Health Services Safety Investigations Body

Investigation report

Mental health inpatient settings: Creating conditions for the delivery of safe and therapeutic care to adults

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Theme:
Mental health

Contents

Before reading this report

This report considers the care of people experiencing mental health problems and includes discussion about suicide and sexual safety. Some readers may find the contents of this report distressing. Information about how to access support for mental health can be found at: Where to get urgent help for mental health - NHS

Acknowledgements

Over a period of almost a year the HSSIB team visited at least 40 care areas across 30 mental health care providers and met with multiple patients, families and staff along the way. We would like to thank the many people who contributed to this investigation. Thank you to the patients and families who described their personal experiences to us, which included the sharing of very intimate and traumatic situations. Thank you to the staff and providers who supported our visits and welcomed us with openness.

The investigation also wishes to acknowledge the multiple complex and interacting factors that influence access to and the quality of care received by patients in mental health inpatient settings. This report sets out the investigation's findings in line with its terms of reference. This has meant some aspects of mental health care were outside of the scope of this investigation; these aspects have been acknowledged throughout the report.

About this report

In June 2023 the Secretary of State for Health and Social Care announced that HSSIB would undertake a series of investigations focused on mental health inpatient settings. This report describes the findings of the first of those investigations. In September 2024 HSSIB also published an interim report titled 'Learning from inpatient mental health deaths and near misses: assessment of suicide risk and safety planning'.

This investigation explored the risks to patient safety associated with the workforce and working conditions in acute mental health inpatient settings for adults. The intention of the report is to support improvements in safety and to realise a 'culture of care within inpatient settings everyone wants to experience' – that is, patients, families, carers and the staff working in these settings (NHS England, 2024a).

The findings of this report are intended for the Secretary of State for Health and Social Care, healthcare policy makers and organisational leaders to help influence improvements in the delivery of therapeutic care that supports patient safety. This report has been published at a time when the government is responding to the findings of the 'Independent investigation of the NHS in England' (Department of Health and Social Care, 2024a). It is expected that the findings of this report will

contribute to the government’s long-term plans in relation to mental health inpatient settings. This report is also intended for those who work in and engage with mental health inpatient settings, such as integrated care boards (ICBs).

Readers can use the links in the contents panel to access sections of interest in the report.

Glossary

The terminology in this report has been chosen while acknowledging that there are differing views across organisations and groups. For example, this report refers to ‘patients’ in line with NHS documents (NHS England, 2024a) and refers to people who experience a ‘mental health problem’ in line with Mind (2024).

Acuity	How unwell a patient is and how much care and support they require from staff.
Adult inpatient services	General acute (immediate) mental health inpatient services for adults aged 18 to 64 years. Sometimes referred to as ‘working age’.
Built environment	Estates (buildings and land) and physical ward environments (ward surroundings).
Culture	Values and beliefs that influence the care of patients and support for staff.
Digital	Use and transfer of information using technology and the infrastructure and processes to do so.
Mental Health Act (1983)	Legislation on assessment, treatment and rights of people experiencing a mental health problem. Amended in 2007.
Mental health problem	Disturbance of a person’s mental wellbeing, impairing their ability to function as normal (Mind, 2024).
Observation	A restrictive intervention where a member of staff watches and engages with a patient continually or intermittently.
Older-adult inpatient services	Wards that care for older patients experiencing a mental health problem.
Physical health problem	Disturbance of the functioning of a person’s organs or body systems, such as their lungs or heart.
Preceptorship	A process to welcome and support integration of newly registered professionals into a team and place of work.
Psychosocial	

	Recognition that mental health is influenced by internal (including psychological) and external (including social) factors.
Relational security/ safety	The knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care (Royal College of Psychiatrists, 2015).
Registered nurses	A qualified nurse registered with the Nursing and Midwifery Council. There are four fields – adult, children, mental health, and learning disability.
Restrictive practice/ intervention	Techniques to reduce a patient's movement, control risk actions, isolate and/or reduce sensory stimulation.
Risk cues	Where a patient provides signals that suggest they may self-harm or cause harm to others, including through violence.
Safe care	The avoidance of physical and psychological harm to patients during the provision of care, and creation of an environment that makes them feel safe.
Secure inpatient services	Wards with a focus on care for adults who present a risk of harm to others and where escape should be prevented/ impeded dependent on the level of security.
Self-harm	Any behaviour where someone causes harm to themselves, may be to help cope with difficult thoughts and feelings (Mental Health Foundation, 2022).
Sexual safety	Protecting patients from feeling uncomfortable, frightened or intimidated in a sexual way, and protecting them from sexual safety incidents.
Technology	The software (for example electronic patient record) and hardware (for example computer) used to provide care.
Therapeutic care – engagement and relationships	Partnership between staff and patient with shared decision making and recovery-focused goals (Care Quality Commission, 2023a). Relationships embody core values, such as respect, compassion, trust and kindness.
Therapeutic care - environment	Creates the conditions for therapeutic care by providing psychological safety and privacy, supporting activity and interaction, and preventing re-traumatising of patients.
Trauma-informed care	Care grounded in the understanding that a patient's past exposures to trauma will have influence on their development and how they respond to situations.
Workforce	

	The multidisciplinary team providing care and support to patients. Includes nursing, medical, allied health professions (such as speech and language therapy and occupational therapy) and psychological professions.

Executive summary

Background

This is one of a series of HSSIB investigations on the theme of patient safety in mental health inpatient settings. This investigation focused specifically on the conditions that contribute to the delivery of safe and therapeutic care to adults who are staying in mental health wards or units.

Patients experiencing mental health problems in inpatient settings should receive care that supports their safety and ensures they feel safe. Care should be therapeutic through the formation of therapeutic relationships and recognition of patients' previous traumas, and be responsive to individuals' mental and physical needs. Care also needs to be delivered by staff who are supported and enabled to develop therapeutic relationships with patients.

The demand on mental health inpatient services in England is high and has been increasing. It is reported that the quality of care received by patients admitted to these services varies. Where quality varies, patients may not receive the therapeutic care they need, with limited shared decision making and a lack of consideration of recovery-focused goals. Patients may also be placed in situations that create safety risks associated with mental, physical or sexual harm.

The aim of this investigation was to examine the impact of workforce challenges on the delivery of safe and therapeutic care to adult patients in acute mental health inpatient settings (settings for people who need urgent care and are experiencing a severe mental health problem). It also aimed to examine the wider workplace conditions and the organisation of care to see how these factors affected care. The investigation's scope included adults, older-adults and secure (adults who pose a risk to the public) inpatient settings.

The investigation's findings offer opportunities to facilitate improvements in systems, practices and future plans to support the delivery of therapeutic care and therefore safety in mental health inpatient settings. Findings may also be applicable to other healthcare services in England.

Findings

Mental health inpatient workforce

- Patients in mental health inpatient settings did not always feel safe and staff were not always able to develop therapeutic relationships with patients in support of their care and safety. Best practice standards for care were not embedded across inpatient settings.
- Some inpatient models of safety continued to focus on restrictive approaches, rather than relational approaches. Approaches were influenced by the ability of the workforce to form therapeutic relationships with patients.
- Workforce challenges across the multidisciplinary workforce had negatively influenced the ability of staff to develop therapeutic relationships with patients and therefore patient safety had been affected.
- Workforce challenges included difficulties recruiting staff and retaining experienced staff, and concerns around the knowledge and skills available to support therapeutic relationship formation and trauma-informed care.
- The mental and physical health care needs of patients cared for in acute inpatient settings may have changed and acuity may now be greater than in the past. Staff were not always equipped with the required knowledge and skills to understand and meet the mental and physical needs of patients.
- Wards were not always staffed to ensure patients could access the knowledge and skills of a multidisciplinary team. Some patients had no or limited access to professionals such as dietitians or speech and language therapists.
- Workforce challenges varied across regions. Barriers to region-wide coordinated workforce planning included unclear national expectations, difficulties predicting workforce needs, limited provider engagement, and a lack of available staff.
- The goals of the NHS Long Term Workforce Plan may be unattainable if barriers to implementation are not recognised and addressed. Barriers found included education capacity to build the workforce and poor working conditions affecting retention.
- There were conflicting views about how best to educate pre-registration nursing (mental health) students and where responsibility should lie to support their development of mental and physical health care skills.
- Registered nurses (mental health) may be being promoted to supervisory roles with limited experience. Inexperience influenced the supervision and development of new staff, and leaders may be reluctant to challenge attitudes that undermine the quality of care.

Built mental health inpatient environments

- The built environments (estates and physical environments) of inpatient settings varied. Some environments were not therapeutic, did not contribute to formation of therapeutic relationships, and had created situations where patients and staff could and had been harmed.
- The short-, medium- and long-term investment requirements for safe and therapeutic built environments across mental health inpatient settings were not always known at regional and national levels.
- Capital funding for the NHS to maintain, improve and create new built environments was finite and unable to meet the needs of mental health inpatient settings. Hazards in built environments could not always be removed or mitigated, and environments could not be improved to be therapeutic.
- There were concerns about the long-term ability of some high-secure built environments to maintain patient, staff and public safety. There was no specific process for high-secure services to access the capital funds they required for long-term estate planning.
- There was limited evidence around how best to design therapeutic built environments to meet potential changes in patients' needs and acuity. Providers wanted clarity on design standards and on the role of technology to support the safety of patients experiencing mental health problems.

Social and organisational factors influencing mental health inpatient care

- The development of psychologically safe and therapeutic social environments was not always possible because of demands on services, workforce constraints, workforce knowledge and skill development, and cultural influences.
- Providers of mental health inpatient care were not always able to accommodate patients in single-sex spaces. Best practice standards in relation to ensuring sexual safety were not always embedded.
- Approaches to accommodating patients who were transgender and non-binary varied in mental health inpatient settings. Staff wanted to meet the needs and preferences of all patients but this was not always possible.
- Digital systems had contributed to incidents where patients had been harmed. Clinical information was not always easily accessible in electronic patient records or had not been shared across different care providers' systems.
- Availability and access to physical healthcare services for mental health inpatients varied. Access was influenced by how providers designed and set up

their services, the knowledge and skills of staff, and collaboration between acute and mental health care providers.

- In some locations, care pathways between different care providers were limited. This reduced continuity of care and made it more difficult to access physical health services, which increased the need for patients to be transferred to acute physical health hospitals.
- Inequalities continued to exist in the care of patients experiencing mental health problems. Availability and access to services for different patient groups further influenced the ability of inpatient providers to deliver safe and therapeutic care.
- Some organisational cultures and individual beliefs surrounding people experiencing mental health problems continued to negatively influence attitudes towards their care, including access to physical healthcare.

HSSIB makes the following safety recommendations

Mental health inpatient workforce

Safety recommendation R/2024/037:

HSSIB recommends that The Shelford Group reviews and updates the Mental Health Optimal Staffing Tool on a regular basis following collection of recent data from mental health inpatient settings. This is to ensure the tool remains valid for potential changes in patients' needs and the level of care they require, and to support providers to make decisions about workforce requirements that support therapeutic and therefore safe care.

Safety recommendation R/2024/038:

HSSIB recommends that NHS England works collaboratively with relevant national bodies and stakeholders including professional regulators, the Department of Health and Social Care, and relevant royal colleges to:

1) Identify and clarify the goals of acute mental health inpatient care and the roles, required skills and ongoing professional development needs of the multidisciplinary workforce team.

