important role here, as well as mental health advocates who will be particularly integral to ensuring that ethnic minority groups benefit from the new rights around advance decision making provided for by the draft Bill.

Our Impact Assessment estimates the resource needed to deliver the implementation of this policy, including the individual 'tasks' we envisage will be required in making advance wishes and decisions known, such as signposting and supporting the patient; which professional/s we think would be best placed to deliver each task; and how much time this would take[3].

This is addition to the work that has already started to create a template Advance Choice Document, which mental health and care professionals will support service users to complete, if they so wish. This implementation model was developed in close collaboration with stakeholders at South London and Maudsley NHS Foundation Trust and King's College London who have already done a great deal of valuable work to understand the best mechanism for engaging with service users to help them record their advance wishes and decisions in such a way that they can inform their future care. We plan to further test this model with delivery partners, with view to developing guidance for professionals and best practice recommendations for the sector.

15. **Why has the provision for transfers from hospital to prison been drafted using the words "seek to ensure" rather than "ensure" or other similar wording, particularly**

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1085873/draft-mental-health-bill-impact-assessment.pdf In particular, see pages 97 - 98

given that there are already provisions for this to be adapted in "exceptional circumstances"?

The draft Mental Health Bill places a statutory duty on all the authorities and bodies involved in a transfer from prison to hospital under Section 47 of the Mental Health Act, to "seek to ensure" the transfer takes place within 28 days from the initial referral for a report. This drafting is designed to recognise that the transfer of a prisoner with severe mental health needs is a multi-disciplinary process across various healthcare providers and commissioners and that no single party can independently guarantee in all circumstances that a transfer takes place within the statutory 28-day time limit, but seeks to ensure that all parties make a reasonable effort to adhere to this.

16. **On supervised discharge, could you please clarify the number of patients likely to be impacted (recognising that an exact number may not be possible for data protection reasons)?**

While it is not possible to make an authoritative assessment of numbers, internal estimates suggest we could expect new cases to be in the low 10s per year. This assessment is based on the number of patients who since the MM judgment have been managed in the community via long-term escorted leave (those with mental capacity) and those who have been conditionally discharged with a DoLS authorisation (those without mental capacity).

Providing an express power will enable greater scrutiny of the numbers of people subject to such arrangements. We are committed to being transparent about the use of the power and intend to publish annual updates as part of the Restricted Patients Statistical Bulletin. However, if the numbers remain very low, we may be constrained from publishing exact figures due to the risk of individuals becoming identifiable.

17. **During the hearing we discussed recent deaths of patients in detention. We look forward to hearing from you about the proposed review of in-patient settings. What is the Government's reasoning for not requiring automatic investigation of deaths of people detained under the Mental Health Act?**

Any death during in detention is a tragedy, and there is a framework in place to ensure that deaths of people who were detained under the Act are investigated where appropriate. This includes:

- the Learning from Deaths Framework (LfD), this sets an expectation for case note reviews to be made as well as requiring an investigation if is it thought more likely than not that the death was due to problems in care
- The Coroners and Justice Act 2009 also sets out that an inquest must be conducted into deaths that occur in state detention, including people detained under the Act.
- The Mental Health Units (Use of Force) Act 2018 (not fully commenced) requires services to record and report on data where a person has died due to the use of force. Under section 8 (still to be commenced), the Secretary of State is also required to conduct a review and for the Mental Health Unit to issue guidance relating to investigations of a death that relates to use of force

In addition to this existing framework, there are other measures that being developed to provide additional safeguards over patient safety such as the implementation of the new Patient Safety Incident Response Framework (PSIRF) and its supporting guidance that was published in August. This references the expectations of the LfD and aims to improve the way the system responds to safety incidents. It does this by focusing on compassionate engagement and introduces a range of national tools and templates to support learning and improvements. In line with the LfD, under the PSIRF an investigation must happen where a patient safety incident may have contributed to a death; how this is done is a local decision.

We are also establishing the Health Services Safety Investigations Body (HSSIB) to replace and build on the work of the Healthcare Safety Investigations Branch. This will be a new independent body that will conduct investigations into qualifying incidents that have implications for patient safety. We expect HSSIB to be operational in April 2023.

As you know, in light of recent reports, we are urgently considering together with NHS England and CQC whether further steps can be taken to improve patient safety and people's experiences of inpatient care and will provide detail of next steps as soon as we are able.