Department of Health & Social Care

Easy Read

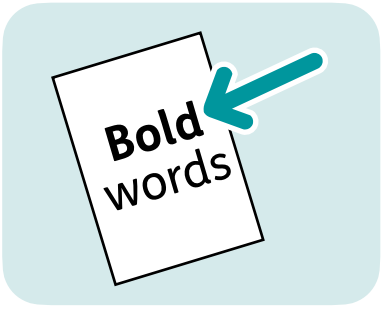
Looking into how information is collected and used in mental health hospitals

This is an Easy Read version of the: **Rapid review into data on mental health inpatient settings: final report and recommendations**

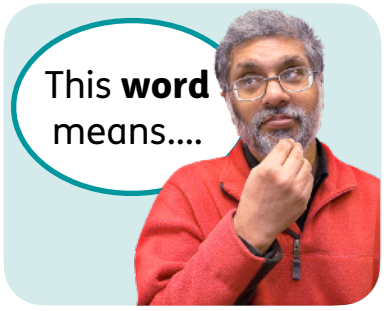
Easy Read

This is an Easy Read version of some information. It may not include all of the information but it will tell you about the important parts.

This Easy Read booklet uses easier words and pictures. Some people may still want help to read it.



Some words are in **bold** - this means the writing is thicker and darker.



These are words that some people will find hard. When you see a bold word, we will explain it in the next sentence.

Blue and underlined words show links to websites and email addresses. You can click on these links on a computer or device.

What is in this booklet

About this report

The Rapid Review was a group led by an independent doctor that was set up to look into how information is collected and used in **mental health inpatient care settings**.

Mental health inpatient care settings are hospitals for people who cannot be cared for at home because they need special care.

We have written a report about:

- Why the Rapid Review was set up.
- What we found out.
- What should happen next.

This is an Easy Read version of our report.

Why the Rapid Review was set up

The Rapid Review was a group that was set up by the government. It was led by an independent doctor called Dr Geraldine Strathdee.

We were asked to look into how information is collected and used in mental health inpatient care settings.

The way information is collected and used can affect how good and safe care is for patients.

Collecting and using information in the right way can help to make sure:

- Every patient is getting the right care at the right time.

- Staff in inpatient care settings can share what is working well and what is not working well.

- Care teams can see where there are problems and deal with them before they get worse.

- More people can learn from problems and make better decisions in the future.

The Rapid Review was set up to look into:

- How information is being collected and used now.
- What needs to be done next.

How we wrote this report

To help us with our report we spoke to more than 300 people, including:

- Staff who give care to mental health inpatients.

- People who run health and care organisations.

- People who have been patients in mental health inpatient care settings, their families and their carers.

We found out information about 5 things:

1. Collecting the right information.

2. Listening to patients, carers and staff.

3. Freeing up time to care.

4. Getting the most out of what we have.

5. Understanding that information on its own is not enough.

What we found out

1. Collecting the right information

Patients must get the right care in the right place so that they can get better.

Staff in mental health inpatient care settings need to be trained to give each patient care that is right for them.

There should be more focus on what a patient needs to make them better, instead of what they don't need.

Inpatient care settings should be places where patients feel safe and staff feel supported to give good care.

We found that the right information is not being collected to check that mental health inpatient care settings are giving patients the right care.

2. Listening to patients, carers and staff

Patients, carers and staff must all have a say about mental health inpatient care services.

We found that patients, carers and staff do not always get the chance to speak up, or say when something is wrong.

Some people told us that this is because they did not know how to speak up, or who to speak to.

Some people said that they were afraid to speak up in case it caused a problem, or affected the care that people get.

Other people said that when they did speak up, they didn't feel listened to, or nothing happened afterwards.

We found out that some mental health and care organisations are very good at giving people a chance to speak up.

Some of them involve patients and carers in decisions about how they run their organisation.

Making sure people can speak up will help to improve services for everyone.

3. Freeing up time to care

The more time staff spend collecting information, the less time they spend giving care to patients.

We found that some staff were spending half their time writing down information or putting it onto computers.

Sometimes they had to write down the same information lots of times.

Many settings are using computer systems that are not good enough.

We also found that organisations across the country collect and share information in different ways.

All of this means staff are spending less time giving care to patients, which might not be safe.

4. Getting the most out of what we have

We found that there is a lot of information about mental health, but not all mental health settings are using it in the right way.