2) Review and update the NHS Long Term Workforce Plan with consideration of the concerns around changes in patients' needs and the need for a multidisciplinary approach to ensure therapeutic care is provided.

3) Develop a strategic implementation plan to address workforce issues in mental health inpatient settings that identifies the social and technical barriers to implementation and sets out actions to address them.

This is to develop, enable, support and retain a future multidisciplinary mental health inpatient workforce that is able to deliver therapeutic and safe care to patients.

Built mental health inpatient environments

Safety recommendation R/2024/039:

HSSIB recommends that the Department of Health and Social Care, with input from stakeholders including NHS England, identifies the short-, medium- and long-term requirements of NHS mental health built environments to ensure they enable delivery of safe and therapeutic care to patients, and create a supportive working environment for staff. This is to support the development of a strategic and long-term approach to capital investment and prioritisation for NHS built environments.

Safety recommendation R/2024/040:

HSSIB recommends that the Department of Health and Social Care undertakes assessment of the capital requirements of the built environments across high-secure services in England and develops plans to ensure the long-term safety of patients, staff and the public.

Social and organisational factors influencing mental health inpatient care

Safety recommendation R/2024/041:

HSSIB recommends that NHS England, working with relevant stakeholders, develops guiding principles for providers of mental health inpatient care to support local decision making when accommodating patients, including patients who are transgender and non-binary. This is to ensure a provider's equality and human rights obligations are considered, and all patients are cared for in environments where they feel safe and that are therapeutic.

HSSIB makes the following safety observations

Safety observation O/2024/034:

Providers of mental health inpatient care can improve patient safety by ensuring that where professional judgement is used to help make workforce decisions, this accounts for ward physical environments, changes in patient acuity, and the individual mental and physical health care needs of patients that require support from a multidisciplinary workforce.

Safety observation O/2024/035:

Those involved in the provision of undergraduate and pre-registration education (educational institutions and placement providers) and preceptorship/induction programmes can improve patient safety by collaboratively ensuring that staff entering mental health related professions are developing the required knowledge and skills, including in trauma-informed care, to care for patients with mental and physical health care needs.

Safety observation O/2024/036:

Those involved in healthcare research can improve patient safety by seeking to understand the design principles for mental health inpatient settings that underpin safe and therapeutic care. Research should include consideration of sensory environments, the role of technology, and the changing needs of patients.

Safety observation O/2024/037:

Those involved in the design of new and upgraded built environments for mental health inpatient settings can improve patient safety and the delivery of therapeutic care by involving relevant stakeholders in design processes. Stakeholders include people with lived experience (patients and staff) and experts in human factors and ergonomics. Any design should also consider the changing needs of patients.

Safety observation O/2024/038:

Providers of mental health inpatient care can support patient safety by evaluating and addressing local barriers to the effective use of technology to support patient care, including through gaining insights from people with lived experience (patients and staff) and ensuring the digital infrastructure is available, usable and reliable.

HSSIB proposes the following safety responses for integrated care boards

Proposed safety response ICB/2024/008:

HSSIB suggests that integrated care boards work collaboratively with the NHS and independent sector to review their system-level workforce plans to ensure they recognise and mitigate the safety challenges in mental health inpatient settings and agree how variation across a geographical area can be mitigated.

Proposed safety response ICB/2024/009:

HSSIB suggests that integrated care boards: 1) ensure system-level infrastructure strategies clearly reflect the risks across their mental health inpatient built environments, and 2) ensure prioritisation of capital funding is equitable across different healthcare settings in a geographical area.

Proposed safety response ICB/2024/010:

HSSIB suggests that integrated care boards: 1) work with mental health inpatient providers to identify patient needs that require input from other providers and agencies, and 2) facilitate cross-provider working arrangements between mental health, acute and primary care providers to minimise the need for transfers of care unless clinically necessary.

1. Background and context

This investigation report is one of a series of HSSIB investigations focused on mental health inpatient settings. This section provides background to the investigation, which focused on the workforce and workplace conditions in acute mental health inpatient settings that deliver care to adults.

1.1 Mental health care

1.1.1 A person's mental wellbeing/health influences how they feel, what they think and how they behave (World Health Organization, 2022). Around a quarter of the population of England will experience a 'mental health problem' each year (Mind, 2024). A mental health problem is a change to a person's mental wellbeing that impairs their ability to function as they would do normally. Mental health is determined by a combination of biological (for example genetics and physical health), psychological (for example beliefs, perceptions and previous traumas) and social (for example relationships, culture and life circumstances) factors (Mental Health Foundation, 2024).

1.1.2 Most people experiencing a mental health problem will be cared for outside of hospital in the community. For some people admission to hospital on a voluntary or compulsory basis is needed. The Mental Health Act (1983) is the main legislation that covers the assessment, treatment and rights of people experiencing a mental health problem in the community and in hospital. Where a person is admitted to hospital on a compulsory basis they may be described as 'detained' under the Mental Health Act. The Act is split into different sections, which contain information about being detained, treatment while detained and the allowance of 'leave' from hospital for an agreed purpose and period (this may be referred to as 'section 17 leave'). The Mental Health Act was amended in 2007 and at the time of writing further reforms were being considered.

Mental health inpatient care

1.1.3 In England there are various mental health inpatient services. This investigation focused on inpatient services for adults when experiencing mental health problems that require immediate (acute) care. The demand on mental health inpatient services in England is high and has been increasing. Between 2016 and 2023 there was a 24% increase in the number of patients in hospital (The King's Fund, 2024a). Bed occupancy has consistently been above the recommended maximum of 85% (except during the COVID-19 pandemic) since 2010/11 (Mental Health Watch, 2024).

Acute adult inpatient wards

1.1.4 These wards provide care to adults experiencing the acute phase of a mental health problem. Care includes medical, nursing, allied health and psychological services. Wards may have a specialist focus, such as caring for older patients. Certain wards, termed psychiatric intensive care units (PICUs), provide care to patients who require more intensive intervention due to the risks they present to themselves or others.

1.1.5 Acute adult inpatient wards are provided by NHS trusts and independent sector hospitals (for private and/or NHS-funded patients). Wards in the NHS are ‘commissioned’ (planned, purchased and monitored) by integrated care boards (ICBs) (NHS England, 2024b). ICBs are part of integrated care systems and plan health services for their local populations.

Secure adult inpatient wards

1.1.6 In England there are three levels of secure adult service for mental health care – high, medium and low. High-secure services are specially commissioned by NHS England for adults who require care in special conditions because of the risk they pose to others (NHS England, 2024c). Patients may also have a criminal conviction. High-secure hospitals are subject to the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2019, which outline requirements for safety, security and patient management (Department of Health and Social Care, 2019).

1.1.7 Medium/low-secure services provide care and treatment to adults who present a serious/significant risk of harm to others and whose escape from hospital must be prevented/impeded (NHS England, 2024c). These services are commissioned by

NHS England via NHS-Led Provider Collaboratives (NHS England, 2019). Collaboratives are groups of providers that are responsible for a budget and pathway of care.

Mental health inpatient workforce

1.1.8 Providers of healthcare ‘must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff’ to ensure the needs of people using services are met (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The mental health inpatient workforce is a multidisciplinary team that provides care and support to patients. The workforce includes:

- nursing – for example registered nurses (mental health and learning disability), advanced practitioners, nursing associates and healthcare assistants/support workers
- medical – for example consultant psychiatrists and resident doctors
- allied health professions – for example dietitians, occupational therapists, physiotherapists, speech and language therapists, and art therapists
- psychological professions – for example psychologists and counsellors
- wider team – for example pharmacists, physical care practitioners, security, managers and students (for example nursing students).

1.1.9 ‘Shortfalls’ in a workforce can affect patient safety and the quality of care received by patients (NHS England, 2023b). NHS England (2023b) has described particular concerns around the shortfall of registered nurses (mental health) with the highest vacancy rates in inpatient settings. There are also shortfalls in the wider workforce, including in medical, psychological professions and allied health professions (National Audit Office, 2023).

1.2 Safe and therapeutic mental health care

1.2.1 Many of the risks to patient safety in mental health hospitals are similar to those in acute (physical health) hospitals. The mental health setting is also ‘unique’ with violence, restriction, harm to self and unauthorised leave (Thibaut et al, 2019). Patients may be at risk of attempting suicide or dying by suicide (Ward-Ciesielski and Rizvi, 2021) and there may be violence and aggression (Kernaghan and Hurst, 2023). Staff are also at risk of being harmed, including through violence.

1.2.2 Patients experiencing severe mental health problems may also have worse physical health than the general population. Patients may have shortened life expectancy, higher levels of obesity contributed to by factors such as medications, and higher rates of behaviours such as smoking (Office for Health Improvement & Disabilities, 2023; Working Group for Improving the Physical Health of People with SMI, 2016).

1.2.3 This investigation also considered the sexual safety of patients as a component of safe care. Sexual safety includes protecting patients from feeling uncomfortable, frightened or intimidated in a sexual way, and protecting them from sexual safety incidents (Royal College of Psychiatrists, 2023a). It also means supporting patients who are unable to protect themselves or who may behave with reduced inhibition (Care Quality Commission, 2018).

Therapeutic care in mental health settings

1.2.4 Patient safety refers to the protecting of patients from physical, psychological and sexual harm, and seeks to ensure patients feel safe. The safety of patients experiencing a mental health problem is contributed to through the formation of therapeutic relationships between staff and patients (NHS England, 2024a). Therapeutic care is provided by all members of the multidisciplinary workforce and includes engagement, relationship building and creation of a supportive environment. It also includes being ‘trauma informed’ (see 1.2.7)

1.2.5 Therapeutic relationships form through engagement – that is, a ‘partnership relationship between staff and patients, with shared decision-making and recovery-focused goals’ (Care Quality Commission, 2023a). Effective engagement has shown positive impacts on treatment outcomes (Hartley et al, 2020) but a lack of therapeutic engagement is sometimes reported (McAllister et al, 2021).

1.2.6 Therapeutic engagement also includes ensuring patients have access to meaningful activities and requires a supporting therapeutic environment. A well-designed environment can support privacy, promote activities, support interaction and allow for self-reflection (Rodríguez-Labajos et al, 2024). It can also reduce stress and anxiety, and contribute to an atmosphere that promotes patient and staff safety (Ulrich et al, 2018).

Trauma-informed care

1.2.7 Therapeutic care is ‘trauma informed’ (NHS England, 2023a; 2024a). There has been increasing recognition that people using mental health services have experienced ‘trauma’ as a child or adult. Definitions of trauma vary and include

where a person has experienced an event/events with subsequent effects (Sweeney et al, 2018). Events may include physical and sexual violence, abuse, racism, poverty and inequality. Events may affect physical, mental and emotional health, and may influence a person's development.

1.2.8 Trauma-informed care and associated approaches are grounded in the understanding that a patient's past exposures to trauma will have influence on their development and how they respond to situations. Effective trauma-informed care includes sensitive discussions around trauma, specific support, prevention of re-traumatising the patient, collaboration and empowerment (Sweeney et al, 2018). The effectiveness of trauma-informed care is affected by the experience of the staff involved, access to training and local cultures.

