Department of Health & Social Care

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

39 Victoria Street
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By email

14 March 2025

My Lords,

Thank you for your valued contribution to the constructive discussions held on the fifth day of the Committee Stage for the Mental Health Bill, on 24 February 2025.

I am pleased to follow up on the points I said I would address following the debate.

Community Support

Baroness Tyler raised several questions in relation to the amendments on community support to which I committed to follow up on:

What consideration has government given to this specific recommendation around therapeutic alternatives to detention including community services

The Bill primarily focusses on duties and powers relating to people that have been detained, but some of the reforms will drive more therapeutic alternatives to detention. For example, Integrated Care Boards (ICBs) will be required to establish and maintain Dynamic Support Registers of people with a learning disability and autistic people who have risk factors for detention under Part 2 of the Mental Health Act. ICBs and local authorities must have regard to information relating to these registers when exercising certain functions and seek to ensure the needs of these groups can be met without detaining them. These measures are intended to improve monitoring of the needs of, and support for, people who may be at risk of going into crisis and being detained under the Mental Health Act, so that they can instead receive the right support in the community. We expect that the reforms relating to the detention criteria for people with a learning disability or autistic people and Advance Choice Documents will reduce the number of patients detained in hospital. We expect that these people will instead be treated in the community and have accounted for the costs of this in the impact assessment.

A large proportion of the work to expand community services and create alternatives to detention sits outside of the Mental Health Bill (the Bill).

a. There are now around 600 new or expanded crisis alternatives services nationally, including crisis cafes, safe havens and crisis houses, providing an alternative to A&E or psychiatric admission. We are committing a further £26 million in capital investment to open new mental health crisis centres, which aim to provide accessible and responsive care for individuals in mental health crisis.

b. NHS England is working to expand the capacity of community-based eating disorder services, including crisis care and intensive home treatment.

c. We are testing neighbourhood mental health centres for people aged 18 and over with serious mental illness. These six pilot schemes, in Tower Hamlets, Lewisham, Sheffield, York, Birmingham and Whitehaven, will offer 24/7 open access care closer to home, with an integrated service including healthcare providers, Local Authorities and the voluntary sector. These pilots build on international evidence that show that similar models have led to a reduction in hospitalisation and waiting times and support our efforts to move more care into the community.

d. We will also continue the rollout of mental health support teams (MHSTs) in schools in line with our manifesto commitment. This is an important part of our early intervention offer and will help the country move from sickness to prevention. Separately, this government remains committed to rolling out Young Futures Hubs in every community.

Taken together, the reforms in the Bill, combined with the wider transformation of community mental health, should reduce coercion and detention in the mental health system, allowing more people to live independently and safely in the community.

<u>What specific mechanism will be used to divert money to community services</u>

Ultimately these reforms should see more patients cared for in the community, either because they have been discharged from mental health inpatient services, or because the need for admission has been avoided.

For people who have been detained and discharged, funding should follow the patient via section 117 arrangements. After-care is a joint responsibility of the NHS and local authority, and as someone leaves hospital, it is up to the local partners to agree what funding is available jointly to provide aftercare in the community.

More widely, this government is committed to a more preventative approach, as evidenced by the investment in the community-based services listed above.

The government is currently co-developing the 10 Year Health Plan with the public, staff and patients. As part of this, we are exploring ways to stimulate the shift from hospital to the community and from treatment to prevention so that we can deliver an NHS fit for the future.

<u>Will detailed plans to grow the workforce be included in the 10 Year Plan</u>

We have committed in our manifesto to recruiting 8,500 additional mental health staff, and the Impact Assessment sets out the estimated burden on staff resource of the Bill reforms, where possible.

We will publish a refreshed Long-Term Workforce Plan this summer, to ensure it fully aligns with the level of ambition and reforms set out as part of the 10 Year Health Plan. It is the refreshed Long Term Workforce Plan that will deliver the transformed health service we will build over the next decade, and will ensure that the NHS has the right people, in the right places, with the right skills to deliver the care patients need when they need it.

I will write separately to Lord Stevens, on his question on the incremental requirements for psychiatrists' year-by-year on a full-time equivalent basis as a result of the reforms in the Bill.

Application of amendment 160BC

Earl Howe raised some detailed points in relation to the application of amendment 160BC and the specific circumstances in which this may apply. I committed to follow up on these points in writing.

Can the Government give greater clarity on the different interpretations of Section 17(3). Will the Government examine the Code of Practice to ensure it is as clear as possible about what the current law permits

Deprivation of liberty for the treatment of a physical health disorder is always an important decision. We think it is right to retain separate authorisation for this where the person is already detained under the Mental Health Act. We would not wish to undermine the protections available to patients under the Mental Health Act, who are already in a vulnerable position.

