GOV•UK

Department of Health & Social Care

Policy paper

Government response to the rapid review into data on mental health inpatient settings

Published 21 March 2024

This was published under the 2022 to 2024 Sunak Conservative government

Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-government-response/government-response-to-the-rapid-review-into-data-on-mental-health-inpatient-settings

Introduction

On 23 January 2023, the government launched an independent 'rapid review' into mental health patient safety, chaired by Dr Geraldine Strathdee. The purpose of the rapid review was to produce recommendations to improve the way data and information are used in relation to patient safety in mental health inpatient care settings and pathways, including for people with a learning disability and autistic people. The rapid review into data on mental health inpatient settings: final report and recommendations (https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations) was published on 28 June 2023.

Anyone receiving treatment in an inpatient mental health facility deserves to receive safe, high-quality care and to be looked after with dignity and respect. The government recognises that we have further to go to improve patient safety and ensure that therapeutic care in inpatient settings is universal. Ensuring that we are collecting and making the best use of data and information and using the most important and impactful metrics to 'measure what matters' in relation to patient safety and therapeutic care, while reducing unnecessary data burden on staff, is an important part of this. Identifying patient safety risks early will enable the healthcare system to intervene where necessary and at the earliest possible stage, helping to prevent serious incidents.

The government's response to the review's recommendations is set out below, including next steps.

In particular, the Department of Health and Social Care (DHSC) has considered these recommendations and how they complement existing work by NHS England to improve mental health inpatient safety and therapeutic care, including its 3-year mental health, learning disability and autism inpatient quality transformation programme (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/), which seeks to tackle the root causes of unsafe, poor-quality inpatient care in mental health, learning disability and autism settings.

All proposed actions will be taken having considered, and in accordance with, the government's obligations under UK data protection laws.

Recommendations

This section sets out the government's response to the rapid review, taking each recommendation in turn, agreed with NHS England and the Care

Quality Commission (CQC).

Recommendation 1

NHS England should establish a programme of work, co-produced with experts by experience and key national, regional and local leaders, including CQC, integrated care systems (ICSs), provider collaboratives, independent safeguarding bodies, professional bodies, provider representatives and third sector organisations, among others, to agree how to make sure that providers, commissioners and national bodies are 'measuring what matters' for mental health inpatient services, and can access the information they need to provide safe, therapeutic care.

This programme should:

- consider what metrics need to be collected, shared and used at different levels to drive improvements in care quality and safety in mental health inpatient settings by the end of 2023. This work should build on the themes identified in the safety issues framework and pay due regard to inequalities. The output of the 'measuring what matters' work should then inform ongoing improvements to quality and safety oversight and support arrangements
- consider what enablers are needed to reduce burdens, improve data sharing and timeliness of reporting - based on co-produced principles to support a reduced data burden at all levels

Government response to recommendation 1

The government supports this recommendation and NHS England will be taking this programme of work forward. This will include agreeing the most impactful metrics in spotting early warning signs of quality and safety issues with 'experts by experience' and key national, regional, and local leaders, including CQC, ICSs, provider collaboratives, professional bodies, provider representatives and third sector organisations, by early 2024.

The programme of work will also:

- agree principles for reducing the data burden where it does not clearly result in improvements to quality and safety
- consider what enablers are needed to improve data sharing and timeliness of reporting, based on these co-produced principles

Once confirmed, the outcomes of the 'measuring what matters' programme will inform ongoing improvements to quality and safety oversight and

support arrangements at a local, regional and national level - in line with:

- NHS England's national guidance on quality and risk escalation in integrated care systems (https://www.england.nhs.uk/publication/national-guidance-on-quality-risk-response-and-escalation-in-integrated-care-systems/)
- the National Quality Board's shared commitment to quality (https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/)
- improving experience of care: a shared commitment for those working in health and care systems (https://www.england.nhs.uk/ourwork/part-rel/nqb/experience-of-care-framework/)

NHS England will update on progress as part of the ministerial-led steering group that will oversee implementation of the recommendations (see the response to recommendation 13 for more details).

