Department of Health & Social Care

From Baroness Merron
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

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By email

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Dear Paul,

First, I wish to thank all Noble Lords for their valued contributions on the Mental Health Bill. I am pleased to follow up on a point which I said I would address during the debate on the 22 January 2025, at the third committee day.

You asked if government could make an assessment of how learning from mental health inpatients' experiences impacts mental health provision and mental health services. This was in relation to the debate surrounding amendment 95, tabled by Earl Howe, and supported by Lord Kamall.

In our view, there are already processes in place to gather and implement the feedback provided by mental health service users, which I have described below. We recognise that these need to be improved and strengthened and have set out below some of the work that is underway to achieve this.

Under the Care Quality Commission's (CQC) statutory duty to monitor the use of the Mental Health Act, they visit and interview detained patients. The insights gained from service users inform the findings of the CQC's annual monitoring the Mental Health Act report. For example, as part of the CQC's most recent annual report (2022/23)[1] they carried out 860 Mental Health Act monitoring visits and spoke to 4,515 patients (3,410 in private interviews and 1,105 in more informal situations) and 1,200 carers. The insights shared were used to inform the report's key findings. For instance, inconsistent inclusion of the patient in care planning, and subpar access to therapeutic activities and planned leave. These reports are published annually online.

The CQC's annual reports are used as an important source of evidence to inform government policy. For example, concerns around the quality-of-care planning, reported by the CQC, influenced the Independent's Review's recommendation for statutory care and treatment plans and the government's broader policy on this issue, as set out in the Bill.

At a provider level, the findings from CQC's monitoring activity inform the action statements the CQC requires from providers, in which they must set out what they will do to improve their

[1] Monitoring the Mental Health Act in 2022/23 - Care Quality Commission

services. Where providers do not take the necessary action, they may be ultimately subject to enforcement action under CQC's regulatory powers.

The CQC has a duty under section 120 of the Mental Health Act, to investigate complaints relating to the care and treatment of people who are, or have been, subject to the Act's formal powers. When upholding a complaint, CQC makes recommendations of action that providers should take to learn and improve. In serious cases, this may also include recommendations for financial redress to the complainant.

For example, the CQC received a complaint that a young person had been detained on an adult medical ward for 11 months because a more suitable placement could not be found. In response to CQC's investigation, the mental health trust involved apologised for failing to ensure a young person was cared for in the most suitable environment. A serious case review was carried out following CQC's investigation team, which identified learning to be implemented. In response, the acute hospital trust apologised for any distress caused to the young person and took action to improve their care and treatment of young people with an eating disorder to avoid other patients having a similar experience.

Another example involves a complaint that a Mental Health Act assessment was not conducted appropriately, and the person was not involved in a suitable manner. In response to the CQC's investigation report, the relevant agencies involved apologised for any distress caused by the failure to meet the needs of the person during the assessment. Providers then took action to improve communication and joint working between the liaison psychiatry team, approved mental health professional and ward staff of the acute hospital trust.

We appreciate that improvements are needed to ensure that some of the government's regulatory systems are working effectively. The CQC has accepted the recommendations of Dr Penny Dash and Professor Sir Mike Richards, who last year undertook reviews of CQC's regulatory operational effectiveness and the single assessment framework. Actions being taken by CQC include strengthening their leadership by appointing a Chief Inspector of Mental Health and improving how they carry out their assessments of services.

The Chief Inspector of Mental Health role will help to strengthen how service user feedback is collected and used in both inspection and monitoring activity. They will also introduce other ways for the CQC to listen to the voices of those in marginalised and underserved communities. The CQC's strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. The new Chief Inspector of Mental Health will have a vital role in championing and embedding CQC's people's experience principles.[2] These are about promoting a culture where service users and people with lived experience are encouraged to share feedback, which is valued and used to inform the delivery of services for the better.

[2] https://www.cqc.org.uk/about-us/how-we-will-regulate/using-peoples-experience-our-regulation

More widely, the CQC receives information about people's experiences of using services through several mechanisms including, Give Feedback on Care, public engagement (including marginalised groups with local Healthwatch), and local outreach projects. This, and other sources or data, are key to understanding how the inpatient pathway is working, for identifying areas of improvement, and whether changes have indeed led to measurable improvement.

At a provider level, guidance from NHS England outlines that all mental health services, including inpatient services, should regularly analyse their routine data and share the findings, to target and develop improvement work. The data collected should include measures of how inpatient services and the wider mental health pathway is operating, as well as information on the experiences and outcomes of people who have received inpatient care, including both clinician and patient reported outcome measures. Frontline teams, people who have used inpatient services, their carers, and senior management should all be regularly involved in reviewing data and use it co-produce service improvements and shape delivery decisions, which drive improvements in access, capacity and flow, care quality, experience, and outcomes.

A good example of partnership working with patients, carers and local organisations to improve services on the ground is provided by the Patient and Carer Race Equality Framework (PCREF). The PCREF was launched in October 2023 by NHS England and is an anti-racist framework which is mandatory for all mental health service providers to embed across England from March 2025. Thirteen pilot Trusts are working with NHSE to help implement the PCREF. The partnership working supports assurance on monitoring data on race inequalities and combined with the independent element of the governance, is critical to ethnic minorities feeling empowered, helping remove historical barriers.

Nationally, NHS England works in partnership with people with lived experience to inform development and delivery of plans to improve mental health services. This includes by employing people with lived experience to work in their programme teams, engaging directly with people with lived experience, and working with user-led and community groups to reach marginalised groups. In particular, when developing the 24/7 Neighbourhood Community Mental Health Centres programme, prospective sites had to demonstrate that 'lived experience leadership' was a core part of their offer. This ensures coproduction firmly embedded into local practice and ensures that local experience shapes local planning, commissioning and delivery.

Furthermore, the Department of Health and Social Care has worked closely in consultation with people with lived experience of the Act to inform policies within the Bill, such as those around the nominated person, advance choice documents and statutory care and treatment plans. This includes consulting directly with people with lived experience and commissioning charities, such Young Minds, Article 39, Black Thrive, and BILD (British Institute of Learning Disabilities)/RRN (Restraint Reductions Network) to consult with

inpatient focus groups on their experiences. Our hope is that the Bill will go on to improve peoples' experiences of mental health services.

I hope this letter has provided further clarification on this issue raised in Committee. I am copying this letter to all the Peers who spoke during the debate and will place a copy in the library of the House.

All good wishes,

BARONESS MERRON