

## Health and Social Care Committee

### 10 September 2025 - Community Mental Health Services - Oral evidence

#### Witnesses:

- The Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health at Department of Health and Social Care
- Caroline Allnutt, Deputy Director for Serious Mental Illness and Offender Health at Department of Health and Social Care
- Gareth Harry, Director of Delivery, Mental Health Learning Disability and Autism at NHS England

See the full transcript [here](#)

This was the fifth and final evidence session of the Committee's inquiry into **community mental health services**, held fittingly on **World Suicide Prevention Day**. Chaired by Paulette Hamilton in the absence of the regular Chair, the session heard from Baroness Gillian Merron (Minister for Patient Safety, Women's Health and Mental Health, DHSC), Caroline Allnutt (Deputy Director for Serious Mental Illness and Offender Health, DHSC), and Gareth Harry (Director of Delivery, Mental Health, Learning Disability and Autism, NHS England). The inquiry examined the future of neighbourhood mental health centres, integration with broader health and social care, the implementation of the **Mental Health Bill**, and the resourcing of community-based provision.

#### Neighbourhood Mental Health Centres

A central focus was the pilot of **24/7 neighbourhood mental health centres**, intended to shift services from hospital to community, from analogue to digital, and from sickness to prevention. Baroness Merron argued these centres could be "transformative" because "they bring together crisis, home resolution and treatment teams under one roof" and crucially would allow people to walk in without referral.

Committee members pressed on the risks of **overwhelm**. Merron pointed to the planned recruitment of **8,500 extra mental health staff** and stressed the multidisciplinary nature of the model, including links to housing and employment support. Gareth Harry noted that pilot sites had not yet reported the feared surges in demand, explaining that the centres integrate existing services rather than add entirely new ones. International examples, such as Trieste, suggested fears of overload were not borne out in practice.

Concerns remained about **geographic inequality**, with MPs warning of a two-tier system. Merron acknowledged this risk but defended piloting as essential before national roll-out. Harry confirmed that transformation funding covers a year of pilots, but local systems were already adopting aspects voluntarily. The intention is to expand, but the **pace will depend on decisions in the Spending Review**.

#### Integration with Neighbourhood Health Models

The Committee queried how the mental health centres align with the wider **neighbourhood health centres** promised in the 10-year plan. Harry explained that while there would be overlaps, particularly through primary care, the focus of mental health centres is distinct: “Between the frail older community and those with severe mental illness there is some overlap, but not massive. That is why we are looking at a separate service, connected but not identical.”

Merron stressed that local tailoring was essential: “What we might do in a city is obviously very different from what we might do in a rural area.”

### **Co-production and Patient Outcomes**

The Committee repeatedly emphasised the importance of **co-production**. Harry stated that experts by experience had been involved “at the very heart” of developing the model, including co-designing principles of 24/7 access. He described efforts to embed **patient-reported outcome measures**, with individuals assessing their wellbeing at entry and exit, enabling more meaningful measurement of recovery, not simply waiting times.

Members pressed further: could patients define what outcomes mattered to them? Harry pointed to the forthcoming **personalised care framework**, replacing the care programme approach, where “everybody has a plan that they own.”

### **Access and Outreach**

Committee members highlighted the need to avoid confusion and thresholds that delay intervention. Merron emphasised a “**one door**” principle: “Somebody should not have to think, ‘Do I go there, or do I wait?’ They can just go, report, and they will be seen.” Harry confirmed the service was intended for crises and for earlier stages when people recognise deteriorating health.

On **outreach**, Merron stressed that assertive outreach would be universal: “We are not even waiting for people to push the door; we are going to them.” Digital access, including through the NHS app, and strong signposting via talking therapies and employment advisers, were presented as complementary.

### **Waiting Times and Standards**

The Committee pressed on **waiting time standards**. While the 2022 consultation proposed new standards, Merron conceded “waiting times are too long”, but did not give a date for introducing national targets. Harry explained that performance against the proposed four-week clinical standard was being reported but not mandated. MPs argued parity with physical health required formal standards.

### **Modern Service Framework and the Community Mental Health Framework**

Discussion turned to the **modern service framework for severe mental illness (SMI)**, due to be published next year. Merron said it would “support consistent, high-quality and high-value care” and define evidence-based interventions. Harry and Allnutt stressed it built upon, not replaced, the **2018 Community Mental Health Framework**, learning from patchy implementation. Digital barriers and variable partnership working were identified as key obstacles.

The Royal College of Psychiatrists had described implementation as “patchy at best, mostly inadequate.” Witnesses partially accepted this, citing good practice in Staffordshire, Shropshire and Sheffield, but agreed on the need for more consistent outcomes collection and stronger local relationships.

### **The Mental Health Bill**

Considerable attention was given to the **Mental Health Bill**, particularly its implications for community provision. Merron confirmed Royal Assent is expected by the end of 2025, with major reforms commencing in **2028** after codes of practice and workforce training. She acknowledged the LGA’s concerns: “There are many aspects of the Bill that just cannot happen without the right services in place.”

Of special importance was the clause removing detention solely on the grounds of autism or learning disability. MPs expressed fear that linking commencement to sufficient community provision risked indefinite delay. Merron insisted: “There is absolutely no intent to evade any responsibilities. We are totally committed.” Allnutt said criteria for “what good looks like” would be co-produced with people with lived experience.

### **Suicide Prevention and Family Involvement**

Given the date, the session placed strong emphasis on **suicide prevention**. Merron announced the launch of a new **suicide prevention e-learning package** for NHS staff and voluntary organisations.

A moving exchange involved the parents of a young man, Leon, who had died by suicide after discharge. MPs demanded monitoring of suicides post-discharge and mechanisms to prevent families from feeling abandoned. Allnutt cited data showing **13% of suicides occur within three months of discharge** and promised improved surveillance, including coroners’ reports. Merron agreed: “Every suicide is an absolute tragedy... the system failed them; let us say it as it is.”

### **Funding and Commissioning**

Committee members scrutinised the impact of ending ringfenced **service development funding (SDF)**. Harry clarified that funds were now part of baseline allocations, giving ICBs local flexibility but raising concerns about a postcode lottery. Merron defended the approach as

empowering local tailoring but emphasised that national standards and planning guidance remained.

There was discussion on **commissioning cycles**. Allnutt accepted that short-term contracts damaged voluntary sector stability and promised a shift to multi-year commissioning. Harry confirmed systems would be required to plan on three- and five-year cycles, with regional teams able to block inadequate plans.

### **Role of the Voluntary Sector**

Witnesses recognised the **vital role of voluntary and community organisations**. Allnutt described them as “integral” to delivering mental health support. Harry cited the £900 million invested in community teams since 2020, much of which had flowed to voluntary sector partners. However, MPs stressed that without predictable funding, smaller organisations could not survive.

### **Conclusion**

The session illuminated both progress and fragility. Pilots of neighbourhood mental health centres were widely welcomed as transformative, but MPs remained concerned about patchy provision, risks of inequity, and the absence of binding standards. The Mental Health Bill was recognised as historic, but its success rests on robust community services that do not yet exist in sufficient strength. Suicide prevention and family involvement were central themes, underscoring the human stakes. The witnesses emphasised intent, pilots and gradual transformation, while MPs sought firmer guarantees on funding, timelines and standards.