Recommendation 2

Every provider and commissioner of NHS-funded care should have access to digital platforms that allow the collection of core patient information and associated data infrastructure to allow timely reporting of information to different decision makers. These systems need to:

- be compliant with the digital technology assessment criteria (DTAC) (https://transform.england.nhs.uk/key-tools-and-info/digital-technology-assessment-criteria-dtac/)
- meet the requirements of the Digital Capability Framework (DCF) for mental health electronic patient records (EPRs)
- ensure usability, with effective workflows and interfaces to reduce administrative burden

The digital platforms and supporting data infrastructure must allow submissions into relevant national data sets, directly or through other interoperable platforms, and facilitate data flows between systems of different local provider organisations to support joined-up understanding of care pathways. These systems should allow the data collected to be made available to different decision makers, including CQC, at the appropriate level of aggregation and without requiring duplicative submissions, and allow benchmarking across trusts and independent sector providers.

NHS England's Transformation Directorate should scope out options for how this ambition could be delivered, including cost implications and a

value for money assessment to help providers meet this aim specifically for mental health, including specific ways in which mental health electronic patient record improvement and data sharing can be prioritised and interdependencies with other systems and programmes of work. These options should be presented to DHSC by the end of December 2023. DHSC and the NHS should continue to implement the commitments set out in Data saves lives, the data strategy for health and care (https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data) aimed at tackling the cultural, technological and legislative barriers to better sharing of data across the health and care system.

Government response to recommendation 2

The government supports the recommendation that all providers and commissioners of NHS-funded care should have access to digital platforms that allow core patient information to be accessed, avoid duplicative submissions and allow benchmarking across trusts and independent sector providers.

This recommendation is likely to have significant funding implications and further scoping needs to take place to cost potential options. As a first step, NHS England will scope out options in early 2024 setting out how this could be delivered for mental health providers, including costings, implications and a value for money assessment to inform the next spending review cycle. This should include expected benefits and costs, including the impact on providers and staff.

DHSC and NHS England and its delivery partners will continue to implement the commitments in the ‘Data saves lives’ strategy. At the end of July 2023, 61% of commitments had already been completed.

Recommendation 3

ICSs and provider collaboratives should bring together trusts and independent sector providers, along with other relevant stakeholders such as independent safeguarding bodies, across all healthcare sectors to facilitate the cross-sector sharing of good practice in data collection, reporting and use. This forum should showcase examples of how data and information could be gathered and used to improve patient safety and quality of care and reduce the data burden on staff, including the ways that digital solutions can enable these improvements.

It should also facilitate the rolling out of examples of good practice and digital innovation between all data commissioners and both NHS and independent sector providers, including the use of administrative staff and coding specialists to gather and process data, the use of consistent codes to record clinical activity, the design of optimal service pathways, and the use of analytical resources to process data and draw out trends and insights to inform quality improvement.

Government response to recommendation 3
The government supports the recommendation that ICSs should provide a leadership role in bringing together the healthcare sector and facilitating the sharing of good practice.

Commissioners of mental health services should be empowered to play an important role in mental health data collection, including bringing together providers and relevant stakeholders to facilitate the sharing of good practice in data collection, reporting and use in relation to mental health services.

This action is for commissioning bodies who are best placed to make decisions on how to take this forward depending on local needs, priorities and structures.

DHSC and NHS England will work with ICS leaders to highlight the importance of ICSs taking a leadership role in ensuring the quality of data, to improve patient safety and therapeutic care in inpatient settings and reduce the time needed for frontline staff to input data. This may also include making use of existing forums to showcase examples of good practice and incorporating best practice around data collection and use in mental health as part of integrated care board (ICB) and ICS strategies and plans.

