Mental Health Bill

Lead department	Department for Health and Social Care
Summary of proposal	The proposal seeks to use primary legislation to modernise the Mental Health Act to improve safeguards in the health and social care and justice systems.
Submission type	Impact assessment (IA) – 31 October 2024
Legislation type	Primary
Implementation date	tbc
Policy stage	Final
RPC reference	RPC-DHSC-5184(2)
Opinion type	Formal
Date of issue	13/12/2024

RPC opinion

Rating[1]	**RPC opinion**
Fit for purpose	The IA provides sufficient evidence and analysis for the RPC to be able to validate the EANDCB. The assessment of impacts on small and microbusinesses is sufficient. The Department has provided a thorough cost benefit analysis, with a good discussion of wider impacts and monitoring and evaluation.

Business impact target assessment

	Department assessment	**RPC validated**
Classification	Non qualifying provision	Non qualifying provision
Equivalent annual net direct cost to business (EANDCB)	£0.7 million	£0.7 million *(2019/20 prices, 2019/20 pv)*
Business impact target (BIT) score	Not provided	
Business net present value	-£10.9 million	
Overall net present value	-£119.3 million	

[1] The RPC opinion rating is based only on the robustness of the EANDCB and quality of the SaMBA, as set out in the Better Regulation Framework. RPC ratings are fit for purpose or not fit for purpose.

RPC summary

Category	Quality[2]	RPC comments
EANDCB	**Green**	The Department has sufficiently set out the assumptions, data, and calculations behind its estimates of the impact of the proposal, based on a share of the health sector cost being incurred by private providers. The IA has accurately classified of impacts into direct and indirect and is in line with RPC guidance.
Small and micro business assessment (SaMBA)	**Green**	The IA includes an adequate SaMBA, describing the possible impacts on independent health and social care and advocacy providers. The assessment would benefit from discussing potential courses of mitigation for Small and Micro businesses.
Rationale and options	**Satisfactory**	The IA presents evidence from the 2018 Independent Review and the Care Quality Commission (CQC) to form the rationale for intervention. The Department presents its preferred option as a single package of measures assessed against a 'Business as Usual' scenario. The IA would benefit from discussing the possibility of alternatives to regulation as an option.
Cost-benefit analysis	**Good**	The IA provides a detailed cost-benefit analysis of the proposal to calculate the net present value (NPV) over a 20-year appraisal period. The assessment also does well to illustrate some of the un-monetised benefits qualitatively. Break-even and sensitivity analyses have been used to test the scale of benefits required to offset the costs and the modelling input and assumptions.
Wider impacts	**Satisfactory**	The IA provides a satisfactory assessment of the proposal's impacts on patients across different categories, including race, age and gender, deprivation and geography. The IA could be improved to include a discussion on the risks of delayed or interrupted implementation to the realisation of the impacts.
Monitoring and evaluation plan	**Good**	The assessment includes a good M&E plan, with a clearly set out timeframe, potential data sources and evaluation questions. This could be improved by considering the potential effect of external factors and unintended consequences.

[2] The RPC quality ratings are used to indicate the quality and robustness of the evidence used to support different analytical areas. The definitions of the RPC quality ratings can be accessed here.

Summary of proposal

The Mental Health Act 1983 (MHA) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. It provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others.

Following an independent review, conducted in 2018, it was concluded that the MHA was out of step with a modern-day mental health service and in significant need of reform. The Department is proposing to reform and modernise the MHA to include the following provisions:

- To set the detention criteria or thresholds against which decisions are made to detain an individual or keep them detained.
- To amend the discharge protocol to require the decision maker to consult with one or more professionals concerned with the patient's care who, where relevant, must be of a different profession to the Responsible Clinician.
- To shorten the initial period that patients under certain sections can be kept in detention for treatment.
- To limit the extent to which the MHA can be applied to individuals with learning disabilities and autism.
- To strengthen patients' control over their care and treatment by enhancing the rights of patients to inform their care and treatment both at the time of detention and in advance.
- To give all formal patients statutory care and treatment plans.
- To revise the criteria for community treatment orders (CTOs) and introduce greater scrutiny that ensures a CTO is used only when absolutely appropriate.
- To improve patient representation and support by allowing patients to choose their own 'nominated person', whose role will have increased powers under the reform.
- To make the use of police cells for the detention of individuals detained under short term police powers, under the MHA, unlawful.
- To increase the frequency with which patients can make appeals on their detention; and
- To allow for patients detained through the courts with restrictions to be discharged from hospital under arrangements which will amount to a continuing deprivation of liberty.