Our understanding is that these circumstances are rare and, where they do arise, there are already frameworks in place to authorise a deprivation of liberty. These include section 17 leave under the Mental Health Act, Deprivation of Liberty Safeguards under the Mental Capacity Act, and, in certain circumstances, the High Court.

Which legal framework is used would depend on the circumstances of the case. The safeguards provided by these frameworks are different, and decision-makers must use their professional judgement to decide which is most appropriate for the individual. We think retaining this flexibility is important. However, we note the concerns raised regarding the complex nature of the interface between the Mental Health Act and the Mental Capacity Act, including in the circumstances referenced, and recognise that this may present challenges for decision makers.

We can assure you we will engage with stakeholders to understand what guidance and additional support could help clinicians when deciding which of the two Acts is most appropriate for particular patients, when we consult on the revised Mental Health Act Code of Practice. This will include in circumstances where a patient is detained under the Mental Health Act, lacks mental capacity and requires treatment in another setting for their physical health, unrelated to their mental disorder.

Mental Health Commissioner

I want to add to my comments that I made in response to Baroness Tyler's amendment on the Mental Health Commissioner to set out more information on the Role of the CQC.

What is the role of the CQC Including the role of the Chief Inspector

CQC is the independent regulator for health and adult social care in England. In relation to the Mental Health Act, CQC has multiple roles, both as the independent regulator of services where people may be detained, and a statutory function under section 120 of the Mental Health Act to keep under review and, where appropriate, investigate the exercise of powers and discharge of duties under the Mental Health Act or to investigate a

complaint. As part of the [UK's National Preventive Mechanism](), CQC also highlights and seeks action when they find practices that could lead to a breach of human rights standards during their Mental Health Act visits. Lastly, the CQC manages the Second Opinion Appointed Doctors service and assesses complaints. To facilitate the delivery of CQC's (and Healthcare Inspectorate Wales) statutory responsibilities under section 120, the Mental Health Act provides CQC with various powers, such as to gather information and to direct a hospital manager or local authority to publish an action statement. This may be in response to the outcome of a review or investigation, for example into the hospital's conduct or an individual patient's case.

As mentioned previously, in our view, CQC's statutory duties and powers would directly overlap with the proposed Mental Health Commissioner's powers to examine cases of people detained under the Mental Health Act and to access information to assist them in their role. They would also overlap with the role of the Health Services Safety Investigations Body, which is responsible for conducting independent investigations that help identify ways in which we can improve mental health care, protect patients and the public and create a safe working environment for staff.

As part of their statutory duties under the Mental Health Act, CQC (and Healthcare Inspectorate Wales) reports annually on the operation of the Mental Health Act. In 2022/23, CQC carried out 860 monitoring visits. This involved speaking with 4,515 patients (3,410 in private interviews and 1,105 in more informal situations) and 1,200 carers, as well as many advocates and ward staff. Every one of these visits resulted in a report of observations and requirements, to be followed up on in action statements by the hospital manager.

CQC's 'Monitoring the Mental Health Act' reports covers many of the issues that the proposed Mental Health Commissioner would be responsible for assessing and reporting on, such as the accessibility of advice and support to mental health inpatients and the quality of services. CQC's annual reports also seek to identify emerging trends and concerns, with a view to positively influencing the mental health sector. For example, past reports have drawn attention to staffing retention and workforce issues, racial inequalities, lack of community support, inappropriate and unsafe patient environments, and restrictive practice. CQC is not bound to look at specific issues, and their reports – and key themes – are based on visits and interviews conducted with patients, families, carers and staff.

Many of the roles and responsibilities CQC has in relation to the Mental Health Act were absorbed from the previous Mental Health Act Commission. Furthermore, the valuable expertise previously within the Commission among Mental Health Act commissioners, second opinion appointed doctors, Mental Health Act policy officers and specialist Mental Health Act support teams shifted across to CQC, with some legacy staff in CQC today.

CQC announced last year that it would create a new Chief Inspector of Mental Health role, in response to recommendations made by Professor Sir Mike Richards. This change aims to put mental health on an equal footing with physical health in CQC. The Chief Inspector has not yet been appointed, but recruitment for the role is underway. The role will oversee both CQC's role in inspecting mental health services and monitoring the Mental Health Act. The CQC expects the Chief Inspector will carefully explore how to strengthen the focus on Mental Health Act compliance in regulatory assessment of providers and how to ensure

CQC have the capabilities and systems to ensure effective monitoring of providers' compliance with all aspects of the Mental Health Act, including the reforms.

