

Written submission to the Department for Health and Social Care on *Reforming the Mental Health Act White Paper*

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

We welcome the publication of the government's *Reforming the Mental Health Act 1983 White Paper*, and our response draws on the input of NHS trusts and foundation trusts. We look forward to supporting subsequent stages of the Act's reform in the months ahead. Reforming the Act, and wider policy and practice, is more important now than ever: the COVID-19 pandemic has placed profound pressures on all parts of the NHS and accelerated mental health trends in particular, intensifying the challenges facing services as a consequence.

Key points

- We welcome the publication of the *Reforming the Mental Health Act 1983 White Paper* and look forward to the government prioritising the introduction of new legislation, and taking the necessary steps to progress the broader changes to policy and practice required, without further delay. Reform of the Act was already long overdue, and it is now over two years since the Independent Review of the Mental Health Act published its recommendations for change.
- We support proposals to simplify the Act and make changes that maintain appropriate safeguards, but enable greater individual rights and liberties, as well as service users having a more active role in their care planning with a focus on recovery. Putting patients at the heart of how they access care and treatment is vital to high quality care. The Care Quality Commission's assessment of the care provided to people detained under the Act during the pandemic period highlighted how a wide range of services have empowered patients by applying the principles of

least restriction and focusing on care planning and co-production. Good practice needs to be shared, and its implementation supported, in a systematic and coordinated way.

- Reform of the Act alone will not be enough to improve how and where good quality mental health services are accessed. We welcome this point being made clear in the White Paper and the government highlighting further proposals, as well as pre-planned and ongoing work, to reform policy and practice more broadly.
- The government rightly acknowledges that the proposed reforms will require additional funding and expansion of the workforce, over and above current commitments. Sufficient funding and investment are crucial to addressing the underlying issues driving the pressures on services and compounding the rising severity and complexity of people's needs. Longstanding system and financial pressures on providers, combined with inconsistent investment in mental health services at local levels, continue to exacerbate bed capacity pressures and increase the likelihood that a person may reach crisis point necessitating use of the Act to admit.
- We must make sure the needs of mental health services are adequately prioritised. A key indicator here will be fully and promptly funding, on a sustainable basis, the expansion of community-based specialist mental health care capacity required to meet the demand for mental health services, and ensuring these services meet the needs of their local populations. We know this investment is key to reducing the need to detain under the Act and providing care in the least restrictive setting.
- Adequate investment to maintain and build on the steps being taken to grow the mental health workforce, and the sector receiving its fair share of capital funding, are both also crucial. There must also be increased support for public health and social care given the crucial role these services play in providing people with the wider care and support they need and helping many avoid reaching a crisis point in the first place.
- We welcome the government emphasising its commitment to working closely with health and care organisations to understand the impact of reform on the system and to develop a robust and achievable plan for implementation. It is right to recognise that other demands placed on the system, and the capacity of health and care staff to deliver what is required, need to be carefully considered as this work progresses.

New guiding principles

We welcome the spirit of the new guiding principles: it is right that changes to the Act hold individuals' human rights, dignity and legal protections as the highest priority. However, the capacity to detain without consent is an important provision for the safety and wellbeing of individuals and, in certain occasions, for the safety of those around them and the broader public. This may need to be made clearer given that, as is recognised in the White Paper, there is a risk the principles in their

current form create tensions for clinicians and judges, which are difficult to resolve in cases where individual or public safety concerns necessitate a higher degree of restriction and compulsion. It is vital that the government fully considers how the principles will impact the practical application of the Act and addresses any issues of compatibility with its underlying philosophy before further progress to reform the Act is made.

A key question to address will be whether the new guiding principles will be enshrined in the legislation alongside being contained in the code of practice. While some trusts see this as a positive step, we also heard from a number who have stressed that the guiding principles only need to be embedded within the statutory criteria for detention and treatment to have an impact on everyday practice, as the decisions made by clinicians are bound by these criteria. Some trusts have argued that making the guiding principles statutory provisions in their own right would be unnecessary, and potentially counterproductive as the duplication could lead to confusion and increase the risk of potential legal challenge. One told us there is also a risk of adding to the record keeping burden on clinicians, taking further time away from them to meet the needs of patients in their day-to-day practice. Another told us they would prefer to see the guiding principles only outlined in the code of practice as it can be more easily updated in line with evolving changes to the provision of mental health care and treatment.