As this policy proposal is primarily about increasing patients' rights, the most significant consequences are likely to fall upon the public sector. The measure is still considered a Regulatory Provision however as this increased responsibility will also affect private healthcare providers who treat privately funded patients.

The proposed set of measures has been assessed against a 'Business As Usual' baseline scenario, with an NPV of -119.3m (2019/20 prices, 2019/20 present value (pv) base year) over a 20-year appraisal period from 2024/25 to 2043/44. The EANDCB is £0.7m (19/20 price and pv year).

The RPC had previously issued a ‘fit for purpose’ opinion on a version of this IA in June 2022 for Pre-Legislative Scrutiny (PLS). The Department has now submitted a new version of this IA to the RPC as the policy has been updated.

EANDCB

The IA’s evidence and analysis of direct impacts on business is sufficient and the RPC can validate the EANDCB figure presented.

The IA helpfully sets out the potential ways in which the proposed reforms may affect the private sector, such as increasing demand for care provided by the NHS and local authorities that has been subcontracted to private providers, increased costs to private providers that deliver treatment under the MHA funded privately and the costs of legal representation required to patients as part of the MHA process. The Department argues that only increased costs to providers for patients that are funded privately come within the scope of ‘regulatory costs’ under the BRF. The assessment could be improved by the inclusion of potential familiarisation costs incurred by legal firms affected by the change in regulations, rather than only considering them for healthcare providers.

The Department‘s EANDCB estimate is £0.7m (2019/20 prices, 2019/20 present value (pv) base year) over 20 years, based on the increased cost to private health providers that treat privately funded patients. This has been estimated using the monetised costs estimated in the IA’s cost benefit analysis for increased staff costs, such as training costs, familiarisation and backfill costs, and process costs across a set of staff groups, including approved clinicians, nurses, key workers and admin staff. The Department has then assumed a 2.8% share of these costs will be incurred by the private sector, based on healthcare market reporting.

The Department’s analysis of the potential direct impact on businesses could be improved with greater clarity over the inclusion of relevant costs. The various costs used to make up the different components of the EANDCB are spread across the cost benefit analysis and have not been drawn together as part of the ‘Direct costs and benefits to business calculations’ section. A clearer description of the costs carried over to these calculations would make the IA more straightforward to follow and would make it easier to independently verify the EANDCB figure presented.

SaMBA

The Department has provided a satisfactory small and micro business impact assessment (SaMBA), with a qualitative assessment of how smaller businesses such as independent health and social care providers and providers of advocacy services could be affected. Due to limited data availability, the Department does not calculate the number of small and micro business in the sector. The IA notes that the costs for independent healthcare providers are likely to be small as the significant majority will be incurred by the public sector and will be proportionate to patient numbers. The Department estimates that there will be no impact on the market share of small and micro business relative to larger firms. The Department also highlights that whilst there is notable variability in the size of advocacy service providers the

reforms are unlikely to have differential impacts based on organisational size. The IA could have included further evidence and discussion on the impacts on SMBs providing advocacy services, such as details on the types of charities involved and the specific impacts that could affect them.

The Department has not exempted small and micro businesses from the proposed measures. This could be improved by the inclusion of a discussion of any possible mitigations that could apply to businesses. The SaMBA also could have been improved with an indication of the potential impact of the policy on medium sized businesses.

Rationale and options

The IA's rationale for intervention is based on evidence from a 2018 Independent Review which identified a variety of issues with how treatment is currently provided under the MHA. These include rising rates of detention, racial disparities in detentions and community treatment orders, poor patient experience and the particular disadvantages felt by people with a learning disability and autistic people. The Department does well to use clear evidence from the review to demonstrate the need for intervention. The Department has also clearly listed the intended objectives of the policy and how they will be monitored, by the Care Quality Commission (CQC).