High-quality mental health care

1.2.9 The quality of mental health inpatient care varies, as demonstrated by Care Quality Commission inspection reports. Different locations also have different frequencies of conflict (such as aggression, self-harm and absconding) and containment (such as seclusion, restraint and special observation). The 'Safewards' model describes how frequencies of conflict and containment are influenced by factors including the staffing team, physical environment and patient characteristics (Bowers, 2015). Modifying these factors can support improvements in the quality of patient care.

1.2.10 The purpose of mental health inpatient care is for patients 'to be consistently able to access a choice of therapeutic support, and to be and feel safe. Inpatient care must be trauma informed, autism informed and culturally competent' (NHS England, 2024a). NHS England's (2023a) vision describes that care should be personalised, joined up, recognising of a patient's traumatic experiences, and offered by a trained workforce. NHS England's (2024a) 'Culture of care standards for mental health inpatient services' also set out a 'culture of care within inpatient settings everyone wants to experience – people who need this care and their families, and the staff who provide this care'. Figure 1 at the end of this section shows NHS England's (2024a) culture of care standards.

1.3 Restrictive practices

1.3.1 Throughout this report reference is made to restrictive practices/interventions. Where there is an increasing risk that a patient may harm themselves or others, de-escalation should be used to help support the patient and reduce the risk. De-

escalation is a therapeutic intervention to defuse anger and avert aggression. It should be non-coercive (not use threats of force) and can be achieved verbally, through observation or by removing environmental risks (Butterworth et al, 2022).

1.3.2 Where de-escalation is ineffective, more restrictive interventions may be needed to help reduce a patient's movement, control actions, isolate and reduce sensory stimulation. Restrictive interventions include observation (watching and engaging with a patient), seclusion, manual restraint and rapid tranquillisation (National Institute for Health and Care Excellence, 2015). Some interventions involve the 'use of force' (see the Mental Health Units (Use of Force) Act (2018)). Restrictive interventions should be a last resort and be as least restrictive as possible (Department of Health, 2014). There are national aims to reduce the use of restrictive practices (Shah et al, 2022).

1.3.3 Undertaking restrictive interventions safely and effectively requires training, supervision and support for the patient and staff. These interventions can be detrimental for patients and staff (Butterworth et al, 2022). Seclusion and restraint may revive past traumas for a patient, increase risks to physical health and create emotions such as anxiety and anger (Chieze et al, 2019; Sequeira and Halstead, 2002).

1.3.4 The use of observation as a form of restrictive intervention should be therapeutic. During observation, staff should aim to promote recovery and engage with the patient to help them develop strategies to deal with distress in the future (Royal College of Psychiatrists, 2020a). Different levels of observation are used, and each should involve therapeutic engagement. Observations range from intermittent (for example where a patient is observed every 15 minutes) to continuous with multiple staff involved (National Institute for Health and Care Excellence, 2015).

1.3.5 Continuous observation may be restrictive and distressing for patients, while also being a strain on healthcare resources (Reen et al, 2020). A previous HSSIB (2024a) investigation included consideration of continuous observation for patients at risk of self-harm in acute physical hospitals. That report described limited evidence that continuous observation effectively reduces the risk of patients harming themselves or others, with evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (2024).

1.4 Investigation approach

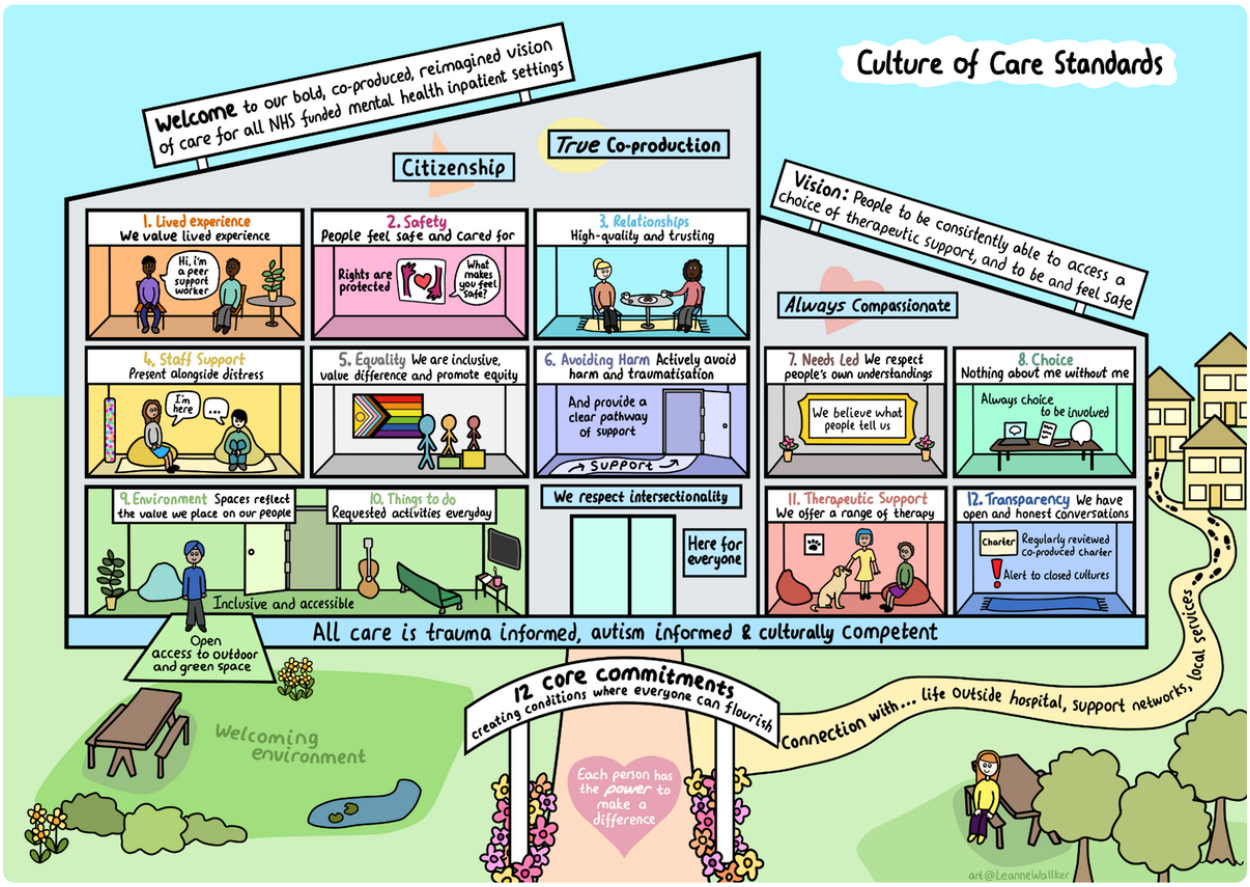
1.4.1 The investigation started by seeking to understand how workforce challenges in acute mental health inpatient settings that deliver care to adults impacted on outcomes for patients. The investigation then explored other factors that further influenced those outcomes.

1.4.2 The investigation aimed to:

- examine the factors affecting the staffing of wards, and the impact those factors had on the delivery of safe and therapeutic care (section 2).
- examine the workplace conditions on wards, and the impact conditions had on the delivery of safe and therapeutic care (sections 3 and 4).

1.4.3 More detail about the investigation methodology and evidence sources can be found in the appendix.

Figure 1 Culture of care standards for NHS-funded mental health inpatient settings (from NHS England, 2024a)



2. Safe and therapeutic care – workforce

This section summarises the investigation's findings in relation to its first aim (see 1.4.2). The investigation examined how workforce challenges faced by providers of acute mental health inpatient care for adults impacted on safe and therapeutic care (section 2.2), and why those challenges had developed (section 2.3). National guidance in support of the delivery of high-quality therapeutic care, in the least restrictive way possible, highlights the need for a 'multi-disciplinary, skilled and supported workforce' (NHS England, 2023a).

2.1 Workforce challenges

2.1.1 National reports describe vacancies in the mental health workforce across different professions and settings (for example Care Quality Commission, 2023b; 2023c; 2024a; NHS Benchmarking Network, 2023; NHS England, 2023b; Royal College of Psychiatrists, 2023b). The high level of registered nursing (mental health) vacancies has been a recurrent reported concern nationally and data shows variation in vacancy rates across England. For example, in the first quarter of 2024/25 vacancy rates were 17.4% in the East of England and 11.5% in the North East and Yorkshire (NHS England, 2024d). At the time of starting this investigation there were specific concerns about registered nursing (mental health) vacancies in adult and high-secure settings (Care Quality Commission, 2023b).

2.1.2 Due to the vacancies, there has been high usage of bank, agency and locum staff (referred to as 'temporary staff'), and recruitment of staff from overseas (Care Quality Commission, 2023c; National Audit Office, 2023). HSSIB (2024b) has undertaken investigatory work in relation to temporary staff. Various recommendations have been made by national bodies calling for the reduction of vacancies, and for ensuring patients receive care from staff with the right skills (Getting It Right First Time, 2021; National Audit Office, 2023).

2.1.3 Workforce vacancies across professions were identified at the providers visited and engaged with by the investigation. These included in both NHS and independent sector providers of NHS-funded care. Vacancies were often documented as a top organisational risk that had the potential to impact on patient safety. Other organisational risks included the experience and skills of staff. Themes identified from the investigation's collated evidence are presented in table 1.

Table 1 Workforce themes identified from the investigation's evidence

Theme	Description
Clinical staff vacancies	Nursing – vacancies included in registered nurse (mental health), nursing associate and healthcare assistant posts. In high-secure settings nursing vacancies had been largely addressed following recruitment campaigns and implementation of additional recruitment and retention pay (premia). Medical – vacancies in consultant psychiatrist posts with variation across England. Concerns about under recruitment and the impact of demand on the mental health of staff. Allied health professions and psychological professions – vacancies across various professional roles, including occupational therapy and dietetics.
Clinical staff experience and proficiency	Due to challenges retaining experienced staff, the workforce was increasingly inexperienced across nursing and some allied health professions. Staff had not always been equipped with the necessary knowledge and skills to effectively care for patients, including through trauma-informed care. Promotion of less experienced staff to supervisory roles (such as ward manager) was happening earlier in careers and so leaders had less experience than they would previously have had. This impacted on supervision and support of other staff.
Use of temporary staff	Temporary staff across medical and nursing posts were commonly used. Posts were short-term or long-term. Providers did not use agency staff in high-secure settings because of the specific nature of that setting. Fluctuating patient needs and risks meant rapid increases in nursing staffing were often required, especially in settings with more unwell patients.
Non-clinical vacancies	Vacancies across inpatient support services included estates teams, digital teams, domestic and post services.

2.2 Impact of workforce challenges

2.2.1 Through the collected evidence (see appendix) the investigation identified that workforce challenges had contributed to patient harm across different inpatient settings. To support examination of the workforce challenges the investigation focused on three patient outcomes – physical harm to self or others, deterioration in physical health, and sexual harm. Other patient outcomes contributed to by workforce challenges were identified but not investigated; these included harm from medications and incidents associated with security such as access to illegal substances.

2.2.2 The investigation did not specifically focus on the impact of workforce challenges on staff, but the impact became evident during visits to providers; it has also been described in multiple national publications (for example The King's Fund, 2024b). The investigation heard how workforce challenges affected staff health and wellbeing, and that some felt “fear” when working with limited support. Temporary staff also described examples of being poorly treated by others and discrimination; these have been highlighted in another HSSIB (2024b) investigation. The investigation also wishes to recognise the ongoing and widely reported influence of racism, sexism and other forms of discrimination that continue to impact the workforce.