The outcomes of the ‘measuring what matters’ programme (set out in recommendation 1) will develop the understanding of best practice in relation to data needs at different levels, to drive improvements in care quality and safety in mental health inpatient settings. NHS England therefore expects that the outcomes of this programme will support ICSs to better understand and facilitate the sharing of good practice.

Recommendation 4

More work is needed to map the full range of data on deaths, including what is collected by which organisation and what can be done to improve it. DHSC, in partnership with NHS England and CQC and supported by key experts from across governmental and non-

governmental organisations, should convene all the relevant organisations who collect and analyse mortality data to determine what further action is needed to improve the timeliness, quality and availability of that data.

This follow up should be completed no later than autumn 2023.

Government response to recommendation 4
The government supports the recommendation that work is needed to build on the data-mapping work of the rapid review to identify improvements relating to data collections on deaths in mental health inpatient settings.

DHSC will bring together the relevant organisations that collect and analyse mortality data to consider what improvements can be made to the timeliness, quality and availability of that data, and identify actions which will be taken forward over the coming months.

In addition, the Health Services Safety Investigations Body (HSSIB) has launched a national investigation into mental health inpatient settings as one of its first priorities. The investigation will identify risks to the safety of patients and HSSIB will seek to address those risks by making recommendations to facilitate the improvement of systems and practices in the provision of mental healthcare in England. The aims of the investigation include learning from inpatient mental health deaths to improve patient safety.

More details on the mental health inpatient settings investigation (https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/), including terms of reference, can be found on the HSSIB website.

Recommendation 5

Provider boards have a vital role to play in ensuring safety and quality of care in mental health inpatient pathways. We recommend the following actions to improve boards' capacity to identify, prevent and respond to risks to patient safety:

- every provider board should urgently review its membership and skillset and ensure that the board has an expert by experience and carer representative
- every provider board should ensure that its membership has the skills to understand and interpret data about mental health inpatient pathways and ensure that a responsive quality improvement

methodology is embedded across their organisations. They should expect those skills to be at least to a level that matches that of financial literacy on the board. They should review and update their recruitment and annual review processes in line with the recommendations of the Kark review of the fit and proper persons test (https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test). This should ensure that people with the necessary competencies, including data literacy skills, are appointed to the board and these skills and competencies are updated. Boards should consider annual mandatory training for their members on data literacy, in partnership with their local ICS and other system partners. Every board should provide Mental Health Act training so that at least half their non-executive directors are trained as associate hospital managers under the Mental Health Act and participate in hearings to best understand the clinical care provided, the challenges, and the views of patients, families and clinical teams for the patients

- CQC should assess and report on whether the membership of the boards of providers of mental health inpatient services includes experts by experience (including carers) representatives and whether boards are maintaining an appropriately high level of data literacy and quality improvement expertise on mental health inpatient pathways among their membership as part of their assessments
- every provider board should urgently review its approach to board reports and board assessment frameworks to ensure that they highlight the key risks in all of their mental health inpatient wards, as set out in the safety issues framework, and that they support the board to take action to mitigate risks and improve care, including both quantitative data and qualitative ‘soft intelligence’ such as feedback from patients, staff and carers. Provider boards should also set out in writing how they will make sure the voice of carers and family members is heard both at board level and with clinical staff and make sure this information is publicly available
- NHS England should review and update the guidance on board assessment frameworks

Government response to recommendation 5

The government supports the recommendation that provider board members should have the skills and capacity to identify, prevent and respond to risks to patient safety.

DHSC and NHS England will work with system leaders to highlight the importance of improving boards’ capacity to identify, prevent and respond to patient safety risks. The National Patient Safety Syllabus module for board and senior leaders is a key tool in supporting provider boards to understand patient safety oversight. This includes emphasising the importance of

patient and family engagement, and the need to include patient safety partners on safety-related committees.

DHSC and NHS England support the recommendation that all provider boards should review their approach to board reports and board assessment frameworks. This is to ensure that they highlight the key risks in all their mental health inpatient wards and support the board to take action to mitigate risks and improve care.

