next day BRIEFING

NHS Providers

Independent rapid review into data on mental health inpatient settings: final report

The report of the independent rapid review into data on mental health inpatient settings, chaired by Dr Geraldine Strathdee, was published on 28 June. The report includes recommendations for improvements in the way local and national data is gathered and used to monitor and improve patient safety in mental health inpatient pathways. NHS Providers supported members to share views with the review and we are pleased to see many of the key points raised reflected in the report's conclusions and recommendations.

The Secretary of State announced on the same day that the Health Services Safety Investigations Body (HSSIB) will be formally established in October and will commence a national investigation into mental health inpatient care settings. A range of issues will be investigated, including care for young people, learning from deaths, out of area placements and staffing models, with recommendations focused on helping providers improve safety standards. The government also announced that an independent inquiry into deaths of mental health patients in Essex will be made statutory.

If you have any questions or comments on these announcements, please contact NHS Providers senior policy advisor, Ella Fuller (ella.fuller@nhsproviders.org).

Key points

- The review was commissioned by ministers in response to concerns the right data and information to provide early alerts to identify risks to patient safety in mental health inpatient settings and prevent safety incidents was not available and impacting efforts to ensure safe, high-quality care.
- The findings are divided into five themes: measuring what matters; patient, carer and staff voice; freeing up time to care; getting the most out of what we have; and data on its own is not enough.
- The review has made 13 recommendations which include one focused on ways trust boards can further improve their capacity to identify, prevent and respond to risks to patient safety. This includes boards reviewing membership and skillsets to ensure experts by experience and carers are represented and boards have the skills to understand and interpret data and ensure a responsive quality improvement (QI) methodology is embedded across their organisations.

- The review also recommends every provider board urgently reviews its approach to board reports and board assessment frameworks, and sets out how it will make sure the voice of carers and family members is heard by the board and clinical staff.
- Other recommendations consider how to improve data collection, management, reporting and access, as well as the role of systems in mental health.
- The review says its recommendations should be implemented by all parties within 12 months of the report's publication, with the government reviewing progress at that point. The government has said it will issue a response in due course.

Background

The rapid review was commissioned by ministers to produce recommendations to improve the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways. It followed a number of undercover investigations coming to light last year that raised serious questions about the quality of care and safety of individuals receiving care in these settings.

Our vision for a better future

The rapid review team devised 11 principles that set out a vision for the future where the potential of data and evidence is fully exploited so that the healthcare system is able to ensure the highest standards of care in all mental health inpatient wards and pathways. The principles include: data being entered once and used multiple times; all data entered being analysed by informatics experts who can create high quality products; and anyone who enters data into a system benefiting from entering that data. Others focus on there being: a clear and explicit rationale for data requests; consistent and national agreed definitions for data collected; and mental health services and ICSs joined up with other sectors as far as possible to facilitate data and information sharing.

Findings

Measuring what matters

To reduce the risk of patient safety incidents, mental health staff and leaders need to focus not just on where things go wrong, but on what is needed for things to go right, such as providing, safe therapeutic, compassionate environments and functioning pathways. Staff also need to feel safe and supported to speak up early. The review has developed a 'safety issues framework' that sets out the key safety issues relevant to mental health inpatient services and the factors that create safety risks or foster protective therapeutic environments.

The review finds a large amount of data on activity and process measures is collected, as well as some on acuity and performance measures, but more systematic metrics on environment and workforce are needed and there are significant gaps in therapeutic care, outcomes and culture metrics. Data and information about patients' protected characteristics, are often not collected or triangulated with other information about patients, meaning that opportunities to address inequalities are often missed.

More needs to be done to understand whether patients are receiving therapeutic care at all times as this is a vital component of care quality and a pre-requisite for safe environments and cultures. There should also be a greater focus on measuring patient outcomes and experience. Information about physical health needs is not always collected and physical health services are not always well integrated into mental health inpatient pathways. Even where this is collected, it is not always given the same priority by national and regional bodies, which can influence the attention on these needs.

What should be measured in relation to patient safety in mental health inpatient pathways

The review has identified the key issues that should be measured when seeking to identify and address patient safety risks in mental health inpatient pathways, which it sets out in a safety issues framework in the report. It is acknowledged that this set of issues is not exhaustive and further work is required to identify what exact metrics should be measured, by whom, and when.

Patient, carer and staff voice

Hearing from patients, carers and staff is essential, both about their experience of services and getting their input into the design of those services. Visitors to inpatient settings, such as carers or advocates, play an important role in proving feedback and escalating concerns. There are barriers to getting real time, honest feedback from the people most closely connected to the wards through to managers and leaders at board level and beyond. Routes to give feedback are, variously, not clear, difficult or time-consuming to use, and patients, carers and staff reported that sometimes they felt feedback isn't listened to or acted upon. Several providers have examples of good practice, for example, having experts by experience on their boards and in their leadership meetings.