2.2.3 The following subsections describe the investigation’s findings relating to the impact of workforce challenges on patient outcomes. Vignettes are included that provide representative examples of incidents and risks. The vignettes have been anonymised and, where required, adapted to ensure anonymity.

Physical harm to self and/or others

2.2.4 Incidents of physical harm included where patients had self harmed while an inpatient or when on leave. Incidents also included harm caused by patients to other patients or to staff, including through violence. Incidents of physical harm had been contributed to by 1) the limited ability of staff to therapeutically engage with and care for patients, and 2) the creation of situations in which patients were able to harm themselves or others. Consideration of physical injury to the public was outside of the scope of this investigation.

2.2.5 Staff told the investigation about the importance of therapeutic relationships with patients to help identify and support those who may be at risk of self harm and completed suicide. They described how time and skill was needed to develop relationships to help ‘get to know patients’ and identify communication difficulties, past trauma and supportive strategies to de-escalate potential harm situations. Staff further described how workforce conditions did not always allow therapeutic relationships to develop.

Staffing vacancies – nursing

2.2.6 Research has shown that shortages of registered nurses can have a negative impact on patient care (Rosseter, 2024). The investigation identified unfilled nursing vacancies across various nursing roles (see table 1) and where reduced staffing levels had contributed to situations where patient safety was not supported. Low

levels of nursing staff reduced staffing capacity to therapeutically engage with patients (**Vignette A**) and meant they had less time to review and consider decisions about care (**Vignette B**).

Vignette A. In recent days the patient had increasingly attempted to self-harm. The patient was to be observed at all times to provide support. Due to short-staffing the patient was left unattended. During that time the patient attained a blade and was able to harm themself.

Summary based on a serious incident report, adult setting.

Vignette B. The patient was allowed episodes of escorted leave. On the day of the incident the ward was two nurses short. The patient approached a nurse to request leave. The nurse was treating another patient and did not have time to read the patient's record. The patient left unescorted and did not return.

Summary based on a report to prevent future deaths, adult setting.

2.2.7 Patients and staff described more incidents of physical violence when wards had limited nursing staff. They also described fear for their own safety and staff were concerned that it made patients more vulnerable. Some patients specifically described feeling "unsafe" when there were limited staff available on the ward, particularly at night. In contrast, they felt safer when staff were visible and engaging with them, and described how talking with staff had helped equip them with strategies to deal with their thoughts and feelings.

2.2.8 Nursing staff described factors that they felt affected patient safety on a ward. These included the experience of the ward team, the presence of an experienced leader supervising care, the amount of unfamiliar and temporary staff, and the "acuity" of patients. Staff across all settings visited told the investigation that "patient acuity had increased" and that the mental health and physical care needs of patients had changed. In response staff felt they needed more time to engage with patients to understand and support their needs. However, there were views heard that local workforce plans had not always accounted for changes in the needs of patients. Concerns about acuity were greater in adult and intensive care areas where there was a high turnover of patients and multiple unwell patients.

2.2.9 In some secure settings the limited availability of nursing staff meant that some patients had been restricted to their rooms (confinement) for an extended period. The investigation was told that extended confinement was an absolute last resort to protect patient and staff safety but was overly restrictive and detrimental. **Vignette C** gives an example of confinement and its effects on a patient. Where confinement had been used, providers were actively working to prevent future use.

Vignette C. The ward was unable to unlock from overnight confinement because there were not enough male staff. A patient became verbally aggressive and damaged their room. Later the patient apologised. They had become angry because they believed the short-staffing meant they were not allowed visitors.

Summary based on a serious incident report, secure setting.

2.2.10 **Vignette C** also highlights a lack of male nursing staff which was described to the investigation as an issue in some secure settings. Staff described the need for a mixed workforce to undertake tasks (such as security searches) and to help therapeutically engage with patients who may have different needs and preferences.

2.2.11 Temporary nursing staff were common across the adult and older-adult settings visited. Research has shown risks to care quality and staff wellbeing when providers rely on temporary workers (Sizmur and Raleigh, 2018). In some wards visited it was not uncommon for at least 50% of the staff to be temporary and some wards had no permanent registered nurse (mental health) on some shifts; this is below the expectation described in the Royal College of Nursing's (2021) workforce standards. Where there were 'regular' temporary staff who were familiar with wards, tasks and patients, staff described that this felt safer. Temporary staff on 'one-off' shifts described difficulties forming relationships with patients and so did not know about individual patients and their histories. From a patient perspective, not knowing staff made them feel unsafe and uncared for (**Vignette D**).

Vignette D. The patient was not able to sleep due to noise and so got up to get a drink. They described how "someone [they] had never met before" said "no" causing frustration. Staff had to de-escalate the situation which they perceived was becoming violent.

Summary of the investigation’s engagement with a patient, adult setting.

Staffing vacancies – allied health professions and psychological professions

2.2.12 Each professional the investigation met described their unique contribution to care and safety; examples are included in table 2. However, unfilled vacancies for allied health professionals and psychological professionals were identified across many of the settings visited. In some settings there were only a small number of posts for these professionals, vacancies therefore meant some patients had no access to their therapeutic contribution to care.

Table 2 Examples of how the multidisciplinary workforce contributes to safe and therapeutic care

Profession	**Example contributions**
Speech and language therapy	Supporting communication between patient and care teams with improved access to therapeutic opportunities and reduced need for restrictive practices (see Royal College of Speech and Language Therapists, 2024).
Occupational therapy	Reducing risk of harm through targeted interventions and activities, and building resilience by developing skills to cope with stress and difficult situations (see Royal College of Occupational Therapists, 2022).
Psychology	Supporting management of patients’ mental health problems through assessment and intervention, and supporting individuals to manage emotions (see The British Psychological Society, 2021).

2.2.13 Occupational therapists and psychologists also described the importance of patients having access to therapeutic activities. Therapeutic activities are those that are meaningful and supportive in enabling recovery; they therefore have therapeutic benefit. The investigation joined activities and saw how they helped patients understand their mental health, develop coping mechanisms and develop life skills. They also contributed to physical health and fitness which was heard to be particularly important due to the risk of weight gain associated with an inpatient stay and some medications.

2.2.14 The investigation saw that workforce shortages had resulted in some therapeutic activities being unavailable or cancelled. Patients described how cancellations were frustrating because activities helped break the boredom and

helped them get better. They further described how cancelling activities impacted on their mental health and in some cases had contributed to thoughts about harming themselves or others.

Staffing vacancies – medical and non-clinical professions

2.2.15 The investigation also identified unfilled vacancies in other professions and roles. Some providers were finding it difficult to recruit to medical psychiatric consultant roles. The Royal College of Psychiatrists (2023b) census highlighted a 'true vacancy rate', which includes both locum (temporary) and vacant consultant posts, of 28.6%. The result of vacancies was heard to impact on the expert clinical oversight of care, limit involvement of medical professionals in multidisciplinary care, reduce longer-term care planning, and increase waiting lists for outpatient care. It was further described how longer waiting lists for outpatient care had the potential to result in patients requiring emergency admission to hospital while awaiting care.

2.2.16 Some providers were also finding it difficult to recruit to vacancies in non-patient facing roles which indirectly impacted on patients. Vacancies in estates teams meant maintenance issues, including the presence of ligature anchor points (points where something could be attached for the purposes of self-harm), could not always be addressed promptly, and vacancies in postal services had delayed deliveries which had contributed to patient aggression and harm. The investigation was told that non-patient facing roles were difficult to recruit to because there are better rates of pay outside the NHS.

Juniority of staff

2.2.17 Across several providers, managers described increasing numbers of newly qualified registered nurses (mental health) and new healthcare assistants. Managers welcomed these staff to help fill vacancies, build consistency in teams and reduce the use of temporary staff. However, they also described patient safety challenges resulting from the juniority of staff.

2.2.18 Experienced nursing staff told the investigation that formation of therapeutic relationships requires specific communication skills, including how to sensitively explore patients' past traumas, recognise risk cues, and de-escalate situations. They further described that recently they had perceived that newly registered nurses (mental health) had not been equipped with necessary skills; examples included **Vignette E**.

Vignette E. The patient believed they had been detained unjustly and got frustrated if their expectations were not met. Staff recognised cues that meant the patient was at increasing risk of being violent and knew how to de-escalate the situation. A newly registered nurse was assaulted by the patient; they had not recognised and responded to the cues.

Summary of the investigation's engagement with staff, secure setting.

2.2.19 Managers also described other examples where they felt the juniority of nursing staff had influenced patient care. Some described how continuous observation was being overprescribed to keep patients safe because of a lack of confidence in ward teams, and others believed that junior staff were quicker to restrain patients. The link between restriction and inexperience is not clearly described in research, but a lack of confidence may lead to being more restrictive (McDonnell et al, 2008). Managers were also concerned that inexperience reduced appropriate positive risk taking which can promote patient recovery.

2.2.20 Experienced staff recognised that undergraduate education is unable to prepare newly-qualified staff for all the scenarios they will encounter once qualified and that support and supervision is required. However, they also described how the workforce shortages and inexperience further impacted on the quality of that supervision. Managers described how a loss of experienced staff over time and a need to promote less experienced staff had impacted on the quality of local preceptorship, inductions and supervision. Similar has been identified by national bodies and is a factor in the retention of staff (Royal College of Nursing, 2017).

2.2.21 Managers were also concerned that inexperience made supervisors less confident to challenge where care was not therapeutic. For example, mental health observation is expected to be therapeutic – that is, provide an opportunity for prolonged engagement with the patient – but managers described unchallenged attitudes among some ward staff that undermined the potential benefits of observation. The investigation saw observation being undertaken and noted that their quality varied in terms of thoroughness and the amount of engagement with patients.

Deterioration of physical health

2.2.22 Deterioration of physical health related to where patients had developed a new physical problem (for example an infection or heart-related problem) or where a pre-existing problem had worsened (for example diabetes or poor nutritional intake). Risks to physical health in mental health inpatient settings are well recognised with reported concerns about the quality of physical healthcare (see 1.2.1). In response, providers have developed their local physical health offers to patients, including through training of staff and dedicated physical healthcare teams.

2.2.23 The investigation was told by managers that nursing staff were not always equipped with the knowledge and skills to recognise and respond to the physical health issues of patients experiencing mental health problems. Factors that contributed to this included limited pre-registration education for registered nurses (mental health) in physical health and limited development opportunities for all staff. The investigation also heard perceptions among some staff that physical care was not part of mental health care.

2.2.24 Managers described the value of physical healthcare teams. However, they were concerned that ward teams were over-reliant on them and had become deskilled. The investigation identified serious incidents of harm and reports to prevent future deaths where deterioration of patients had not been recognised or responded to. In several reports concerns had been raised about the use of physical observation tools, such as the national early warning score 2 (NEWS2) (**Vignette F**).

2.2.25 The investigation also identified incidents where physical health monitoring had not supported recognition of changes in a patient's long-term condition or prevented known complications from care. Several incidents involved patients with diabetes developing diabetic ketoacidosis (a life-threatening complication of diabetes). There were also incidents where weight gain caused by medications was a contributory factor, and where patients had developed blood clots contributed to by inactivity and dehydration. The assessment for and prevention of blood clots was a further concern in reports to prevent future deaths (**Vignette G**).

