

Written submission to the Joint Committee on the Draft Mental Health Bill

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 foundation trusts and 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 England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

Key points

- We welcome the publication of the draft Mental Health Bill and look forward to the government prioritising the introduction of this legislation and taking the necessary steps to progress the broader changes to policy and practice required.
- We support proposals to simplify the Act and make changes that maintain appropriate safeguards, while enabling greater individual rights and liberties, as well as enabling service users to have 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. Good practice needs to be shared, and its implementation supported, in a systematic and coordinated way.
- However, reform of the Act alone will not be enough to improve how and where good quality mental health services are accessed. We welcome the acknowledgement of this in the 2021 white paper and the paper's further proposals, as well as planned and ongoing work, to reform policy and practice more broadly.
- 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 a crisis point necessitating use of the Act to admit.

- Full funding, on a sustainable basis, of the expansion of community-based specialist mental health care capacity is required to meet the demand for mental health services and to ensure 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. Public health and social care need additional support given the crucial role these services play in providing people with the wider care and support and helping many avoid reaching a crisis point.
- We welcome the engagement on the Bill to date, and look forward to working with government to ensure the impact of reform on the system is understood and to develop a robust and achievable plan for implementation.

How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should those risks be mitigated?

Dividing line between the Mental Health Act and Mental Capacity Act

The lack of clarity around the interface between the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) has been a longstanding cause for concern for trusts. A number of trusts have previously suggested to us that the demarcation between the two Acts should be 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 trust believed that the existing nuanced case law position would ensure more appropriate options for patients than an unsuitable, artificial simplification.

We therefore welcome the plan to assess the impact of Liberty Protection Safeguards (LPS) before introducing reforms to the MHA to ensure that any gaps can be addressed. However, some trusts have expressed their concern that there will not be a clearer dividing line between the two Acts in the meantime and believe this is a missed opportunity to help practitioners decide which legal framework would be most appropriate. Trust leaders have stressed the importance of the codes of practice for each Act providing clear guidance and case studies, including flow charts, to assist in such decision-making.

Wider reforms to the health and care system

Reform of the MHA takes place within the context of the reforms made by the Health and Care Act 2022 (the 2022 Act), as well as wider transformation work underway within the NHS and across government. We welcome the provisions in the 2022 Act to increase transparency in mental health spending, with the Secretary of State now required to publish government expectations as to increases in mental health spending by NHS England and integrated care boards (ICBs). ICBs are also required to report on mental health spending and include in their membership an individual with expertise and knowledge of mental illness. Wider strategic changes like the triple aim will also have an impact, alongside broader developments such as the mooted cross-government mental health plan.

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 how mental health services and other system partners delivering interdependent services are resourced, commissioned and funded. At the moment, services struggle to consistently intervene early enough to meet the needs of people with mental illness and prevent crises or more serious illness developing, thereby making use of the MHA to admit more likely.

Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?

We agree that the Act must hold 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.

We also welcome the principle behind the provisions reforming the detention criteria to ensure people in all areas of the country are detained only when and for as long as necessary. However, it will be important for the Bill to make clear that 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. Trusts have highlighted that there are already significant pressures on community services as well increasing levels and complexity of need at the point of contact with services, and they are concerned about how this need can be met outside of hospital detention under these circumstances without negatively impacting on the safety of patients and others.

Trusts have also told us that the criteria of “therapeutic benefit” requires further clarification, and there will need to be clear guidance provided, to fully understand the implications of these changes in

practice and to ensure they are interpreted by all parties consistently. Further issues that trusts have highlighted they would welcome clarity on include clarifying:

- 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;
- how, as proposed, the further checks on whether a patient's detention continues to be appropriate would be introduced; and
- the definition of "serious" (with trusts flagging that, if this is meant to be a higher bar than currently, then this will need agreement and understanding from partner agencies).

A number of trusts 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 identified the tension between the "therapeutic benefit" guiding principle and the right to refuse treatment, while another told us they felt there is a contradiction between the principle of early intervention and increasing the threshold of detention to serious harm.