Detention criteria and challenging detention

We welcome the aspirations behind the proposed reforms to the detention criteria and processes for challenging detention, to ensure people in all areas of the country are detained for shorter periods of time, and only when absolutely necessary. Trust leaders previously raised concerns with us that there were insufficient safeguards as well as clarity around processes for renewals of detention under the current Act.

Detention criteria

Trusts have told us that the criteria of “therapeutic benefit” and “substantial likelihood of significant harm” requires further clarification to fully understand the implications of these changes in practice, and to ensure they are interpreted by all parties consistently. A number have questioned whether interventions that meet the needs of certain patients, such as habilitation and milieu therapy for people with a personality disorder, could be excluded from the scope of the Act under the new “therapeutic benefit” criteria: this will be important to clarify. Trusts have also highlighted potential challenges with identifying specific risks and evaluating ‘likelihood’ of risks and how ‘substantial’ that likelihood is. There is a risk the “substantial likelihood of significant harm” criteria could unintentionally

lead to increasing patients' length of stay – the severity of patients' condition on admission is likely to be greater and require a longer period in hospital to recover, and it may also add delays to their discharge.

Further areas trusts would welcome clarity on include:

- who would undertake the proposed assessment on what setting provides the most therapeutic package of care, when there are decisions to be made about when and whether to discharge a patient; and
- how the government is envisaging introducing more checks on whether a patient's detention continues to be appropriate.

Trusts have also told us the distinction made between Parts II and III of the Act in relation to the detention criteria may cause some confusion, given some people detained under Part II of the Act can present with extremely high associated risks: there are patients in both high and medium secure services under Part II provisions. Concerns have also been expressed that the proposal to only tighten Part II criteria could risk pushing a significant number of people into the criminal justice system as an unintended consequence. We need to ensure people who may be slowly deteriorating at home, but not posing any obvious significant risk in the short term, are able to access care and support that meet their needs. This is about fully investing in high quality, community based mental health support including crisis care – and not just these services being available but also delivered in a way that meets the needs of their local populations. We fully agree with the White Paper's acknowledgement that legislation and proposals outlined in the paper can only go so far and wider investment is needed to support the broader changes required in policy and practice.

While the proposals for more stringent criteria may help reduce detention rates and use of the Act, we need to address the underlying issues driving the pressures on services and the rising severity and complexity of people's needs at the point at which they present to services fundamentally. One trust told us: *"the choice between detention and any alternative care and treatment plan was often stark and unrealistic at the point of assessment. Were there to be a genuine, safe alternative which would provide a therapeutic benefit to the individual, that would readily be chosen but it rarely exists at a time of mental health crisis"*. We also need to be able to reach people earlier, before they reach crisis point. We do acknowledge that the NHS long term plan sets out to significantly strengthen and improve community provision, but this will of course take time given the longstanding underinvestment and prioritisation of these services.

In supporting patients who will not meet the criteria for detention under a reformed Act and when using least restrictive approaches, trusts have highlighted to us that there will be a particular need for improved collaborative working with community partners and multi specialist agencies. This will help to ensure referral pathways back into community providers and safety plans are clear, robust and effective.

We also need to ensure that there is enough capacity for people who do require care and treatment under the Act in an inpatient setting, and investment is also put in to ensure these settings are fit for purpose across the country. As one trust leader told us: *"I am very much for the proposed changes, but I am mindful that resources in the system are strained as they are, and more needs to be put into the both the number of beds and early intervention. We need to recognise that there will always be people who ultimately need detention and we have to have enough capacity for this. If we are hoping to detain less (which is the right way forward) we need to be able to have the right support in place to support them and manage the risk in the community. We haven't quite got that balance right at the moment."*

Challenging detentions, renewals, granting leave and discharge

Trusts are supportive of the proposal to increase individuals' access to the mental health tribunal. One told us that the change in timescales to shorten the length of the first two detentions under section 3 will be *"hugely significant for service users"*. However, the impact of these proposals on trusts' resources and workload need to be fully assessed. Some have told us the changes may require staff to spend more time writing reports and attending tribunals, and risk negatively affecting patient care if it is not accompanied by a commensurate increase in staffing levels. Trusts may also need to ensure physical space is available to accommodate an increased number of meetings. There may also be resource issues for the first tier tribunal, though it has been recognised that the continued use of videoconferencing may provide an opportunity to reduce costs. Trusts welcome the proposals to reduce paperwork and bureaucracy, and have told us the introduction of report templates that can be amended would be particularly beneficial.