Vignette G. The patient died from a pulmonary embolism (blood clot in the lung). The patient had been sitting motionless the day before their death and had not taken food or drink for at least 2 days. HM Coroner concluded that there had been no assessment of the patient's risk of blood clots and instructions given by a dietitian to monitor and record food and fluid intake were not followed.

Summary based on a report to prevent future deaths, adult setting.

2.2.26 Several further incidents were identified where limited monitoring of food and fluid intake had contributed to the deterioration of patients' health. Nursing staff described challenges accurately recording food and fluid intake (explored in 4.2.20), interpreting measurements and knowing what to do in response. Ward staff wanted more input from speech and language therapists and dietitians, but allied health professionals were not always available (see 2.2.12) and some ward staff did not know how to contact them.

2.2.27 The investigation met with speech and language therapists and dietitians who described a limited awareness of their capabilities among ward teams. For example, in addition to the role described in table 2, speech and language therapists assess and support swallowing which can help reduce the risk of choking. Choking is a risk among patients experiencing severe mental health problems (Guthrie and Stansfield, 2017). The investigation identified incidents where patients had choked and been harmed.

Sexual safety

2.2.28 The investigation's terms of reference led to a focus on harm to patients by other patients, and on situations where staff may contribute to conditions where sexual safety incidents can occur. The investigation did not focus on sexual harm to patients perpetrated by staff nor on harm to staff. However, the investigation recognises the recurrent reports of sexual harm to patients and staff (for example Bawden and Batty, 2023; Thomas and Mulhern, 2024) and that everyone should be safe and feel safe in mental health inpatient settings.

2.2.29 The risks associated with sexual safety have become increasingly apparent in recent years (Care Quality Commission, 2018). The investigation was told by managers that workforce challenges meant patients may not always be supported or protected from harm. They described examples where workforce shortages had meant staff had not been able to observe patients and intervene (**Vignette H**), and where limited recognition or understanding of the risks associated with sexual safety had contributed to incidents.

Vignette H. A patient with dementia had previously acted in a sexually inappropriate way. The patient was meant to be under continuous observation. Due to low staffing the level of observation of the patient was reduced. The patient approached another patient of the opposite sex and acted inappropriately.

Summary based on a serious incident report, older-adult setting.

2.2.30 Managers specifically referred to the importance of being “trauma informed” in relation to sexual safety and the need to create environments which minimised the risk of patients being re-traumatised. However, they also described variation in staff knowledge around trauma-informed care and the skills to sensitively explore patients’ histories. This variation existed across newly qualified and experienced staff.

2.2.31 Several incidents of patients being re-traumatised were observed, such as in **Vignette I**. These incidents were influenced by factors including awareness of a patient’s history, the ward environment (see 3.1) and decisions around accommodating patients (see 4.2). Managers also shared concerns that staff attitudes towards some actions had become “normalised”, meaning they did not see them as a sexual safety risk and did not challenge them.

Vignette I. The patient had recently been restrained to be given medications. As the time approached for them to receive their next medications they became agitated. When staff approached the patient they reacted violently. They did not want to be restrained as it led to flashbacks of a previous trauma. Staff were not aware of the patient’s history.

Summary of the investigation’s observations, adult setting.

2.2.32 Nationally, in response to the recognition of the need to improve sexual safety on mental health wards, a National Sexual Safety Collaborative (SSC) was established. The SSC has co-produced a set of ‘sexual safety standards’ for inpatient services providing care to patients experiencing a mental health problem (National Collaborating Centre for Mental Health, 2020). The standards describe requirements to understand and respond to the needs of individuals, improve organisational cultures, train staff, develop resources, support multiagency working, and appropriately respond to incidents. National stakeholders told the investigation

that there had been varied uptake and application of the standards by providers, and that they were aware of examples where some sexual safety risks had been normalised. They also highlighted how mixed-sex wards continued to exist across the country and that this contributed to risks associated with sexual safety (see 4.2.2).

2.2.33 The investigation also found variation in the work undertaken by providers to achieve the SSC's standards. Some providers had taken multiple steps towards improving sexual safety for patients and staff, including supportive training, new processes, collaboration with safeguarding teams and external agencies, and introduction of a sexual safety charter (NHS England, 2023c). However, the investigation also found limited awareness about sexual safety among some staff and varied access to support and training. In some providers, managers told the investigation of their concerns that single awareness-building sessions on sexual safety would not be enough to change culture or equip staff with the ability to care for patients.

Summary

2.2.34 The investigation's examination of the factors affecting staffing of wards identified multiple factors that influenced the safe and therapeutic care of patients in mental health inpatient settings. These factors interact to influence the availability and ability of a workforce to deliver therapeutic and therefore safe care. From a workforce perspective, the investigation found that limited availability of a workforce with the knowledge, skills and supervisory support to therapeutically care for patients and meet their needs contributed to patients and staff being harmed. The investigation further heard that the needs of patients in mental health inpatient settings had changed and experienced staff perceived that newly qualified staff were not always equipped to meet patients' needs.

2.2.35 The following section describes the investigation's further examination of factors surrounding the creation of an available and proficient workforce following engagement with national stakeholders. Safety recommendations and safety observations are made where opportunities exist to support improvements in the delivery of safe and therapeutic care.

2.3 Developing a multidisciplinary and skilled workforce

2.3.1 The workforce factors found by the investigation are longstanding issues. NHS England's (2023b) Long Term Workforce Plan was published to help resolve some of these issues. During the investigation, stakeholders questioned whether the NHS's

workforce model is flawed and whether it is able to create a workforce that can provide safe and effective care. Stakeholders described how the model did not surround the patient with a “proficient” (skilled and experienced) workforce and did not help retain an experienced workforce.

2.3.2 The healthcare workforce model is different to models used in other safety-critical industries. The investigation was told by academics that safety-critical industries aim to ensure that a proficient workforce is consistently available. In contrast, healthcare has what is referred to as the ‘Christmas tree model of skill mix’ (Hayton, 2016). In this model few qualified professionals supervise the delivery of care by less skilled or unqualified workers. The qualified professionals maintain accountability for the work but are themselves also becoming increasingly inexperienced (see 2.2.17). The impact was described as “dilution” of skills at the point of care, and this contributes to a supervisory burden, which can lead to stress, anxiety and staff leaving (Leary, 2023a).

2.3.3 The examination of different workforce models was outside the scope of this investigation. The investigation focused on current and future workforce issues aligned with NHS England’s (2023b) Long Term Workforce Plan. However, it is important to acknowledge that some stakeholders have challenged the goals of the Plan and suggested that healthcare should take a different approach to workforce planning.

Workforce numbers and patient acuity

2.3.4 A repeated concern heard across all inpatient settings was that “acuity” and the needs of patients were changing. Similar concerns have been identified by other national bodies (for example NHS Providers, 2022). Acuity relates to how unwell a patient is and how much care and support they need from staff. Ward staff described that patients’ needs, both mental and physical, were more acute than in the past. As a result, staff were finding it increasingly difficult to therapeutically engage with patients and support their safety.

2.3.5 There were differing views among stakeholders about whether the acuity of patients in inpatient settings was increasing or whether this was a staff perception. Factors thought to be contributing to a perception included a less experienced workforce, staff feeling “overwhelmed” (due to demands), limited team cohesion and a lack of support. The investigation noted that discussions around acuity focused on mental health, with limited consideration of physical health or the overall variety of patients’ needs. The physical health acuity of patients in mental health inpatient settings is known to be high (see 1.2.1). Physical health acuity is

also likely to increase as the population ages and more people live with long-term conditions (The Health Foundation, 2021). The investigation saw the range of physical health conditions being cared for in mental health settings.

2.3.6 The investigation was unable to draw a clear conclusion that the acuity of patients receiving mental health care had increased, either in general or in inpatient settings. Local policies, national policy documents, benchmarking data and the research literature suggest that acuity may be increasing. For example, detentions under the Mental Health Act have increased (Care Quality Commission, 2024a) but this increase is due to multiple factors. Rather, inpatient settings may be seeing a more ‘concentrated’ population of patients who are acutely unwell with multiple needs. Factors that contribute to this include increasing community-based care, which means only the most unwell patients are admitted to hospital; lengthening waiting lists for treatment; reduced inpatient bed numbers, which creates a concentrating effect (Keown et al, 2011); and societal factors influencing mental health. The investigation was also told by national stakeholders that a lack of services to support the needs of people with personality disorders, a learning disability or autism was resulting in hospital admissions and influenced acuity.

2.3.7 Ward staff told the investigation that the acuity of patients had increased and that they needed more staff to enable them to provide therapeutic care. Some suggested fixed ratios of staff to patients were needed, but other stakeholders warned against fixed ratios because they had the potential to focus on numbers rather than meeting patients’ needs. The investigation met with the National Quality Board (NQB) to discuss guidance around safe staffing in mental health inpatient settings. The NQB does not advocate for ratios but instead for the right skill mix of staff (National Quality Board, 2016).

Evidence-based workforce tools

2.3.8 The NQB also advocates for using evidence-based tools to help inform multidisciplinary workforce planning, and the role of leaders in monitoring and addressing workforce issues. The NQB has published an improvement guide for the mental health inpatient workforce (National Quality Board, 2018) which was informed by a National Institute for Health and Care Excellence (NICE) evidence review of safe staffing (Rutter et al, 2015). NICE was tasked by the (former) Department of Health to develop an evidence-based guideline on safe staffing in inpatient mental health settings. The review found limited high-quality evidence and the guideline was not published. NICE told the investigation that development of a number of staffing guidelines was stopped due to resource and the need to focus where it could make most difference.

2.3.9 The investigation explored with providers the use of evidence-based workforce tools. NHS providers commonly used the Mental Health Optimal Staffing Tool (MHOST) (The Shelford Group, 2019) which is free of charge to NHS trusts. The independent sector provider engaged with used its own evidence-based tool developed for its needs. The output of MHOST, alongside professional judgement, supports determination of staffing numbers per shift to meet patient needs. In practice, the investigation observed that numbers were mostly met using registered nurses (mental health), nursing associates and healthcare assistants.

2.3.10 The investigation met with The Shelford Group which provides and oversees MHOST. The Group described how MHOST was developed for different settings using workload and acuity data. The Group was clear that MHOST is an asset but is only a guide and should be triangulated with professional judgement. Judgement should consider contextual factors such as how the physical ward environment creates additional risks (see section 3) and which multidisciplinary staff are needed to meet patients' needs. The Group described some limitations of MHOST, including that the data used in its development was collected between 2016 and 2018, and that it takes limited account of physical acuity.

2.3.11 The investigation noted a difference between the intent of MHOST and how it was being used by some providers. The investigation heard some concerns that MHOST was used to determine a minimum level of staff for safety, but not for therapeutic care, and that the need to release staff for development was not considered in line with workforce standards (Royal College of Nursing, 2021). It was also heard that professional judgement was sometimes overruled because it asked for more staff than MHOST had suggested. Some stakeholders questioned whether decisions about staffing were influenced by local beliefs around acuity and the need to make financial savings.