Freeing up time to care

The scale of the issue around data burden exceeded the expectations of the review. Some of the issues highlighted include frontline nursing and clinical staff spending as much as half their shifts in the office entering data, and roughly half of analysts' time being used to flow data to national and local data sets instead of providing support for quality improvement to frontline staff and trust

leaders. The data burden presents risks to safety as it reduces the amount of time staff can spend providing therapeutic care to patients.

The systems used to enter data are often outdated and do not communicate well with each other, and requirements for data entry have grown, as more demands are made to provide assurance to local, regional and national colleagues. Multiple data requests from different parts of the system were also reported as an issue as they often had slightly differing asks, and the same data requested with different definitions and formats therefore required separate returns. This was thought to be a particular challenge for providers and commissioners covering large geographies.

While it was clear that data and information provided by frontline staff was critical to ensuring safety, there was widespread agreement that this should be streamlined as far as possible, focused on the most important things, and tools should be made available to make entering data as easy as possible.

Getting the most out of what we have

There is no shortage of data on mental health, but local regional and national bodies often to do not make the most of the data they receive. For data to be effective in providing early alerts to reduce risks to patient safety, it has to be available in as close to real time as possible in an accessible format. Often, this is not the case. Staff at all levels do not receive value from the data they enter – too little comes back to frontline staff and provider leadership that can provide them with insights about their patients and services. Key information, such as risk factors, does not always follow patients through their therapeutic journey also.

Providers often do not have enough analytical resource to service the needs of all their teams, in part because of the amount of time spent feeding information to external local and national data sets. There is a desire from staff at all levels, to receive shared training in the use and interpretation of 'data for improvement'. There was also a request for a review of mandatory training. Frontline clinical staff also said they would value more targeted, directed, digestible information being sent to them in easy-to-use formats, so they did not have to spend their time on data analysis.

Trust non-executive directors and quality committee chairs said that, while there was an appreciation for the drive from NHSE to use statistical process control analyses, there is a need to not only analyse trends, but to also understand the root causes and themes, benchmarking, and how that can inform the selection and implementation of quality improvement (QI) methods.

There is an appetite among providers to benchmark their services against other similar services, but despite the valued presentations and outreach offered by organisations such as the NHS Benchmarking Network, sufficient data often is not shared between providers to benchmark with sufficient rigour. Furthermore, fear of negative attention is a barrier to providers sharing information. NHSE and CQC have a role to play in fostering a supportive culture of mutual transparency where data can play a role in driving up standards across the country.

Senior clinicians and professional training leaders also said they have conflicting advice from local and national commissioners about the way to code diagnoses, patient needs and therapeutic interventions, so data is not often in a consistent format with a consistent set of definitions.

There are several local examples in trusts and independent sector providers of high-quality dashboards that gather and triangulate data about the key categories of risks to inform leaders.

Data on its own is not enough

Leaders at all levels, and especially in trust and provider boards, need to understand the risk factors in their own services and to take action to address them. Key decision makers at every level often felt like they did not have the skills or capacity to make the best use of the data and information available to them and were therefore not able to gain the insights they needed.

The review heard the best way to identify where things are going wrong is for leaders at all levels to visits wards and see for themselves. The most effective leaders were identified as making regular, unannounced visits to wards and do so at all hours. 'Soft' intelligence is important, as is the need for leaders to act on information from all sources rather than relying on one dashboard or data set.

Commissioners and providers should work together to establish QI programmes that drive up the quality of safe, therapeutic care and ensure that staff have time to undertake this work.

Data on deaths in mental health inpatient settings

The report provides a breakdown of the range of organisations that collect and use data on service user deaths in mental health inpatient services, as well as the data that is either shared with providers or other system partners, or available in the public domain. The review found these collections are fragmented, which presents significant challenges in providing an overview of how many people die while in contact with inpatient services and the cause of their deaths.

Recommendations

1 NHS England (NHSE) should establish a co-produced programme of work to agree how to make sure providers, commissioners and national bodies 'measure what matters' for mental health inpatient services, and can access the information required to provide safe, therapeutic care. What metrics to collect, share and use at different levels should be considered by the end of 2023.

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. NHSE's transformation directorate should scope out options to deliver on this and present these to DHSC by the end of December 2023.

3 ICSs and provider collaboratives should bring together trusts, independent sector providers and other relevant stakeholders to facilitate the sharing of good practice in data collection, reporting and use. This forum should also facilitate the rolling out of good practice examples and digital innovation between all data commissioners and both NHS and independent sector providers.

