

Our response to the rapid review on inpatient safety - 28 June 2023

The screenshot shows the Rethink Mental Illness website with the article 'Our response to the rapid review on inpatient safety' dated 28 June 2023. The page features the Rethink Mental Illness logo, a search bar, and navigation links for 'Advice and information', 'Help in your area', 'Campaigns and policy', 'Get involved', and 'About us'. The article text is as follows:

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28 June 2023

In response to the publication of the rapid review into data on mental health inpatient settings, published today by the Department of Health and Social Care, Mark Winstanley, Chief Executive of Rethink Mental Illness, said:

"When people experience a mental health crisis or are very unwell, they expect the NHS to keep them safe and support their recovery. In a shocking, ever-increasing number of cases, there have been appalling failures in the standard of care delivered to people when they are at their most vulnerable. The harm and distress caused has been felt by those directly affected, their loved ones and those working in mental health services who do strive to deliver first rate care and support."

"The rapid review published today represents an opportunity to take steps to reset the balance of care in inpatient settings. It highlights how data can play a critical role in illustrating the current picture across services and help to ensure people receive a high-quality service when they're most in need. We particularly welcome the focus on carer and patient involvement, including better access to wards for carers, family and friends plus improvements to the information patients and families receive about the quality of their care. It is imperative the government enacts this review within the 12-month timeframes set out.

The screenshot continues the article 'Our response to the rapid review on inpatient safety'. The text is as follows:

"But the review only represents one part of the answer. We welcome the announcement of the Healthcare Safety Investigations Branch which must work closely with patients, families and carers to investigate incidents that occur, with powers to issue alerts to improve patient safety. Lessons must also be learnt and acted on from the Essex Mental Health Independent Inquiry, which has now been given vital statutory powers to compel witnesses to give evidence.

"In tandem, the government must bring forward long overdue reform of the Mental Health Act and address the staffing crisis in mental health services through its imminent workforce plan for the NHS. We believe that only if the government prioritises and urgently acts on these factors, can we prevent more avoidable tragedies and pave the way towards improved, safer care in mental health inpatient units."