Both cautioned that refusing some treatments, or delaying interventions, until there is a high probability of serious harm, may lead to patients staying in hospital for longer and receiving suboptimal care. This is not just because of the severity of an individual's condition is likely to be worse in such circumstances, but also because of the impact on their personal circumstances. For example, they may have put their tenancy or placement at risk, or their home may be severely neglected resulting in a delay in discharge to suitable accommodation, or they may have become isolated and there may be damage to relationships with family and friends, or significant debts accrued, that take longer to repair.

It will be important to ensure staff have sufficient capacity to deliver on provisions aimed at increasing patient autonomy in a meaningful way in practice, such as the duty on the clinician in charge of the patient's treatment to consider certain matters and take a number of steps when deciding whether to give treatment under Part 4 of the Act. Trusts have also highlighted existing demand on second opinion appointed doctors (SOADs) is high and they have concerns about timely access to a SOAD under current proposals and the knock-on impact of this on timely treatment and the best outcomes for patients.

To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black African and Caribbean heritage? What more could it do?

Experiences of people from Black, Asian and minority ethnic backgrounds

The inequalities in experiences of people from Black, Asian and minority ethnic backgrounds is a significant source of concern for trust leaders. They are supportive of the proposal to legislate for culturally competent advocacy to be available to detained patients, working on the basis that they will be able to build on the learning from pilot schemes and access appropriate funding and resources. One trust has also suggested that the draft Bill should include a previous proposal to time-limit or remove Community Treatment Orders (CTOs) from statute to help tackle Black, Asian and minority ethnic patients being disproportionately treated via CTOs.

However, there is more that needs to be done beyond changes to legislation. During the development of proposals for this draft Bill, the government **rightly emphasised** that a targeted, multi-pronged approach is crucial to improving these groups of individuals' care and treatment under the Act, as well as their earlier interactions with the mental health system more broadly. We need to see sustained support for local health systems to better address inequalities in access, experience and outcomes of mental healthcare. Trusts have also told us they would welcome national support to take effective action on race equality by providing challenge, sharing best practice resources, and holding boards to account.

Trust leaders agree that more must be done to tackle structural racism, bias and discrimination and they are committed to doing all they can to address systemic inequality. They have also emphasised the need to consider wider inequalities experienced by the communities they serve, including in housing, employment, public health and other areas that have a profound effect on life chances and mental health.

Experiences of people with learning disabilities and autistic people

We expect that the move to make it harder for patients with a learning disability and autistic people, without a co-occurring mental disorder, to be detained may improve the experiences of these patients. However, without investment in alternative care pathways it is unclear to what extent the inequalities facing these patients will be addressed.

What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?

We support the principle of the provisions changing 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, a concern has been raised by a number of trusts that an unintended consequence of the proposed changes to the Act might be these groups of individuals staying in hospital for long periods of time, but held under the Mental Capacity Act rather than the MHA which will provide them with fewer legal safeguards. Trusts have also highlighted that patients with a learning disability and autistic people not being subject to section 3 would impact section 117 aftercare and potentially make finding community placements more complicated than it is currently. Trusts have also highlighted there are difficulties with being able to decide within 28 days whether a person's challenging behaviour is due to a mental illness, social and/or environmental factors for the majority of clinical presentations that meet the criteria for detention under the MHA, given the complex inter-relationship of biological, psychological and social factors in a patient's condition.

Trusts are also concerned that by prohibiting detention beyond 28 days in Part 2 settings, but retaining the option of long-term detention in Part 3 settings (with these settings as defined in the Mental Health Act 1983), the proposed changes might have the unintended consequence of driving individuals into the criminal justice system, or lead to increased use of medication in the community. Trusts have concerns that these proposals presuppose that patients detained under Part 3 of the 1983 Act are inherently more risky than patients detained under Part 2, 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 via a civil or forensic route. This is a particular concern given the potential vulnerabilities of people with a learning disability and autistic people, and we are also mindful that they may have entered the criminal justice system as a consequence of inequalities in access to care and support at an earlier stage. The CQC has previously [found](#) that opportunities were missed early in the lives of people with a learning disability and autistic people to prevent their admission to hospital and the 'system of care' for these groups of individuals is not fit for purpose.

Beyond this legislation, it will important to address the [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.