Provider boards should also consider how the voices of carers and family members are currently heard and acted on at board level. This includes the expectation that there is an expert by experience and carer representative on all provider boards.

Providers are encouraged to review the timeliness and suitability of existing experience measurement approaches - such as feedback from the Friends and Family Test, staff surveys and other local approaches - and seek ways to make them more transparent, demonstrating the clear link to actionable co-produced quality improvements in care, experience and safety.

DHSC and NHS England expect that by spring 2024, local systems and providers will:

- review their approach to board reports to ensure they can identify, prevent and respond to patient safety risks in inpatient mental health settings
- review lived experience at board level and, where required, communicate how it will be strengthened
- review approaches to gathering and acting on patient experience measures in inpatient mental health settings

In addition, CQC currently looks at these areas as part of its well-led assessment of trusts. CQC has started rolling out its new single assessment framework (https://www.cqc.org.uk/introducing-new-approach/starting-our-new-assessment-approach), with the plan that all of CQC's operational teams will have adopted the new model by early 2024. This includes a 'quality statement' focusing on an assessment of trust leadership. CQC's quality statements include a focus on capable, compassionate leaders who understand the context in which care is delivered and who have the necessary skills, knowledge and integrity to serve their roles.

There will also be a focus on assessing how providers collaborate with the people who use services, the public, staff and external partners. Under the 'Governance, management and sustainability' quality statement, CQC will assess how boards act on information about risk, performance and outcomes. This will focus more broadly on oversight and assurance rather than a specific focus or assessment of data literacy.

As part of its quality statements, under the responsive key question, CQC will also consider how providers make it easy for people to share feedback or raise complaints, and how providers actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes.

NHS England will consider ways to embed learnings of this review into its guidance for NHS provider and quality boards.

Recommendation 6

> Trust and provider leaders, including board members, should prioritise spending time on wards regularly, including regular unannounced and 'out-of-hours' visits, to be available to and gather informal intelligence from staff and patients.
>
> Priority should be given to those units where there is a known higher risk of 'closed cultures', including services for people with learning disabilities and autistic people, children and young people, those with cognitive impairment and neurodevelopmental conditions and patients held under powers of detention.

Government response to recommendation 6

The government supports the recommendation that trust and provider leaders should prioritise spending time on inpatient wards to gather informal intelligence from patients and staff about their experience, including unannounced visits. This can help to increase leaders' capacity to identify, prevent and respond to risks to patient safety and improve patient and staff experience.

DHSC and NHS England will work with system leaders to continue to build on best practice and highlight the importance of senior leadership visibility on all inpatient wards, particularly in units that are at higher risk of closed cultures.

It is expected that all trust and provider leaders should actively seek out and listen to feedback from patients, visitors and staff, and have a regular presence on hospital wards. As set out in the response to recommendation 5, CQC has started rolling out its new single assessment framework, with the plan that all of CQC's operational teams will have adopted the new model by early 2024. This includes a quality statement focusing on an assessment of trust leadership, with a focus on having capable compassionate leaders who understand the context in which care is delivered. As part of the quality statements, CQC will also look at how

providers make it easier for people to share feedback about their experience, including actively seeking input and feedback from people who are most likely to experience inequality in experience or outcomes.

Recommendation 7

> All providers of NHS-funded care should review the information they provide about their inpatient services to patients and carers annually and make sure that comprehensive information about staffing, ward environment, therapeutic activity and other relevant information about life on the wards is available. CQC should assess the quality, availability and accessibility of this information as part of their assessment of services.

Government response to recommendation 7
The government supports this recommendation and recognises the importance of patients and carers being able to access the right information about their inpatient care. DHSC and NHS England expect that all providers provide relevant information to patients and carers as a matter of course, in accessible formats, including:

- on the ward environment and therapeutic activity
- other relevant information about life on the wards

As part of its single assessment framework, CQC will consider under a quality statement on providing information, whether providers have appropriate, accurate and up-to-date information in formats that are tailored to individual needs. This should include information for patients and carers about their care, according to their needs.