4 DHSC, in partnership with NHSE and CQC and supported by relevant experts, should convene all relevant organisations who collect and analyse mortality data to determine what further action is needed to improve timeliness, quality and availability no later than autumn 2023.

5 The review recommends a number of actions to improve boards' capacity to identify, prevent and respond to risks to patient safety. These include for every provider board to:

- **a** urgently review its membership, skillset and ensure they have an expert by experience and carer representative;
- **b** ensure its membership has the skills to understand and interpret data about inpatient pathways and a responsive quality improvement methodology is embedded across their organisations. Annual mandatory training for members on data literacy should be considered.
- **c** provide Mental Health Act (MHA) training so at least half their non-executive directors are trained as associate hospital managers under the MHA and participate in hearings.
- **d** urgently review its approach to reports and assessment frameworks to ensure key risks in all wards are highlighted and it is supported to take action to mitigate risks and improve care.
- **e** set out in writing how it 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.

The review also recommends NHSE review and update the guidance on board assessment frameworks, and CQC should assess and report on whether the membership of boards of mental

health inpatient services includes experts by experience representatives and are maintaining an appropriately high level of data literacy and quality improvement expertise.

6 Provider leaders should prioritise spending time on wards regularly, including unannounced and 'out-of-hours' visits, to be available to, and gather informal intelligence from, staff and patients.

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 comprehensive information (such as about staffing, ward environment and therapeutic activity) is available. CQC should assess the quality, availability and accessibility of this information as part of their assessment of services.

8 ICSs and provider collaboratives should map out which parties need access to relevant data at all points on the pathway for all their mental health service lines and take steps to ensure that data is available to those parties. They should also make sure their members have access to data literacy training, and bring together local mental health population leads to map out local mental health need and the potential for prevention as well as equitable access to safe therapeutic services.

9 ICSs should review their local mental health estate to inform their infrastructure strategies (to be developed by December 2023) and subsequent local action plans and strategies, recognising the impact of evidence-based therapeutic design features on reducing risk and improving safety.

10 Providers should review their processes for allowing ward visitors access to mental health inpatient wards with a view to increasing the amount of time visitors can spend on wards. DHSC should consider what more can be done to strengthen the expectation for all providers to allow visiting.

11 All providers of NHS-funded care should meet the relevant core carer standards set by NICE and Triangle of Care, England. Regulators should consider how to monitor these standards' implementation and ICSs should consider how to routinely seek carer feedback. Inpatient staff training programmes should identify how they can benefit from carer trainers. Families and carers should be part of all MHA detention reviews.

12 Professional bodies should come together to form a multi-professional alliance for compassionate professional care to work together to share learning and identify ways to drive improvement.

13 Except where specified, these recommendations should be implemented by all parties, and government ministers should review progress, within 12 months of the publication of this report.

NHS Providers view

We welcome the publication of the rapid review's findings and announcement of a nationwide investigation into mental health inpatient care. We must see the government's response to the rapid review, and the nationwide investigation conclude, as soon as possible so focus can turn to implementing the actions locally and nationally that will make a difference without further delay.

All mental health trusts have been reviewing services urgently to assure the safety and quality of their care, and identify where and how they can improve certain services' culture and practice. The report sets out some important ways all boards can further improve their capacity to identify, prevent and respond to risks to patient safety. We welcome the rapid review highlighting innovative practice being undertaken by specific providers to try to address some of the issues that have been identified.

Abuse is unacceptable and trust leaders are committed to improving and 'letting the light in' to services. As the rapid review highlights, listening to patients and their families is paramount and we welcome the review's emphasis on this as well as on improving the culture of care within services and making sure staff feel safe and supported to speak up. We also welcome the review stressing the importance of measuring what matters, using data more effectively, and improving digital infrastructure and data literacy and skills. There are number of actions recommended in the report that would be beneficial to apply beyond mental health inpatient services.

We know there is other action required beyond the original focus of this review to prevent abuse and improve culture and practice. It is welcome that the report highlights this and includes recommendations to address elements of some, such as staffing and investment in the mental health estate. It is vital that the nationwide review takes full account of and develops recommendations that more squarely address these wider areas where action is needed. This is necessary if it is to deliver on its aim to help providers improve safety standards in mental health services across the country.

We need long-term, sustainable investment and support for mental health services and the workforce to provide the best care possible. We also need more support for public health, social care and the wider system of services that play a crucial role in helping to ensure people with mental illnesses' needs can be met compassionately and effectively as early as possible.

Our press release responding to the publication of the report can be accessed here.