The Department presents two options, a 'Business as Usual' baseline scenario and the preferred option, which involves implementing a range of measures to reform the MHA. In addition to this, the IA does well to set out the non-legislative actions that will accompany regulatory reform to achieve the policy objectives, such as statutory guidance via a Code of Practice, changes to training practices and the improved collection and use of data. The IA could have considered if these non-legislative actions could have formed an alternatives option to regulation, even if it was to conclude that it would not be appropriate.

Cost benefit analysis

The IA includes a comprehensive cost-benefit analysis which sets out the potential impact of the proposed policy on the health and social care sector and the justice system. This proposed set of measures has been assessed against a 'Business As Usual' baseline scenario, with an NPV of -£119.3m (2019/20 prices, 2019/20 present value (pv) base year) over a 20-year appraisal period from 2024/25 to 2043/44. This is based on increased transition, training and process costs incurred by the NHS and other organisations, alongside higher housing and care related costs for learning disability or autistic people. This is offset by some benefits, including cost savings from fewer hospital admissions as a result of the introduction of Advanced Choice Documents (ACD).

Evidence and Assumptions

The IA is based on a reasonable level of evidence. The data and assumptions used in the modelling are based on information from the NHS England, CQC and the

Mental Health Tribunal. The assessment would benefit from going into greater depth about how data from these organisations has informed specific assumptions. The Department does well to set out its analytical assumptions in detail as part of Annexes B to E. The IA has also conducted a sensitivity analysis to test some of these key assumptions.

Many of the proposed measures are set to be phased in at separate times over a 10-year period, requiring the IA to use a 20-year appraisal period to cover 10 years after implementation. This is a reasonable analytical approach. The IA helpfully provides a clearly defined baseline scenario, setting out clear assumptions for how the Department expects the sector to operate without intervention.

Methodology

The IA features a relatively short section on monetised benefits, however the assessment does well to mitigate this by including a break-even analysis to illustrate the scale of monetised benefits required to offset the costs. This section also includes an estimation of the indirect health benefits, calculated using a multiplier based on the already quantified NHS benefits. This has been excluded from the NPV, however the IA could be improved by providing a justification as to why this has been omitted.

The IA also presents the opportunity cost of redirecting resources from potential alternative uses in the NHS. This is correctly excluded in the calculation of the NPV.

The Department also notes that wider costs and benefits of investment and quality improvement that are required to deliver the wider ambitions of the Bill in terms of patient experience and treatment outcomes, "*fall beyond the scope of the legislation and therefore the IA*". The IA could be improved however by considering the potential risk that the additional funding required for reform is not forthcoming, resulting in potential resource savings and welfare gains not being realised. Similarly, the IA could also have been improved by considering the consequences of increased costs to Legal Aid. Without additional funding, this could lead to delays in the system which would have knock on effect on the tribunal backlog, delivery of services and moving of patients from in-patient to out-patient.

Wider impacts

The IA provides a detailed summary of the potential wider impacts of the proposed reforms. This includes an assessment of the possible impact on racial disparities, with an expected reduction in inappropriate treatment being provided for minority groups. This is helpfully linked to the Department's policy objective of reducing racial disparities under the MHA. The Department has also considered the potential impact on age and gender, learning disability and autism, religion or belief and deprivation.

The consideration of wider impacts could be improved by considering the potential risks associated with the policy, such as the consequences of the phased introduction of the reforms and how any disruption or delay could affect the expected impacts.

The IA also could have been improved by including a discussion of the impact on competition, such as the need for of expanded services for outpatients providing the potential an increased role for private sector providers for these services. The IA also could have considered the potential investment opportunities of expanding services in the community that could then be met by private sector.

Monitoring and evaluation plan

The IA includes a good monitoring and evaluation plan, with a PIR to take place 5 years after implementation. The plan sets out the evaluation questions it seeks to answer as part of the PIR process and what data will be used to assess the impact of reforms. This has been broken into an evaluation of the implementation of the policy and evaluating the impact on patients and carers. The assessment could be improved by including a discussion of the potential unintended consequences of the proposed intervention and the potential effect of external factors, as well as how DHSC could respond to these issues.

Regulatory Policy Committee

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