New duties on integrated care boards

We welcome the introduction of a duty on integrated care boards (ICBs) to establish and maintain a register of people usually resident in its area who the ICB considers to be autistic or have a learning disability and who are at risk of detention under Part 2 of the 1983 Act. Trusts would welcome clarity on how the government envisages local registers being resourced, supported and monitored.

We welcome the provision that ICBs and local authorities must have regard to the information on the register that covers their area when fulfilling their commissioning functions. We have previously **emphasised** the need for local systems to keep a sharp focus on the need to invest and strengthen community services for people with a learning disability and autistic people and disinvest in inappropriate and poor-quality care.

This provision needs to be backed by substantial sustained levels of investment, especially for social care, given the current lack of robust community providers and specialist staff to deliver such services. Funding mechanisms also need to be improved and made more transparent, and we welcome provisions in the 2022 Act requiring the government to set out its expectations for levels of mental health expenditure by NHS England and ICBs. Greater transparency 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 bespoke packages of care required.

More fundamentally, 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 historically suffered. Key here is delivery of reasonable adjustments in mainstream inpatient settings, when they are appropriate, which is already a national requirement.

Decision making regarding delivery of high-quality, person-centred care in highly specialist and forensic settings also needs to be more balanced and evidence-based. Better account needs to be taken of the nature of the care and support provided by these services and the geographic spread of their service user populations. This would better mirror the approach taken for specialist physical health services.

To what extent will the draft Bill achieve its aims of reducing detention, avoiding detention in inappropriate settings and reducing the number of Community Treatment Orders?

Reducing detention and avoiding detention in inappropriate settings

We welcome the aspirations behind the proposed reforms to the detention criteria and processes for challenging detention, though a number of elements require clarification to fully understand the implications of any changes in practice and to ensure consistent interpretation by all parties. This includes clarifying:

- 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;
- how, as proposed, the further checks on whether a patient's detention continues to be appropriate would be introduced; and
- the definition of "serious" (with trusts flagging that, if this is meant to be a higher bar than currently, then this will need agreement and understanding from partner agencies).

It will also be important to assess the impact of more frequent reviews and renewals on trusts' resources and staff workload.

We are concerned that the proposed distinction between Parts 2 and 3 of a reformed Act in relation to the detention criteria may cause some confusion: it is not necessarily the case that patients detained under Part 3 of the Act are inherently more risky than patients detained under Part 2. The proposal to tighten Part 2 criteria may also risk inadvertently pushing people into the criminal justice

system, as well as potentially raising the access threshold, with people who are a significant risk to themselves or others needing to be more acutely unwell in order to access care and treatment. We need to ensure that 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 meets their needs as soon as possible. This is about investing in community-based mental health support, including crisis care, which is delivered in a way that meets the needs of local populations, and particularly those groups of individuals who have been historically under-served.

Some trusts have fed back to us that they do not feel the proposed changes to the Act will change detention rates. This is due in part to the subjective nature of criteria. Clinicians also feel the thresholds for detention have already risen significantly over the last decade and they have worked hard in this time to avoid unnecessary use of the Act. One trust said they were uncertain of the impact on detention rates given current issues with bed availability and limited community resources. We must 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.

Other trusts have highlighted that there are significant challenges with current risk assessments accurately predicting risk and this may make it difficult for individuals to meet the criteria for high probability particularly in the short term. Risk assessments are based on research that investigate outcomes in a group of individuals with certain characteristics over defined periods of time, and therefore do not translate easily to assessment of an individual at a point in time.

In supporting patients who will not meet the criteria for detention under a reformed Act and when using least restrictive approaches, trusts have highlighted 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. Trusts have also highlighted the importance of monitoring whether there are more adverse outcomes following MHA assessments that do not result in detention and taking this fully into account when incidents are investigated or reviewed.

Community treatment orders

We welcome the provision to revise the criteria for the use of CTOs and enhance the professional oversight required for any CTO. Trusts have previously told us that the scope of mandatory restrictions under CTOs is complex and CTOs are ineffective at preventing readmissions, but the changes proposed should ensure a more rigorous approach to the making and extension of CTOs.