We would welcome the government clarifying its proposals with regards to hospital managers' panels. Some trusts understand that the White Paper does not propose removing the hospital managers' power of discharge itself, so it will be necessary to clarify this and under what circumstances the government envisages this power being used and the process for doing so, if it does remain. Trusts would also welcome clarification on the role for hospital managers in renewals. A number have expressed support for removing hospital manager panels, but emphasise the

importance of this being accompanied by the proposed measures to increase patients' access to the tribunal to ensure their rights and access to timely reviews are not affected.

Trusts support the automatic referral to a tribunal for community treatment order (CTO) revocation, though the importance of making special provisions to ensure people in specific circumstances do not fall through the net has been emphasised. Trusts have previously told us that the scope of mandatory restrictions under CTOs are complex and CTOs are ineffective at preventing readmissions. Efforts to reform them and a commitment to monitor the effects of changes, particularly the impact of increasing evidence requirements, are therefore welcome.

We understand the government intends to legislate so that the tribunal is able to grant leave and transfer, and direct services in the community. The government also proposes that there should be an obligation in legislation on health and local authorities to take all reasonable steps to follow the tribunal's decision: if the authority is not able to give effect to the tribunals' decision, it must provide an explanation to the tribunal, setting out the steps it took and why it was not possible to follow the decision. We would recommend the government explores this proposal in more detail with trusts, in particular what powers the tribunal would have in practice to grant leave, order transfers and direct the provision of community services in circumstances where those with clinical and legal responsibility for the patient deem it unsafe (for the patient, those around them and/or the broader public) or inefficient to comply with the tribunal's decision.

Choosing and refusing treatment

We agree that the Act must hold the individual service user's human rights, dignity and legal protections as the highest priority. More effort must also be made to ensure that service users and, where appropriate, their families are active participants in the treatment and care planning for their recovery at the earliest opportunity.

A number of trusts have indicated their support for respecting the right of patients with capacity to refuse treatment if they wish, even if the treatment is considered immediately necessary to alleviate serious suffering. However, others have stated their preference for considering cases where this issue might arise on an individual basis. One trust told us they felt there is a contradiction between the 'therapeutic benefit' guiding principle and the right to refuse treatment, as well as cautioning that refusing some treatments may lead to patients staying in hospital for longer and receiving sub-optimal care. Any change would need to be supported by clear guidance for all concerned. Trusts had fed back to us previously that frontline professionals need greater clarity as to what constitutes

appropriate consent to treatment, confidentiality and information sharing, especially with regards to CTOs, which will be important to make clear in the reformed Act regardless.

Trusts support updating the nearest relative provisions and, on the whole, the proposed additional powers of the nominated person. Some anticipate that the tribunal will have a key role to play in making further determinations if a person's choice is potentially inappropriate or harmful, which will be important to clarify. Trusts have also highlighted it will be important to work through who determines what the patient's best interests are if the nominated person is objecting to a CTO, and other practical issues such as how and when people can change their mind regarding who their nominated person is and who should keep track of this. One voiced concerns that legislating so that the nominated person's objection to admission can be temporarily overruled, as opposed to them being removed or displaced, might give rise to a need for serial proceedings to overrule every single decision.

A number of trusts support making the proposed legislative changes applicable to children and young people, taking into account recent case law regarding parental consent, though it has been stressed that robust guidance is required regarding the appointment of a nominated person for children under the age of 16.

We would recommend the government explores the proposals regarding advance choice documents, and care and treatment plans further with relevant stakeholders in light of the questions trusts have raised through our engagement with them. For example, trusts would like clarity on what their obligation would be to accept a patient in situations where they had not been involved in developing the advance choice document. Trusts have also raised concerns regarding the proposal for each care and treatment plan to be subject to internal scrutiny and approval by the medical or clinical director, specifically: its practicability; purpose – given the role of the tribunal; and potential implications on the funding of medical management posts in mental health trusts. One trust proposed that an alternative standard for practice could be that MHA administrators provide the director with an assurance report that the statutory care plan has been completed within the 7 day standard, with any breaches amounting to an exception report to the director with a requirement to complete and submit within 24 hours.

