Department of Health & Social Care

From Lord Markham
Parliamentary Under-Secretary of State

39 Victoria Street
London
SW1H 0EU

17 July 2023

Dear Noble Lords,

I write further to the statement I made on Mental Health Inpatient Services: Improving Safety on 3 July 2023, in which I undertook to update you on a number of issues raised in the subsequent exchanges.

It may be helpful if I recap some of the details of the announcements that were made by the Secretary of State and myself; the first being on the Essex Mental Health Independent Inquiry. This was announced in January 2021 to investigate matters surrounding the deaths of mental health inpatients across NHS Trusts in Essex between 2000 and 2020. It was set up as a non-statutory inquiry.

Following discussions with the Chair of the Inquiry, Dr Geraldine Strathdee, about the challenges in fulfilling the Inquiry's terms of reference, in particular due to poor engagement from former and current staff at the Essex Partnership University NHS Foundation Trust, the Secretary of State announced on 28 June that the current inquiry would be converted to a statutory inquiry.

Statutory public inquiries run according to the rules in the Inquiries Act 2005 and Inquiry Rules 2006. They have specific powers to:

- compel witnesses to give evidence and to secure access to documents, with criminal sanctions for non-compliance;
- take evidence under oath; and
- designate 'core participants' - people or organisations with a particularly close connection to the inquiry's work - with particular legal rights and, in some circumstances, legal representation funded by the inquiry.

Subject only to certain restrictions set out in the Inquiries Act, a statutory inquiry must ensure that members of the public (including the press) are either able to attend the inquiry in person or to hear a simultaneous transmission of the proceedings and are also able to obtain or view a record of the evidence presented.

Secondly, we have also announced a national investigation into mental health inpatient services in England. A new statutory investigatory body, the Health Services Safety Investigations Body (HSSIB), will be established in October and we are working with the current organisation, Healthcare Safety Investigation Branch (HSIB) to prepare for the launch of the investigation once HSSIB has been established. This will look at a range of issues including how young people with mental health needs can be better cared for, how providers can learn from tragic deaths that take place in their care, how out-of-area placements are handled, and how staffing models can be improved. Across all these themes, HSSIB will also be looking at how data is used by providers.

We expect HSSIB will want to work with people involved across the healthcare system, including patients, families and front-line staff, to understand the issues and identify how care can be improved. The investigation will focus on improving safety and quality of care and any recommendations would focus on promoting wider system learning.

Due to the interest in the Mental Health Bill, I will again reiterate that we are working through the recommendations in the pre-legislative scrutiny committee's report. As Minister Caulfield said in the other place on the 11 July, we hope to respond fully, shortly after the summer recess.

In response to the specific points raised by colleagues, I have responded to the questions in the order they were raised:

Baroness Merron asked how we are ensuring access to mental health services especially for those from the poorest families. We recognise that the COVID-19 pandemic and the rise in the cost of living have had a significant effect on the mental health of many people including those in poverty or financial difficulty. That's why we provided an additional £500 million in 2021/22 to address waiting times for mental health services, following the rise in referrals as Covid-19 restrictions eased.

This included providing a £15 million Prevention and Promotion for Better Mental Health Fund to help level up mental health and wellbeing across the country by investing in activity to promote positive mental health in the 40 most deprived local authority areas in England. And we are continuing to invest in our NHS mental health services so that, year on year, more people, including those from the lowest socio-economic backgrounds, are able to get the help they need.

The noble lady also raised a question on the implementation of the recommendations from the 'Out of sight – who cares?' report by the Care Quality Commission (CQC). We welcomed the publication of the CQC's report on the use of restraint, seclusion and segregation and published our response in July 2021, in which we accepted in full or in principle all recommendations for the department. We are focused on ensuring all patients, including people with a learning disability and autistic people, receive safe and high-quality care.

In response to the recommendations made in the report, we have taken several actions including undertaking independent case reviews and introducing a Senior Intervenor pilot to help move individuals in the most restrictive settings towards discharge. We are carefully considering the outcomes of these programmes to inform our ongoing work.

We have also introduced the Mental Health Units (Use of Force) Act 2018 which includes measures to both reduce the inappropriate use of force and to ensure accountability and transparency about the use of force in mental health units.

The CQC report recommended improved community support for people with a learning disability and autistic people and single Ministerial ownership of the actions taken. We published the Building the Right Support Action Plan in July 2022, which sets out actions to improve community support for people with a learning disability and autistic people. Progress is overseen by a cross-system, cross-Government Delivery Board, established to bring together all partners who can make change happen.