We found that settings that did use information well were providing better and safer care.

Their staff had a better understanding of what needed to be done and when.

They were also better at dealing with problems before they got worse.

We found that staff in mental health inpatient care settings want to be able to get important information quickly and easily.

They also want to be able to find out how well their care setting is doing compared to others.

We found that staff in mental health and care organisations want training on collecting and using information to make their services better.

5. Understanding that information on its own is not enough

We found that nearly everyone agrees it is important to collect information.

Many people also said that more needs to be done with the information that is collected.

Information can show where there are problems but not enough is being done to deal with them.

People said it is most important that the managers who run mental health and care organisations go and visit inpatient care settings.

This will mean the managers can see what is happening for themselves.

People said visits should be unplanned and done at different times of the day to get a real sense of what is going on within each setting.

What should happen next

Next, we will tell you about our **recommendations**.

Recommendations are the things that we think should be done next.

There are 13 recommendations:

Recommendation 1

NHS England should make a plan for how all mental health inpatient care settings should collect and use information.

NHS England is an organisation that leads the National Health Service in England.

The plan should be written with the help of patients, their families and carers, care staff and people who run mental health and care organisations.

Recommendation 2

Every NHS care service should have up-to-date computer systems that can collect and share information.

NHS England and the **Department of Health and Social Care** should look into how this could be paid for and what needs to be done next.

The **Department of Health and Social Care** is part of the government. It decides the rules for health and care services in England.

Recommendation 3

Health and care organisations should work together and share ideas about how to improve the way they collect and use information.

Recommendation 4

More should be done with information about when a patient has died, to learn what can be done differently to improve the way that information is collected and used.

Department of Health & Social Care

The Department of Health and Social Care should lead this work.

Recommendation 5

Patients, families and carers should have a say in how the organisations that provide mental health inpatient care settings are run.

The people who run mental health inpatient care settings should be given training to help them understand how to use information about mental health patients.

The **Care Quality Commission (CQC)** should check that the people who run settings have the right training in mental health inpatient care.

The **CQC** is an independent organisation that checks the standard of health and care services in England.

The people who run mental health inpatient care settings should look at the way they work and write reports about what they have done.

They should also make sure they have a way for patients, carers and staff to speak up about their services.

NHS England should give organisations up-to-date guidance on how to do these things.

Recommendation 6

People who run organisations that provide mental health inpatient care settings should:

- Go and visit the care settings regularly.

- Speak to staff and inpatients and get information from them.

Recommendation 7

Mental health inpatient care settings should check the information they are collecting and using, every year.

The CQC should check that sharing with patients and carers is happening and how well it is being done.

Recommendation 8

Mental health and care organisations need to plan how they will use information about mental health, including:

- Making sure that those who need the information can get it.

- Making sure staff can get important information quickly and easily.

Mental health and care organisations should also have information about people's mental health needs in their local area, to make sure people are getting the right help.

Recommendation 9

Health and care organisations are all writing new plans for their organisations that will include their properties and buildings.

These need to include plans for mental health inpatient care settings.

The plans for mental health inpatient care settings should include checking for safety issues in buildings and making them safer.

The plans for mental health inpatient care settings should also include:

- Keeping information up-to-date.

- Spending money in the right way.

- Providing space for other treatments and better care.

- Making it easier for families to visit inpatients.

Recommendation 10

Mental health inpatient care settings should be easier for visitors to visit and spend more time with the person they are visiting.

Mental health inpatient care settings should do more to listen to visitors, like the family and friends of patients.

The Department of Health and Social Care should think about how to do this.

Recommendation 11

All NHS care services should meet the standards for carers in England.

This should include listening to carers and involving them in mental health inpatient care training.

Recommendation 12

Professional bodies that represent health professionals like doctors and nurses should work together to:

- Learn from each other.

- Improve quality of care.

- Improve support for staff.

- Improve the use of information.

Recommendation 13

These recommendations should be followed by the end of June 2024.

The Department of Health and Social Care, NHS England and CQC should look into what difference our recommendations have made by the end of June 2024.

Next steps

The Department of Health and Social Care will work with organisations, including NHS England and the Care Quality Commission.

Together they will take action to deal with the issues that are mentioned in our recommendations.

They will provide an update on what has been done by July 2024.

Find out more

You can read the full version of this report on GOV.UK.

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