It will be important to make sure the language used in matters regarding advance decision making is consistent to ensure clarity for service users and clinical staff: there is concern amongst trusts about the different terminology used in the White Paper in comparison to the Mental Capacity Act (MCA) and National Institute for Health and Care Excellence (NICE) guidelines and quality standards. One

trust has recommended the adoption of terminology used in the MCA and by NICE on the basis that the language is already in existence, standards are based on evidence, and consistency will provide transportability across all areas of health and social care. Consistency will also provide stronger safeguards and protection from misuse. They also highlight that advance decision making options are supported by Quality Standards for which compliance can be audited.

Improving support for detained people

Trusts have told us that the proposal to expand the role of independent mental health advocates (IMHAs) is positive, although they also note that it will require investment and additional training, with particular resource implications for local authorities given current commissioning arrangements.

Drawing a clear distinction between IMHAs and the role of the legal representative has also been raised as important.

More broadly, trusts have emphasised the value of advocacy services and their concern at the level of variation in service provision and advocacy support at the moment, depending on where a patient lives. Whilst a number of trusts think enhancing standards, regulation and/or accreditation could help to improve services, many have told us the government should focus on increasing resources for advocacy services first and foremost. Trusts have also highlighted they are aware that most advocacy services face recruitment and retention challenges.

Interface with the Mental Capacity Act

The lack of clarity around the interface between the Mental Health Act (MHA) and the Mental Capacity Act (MCA) is currently a cause for concern for trusts. There must be very clear guidance to support practitioners when making decisions on the correct legal frameworks to apply. As one trust told us: *"the current situation has resulted in differing interpretations across the country which leads to confusion and leaves the person at the centre of proceedings in an unacceptable position"*.

The sector is awaiting the new MCA code of practice and regulations to accompany the implementation of liberty protection safeguards (LPS). Trusts hope that this new code of practice will address many concerns, including providing advice for clinicians regarding the appropriate legal frameworks to apply. It will also be important to assess the impact of LPS before introducing reforms to the MHA to ensure that any gaps can be addressed.

A number of trusts have expressed concern with addressing the uncertain interface between the MHA and MCA through the introduction of a clearer dividing line in legislation between the two Acts based

on whether or not a patient is clearly objecting to detention or treatment. They have warned that the effect of this would be that all patients, without the relevant capacity who do not object, receive care and treatment under the MCA despite it potentially not being the least restrictive option. They have also highlighted that, when comparing the rights of patients detained under each Act, there is little chance of practical appeal/review by a court and a lack of safeguards of independent oversight with regards to what longer-term medication regime is used under the MCA. One acute trust has also told us they envisage a demarcation, based on whether or not a patient is clearly objecting to detention or treatment, prolonging the admission-discharge process and having an impact on patients' length of stay and the safe management of care within the acute hospital setting.

A number of trusts have suggested that the demarcation between the two Acts be instead based on the nature and purpose of the detention, so that all those being detained in hospital for assessment or treatment for a mental disorder receive MHA safeguards. One warned that the existing nuanced case law position would ensure more appropriate options for patients than an unsuitable, artificial simplification.

A number of trusts have expressed their support for the extension of section 5 of the MHA so that it also applies to those attending A&E, accepting that section 4B is still available and can be used where appropriate. Trusts have emphasised that there will need to be a package of training and development made available to support clinicians in acute trusts to understand the framework and make assessments effectively. It is important that the aim of increasing people's safety and their ability to receive a timely and robust assessment is at the core of the decision the government takes with regards to the extension of section 5, and on the broader issues at play here that require action beyond any change of powers within the Act.

Caring for patients in the criminal justice system

Members had previously told us that the inequitable arrangements for patients in the criminal justice system compared with others assessed under the Act is a key issue, and support was expressed for equivalence of care for restricted patients and those in the community; shortening timescales from assessment to hospital admission; and making return to custody easier.

Trusts have raised particular concerns that, as forensic services provide care for people under Part II and Part III of the Act, they will be required to operate under two different criteria for detention under the White Paper's proposals. They are also concerned that the proposed changes to the detention

criteria risk people who are a significant risk to themselves or others needing to be more acutely unwell than their civil counterparts in order to access the care and treatment they require.