They will use their independent voice to amplify and respond to the experiences of and outcomes experienced by people who use services, strengthening how service user feedback is collected and used in both inspection and monitoring activity. CQC also expect that the Chief Inspector will have a vital role in championing and embedding CQC's people's experience principles.

The appointment of a Chief Inspector of Mental Health will facilitate closer working between inspection teams and Mental Health Act monitoring teams, leading to better information sharing and ensuring that regulatory action is taken when a provider fails to comply with the Mental Health Act or the Code of Practice.

What reforms have been made to the CQC

The CQC was reviewed by both Dr Penny Dash and Professor Sir Mike Richards last year. Dr Dash's review focused on the operational effectiveness of CQC as a regulator. Specifically, it examined the suitability of the Single Assessment Framework methodology for inspections and ratings, including for local authorities and integrated care systems. This review was limited to social care providers (residential and care delivered in the home), NHS providers (trusts, GPs), dentists and independent sector (private and charitable) healthcare providers.

This review is separate from the ongoing Dr Penny Dash review of patient safety across the health and care landscape, which we expect to report shortly. The forthcoming review is looking at the broad range of organisations that impact on quality, with a focus on the six key organisations overseen by the Department of Health and Social Care, which have a significant impact on safety (including the CQC). This review will provide recommendations on whether greater value could be achieved through a different approach or delivery model.

Professor Sir Mike Richards' review looked at the CQC's Single Assessment Framework and made recommendations on how CQC assesses and works with providers of health and social care.

CQC has accepted all recommendations made by both Dr Penny Dash and Professor Sir Mike Richards. They have already taken action to improve leadership around mental health by beginning the recruitment of a Chief Inspector of Mental Health. They also intend to strengthen the expertise in their workforce and improve how they carry out assessments of services.

In recent months, they have appointed a new Chief Executive, Sir Julian Hartley. They are working to build the foundations for 'good' regulation, including looking at the organisation's purpose and values.

Our expectation is that under new leadership and following action to make tangible and important improvements to CQC, in light of the recommendations made by Dr Dash and Professor Sir Mike Richards, we will have a regulator that all of us can trust in. We appreciate that this will take time to achieve, but we are encouraged by the progress being made.

I also want to set out further details on the role of the Children's Commissioner.

What is the role of the Children's Commissioner

The Children's Commissioner's primary purpose is to advocate for, promote and protect the rights of children. The role was initially established under the Children Act 2004. The Commissioner's statutory remit includes understanding what children and young people think about things that affect them and encouraging decision makers to always take their best interests into account. The Children and Families Act 2014 also gave the Commissioner special responsibility for the rights of children who are in or leaving care, living away from home or receiving social care services.

The remit of the Children's Commissioner is broad, giving the Commissioner a significant amount of freedom over the areas they explore and report on. For example, in recent years, they have addressed a diverse range of issues, such as child poverty, youth violence, youth justice, education, disability, children's homes, online harms and mental health. The current Commissioner recently ran a survey of children to understand their priorities and concerns, to inform where they place their attention next.

To facilitate the Commissioner's role, they have statutory data gathering powers and powers of entry to talk with children and gain evidence.

The Commissioner is supported by an office, an advisory group, an audit and risk committee and children's groups, stakeholders, and specialists. The office spans policy, research, communications, public service innovation, as well as the Help at Hand service and In My Opinion initiative. The Help at Hand service is for children in care, leaving care, living away from home or working with children's services to offer free support, advice, and information. In My Opinion (IMO) is a voice for teenagers in care and for care leavers to share their experiences and stories.

According to their 2023/24 annual report and accounts, grant in aid received from Department for Education (the Commissioner's sponsor department) was £2.7m in 2023/24.

Previously, it has been raised that the overlap between the proposed Mental Health Commissioner and the CQC is analogous to the Office of the Children's Commissioner and Ofsted. We acknowledge that both have an independent statutory duty in relation to children's rights and views. However, we consider Ofsted's role in the inspection and regulation of a wide range of institutions, establishments and services as distinct from the Children's Commissioner. It is true that their respective roles can mean that both organisations may secure children's views as part of delivering their primary functions, however, the ends to which they use this information is largely different. Therefore, we do not consider the interaction between these organisations as analogous to the proposed Mental Health Commissioner and the CQC, particularly in light of CQC's specific role in monitoring and reporting on the operation of the Mental Health Act and investigating and ensuring accountability where there are issues.

Point of Clarification - Implementation

I would also like to provide a point of clarification. I would like to add to my statement that "we will commission an independent evaluation of the reforms." While this is indeed our

intention and work is already underway for this, an independent evaluation is subject to the availability of funding and to receipt of fundable research application(s).

I hope this letter has provided further clarification on several points 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