For people detained under the Mental Health Act, the statutory Mental Health Act code of practice (https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983) sets out the information that patients and carers should receive during their admission, including important information about their care and treatment in hospital and their rights under the act (chapter 4: information for patients, nearest relatives, carers and others). CQC also monitors compliance with the act and code of practice as part of its Mental Health Act monitoring visits to wards where patients are detained, and this information is shared into regulatory assessments.

Recommendation 8

ICSs and provider collaboratives should map out the pathway for all their mental health service lines to establish which parties need access to relevant data at all points on the pathway and take steps to ensure that data is available to those who need it.

To facilitate this, ICSs and provider collaboratives should make sure that their members have access to data literacy training relevant to mental health, including in relation to quality improvement and safety. They should also bring together the mental health population leads from across their footprint to map out the mental health needs of their local populations and the potential for primary, secondary and tertiary prevention as well as equitable access to safe therapeutic services.

Government response to recommendation 8

The government supports the recommendation that local commissioners should ensure that the right data is available to those who need it and should provide a leadership role in ensuring the commissioning of mental health services meets the needs of the local population. Recognising that there are spatial disparities in access to treatment, these structures offer a significant opportunity for locally focused strategies and efforts. These will, in turn, act to reduce spatial disparities in mental health treatment, and improve health equity across England.

This is an ICS-led action and ICSs should decide how to take this forward, dependent on local needs and priorities. DHSC and NHS England will work with ICS leaders to highlight the importance of taking this recommendation forward and seek to understand and address barriers to this.

The mental health needs of the local population are a key consideration in the formation of strategies, plans and assessments developed across ICSs. All ICBs and their partner trusts have published their joint forward plans which describe how each ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population’s physical and mental health needs.

The joint strategic needs assessments (JSNAs), produced by statutory health and wellbeing boards, are how local leaders work together to understand and agree the needs of all local people, with the joint local health and wellbeing strategy setting the priorities for collective action to address the needs identified in the JSNA. In addition, integrated care partnerships (ICPs) are responsible for developing an integrated care

strategy that sets out how commissioners in the NHS and local authorities, working with providers and other partners, can meet the needs identified in the JSNAs. DHSC and NHS England will continue to work with ICS leaders to emphasise the importance of considering mental health in the formation of these strategies and plans.

In the 2023 to 2024 operational planning guidance (https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/), NHS England also included the requirement for all ICBs to develop 3-year plans to localise and realign mental health inpatient care in line with the latest available evidence. All ICBs are expected to have these plans in place and be delivering against them by June 2024.

Recommendation 9

ICSs will develop system-wide infrastructure strategies by December 2023 and the mental health estate needs to be fully incorporated and represented in these strategies and in subsequent local action plans. This recommendation is for local ICSs to review the mental health estate to inform these and future strategies, recognising there are evidence-based therapeutic design features that can contribute to reducing risk and improving safety.

The review should include:

- identification of critical and significant safety issues and major derogations from National Health building notes, where ligatures or unsafe observation areas are present. Including, where appropriate, updating the Estates Returns Information Collection (ERIC) to ensure that returns are thorough and underpinned by up-to date site surveys and identify safety risks relating to mixed sex accommodation
- a parallel identification of current capital plans which will reduce or remove these estate risks - for example, the eradication of mental health dormitory provision by March 2025 and the plans for mental health safety work announced at recent fiscal events
- a collaborative approach across the ICS and within individual providers to interrogate estates data to inform capital plans and investment priorities
- identification of additional beneficial work that is vital to the inpatient estate’s capacity to provide modern therapeutic interventions, including self-management sensory rooms, rooms suitable for therapies and group psychological interventions, rehabilitation, occupational therapies rehabilitation treatments and faith rooms

- provision for safe family rooms for visiting with children and other dependents, and a room in which a family member can stay overnight - especially when a young person is admitted for a first episode of illness

Government response to recommendation 9
The government recognises the importance of ensuring that all mental health inpatient settings are designed to reduce patient safety risks and improve the capacity for therapeutic interventions.