Trusts support the proposal to introduce, where appropriate to do so, a nominated person for those people detained under Part III of the Act with powers limited to care and treatment planning. They also support the intention to divert mentally ill people from prison, but have stressed the estate and services available to support this increased demand will need to be costed and put in place prior to implementation.

Trusts had previously told us that the difficult and lengthy process of decision making and transferring patients within forensic services, including the commissioning arrangements and gatekeeping assessments, were not issues that could be addressed solely via changes to the Act. We therefore welcome the government considering changes proposed by the review alongside wider reforms suggested by the Law Commission in their 'Unfitness to Plead' report, for example to better align magistrate and crown courts.

We also welcome, in principle, the government developing a stronger monitoring system to better understand and provide greater transparency on how the transfer process is working: it will be important to ensure this is not overly burdensome and any additional costs to implement this system are fully met. One trust told us it is concerned that the proposed independent body responsible for managing the flow of patients between court, prison and hospital will be overly cumbersome and bureaucratic.

We believe it makes sense for the government not to commence the statutory time limit provision proposed in the White Paper until NHS England and NHS Improvement's guidance on transfers and remissions is properly embedded. However, it is important to note that one trust told us the 28-day limit would be difficult to achieve at the moment due to the high demand on beds. We need to ensure there is enough capacity to provide care and treatment under the Act in an inpatient setting for people in the criminal justice system who require it, and investment is also put in to ensure these settings are fit for purpose across the country.

We note that the government has said it will ensure that the necessary adaptations and investment are in place before legislative changes are commenced as a final step to delivering the objective of removing police stations as a designated place of safety. It is important that this promised investment is targeted at increasing resources and capital funding for trusts to the level they will require to be

able meet the demand in hospital emergency departments and other health-based places of safety that is likely to result from this change.

People with a learning disability and autistic people

We support, in principle, the proposals to change how people with a learning disability or autism are treated under the Act. Changing the Act to make it clear someone with a learning disability or an autistic person will not be detained unless they also have a mental illness is a long overdue step. However, we would recommend the government explores further with stakeholders how the suggested criteria for use, “mental health cause” and/or “mental health condition”, will be defined: trusts have highlighted the availability of the Act is based on the presence of “mental disorder” at present.

A concern has also been raised by some trusts that, by prohibiting detention beyond 28 days in Part II settings but retaining the option of long-term detention in Part III settings, the proposed changes might have the unintended consequence of driving individuals into the criminal justice system. Trusts have concerns that these proposals, as per feedback on the detention criteria more broadly, presuppose that patients detained under Part III of the Act are inherently more risky than patients detained under Part II, which is not necessarily the case.

More broadly, trusts are concerned at the creation of two very differently described Acts, depending on whether the patient has come into a service through a civil or forensic route. This is a particular concern given people with a learning disability and autistic people remain vulnerable wherever they are, but also if they have entered the criminal justice system as a consequence of inequalities in access to care and support at an earlier stage. The CQC’s [interim report](#) from its recent review into the use of restraint, prolonged seclusion and segregation found that opportunities were missed early in the lives of the people with a learning disability and autism to prevent their admission to hospital, and the ‘system of care’ is not fit for purpose.

We have also [highlighted](#) that there is clear evidence of a historical inequity in the development, commissioning and provision of care and support for people with a learning disability and autistic people, which means that many individuals are not able to access the care and support that they need, from diagnosis and throughout their lives, in a timely way. Historical under-investment in the NHS’ core capacity to deliver services for people with a learning disability and autistic people, exacerbated by a sustained period of cuts to local authority support, is a key issue to address. Further significant challenges impacting trusts’ ability to consistently provide the right level and nature of

support for these groups of individuals include: increasing demand, disjointed and fragmented approaches to commissioning, workforce shortages – particularly of specialist staff, and constrained funding for high-quality services in the community and social care.

We would welcome in principle the creation of a new duty on local commissioners to ensure adequacy of supply of community services. However, this proposal needs to be backed by substantial, sustainable investment, especially for social care, given the current lack of robust community providers and specialist staff to deliver such services. We also welcome, in principle, the introduction of a supplementary duty on commissioners that every local area should understand and monitor the risk of crisis at an individual level for people with a learning disability and autistic people in the local population through the creation of a local “at risk” or “support” register. Trusts would welcome clarity on what the consequences are for those areas failing to comply, as well as more detail on how the government envisages local registers being resourced, supported and monitored.