2.3.12 In summary, the investigation found evidence to suggest that patient acuity and the range of patients' needs may have changed in mental health inpatient settings. There may also be under-recognition of how physical health needs contributed to acuity. Understanding and managing actual and perceived acuity is a complex challenge. Addressing perceptions requires stable teams and strong leadership. Actual increases require the demand to be met and a factor that affects this is having the right number of proficient staff. MHOST can contribute insights into the number of staff required to meet acuity but would benefit from review in light of any changes in the inpatient population.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/037:

HSSIB recommends that The Shelford Group reviews and updates the Mental Health Optimal Staffing Tool on a regular basis following collection of recent data from mental health inpatient settings. This is to ensure the tool remains valid for potential changes in patients' needs and the level of care they require, and to support providers to make decisions about workforce requirements that support therapeutic and therefore safe care.

HSSIB makes the following safety observation

Safety observation O/2024/034:

Providers of mental health inpatient care can improve patient safety by ensuring that where professional judgement is used to help make workforce decisions, this accounts for ward physical environments, changes in patient acuity, and the individual mental and physical health care needs of patients that require support from a multidisciplinary workforce.

2.3.13 At the time of writing, the NQB (via their NHS England commission) were reviewing and updating the safe and effective staffing resources, including in mental health settings. The NQB's commissioned review has included a systematic review of supporting evidence to inform the resources. The NQB commissioned review group has used the findings of this HSSIB investigation to inform the review and update of the guidance.

Workforce roles and proficiency

2.3.14 Across inpatient settings, the investigation saw variation in the numbers of staff in different roles. Depending on the setting, ward staffing requirements per shift were often met by one or two registered nurses (mental health) (who may be temporary staff) and the rest by nursing associates and/or healthcare assistants. Stakeholders said that the low number of registered nurses (mental health) and increasing use of associate/assistant roles had "diluted" the skills on the wards (see also Jones, 2023); this aligns with the description of the 'Christmas tree model' in 2.3.2. Stakeholders said that dilution affected therapeutic engagement between registered nurses and patients.

2.3.15 The investigation heard from several providers that they aimed to staff wards for “safety” but could not always staff for “therapy”. They described that staffing for safety meant having a minimum number of staff in nursing roles (including temporary staff) on a ward to undertake tasks to protect patients from harming themselves or others. In contrast, the investigation found no minimum requirements for other staff such as allied health professionals and psychological professionals. Several wards visited had no or limited provision of these professionals, and some lacked access to other support services such as those for people with hearing impairment (see also Care Quality Commission 2024a). The investigation heard on several occasions perceptions that “other” professionals were “nice to have” but nursing staff kept patients “safe”.

2.3.16 The above findings were shared with national stakeholders and it was challenged whether a ward could be considered safe without input from a multidisciplinary team and the time to ensure therapeutic engagement occurs. Stakeholders described the ‘model’ of safety, created by just having the minimum number of nursing staff to prevent patient harm, as “reactive”. They further described how it did not align with efforts to be least restrictive or the expectations of workforce standards (Royal College of Nursing, 2021). Rather, in line with the ethos of therapeutic care outlined in 1.2.5, stakeholders described the need for a multidisciplinary team to “proactively” support and work with patients in support of recovery. As part of that team, nurses have a key role as providers of therapeutic care and need to be enabled to undertake that role.

2.3.17 The investigation saw examples of where providers had broadened the mix of staff roles on wards. This was in response to recognition of the benefits of multidisciplinary care but also due to shortages of registered nurses (mental health). Some providers had included registered nurses (adult) and described that their addition helped support most ward tasks while contributing experience in physical healthcare (see 2.2.22). However, concerns were raised by national stakeholders that providers may be replacing registered nurses (mental health) with registered nurses (adult) (Royal College of Nursing, 2023a). The investigation was told that registered nurses (mental health and learning disability) have statutory responsibilities (Mental Health Act 1983) and as such there must always be at least one present on a mental health ward. The Royal College of Nursing (2023a) has stated the need ‘to challenge incidents where the substitution of mental health and learning disabilities nurses … is being planned or has occurred’.

Allied health professionals and psychological professionals

2.3.18 Some providers visited had also included occupational therapists in the minimum staffing requirements for their wards. The benefits of this were heard to include greater access to therapeutic activities for patients. However, the investigation observed occupational therapists undertaking tasks such as observing patients or providing basic activities to alleviate boredom. While important, these tasks did not use a therapist's full capabilities, which include supporting the rehabilitation and recovery of individuals.

2.3.19 Stakeholders described "under-recognition" of the role of allied health professionals and psychological professionals in patient safety. Some felt this was demonstrated by an additional pay ('pay premia') given in high-secure settings to nursing staff (among other staff groups depending on the hospital) but not to allied health professionals or psychological professionals. The investigation had been told the rationale for prioritising nursing staff with the pay premia was that it was for "patient safety".

2.3.20 Stakeholders described several factors that may be behind the under-recognition of the additional benefits of allied health professionals' and psychological professionals' roles:

- the continued influence of traditional models of mental health care that are medically focused with limited recognition of the benefits of psychosocial interventions
- historical lack of research evidence demonstrating the beneficial impact of these roles on physical health, mental health and patient safety
- historical leadership models at national, regional and local levels that were medical and nursing focused with limited wider professional involvement or leaders from the allied health professions
- national safe staffing plans and workforce strategies focused on nursing
- lack of commissioning direction and support for multidisciplinary roles.

2.3.21The investigation was told by royal colleges and national bodies that limited data had historically been collected to demonstrate the impact of the allied health professions or psychological professions on positive patient outcomes. However, increasingly evidence has shown the benefits of roles such as occupational therapists reducing lengths of stay (Royal College of Occupational Therapists, 2022), music therapists supporting reductions in agitation and aggression (Thompson et al, 2023), and speech and language therapists supporting access to treatment and care (Guthrie and Leslie, 2024). The investigation also heard about

further benefits including speech and language therapists influencing levels of seclusion, physiotherapists helping manage chronic pain, and dietitians supporting healthy eating habits.

Multidisciplinary workforce planning

2.3.22 National stakeholders acknowledged that historical safer staffing guidance and workforce plans had often focused on nursing and increasing the number of associate/assistant roles. NHS England (2023a) directed the investigation to its commissioning guidance, ‘Acute inpatient mental health care for adults and older adults’, which recognised the importance of a workforce that can provide therapeutic care (note this does not refer to secure settings). However, stakeholders also described difficulties knowing what that workforce should look like and the specific roles and responsibilities of each profession (the ‘role’ of the mental health nurse is considered further in 2.3.38). The need for a “mindset change” by some providers was also described to still be required to help move away from restrictive models of care to more proactive, trauma-informed and therapeutic approaches.

2.3.23 In summary, the investigation found variation in the availability of staff from different professions and therefore their contribution to proactive and therapeutic care in support of patient safety. The factors that contributed to variation included workforce shortages and recruitment challenges, limited recognition of the multidisciplinary contribution, and an ongoing focus on restriction for patient safety. Safe and therapeutic care requires a proficient multidisciplinary inpatient team – including nursing, medical, allied health and psychological professions – and it is therefore essential that workforce plans recognise this. This finding will be considered further in relation to the safety recommendation in 2.3.57.

Workforce shortages, recruitment and retention

2.3.24 The investigation recognises that to address workforce challenges an available and proficient workforce is needed. As demonstrated by national reports and inquiries, that workforce is not always available, with shortages in qualified staff, staff not applying for vacancies, and staff not staying in roles (retention). The causes of current workforce shortages are multiple and longstanding. National factors reported to have contributed to the shortage include limited long-term planning and funding; non-competitive levels of pay; policies influencing the numbers of staff coming to England from abroad; and societal changes influencing

people’s decisions to take up and stay in work (The King's Fund, 2022; Waitzman, 2022). The COVID-19 pandemic was also a contributing factor, with providers seeing working practices change and more people retiring earlier than planned.

Recruitment and retention

2.3.25 Shortages across the workforce meant the providers visited often had vacancies they could not fill. There was a gap between the number of vacancies and the number of people suitably qualified and available. The range of vacancies also meant applicants had their choice of providers so could be selective and consider factors such as pay, location, reputation, incentives and differences in roles. As a result, “poor performing” providers that were already short-staffed struggled to recruit the staff they needed.

2.3.26 Further barriers to applying for inpatient roles were also identified. From a registered nursing (mental health) perspective, barriers included unfamiliarity with the inpatient settings (see 2.3.42), the nature of working in those settings, the acuity of patients, the bureaucracy of NHS hospitals, and the lack of development and progression opportunities. For allied health professionals, such as speech and language therapists, further barriers included the generic nature of their training with limited exposure to mental health settings, and that providers might not make best use of their capabilities.

2.3.27 Across several professions, including registered nurses (mental health), occupational therapy and some psychological professions, a further challenge to recruitment and retention was staff choosing to work in the community. This followed an increase in community roles and reduction in the number of inpatient beds (NHS, 2019). Staff told the investigation they would rather work in the community because it paid the same as inpatient settings, had better promotion prospects, was less restrictive, had limited out-of-hours work, and provided better work-life balance. Hospital nursing managers described that the move to community care had significantly affected their ability to staff wards and they felt there had been little national planning for this.

2.3.28 Dissatisfaction with pay was also described as an influence on recruitment and retention (see also NHS, 2024). The investigation did not examine pay rates but noted that the introduction of the pay premia in high-secure settings had coincided with successful recruitment of nursing staff with minimal remaining vacancies. Managers told the investigation that the premia had helped them to recruit to nursing roles, but they had also invested in recruitment efforts and programmes to support staff. Retention was now their major focus and concern, with a need to keep

staff and build their experience. In addition, where NHS and independent sector providers were in competition for staff, independent providers were not restricted by NHS pay structures and so had more flexibility to attract applicants.

2.3.29 The factors affecting retention are well documented and overlap with those affecting recruitment (NHS England, 2024e). Attrition rates are high among staff early in their careers, including registered nurses in their first year of practice and occupational therapists within their first 2 years of qualifying. The investigation heard that a significant factor in attrition was that newly qualified staff found workplaces did not meet their expectations. The transition from student to qualified status is difficult and is worsened by limited support and the cultures in teams (Wray et al, 2021).

2.3.30 Across different professions, the investigation identified multiple factors influencing retention. These included a lack of role identity, lack of career progression, inflexible working, limited support from inexperienced leaders, team cultures, and poor or frustrating working environments. Some staff, including temporary and overseas staff, have also reported discrimination from patients and colleagues (see Health Services Safety Investigations Body, 2024b; NHS, 2024).

2.3.31 Good employment practices are key to retention, including acknowledgement of unseen work, the availability of support systems, the addressing of inequalities, the valuing of staff time and effort, genuine gratitude, and development opportunities (Leary, 2023b). The investigation saw examples where providers were attempting to attract and retain staff with offers such as increased preceptorship support, health and wellbeing incentives, flexible working and career advancement. Several providers were also working with local educational institutions to support placements of students in the hope of attracting them to a job when they qualified, and to set expectations to help them stay in post. NHS Providers (2021) have further published example case studies of how mental health providers are responding to the challenges facing the NHS workforce.

2.3.32 To support retention of experienced staff, multiple providers were also focusing on ‘growing their own’ to build their registered nursing (mental health) workforce. The investigation met staff who had progressed from working as a healthcare assistant, to training as a nursing associate, to becoming a registered nurse. They then had access to further postgraduate courses to enhance their future employment opportunities. Providers and staff were positive about this approach as it retained experienced staff who knew the work, environments and patients. The barriers were the cost to the provider and difficulties releasing staff to access development opportunities.