Nevertheless, some trusts have also shared concerns that the additional requirements may result in the unintended consequence of a small number of individuals becoming 'revolving door' patients, or an increase in the use of section 17 leave. We have also heard concerns from some trusts that the draft Bill does not take up the proposal to time-limit or remove CTOs from the statute, which could have helped reduce black, Asian and minority ethnic patients being disproportionately treated via CTOs. It will be important that the government monitors the effects of the changes, particularly the impact of increasing evidence requirements.

What changes and additional support do you think will be needed to help professionals and the third sector implement the proposals effectively? Will additional staffing and resources be required?

Workforce

Trusts have told us there will be a significant impact on their multidisciplinary teams across all services, particularly as a result of the significant increase in tribunal activity. One trust has highlighted the move from three-yearly to annual referrals for restricted patients as a particular area of concern given the degree of preparatory work required for these often complex cases. Even if the proposed changes to section 3 admissions result in shorter periods of detention, the overall throughput of admissions is unlikely to reduce so tribunals will become a much more common feature of life in acute wards which will need to be resourced accordingly for the requirements to be workable. Using statutory care and treatment plans as a basis of the responsible clinician's report has been suggested as a potential way to help to reduce the burden of report writing.

The 2021 government response to the consultation on its white paper **acknowledged** that its proposed reforms to the MHA will require an expansion of the workforce, over and above current commitments. While there has been a welcome focus, and some good progress made, to grow the mental health workforce in recent years, adequate investment is crucial and retention is also a significant challenge, with thousands more staff required to deliver the ambitions for the sector. Moreover, with 132,000 vacancies across the NHS, greater robustness and transparency in support of long-term workforce planning is essential. We are disappointed that provisions in the 2022 Act remain limited to the Secretary of State reporting on workforce responsibilities, when the opportunity was there to help find a way forward to ensure the NHS and social care workforce could be put on a sustainable footing.

Funding

The same government response to the white paper consultation also **acknowledged** that the proposals will require additional funding over and above current commitments. Funding will be needed for training to enable compliance with a new Act, as well as to deliver specific proposals, for example expanding and improving advocacy services, making them culturally competent, and removing police stations as designated places of safety.

Sustained funding for community-based specialist care will also be crucial to mitigating the potential unintended consequences of some proposals. For example, caring for people who will not meet the new criteria for detention, and in particular specific vulnerable groups of individuals such as people with learning disability and autistic people. Capital investment will also be required to ensure there is capacity for people who require care and treatment under the Act in an inpatient setting, as well as more broadly to ensure mental health care settings are fit for purpose across the country.

Funding and investment are also fundamental to addressing the underlying issues driving the pressures on services and compounding the rising severity and complexity of people's needs. Longstanding pressures on providers, combined with inconsistent investment in mental health services at local levels, continue to exacerbate capacity pressures and increase the likelihood that a person may reach crisis point necessitating use of the Act to admit. There must also be increased support for public health and social care given the vital role these services play in providing people with the wider care and support they need and helping many avoid reaching crisis point.

How far will the draft Bill allow patients to have a greater say in their care, with access to appropriate support and avenues for appeal?

We support changes to the 1983 Act that enable service users to have a more active role in their care planning with a focus on recovery. We have said previously that more effort must 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, and making care and treatment plans statutory should help with this. It will be important to ensure health and care staff have sufficient capacity to deliver this provision as intended in practice.

We also support provisions that increase individuals' access to a mental health tribunal, but the impact of these provisions on trusts' resources and workload needs to be fully assessed. Some trusts have told us the changes may require staff to spend more time writing reports and attending

tribunals, and risk negatively affecting patient care if not accompanied by a commensurate increase in staffing levels. Consideration also needs to be given to how trusts will be able to ensure the physical space is available to accommodate an increased number of meetings.

Trusts support there no longer being an automatic referral to a tribunal for CTO revocation, though the importance of making special provisions to ensure people in specific circumstances do not fall through the net is also a concern.

Advocacy

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 by trusts 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. Enhancing standards, regulation and/or accreditation could help to improve services, and many trusts have told us that the focus should be on increasing resources for advocacy services first and foremost.

What do you think of the proposed replacement of “nearest relative” with “nominated persons”? Do the proposals provide appropriate support for patients, families and nominated people?