With regards to overcoming challenges around use of pooled budgets and reporting on spend on services, we have **emphasised** the need for local systems to keep a sharp focus on the need to invest and strengthen community services and disinvest in inappropriate and poor-quality care. However, funding mechanisms also need to be improved and made more transparent. This would help to guarantee that funding for the sector reaches the frontline services that people with a learning disability and autistic people rely on and need most, and is invested in establishing the full range of high-quality services these groups of individuals need to live as independently as possible. Prioritising the NHS long term plan’s ambition to give people a personal health budget where possible, with the appropriate governance and safeguards, is also important so that funding truly follows service users and they can get the tailored and bespoke packages of care required.

More fundamentally, immediate action needs to be taken nationally and locally to tackle the stigma associated with learning disabilities and autism, and raise awareness of the need to improve the accessibility and quality of care and support for these groups of individuals. This is vital to ensuring appropriate support and priority is given to the full range of services people rely on, at levels which reflect the significant structural inequities these groups of individuals and services have suffered historically. A key part of improving accessibility and the quality of the care and support people receive is through the delivery of reasonable adjustments in mainstream inpatient settings, when they are appropriate, which is already a national requirement. Discussions and decision making regarding the best approach to delivering high-quality, person centred care in highly specialist and forensic settings also needs to be more balanced and evidence-based, taking into better account the nature

of the care and support provided by these services and the geographic spread of their service user populations as per the approach taken for specialist physical health services.

Role of the Care Quality Commission

Trusts have a vital role to play in overseeing how the Act is working at a local level, ensuring that there is the right culture on wards, and feedback from service users is actively sought out and acted upon to improve people's experience of care. However, we know the wider health and care system working effectively together in partnership is also crucial to ensuring the nature of care being delivered to people is appropriate and available in the right setting. We believe that CQC, as a national regulator, has an important role to play in drawing attention to systemic barriers and would be able to do this more effectively if its monitoring powers were extended to consider the effectiveness of local joint working; we therefore support this proposal in principle.

There is an appetite among trusts to explore how this proposal could improve the quality, safety and experience of care and care pathways. For example, this may include CQC supporting trusts and system partners to look into reasons for delayed admissions and discharge and use this information to make improvements locally, while recognising the roles of other national bodies in this space.

In developing this proposal, we would emphasise the importance of clear lines of responsibility, accountability and decision making within systems and for their constituent organisations. We also need to be clear about how the government envisages CQC assessing and responding to issues that lie outside of its remit or a system's control. Finally, it is important that the implementation of this proposal does not add unnecessary bureaucracy and burden for trusts or duplicate other work already underway nationally.

Impact assessment

All changes to the Act and associated regulations and guidance that will result in increased costs to providers need to be fully and promptly funded, on a sustainable basis, to ensure that they can be appropriately taken forward. Financial plans for all associated costs will need to be included in trusts' budgets for the years the government expects them to be incurred: finance teams in previous years have needed to develop business cases by October in order to secure any additional funding that might be necessary for the following financial year.

We welcome efforts in the current assessment to account for the fact the Act operates in a complex and dynamic system as much as possible. We note that there are a number of recommendations for

which costs have not been provided because further consultation or work is required before any reliable estimates can be provided. We would be happy to support, where helpful and appropriate, further engagement between the government and trusts to aid efforts to make the impact assessment reflect the effect of the final policy as accurately as possible.

It will be important for the assumptions used in all the models and underlying cost estimates to take into account the short and longer term impacts of the Covid-19 pandemic on mental health and services, as well as the anticipated reforms in the forthcoming Health and Care Bill and wider transformation work underway within the NHS.

Policy issues warranting further consideration

Wider reforms to the health and care system

We welcome the government emphasising its commitment to working closely with national and local health and care organisations to understand the impact of reform of the Act and to develop a robust and achievable plan for implementation. This will need to take into account the demands placed on the system by wider transformation plans and the capacity of health and care staff to deliver what is required.

Reform of the Act needs to be aligned with the reforms expected to be made in the forthcoming Health and Care Bill, as well as wider transformation work underway within the NHS. System working is a key vehicle for supporting health and care organisations to improve and co-ordinate local planning, better integrate services, and to maximise the use of collective resources. However, we also need to address in the round how mental health services and other system partners delivering interdependent services are resourced, commissioned and funded – the nature of demand across local systems is not straightforward, with increasing numbers of individuals presenting with complex needs that can require a response from multiple services. At the moment, services struggle to consistently intervene early enough to meet the needs of people with mental illnesses and prevent crises or more serious illness developing, making use of the Act to admit more likely.