Lord Allen asked whether private providers will be covered by the HSSIB investigation. When established, HSSIB will have the powers and the independence to conduct investigations into incidents that occur in England during the provision of healthcare provided in both NHS services and the independent sector that have implications for the safety of patients, not just care that is paid for or provided by the NHS. We envisage that its investigation into mental health inpatient services will cover care provided by both NHS and independent sector providers.

On the matter about the scope of the HSSIB investigation and whether HSSIB would look at related services that the noble Lord raised, the detailed scope of the HSSIB investigation is still to be decided, but we expect that it will include the whole of the mental health inpatient pathway, including the period post-discharge.

The last of the questions that the noble Lord Allen raised was around the consistency and quality of the data that is collected on deaths within mental health services. The Rapid Review's report makes recommendations focused on improving the way data and evidence is used to identify and respond to risks to patient safety in mental health inpatient pathways. The Government will respond to the Review's recommendations in due course.

Baroness Buscombe raised the question of an update on the use of the palliative care app 'Coordinate My Care' for mental health pathways. My officials and I thank and are grateful for the time Professor Riley took to present the Coordinate My Care app. I know my officials found the presentation useful they have taken away insights on how future tech architecture might achieve the necessary Mental Health Act digital capabilities. Whilst the difficulties involved with mapping the Coordinate My Care app across to the advanced choice documents pathway means this app in its current form is not appropriate; we continue to consider how digitisation can improve mental health care.

I come now to the issue of the report from the Parliamentary and Health Service Ombudsman that **Baroness Watkins** raised. We welcome the Ombudsman's latest report into patient safety. It provides valuable insights in relation to how the NHS can improve its response to patient safety incidents. But there should be no doubt of the government's ongoing and firm commitment to advancing patient safety in the NHS. The Government's Long Term Workforce Plan will also work towards putting the NHS workforce on a sustainable footing. We are considering the Ombudsman's report carefully and will respond in due course.

Lord Bradley then raised whether the issue of banning of prisons as a place of safety will be included in the upcoming HSSIB investigation. We expect the HSSIB investigation will cover a range of issues related to the care and safety of patients in mental health inpatient pathways. While the detailed scope is still to be determined, we do not plan at this stage to ask HSSIB to look at issues related to prisons as a place of safety or transfers between prisons and mental health inpatient services. However, we continue to look at this through the work on the draft Mental Health Bill.

Both **Baroness Berridge** and **Lord Harris of Haringey** asked whether, given that the Essex independent inquiry will look at a series of deaths over a period of time, if it will it be within its remit to look at whether or not, had there been some kind of independent investigation of those deaths, the themes and problems faced by the trust might have been spotted earlier.

The Inquiry's terms of reference cover the deaths which took place in mental health inpatient facilities across NHS Trusts in Essex between 1 January 2000 and 31 December 2020. The aim of the inquiry has been to draw conclusions in relation to the safety and quality of care provided locally and nationally to mental health inpatients, in particular the key factors that led to the deaths of mental health inpatients who were under the care of the Trust(s), including care and treatment pathways. Part of the inquiry's remit is the examination of the quality of previous investigations into mental health inpatient deaths, the conclusions and recommendations of those investigations, and the response by the Trust(s) and the wider system. The statutory inquiry's terms of reference will be announced in due course.

Lord Harris also asked about the transition from children and young people's mental health services to those for adults. We recognise that this has not proved easy for some young adults and that is why the NHS Long Term Plan commits to developing a comprehensive offer for 0–25-year-

olds that reaches across mental health services for children, young people and adults. The *Mental Health Implementation Plan 2019/20 – 2023/24* lays out the roll-out approach for this with the aim being for all local areas to have a comprehensive 0-25 model in place by March 2024.

Finally, the noble Lord asked what was being done to ensure that mental health inpatients get the care they need for their physical health as well as their mental health. People with mental health problems should receive the same standard of physical healthcare as any other member of society and mental health providers are expected to deliver this through their own appropriately qualified and experienced staff or in partnership with other providers. As set out in the NHS long-term plan, physical health checks are an important part of improving care for people with serious mental health illnesses. As of Q4 2022-23, the number of people with SMI to receive the complete list of physical health checks in the preceding 12 months was 313,022.

I hope this response is helpful and I have deposited this letter in the libraries of both Houses.

With my very best wishes,

LORD MARKHAM CBE