All ICBs are currently developing ICS infrastructure strategies to support improved long-term planning across their estates and assets. To ensure flexibility for local needs and priorities, DHSC and NHS England do not support mandating how systems review the mental health estate. However, we expect ICBs to fully consider the mental health estate as part of their system-wide infrastructure strategies. These strategies will set out how estates will support the future clinical model of the ICS and how it intends to prioritise resources and inform capital plans.

As part of a commitment in the NHS Long Term Plan (https://www.longtermplan.nhs.uk/) to improve mental health inpatient services, over £500 million was secured for a multi-year capital programme to improve mental health facilities by eradicating dormitories and giving patients the privacy of their own bedroom by 2025.

The Mental Health Act code of practice sets out statutory guidance in relation to separate facilities for men and women in mental health inpatient settings. This includes having separate male and female toilets and bathrooms and women-only day rooms. In addition, NHS England guidance on delivering same sex accommodation (https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/) (September 2019) sets out that women-only day rooms must be provided in mental health inpatient units, and that this requirement should be incorporated into local reporting. This guidance is currently being updated and the updated guidance will be published in due course.

DHSC recognises the importance of investing in the mental health estate and that mental health inpatient settings are designed to provide a safe, therapeutic environment. We will consider mental health capital requirements at the next comprehensive spending review.

Recommendation 10

Ward visitors, whether unpaid carers, family members, friends or advocates, play an important role in providing feedback regarding the care provided and escalating any concerns. Trusts and providers should review their processes for allowing ward visitors access to mental health inpatient wards with a view to increasing the amount of time families, unpaid carers, friends and advocates can spend on wards. DHSC should consider what more can be done to strengthen the expectation for all health and care providers in England to allow visiting.

Government response to recommendation 10
The government supports the recommendation that more should be done to strengthen the expectation that all mental health inpatient settings facilitate visitors, and mechanisms are in place to record and act upon their feedback. We recognise that visitors, whether family, unpaid carers, friends or advocates, play a valuable role in caring for people admitted to an inpatient unit, including providing feedback, escalating concerns and co-producing quality improvements together.

The government recently published its response to a public consultation on introducing visiting as a CQC fundamental standard in care homes, hospitals (including mental health) and hospices (https://www.gov.uk/government/consultations/visiting-in-care-homes-hospitals-and-hospices). The majority of responses supported the government's proposal to introduce a fundamental standard on visiting. Regulations were laid in December 2023 and the government is now working with CQC to develop guidance ready for when the regulations come into force on 6 April 2024.

NHS England also recognises the value of open cultures. Visitors play a valuable role in supporting people's overall wellbeing and connection to community. NHS England's mental health, learning disability and autism quality transformation programme will be encouraging this via its inpatient mental health culture of care improvement programme, launching in 2024.

Recommendation 11

All providers of NHS-funded care should meet the relevant core carer standards set by the National Institute for Health and Care Excellence (NICE) and Triangle of Care, England. Regulators, including CQC and professional regulators, should consider how to monitor the implementation of these carer standards, especially where there is greater risk of unsafe closed cultures developing.

ICSs should consider how to routinely seek carer feedback. Inpatient staff training programmes should identify how they can benefit from carer trainers. For patients detained under the Mental Health Act, families and carers should be part of all detention reviews.

Government response to recommendation 11

The government supports the recommendation that NHS services should meet relevant core carer standards. DHSC and NHS England expect providers to implement relevant carer standards, routinely seek carer feedback, develop co-produced quality improvements and identify ways to incorporate the expertise of carers to, for example, co-deliver staff training programmes.