We support updating the nearest relative provisions and, broadly, the proposed additional powers of the nominated person. Some trusts have told us they anticipate that the mental health tribunal will have a key role to play in making further determinations if a person’s choice is potentially inappropriate or harmful.

Trusts have also highlighted that 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 trust has said that, while they support moves to maximise the

nominated person's participation by consulting them at junctures other than when considering making an application under the Act, the ability to waive this due to non-practicability should also be made clearer in the Bill. When revoking or assuming the role of a nominated person, trusts also told us that the direct involvement of an approved mental health professional (AMHP) risks placing an unnecessary strain on their resources. They have suggested such matters could be dealt with via a delegated representative with an obligation to update the local authority on any material change in the patient's circumstances.

Trusts have raised concerns that there may be a risk 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. Trusts have highlighted to us that new duties for the responsible clinicians to consult with the nominated person at the point of the renewal of a detention will need to be carefully managed to ensure this is a meaningful safeguard.

To what extent is the Government right in the way it has approached people taking advance decisions about their care?

Trusts raised questions through our engagement with them during the white paper consultation process last year on the proposals regarding advance choice documents and care and treatment plans. We would welcome further engagement by the government here. For example, trusts wanted 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 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 reported to the director with a requirement to complete and submit this within 24 hours.

We have also stressed previously the importance of making sure the language used in matters regarding advance decision making is consistent to ensure clarity for service users and clinical staff. Trusts raised concerns with us about the different terminology used in the white paper compared to the MCA and National Institute for Health and Care Excellence (NICE) guidelines and quality standards. One trust 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 highlighted that advance decision making options are supported by quality standards for which compliance can be audited.

What impact will the draft Bill have on children, young people and their families? Does it take sufficient account of the existing legal framework covering children and young people?

The inequitable arrangements for children and young people compared with adults assessed under the current Act is a key issue. Trusts are keen to ensure reform is focused on children and young people as much as adults, and so welcomed the earlier proposal 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. Trusts have stressed the importance of taking into account recent case law regarding parental consent, and that robust guidance is required regarding the appointment of a nominated person for children under the age of 16.

There are also broader key issues here, including:

- shortfalls in child and adolescent mental health services (CAMHS);
- 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.

To what extent are the proposals to allow for conditional discharge that amounts to a deprivation of liberty workable and lawful?

Broadly, trusts believe this is a positive development as it, with the appropriate oversight by the tribunal, will enable a less restrictive environment for these relatively rare cases. Trusts have stressed the importance of staff involved in such cases having the protection of a judicial decision to ensure that their actions for the protection of the wider public are lawful and supported. One trust has also told us that they expect that there will be a positive impact in terms of length of stay for the small number of patients where these new arrangements will apply.

What are your views on the proposed changes in the draft Bill concerning those who encounter the Mental Health Act through the criminal justice system? Will they see a change in the number of people being treated in those settings?

Trusts have told us that the inequitable arrangements for patients in the criminal justice system compared with others assessed under the 1983 Act is a key issue for reform. Trusts also expressed support 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 2 and Part 3 of the 1983 Act, they will be required to operate under two different criteria for detention. They are also concerned that the proposed changes to the detention criteria may mean that people who are a significant risk to themselves or others need to be more acutely unwell than their civil counterparts in order to access the care and treatment they require.

Trusts have also expressed concern that the 28-day limit on transfers from prison or immigration removal centres to a secure hospital depends on the number of patient beds available, as well as means of transport and the location of a secure hospital. We welcome earlier government acknowledgement of these concerns and clarification that requirements will only commence once NHS England guidance on transfer and remissions has been fully embedded. We need to ensure there is enough fit for purpose capacity to provide care and treatment according to legislative requirements in an inpatient setting for people in the criminal justice system who require it.

Are there any additions you would like to see to the draft Bill?

Trusts would like to see some clarification in respect of the current Hospital Managers role and how this will look going forward as this was one of the most debated aspects of the independent review.

In addition, some trusts have expressed disappointment that the proposals to extend the use of section 5(2) 'holding powers' to Emergency Departments have not been taken forward in the Bill. However, others have said that, while in principle they supported the proposals, in practice it is not workable given the significant operational pressures in these settings in addition to the need to implement the new MCA.