Trust leaders have also stressed the importance of public health leaders at national and local levels developing prevention strategies which align with their inpatient and community pathways. Planned changes to the organisation of public health at a national level offers a window of opportunity to rethink the way population mental health, health inequalities and public health services are coordinated and delivered to the benefit of people with mental illnesses as well as the population's health and wellbeing more broadly.

Children and young people

Trusts are keen to ensure reform is focused on children and young people as much as adults, and so welcome government proposing that all legislative changes will be available to children and young people, and care and treatment plans are provided to all children and young people receiving inpatient mental health care. The inequitable arrangements for children and young people compared with adults assessed under the current Act is a key issue trusts have raised with us previously. Broader key issues include: shortfalls in CAMHS services; increasing demand for mental health services and support for children and young people; lack of access to specialist CAMHS Tier 4 beds; and often protracted waits for children and young people in suboptimal areas in general hospitals. These issues are worsening, and trust leaders are clear that the need for a more effective model of care for children and young people is greater than ever.

Improving quality, inpatient safety and risk

We welcome the focus in the White Paper on the importance of the government, NHS and other partners working together to bring about an overall cultural change within mental health services, including a national quality improvement programme looking specifically at care under the Act to enable and support this system-wide drive for change. We also welcome the government's commitment to ensuring the new patient safety interventions and programmes make positive contributions to the therapeutic environment of mental health settings.

This work will require additional resources – for example, training for inpatient staff – but more broadly, we remain concerned that quality of care and patient safety may be at **increasing risk** due to the mismatch between demand for services and the overall funding, capital and workforce available. Despite the pressures of the last few years, quality has in most cases been maintained and most people have a good or excellent experience of care. However, we cannot continue to rely unreasonably on staff goodwill and resilience, especially in the context of the extended, intense pressures of the pandemic.

Mental health trusts also need capital investment, allocated quickly, fairly and transparently. The under-prioritisation of investment in the mental health estate is **having a real impact** on trusts' ability to ensure a safe and therapeutic environment, and promote an individual's rehabilitation and recovery. The longstanding neglect and underinvestment in the mental health estate is rooted in the **historical, structural disadvantage** the sector has suffered compared to physical health provision. This was exemplified by the last announcement on investment in new hospitals almost entirely overlooking the needs of mental health trusts, as well as **the delay in allocating the funding to eliminate** mental

health dormitory wards, which made it harder for mental health trusts to plan effectively and deliver maximum value for patients as the money needed to be spent in-year.

Whilst the national patient safety strategy continues to bring much-needed clarity, consistency and alignment to patient safety efforts across the NHS, it is vital that trusts are supported through training, expertise and resources to fully embed an effective safety culture. The upcoming framework for involving patients in patient safety provides an opportunity to share deeper insights on the approaches to patient engagement that work, including the level of resources and time invested, and lessons learned.

Finally, we would note that it takes a whole board and whole organisation approach to embed a just culture. Furthermore, despite progress and commitment from providers, a blame culture arguably still exists within the NHS. Compassionate and inclusive leadership from provider boards remains fundamental in addressing this, but positive behaviours must also be modelled at all levels of the system including by national and regional bodies. Clarity and alignment on what systems and processes support compassionate and inclusive leadership is also crucial.

Workforce expansion

We welcome the White Paper recognising that reforms to the Act will require further expansion of the workforce, over and above what the NHS long term plan sets out to deliver. Shortfalls in the number and skill-mix of staff in the mental health sector pose the most pressing challenge to the sustainability, accessibility and quality of services, and will take a number of years to resolve.

Trusts have been **working hard** over the years to meet the workforce gaps they face, by using new roles, changing skills-mixes, and pursuing a range of recruitment and retention initiatives. However, the impact of these steps are limited without greater national progress on growing and funding the domestic pipeline and retention initiatives.

We are still waiting for a fully costed and funded national workforce plan for the longer term that builds on the steps taken to grow the mental health workforce to date, taking into account the new context trusts are now operating in. There also remains a need for national policy makers to align their thinking across the health and social care sectors.