The Health and Care Act 2022 amended the National Health Service Act 2006 to provide that ICBs must promote the involvement of patients and their carers and representatives in decisions about the provision of health services to patients, including in relation to the prevention or diagnosis of illness in the patient and their treatment and care. In relation to inpatient care, the 2022 act also amended the Care Act 2014 to provide that NHS trusts in England must ensure that unpaid carers are involved as soon as feasible when plans for a patient's discharge after treatment are being made.

CQC is currently looking at the best way to monitor compliance with the carer standards. One option CQC is considering is to request providers' most recent report, detailing how they monitor their own action to comply with the carer standards and asking specific questions at service level while inspecting. CQC will further develop such thinking as it continues to develop its single assessment framework.

CQC is also making changes to the way it approaches regulating mental health settings to ensure they are better able to identify issues early on, which includes having worked with people with lived experience to develop an observational-based methodology, to enable focused onsite inspections of mental health services where closed cultures and restrictive practice are at greatest risk of developing. CQC takes the risk of closed cultures seriously and, as such, it will check for and tackle closed cultures in services throughout all its work.

CQC also looks at leadership and how this sets the culture of a service. For example, CQC has recently set out its new position on reducing restrictive practice, which makes it clear that the regulator expects health and care leaders to take immediate steps to identify and reduce restrictive practices in their services, where possible. Moreover, CQC takes a person-centred view, using information it gathers by speaking to people who use services and their families, advocates and carers to inform its view and assessment of cultures in services.

There are examples of good practice in relation to carer standards and voluntary schemes for providers to implement. For example, the Triangle of Care, which was developed by Carers Trust, is a carer engagement approach for mental health services, that ensures carer inclusion throughout the person's care journey. The scheme recognises providers who have committed to change through self-assessment of their existing services and ongoing action planning to ensure the Triangle of Care standards are achieved and maintained. Many NHS mental health trusts are members of the scheme.

The statutory Mental Health Act code of practice already sets out that hospital managers should have a process in place to involve the patient, their nearest relative under the act and, if different, carer, including at the hearing to determine if the person should continue to be detained under the act.

Recommendation 12

Professional bodies, such as the royal colleges, should come together across healthcare sectors to form an alliance for compassionate professional care. This multi-professional alliance should:

- work together and learn from each other to identify ways to drive improvement in the quality of compassionate care and safety across all sectors, including mental health services and how they can support staff to provide it
- along with their specialist data units, where they exist, contribute to the work set out in recommendation 1

Government response to recommendation 12
The government supports this recommendation and recognises the importance of identifying ways to drive improvement in the quality of compassionate care and safety in mental health services, including how services can support staff to provide compassionate care. DHSC will work with professional bodies, including the royal colleges, to agree how to take this forward.

As part of its quality transformation programme, NHS England, with input from royal colleges including the Royal College of Psychiatrists and Royal College of Nursing, is developing core commitments and standards for inpatient mental health care, which will be backed by a national support programme available to all inpatient providers from 2024 onwards. This will

include commitments and standards in relation to how staff can be supported to deliver compassionate, therapeutic care.

Recommendation 13

> Except where specified, these recommendations should be implemented by all parties within 12 months of the publication of this report. Government ministers, through DHSC, should review progress against these recommendations after 12 months.

Government response to recommendation 13
The government is committed to working with healthcare system partners on taking forward the key deliverables set out in its response to each of the recommendations and intends to provide an update on progress by July 2024 - one year on from the publication of the rapid review's report.

To oversee this work, DHSC has convened a ministerial-led steering group co-chaired with an external expert, Professor Sir Louis Appleby. The ministerial steering group will meet in the coming months to oversee implementation. We will ensure that the voices of service users and their carers continue to be prioritised in the implementation of the recommendations.

Conclusion and next steps

The rapid review has made an important contribution to the government's understanding of how data can be used and improved to understand risk factors to patient safety, and ultimately improve access to high quality therapeutic care for people in mental health inpatient settings. The government recognises the importance of timely and effective implementation of these recommendations.

DHSC has set up a ministerial-led bespoke steering group to oversee a work programme based on these recommendations, focused on the key areas above.