Regional workforce planning

2.3.33 The investigation heard from providers that they had limited awareness of how integrated care boards (ICBs) were co-ordinating workforce plans across their geographical areas. Providers felt a more co-ordinated approach may be beneficial, particularly where providers, including those in the independent sector, were competing for a limited pool of staff.

2.3.34 ICBs are expected to publish ‘joint forward plans’ before the start of each financial year which should include workforce plans that ensure ‘the right workforce with the right skills is in the right place’ (NHS England, 2024f). The investigation saw how the maturity of these plans varied across ICBs and ICBs told the investigation that plan development was difficult due to unclear expectations from NHS England, difficulties predicting future needs, limited engagement from some providers, and the challenges of getting enough staff to meet their needs. It was also described that the mental health inpatient workforce had sometimes felt “forgotten”.

HSSIB proposes the following safety response for integrated care boards

Proposed safety response ICB/2024/008:

HSSIB suggests that integrated care boards work collaboratively with the NHS and independent sector to review their system-level workforce plans to ensure they recognise and mitigate the safety challenges in mental health inpatient settings and agree how variation across a geographical area can be mitigated.

2.3.35 In summary, the investigation found that an array of recruitment and retention issues were contributing to providers’ workforce shortages. Providers were not able to address some of these factors as they were outside of their control. The findings highlight the need for a national strategic approach to addressing the workforce issues. The NHS England (2023b) Long Term Workforce Plan is England’s strategic approach and this finding will be considered further in relation to the safety recommendation in 2.3.57.

Workforce education and development

Pre-registration nursing (mental health) education

2.3.36 Across inpatient settings, managers and experienced staff described their perceptions that newly qualified registered nurses (mental health) were now more “academic”, less equipped to interact with patients, and lacked specific knowledge such as how to provide trauma-informed care. The investigation met with leads for pre-registration nursing (mental health) education across several English academic institutions. Institution leads had heard similar concerns from providers about their graduates. They described how pre-registration curricula had changed in ways that had potentially reduced the depth of mental health knowledge development (depending on the institution) but had increased exposure to aspects such as physical health.

2.3.37 The Nursing and Midwifery Council (NMC) sets the standards for pre-registration nursing education in England and approves educational institutions to provide courses. Specific curricula are set by institutions and must fulfil the NMC’s standards. Before 2018 standards for pre-registration nursing described competencies for entry to the register for adult, mental health, learning disabilities and children’s nursing. The standards were reviewed and updated in 2018, and updated further in 2023 (Nursing and Midwifery Council, 2023a). The NMC’s updated standards refer to ‘proficiencies’ with recognition of the need for continued professional development after registration (Nursing and Midwifery Council, 2024a).

2.3.38 Stakeholders told the investigation that several of them had opposed the NMC’s “generic” approach to nursing education and that it had lost the “uniqueness” of the different fields of nursing. Publications have also highlighted concerns about the physical health and adult-centric nature of the course, which has impacted on mental health (Nursing Times, 2023) and children’s (Reynolds et al, 2024) nursing education. It was felt that mental health had been “sidelined” with limited recognition of the elements of mental health nursing that are different to general adult nursing.

2.3.39 The NMC told the investigation that they were aware of concerns about the generic nature of the 2018 standards but described them as being developed (through stakeholder engagement) to be “holistic” – that is, more focused on the patient as a whole person rather than separating mental and physical health. The updated standards therefore provide greater exposure of pre-registration nurses to physical healthcare education. The NMC were actively engaged in responding to concerns about the standards, providing support to education institutions and were monitoring the impact of changes through annual quality assurance and monitoring activities.

2.3.40 The NMC further told the investigation that their role is to set standards for nursing education. Standards are outcome focused and it is the responsibility of educational institutions to develop and implement curricula to meet them. They described that a pre-registration nursing course will not be able to equip a newly-qualified nurse with all the required knowledge and skills for all their future roles. Effective preceptorship programmes are required to support newly-qualified nurses to develop proficiencies for specific roles and care settings (Nursing and Midwifery Council, 2023b). The investigation saw examples of where preceptorship programmes had been enhanced to better support newly-qualified nurses.

2.3.41 Academics in mental health nursing also described the need to clarify the role of the registered nurse (mental health) to help set expectations for pre-registration education and continuing professional development. Expectations need to align with modern definitions of nurses (Royal College of Nursing, 2023b) and principles surrounding psychosocial care and therapeutic safety (see also NHS Health Education England, 2022). Nursing care was described to have become transactional and “task” focused with less time allocated to getting to know and support patients (see Strathdee, 2024). The investigation was also told that there is no specific competency list for registered nurses (mental health) and that this is needed. NHS England (2023a) has published ‘skills and competencies for the inpatient workforce’ in mental health, but these are generic and not ‘profession or discipline specific’.

Undergraduate/pre-registration mental health placements

2.3.42 Academic institution leads told the investigation about the importance of high-quality clinical placements to support the development of students’ practical skills. From a pre-registration nursing perspective, the NMC (2024a) requires the undertaking of 2,300 hours of ‘practice learning’, up to 600 hours of which can be in a simulated environment (see also Nursing and Midwifery Council, 2024b). The in-practice component is 50% of the pre-registration course and aims to expose the student to a range of settings through placements. A pre-registration nurse (mental health) may get one inpatient placement, and it was heard that few will see older-adult or secure settings. Some universities included options for secure placements, but not all had links with secure settings.

2.3.43 Institutional leads and academics said that the quality of some placements had degraded in recent years because of the clinical demands on the workplace. Academic institutions were also struggling to find new placements; these are

required if there is to be an increase in undergraduate/pre-registration places to support national workforce plans. Leads described how placements were not just shadowing opportunities and that they needed to be supportive and educational.

2.3.44 The issues with clinical placements were not unique to nursing. The Royal College of Occupational Therapists told the investigation that there was limited provision of placements for its students in mental health inpatient settings. Similar was heard across other allied health professions. As with nursing, the reduced exposure to mental health inpatient settings was thought to influence future recruitment and retention.

2.3.45 In summary, the investigation found evidence to suggest that newly qualified staff in mental health inpatient settings may not have always been equipped with the necessary knowledge and skills to care for patients safely and therapeutically. For pre-registration nurses (mental health) there were also conflicting views on where the responsibility lay to equip nursing students with the necessary knowledge and skills. The investigation found that responsibility for education is held across educational institutions, providers of placements, and the providers of preceptorship programmes. A collaborative approach is required to ensure newly-qualified staff are able to meet the needs of patients.

HSSIB makes the following safety observation

Safety observation O/2024/035:

Those involved in the provision of undergraduate and pre-registration education (educational institutions and placement providers) and preceptorship/induction programmes can improve patient safety by collaboratively ensuring that staff entering mental health related professions are developing the required knowledge and skills, including in trauma-informed care, to care for patients with mental and physical health care needs.

2.3.46 The investigation also found differences in opinion about how best to educate pre-registration nurses (mental health) for the future, and concerns that institutions and providers had limited capacity to support future increases in workforce numbers. This has the potential to prevent further course expansion to meet workforce requirements (see NHS England, 2023b). This finding will be considered further in relation to the safety recommendation in 2.3.57.

Leadership and supervision

2.3.47 To support the development of newly qualified staff, experienced supervision in practice is needed. The investigation was told that experienced supervision was not always available for newly qualified staff across nursing, allied health professions and psychological professions. A lack of experienced supervision has been highlighted as contributory to patient harm in high-profile reports, such as the Independent Review of Greater Manchester Mental Health NHS Foundation Trust (2024).

2.3.48 As described in 2.2.20, the investigation heard that registered nurses (mental health) with limited experience were increasingly taking on supervisory roles. This has resulted from high staff attrition rates due to retirements, particularly of experienced staff. For allied health professions, national stakeholders described that due to their small number in some providers, access to supervision may be limited and they may need to seek supervision from outside of their organisation or from other professions.

2.3.49 The investigation heard that experienced leadership was also needed to lead clinical interventions, challenge normalised attitudes that were not in line with modern views on safe and therapeutic care, and to help prevent the creation of ‘closed’ team cultures (see 4.3.6). Where leadership was described as “lacking”, students had poor experiences which prevented them returning as qualified staff, and substantive (permanent contract) staff left quickly. The investigation was told by stakeholders of a lack of postgraduate nursing development opportunities, including for leaders. Limited funding for professional development and difficulties releasing staff to take up such opportunities contributed to the lack of development.

2.3.50 The Royal College of Nursing (2021) describe the expectation that staff receive practice development, but also told the investigation that there was a need for more postgraduate development opportunities for registered nurses, including for leadership roles. It also described the need for pre-existing ward staff to be familiar with psychosocial approaches to care learnt by students to ensure new staff come into environments where that approach is the norm. In support the investigation heard about the following postgraduate development opportunities:

- The Royal College of Nursing (2023c) has launched a psychosocial programme for mental health settings commissioned by NHS England.
- NHS England is developing a capabilities framework for the mental health inpatient nursing workforce. Associated work will include exploring how staff can access opportunities and have the capacity to do so.

Workforce planning as a complex problem

2.3.51 Mental health inpatient settings require a workforce that is ‘fully multi-disciplinary, skilled and supported’ (NHS England, 2023a) with the time and ability to form therapeutic relationships with patients to support recovery and safety (NHS England, 2024a). The investigation’s findings demonstrate how workforce requirements are not always being met, but also how addressing the workforce challenges faced in mental health inpatient settings is complex. There are multiple stakeholders involved, including regulatory and standards bodies, professional regulators, policy and commissioning bodies, NHS and independent healthcare providers, and those in education. There are multiple factors that influence workforce planning including societal, financial and organisational. There are also issues for individual providers that influence recruitment and retention, including working conditions and team cultures.

2.3.52 The NHS’s approach to addressing the workforce challenges in the long term are described in NHS England’s (2023b) Long Term Workforce Plan. The Plan describes the modelling of workforce demand and supply, and the reforms needed to support the strategy. Key to the implementation of the Plan are aspects considered in this investigation, including increasing training places for the future workforce, creating supportive workplaces, engagement with stakeholders, and the role of integrated care systems in addressing current and future local workforce requirements. The intention is for the Plan to be iterative, with a review and update due in 2025.

2.3.53 The investigation met with representatives of NHS England in relation to the Long Term Workforce Plan. They described how increasing demand on mental health services and greater recognition of workforce requirements had resulted in increasing need for mental health nurses. The investigation saw data showing how the numbers of mental health nurses had increased in recent years with contributions from national programmes, such as the ’50,000 Nurses Programme’ (Department of Health and Social Care, 2022). ‘Increases in the number of nurses have been mainly in community settings, while the number of nurses in inpatient settings has fallen…’ (The King’s Fund, 2024a).

2.3.54 The investigation heard from stakeholders across the healthcare system that the Plan (at the time of writing) had set expectations that were potentially unachievable, but that also fell short of what will be required in the future (see also National Audit Office, 2024). They also described difficulties engaging with relevant stakeholders around the Plan and its future. Various reports have highlighted concerns that the Plan is unlikely to meet future needs because of complicating

factors, such as changing patients' needs, limited social care and changing societal attitudes towards work (Leary, 2023a; The King's Fund, 2023; Twycross and Wray, 2023).