Tackling disparities in the experiences of Black, Asian and minority ethnic communities

The inequalities in experiences of people from Black, Asian and minority ethnic backgrounds is a significant source of concern for trust leaders. The government is right to emphasise in the White Paper that a targeted, multi-pronged approach is crucial to improving these groups of individuals' care and treatment – and in particular people of black African and Caribbean descent – under the Act. It also rightly acknowledges the need for this approach to be taken to better support these groups of individuals' access to services and the disparity in their outcomes from earlier interactions with the mental health system more broadly. Trusts have expressed support for the specific proposal to legislate for culturally competent advocacy to be available to detained patients, subject to successful learning from pilot schemes and appropriate funding and resources following.

The White Paper also puts an emphasis on plans NHS England and NHS Improvement has already set out, in its *Advancing mental health equalities strategy*, to support local health systems to better address inequalities in access, experience and outcomes of mental healthcare more broadly. We welcomed the strategy, and its focus on the need to identify and share positive practice so that local areas can learn from what works in a systematic and coordinated way. It is also right for NHS England and NHS Improvement to prioritise supporting local systems and improving data and information, given the need for a greater understanding within systems of the mental health and wellbeing needs of the specific communities they serve, and for services that meet these needs to be prioritised by systems accordingly.

The strategy also rightly emphasised that, while the NHS cannot alone solve the causal factors which increase the likelihood of individuals developing a mental health problem, it is the NHS's duty to advance equalities in NHS services. Trust leaders have stressed that, while progress is being made on race equality in the NHS, it is clear more must be done to tackle structural racism, bias and discrimination – both within the NHS and across other public services as well as society as a whole – and they are committed to doing all they can to address systemic inequality. As one trust leader told us: *"The overrepresentation of BAME people in hospitals has many different factors including psychosocial issues linked to understanding of mental health and the medical model, but I have always believed that the concept of "dangerousness" plays a part i.e. a 6 foot 5 BAME male is routinely considered more dangerous and more of a risk to others than a 6 foot 5 white British male and is consequently more likely to be sectioned and detained more often even with same presentation. There has to be a concerted effort to address this in mental health."*

Recommendations put forward by the chairs and chief executives ethnic minority network to NHS England and NHS Improvement most recently would be a good starting point for action within the NHS specifically.

Trust leaders have also emphasised to us the need to consider wider inequalities experienced by the communities they serve, including in housing, employment and other areas affecting life chances. Broader action is needed to tackle these wider determinants of mental ill health, which includes national policy focused on increased support for public health as well as mental health. Further key priorities for action to address the historical, structural disadvantage facing mental health provision which impacts on access, experience and outcomes of mental healthcare include: ensuring the sector receives its fair share of revenue and capital investment; improving and making funding mechanisms more transparent; and setting clear expectations around the delivery of national investment and initiatives.

Data and digital

The advances in the use of digital technologies made by services during the pandemic may offer a way of improving the pathways set out in the Act, as well as aspects of current models of care and aiding earlier intervention more broadly. One trust noted that, during the pandemic, a number of patients preferred remote attendance at tribunal hearings, and we understand many services plan to continue to use technology to improve choice and access.

However, trusts have emphasised the importance of having clear guidance from government to ensure the implementation of any changes is consistent across the country. Trusts leaders are also conscious that there are still significant barriers to overcome – including accessibility, information governance issues and the appropriateness of a digital setting for some therapeutic interventions and each patient's individual needs – and of the need to assess and evaluate the impact of delivering services digitally over the longer term.

More broadly, we are keen to see a broader approach taken to digital funding, with clarity provided to trusts about how they can expect to make longer term, sustainable investments in digital ways of working, that recognises both the revenue and capital implications. Trust leaders themselves will be best placed to make investment decisions. For many, this will involve investing in core infrastructure to make things easier for staff: from improving wi-fi coverage to fixing slow log in times.

We welcome the government recognising that improving data is a critical enabler to the wider system changes and ambitions set out in the White Paper. It is right that trusts and national bodies prioritise working together to make further progress on data collection and data quality to give a better understanding of mental health activity, access and outcomes that can then enable better commissioning and the provision of services.

It will be important for the government to prioritise making decisions around required changes to data monitoring and national documentation, and provide that clarity to trusts as early as possible to assist the preparations they will need to make, and the consistency of recording, data monitoring and reporting on the use of the Act more broadly going forwards.