2.3.55 Some stakeholders have also expressed concerns that the Plan is too focused on recruitment and not retention, has not articulated how implementation would be achieved, and has not fully considered enablers and barriers to implementation (for example NHS Providers, 2023a). This investigation found several barriers to implementation to which solutions have not been described – examples included the shortage of placements for students, limited cross-disciplinary engagement in the Plan, support for ICBs to undertake workforce planning, and wider issues with working conditions.

2.3.56 In summary, the investigation found the workforce challenge in mental health inpatient settings to be a complex 'sociotechnical' problem – that is, it is the result of multiple interrelated social and technical factors that cannot be considered in isolation. This investigation has described components of that problem which include factors with a direct influence on the future workforce, such as those related to undergraduate/pre-registration training, and an indirect influence, such as the culture surrounding care and working conditions. These indirect factors are considered further in sections 3 and 4.

2.3.57 To address a complex sociotechnical problem a system-wide strategic approach is needed that recognises and sets out plans to overcome barriers to the implementation of that strategy. Through the lens of the mental health inpatient workforce, the strategic approach includes collaborating with relevant national bodies to understand what a multidisciplinary workforce model should look like, the roles and responsibilities of different professions, the knowledge and skills required of the workforce, and the culture of therapeutic safety and care being aimed for. The following safety recommendation has been made in relation to mental health inpatient settings in line with the scope of this investigation and refers to a multidisciplinary workforce in its broadest sense – that is, including nursing, medical, allied health professions and psychological professions. The investigation believes the principles within the safety recommendation have the potential to influence considerations in the government's plans to radically reform the health service (Department of Health and Social Care, 2024a).

HSSIB makes the following safety recommendation

Safety recommendation R/2024/038:

HSSIB recommends that NHS England works collaboratively with relevant national bodies and stakeholders including professional regulators, the Department of Health and Social Care, and relevant royal colleges to:

1) Identify and clarify the goals of acute mental health inpatient care and the roles, required skills and ongoing professional development needs of the multidisciplinary workforce team.

2) Review and update the NHS Long Term Workforce Plan with consideration of the concerns around changes in patients' needs and the need for a multidisciplinary approach to ensure therapeutic care is provided.

3) Develop a strategic implementation plan to address workforce issues in mental health inpatient settings that identifies the social and technical barriers to implementation and sets out actions to address them.

This is to develop, enable, support and retain a future multidisciplinary mental health inpatient workforce that is able to deliver therapeutic and safe care to patients.

3. Safe and therapeutic care – built environments

In the following sections, 'working conditions' are elements of the wider system that influence the delivery of safe and therapeutic care in mental health inpatient settings. During the investigation's examination of the workforce, it became apparent that local and national working conditions also had an impact on patient outcomes. Some conditions also increased demands on staff, resulted in the need for more staff, and created poor working environments.

Using the outcomes in 2.2, the investigation explored how conditions affected patient care and why those conditions had developed. Due to the breadth of factors found, this report focuses on conditions that were identified as having an impact across a range of outcomes and inpatient settings. This section summarises the investigation's findings in relation to its second aim (see 1.4.2) relating to built environments. Further conditions are considered in section 4.

3.1 Impact of built environments

3.1.1 The term ‘built environment’ refers to estates (buildings and land) and physical ward environments (ward surroundings). The investigation observed variation in the built environments across providers. This variation was typified by the high-secure estates visited:

- **Site 1** – Modern buildings with individual en-suite bedrooms, bright and open spaces on each ward, good lines of site, and access to outdoor spaces. Patients described no specific concerns about the built environments.
- **Site 2** – Modern and ageing buildings with variability in lines of sight and access to outdoor space. Not all bedrooms were en-suite and maintenance challenges meant one ward had one functioning shower. Some patients described that the environments made them feel unsafe.
- **Site 3** – Ageing buildings, some of which had been condemned and others were awaiting refurbishment. Variability in lines of sight and space on wards. Not all bedrooms were en-suite. Some patients described problems getting the temperatures comfortable on the wards.

3.1.2 The investigation visited new estates with wards yet to open and old refurbished wards in buildings over 100 years old (see figure 2). The wards had varying layouts, but in general newer wards had more natural light, open layouts, good lines of sight for observation, en-suite bathrooms, and access to natural outdoor spaces. Older and refurbished wards had varying access to outdoor space, poor lines of sight, and were not all en-suite. Some sites had dormitory-style wards. Some older environments were described by patients and staff as “grim”, “oppressive” and “no longer fit for purpose”.

Figure 2 Pictures representing the variety of mental health estates. Pictures are examples only and were not visited by the investigation (pictures: Shutterstock.com). Old estate (top left), more modern estate (bottom left) and example interior of a more modern estate (right)

3.1.3 Focus on the built environments of inpatient settings has traditionally considered the need to reduce the potential for patients to harm themselves from ligatures in combination with anchor points. While it is important to make plans to remove and/or mitigate hazards that have the potential to cause harm, therapeutic engagement and relationship formation is vital to support recovery and to create plans with individual patients to manage times of distress (Care Quality Commission, 2023a; Royal College of Psychiatrists, 2020a). This investigation considered the creation of therapeutic built and social environments (see 4.1). However, due to the workforce challenges influencing the ability of the workforce to therapeutically engage with patients (section 2), the investigation also considered how hazards in built environments could be removed or mitigated.

3.1.4 The investigation identified incidents in which built environments had contributed by 1) preventing staff from supporting patients to minimise the potential for harm because of poor lines of sight, and 2) where fixtures and fittings were able to be used as ligature anchor points (**Vignette J**). Patients were also able to abscond by breaking through locked doors or overcoming security (**Vignette K**) and built environments had created conditions that had contributed to the deterioration of patients' physical health (**Vignette G**, 2.2.25). Mixed-sex wards are considered later in 4.2.2.

Vignette J. Staff approached the patient's bedroom. They struggled to open the door. After managing to open the door they found the patient unconscious on the floor. The patient had tied a ligature using [redacted] as a fixing point.

Summary based on a serious incident report, adult setting.

Vignette K. The patient was left unescorted in a courtyard area. The patient climbed over the fence. After absconding, the patient was fatally injured. Staff had concerns about the height of the fence and other patients had previously absconded.

Summary based on a report to prevent future deaths, adult setting.

3.1.5 During the investigation's visits it was also observed that several physical environments were not supportive of therapeutic engagement and care. Patients described how some wards made them feel restricted and aspects reminded them of previous events in their lives; these environments contributed to re-traumatising some patients. Staff described environmental factors that impaired their ability to build therapeutic relationships with patients, including uncomfortable and damaged fixtures and fittings, limited space (indoor and outdoor), inadequate lighting and fluctuating temperatures, limited privacy, and factors that led to overstimulation. Similar descriptions have been heard by other national bodies (for example NHS Providers, 2023) and were highlighted in the recent 'Independent investigation of NHS in England' (Department of Health and Social Care, 2024a). With respect to privacy and dignity, on one high-secure ward, maintenance issues and an old estate meant 16 men had to share one shower at the time of the investigation's visit. These circumstances were described as a "pressure cooker" that could and had led to violence, particularly on hot days.

3.2 Patient acuity, ageing estates and maintenance

3.2.1 Estates teams told the investigation that their ageing built environments could no longer cope with the needs of the patients being cared for nor be maintained to support therapeutic care. Damage was seen across wards, including where patients had broken through doors guaranteed for their durability. The age of many estates and associated deterioration was noticeable – a 2014/15 survey identified that 18% of estates predated the formation of the NHS and 43% were more than 30 years old (Naylor, 2017). Similarly ageing estates were seen in the

independent sector. Providers described the increasing costs of trying to keep estates functioning, let alone therapeutic, and how in some cases they had had to condemn wards. This meant reduced capacity to move patients when other wards needed maintenance work.

3.2.2 The investigation visited several refurbished wards. On these wards, work had focused on mitigating risks associated with lines of sight and ligature anchor points with some consideration of wider therapeutic aspects. However, managers explained that a time would come when estates could no longer be refurbished (either because of the financial implications or the unsuitability of the building) and new locations would be needed. This was demonstrated during the investigation's visits to high-secure settings. One such site was at a critical point where, within the next 10 years, managers were concerned it would no longer meet safety and security requirements to ensure it could keep patients, staff and the public safe. With the time needed to find money, plan and build a new unit estimated to be at least 10 years, this was a significant concern.

3.2.3 On each ward visited, patient safety was supported through risk assessments. Ligature anchor points have been associated with multiple patient deaths (National Confidential Inquiry into Suicide and Safety in Mental Health, 2024) and so risk assessments described the location of anchor points and other hazards, including security and poor lines of sight. To manage the risks, wards allocated staff to these locations to observe and engage with patients. However, staff told the investigation that, due to staff shortages and multiple required tasks, mitigating the risks from hazards focused on observation and prevention rather than engagement; the investigation observed several situations where staff were observing but not actively engaging patients.

3.2.4 Figure 3 shows examples of hazards created by fixtures and fittings that were seen by the investigation. The investigation noted that some hazards could be eliminated (for example removal of non-functioning fixtures) or changed for something less hazardous (for example replacing with an anti-ligature type) and explored local processes for maintenance and fixing of hazards. Factors limiting providers' ability to address hazards related to the age and underlying fabric of estates (including buildings having listed status), workforce vacancies in estate teams, and the cost of work. From a prioritisation and allocation of funding perspective, it was heard that if a risk could be mitigated by ward staff then it was given lower priority. Limited funding (capital) made it challenging for providers to address low-priority risks.

Figure 3 Pictures showing examples of hazards created by fixtures on mental health inpatient wards (pictures: investigation's own). Broken telephone (top left), radiator (top right) and maintenance to securely close a window (bottom)

3.2.5 Limited funding (capital) also made it challenging for wards to make their environments more supportive of therapeutic care. The investigation experienced environments that staff wanted to make less noisy or less stimulating, and saw the need for other improvements including painting of damaged walls, replacing of ripped upholstery, and fixing of broken toilets and washing facilities. NHS ward managers told the investigation that if they wanted to make an environment "nicer" for patients, for example by getting new seating, they had to follow a protracted process and the only route may be to bid to a hospital's charity. By contrast, managers of independent sector wards caring for NHS-funded patients described easier access to funding as long as it was justified.

3.3 Capital funding for estates management

3.3.1 Providers said that the main barrier to the building or refurbishing of estates and physical environments was a lack of ‘capital’ funding (finances for long-term investments, maintenance and other developments). The Department of Health and Social Care (DHSC) described the process for distributing capital funds to the NHS (Department of Health and Social Care, 2024b; NHS England, 2022). An overall ‘capital envelope’ (around £8bn for 2024/25) is allocated to NHS providers. Over half of this is distributed directly to integrated care boards (ICBs) to cover regular business as usual capital needs of the NHS. Funds are also issued directly to NHS trusts for centralised and large projects, and to national priority programmes such as the New Hospital Programme and the eradication of dormitory wards. The amount of the envelope is directed by HM Treasury (2024) following a spending review. The last spending review set government departments’ resource and capital budgets for the 3 years 2022/23 to 2024/25.

3.3.2 Capital funds distributed to ICBs are managed by ICBs through a prioritisation process. Mental health providers described writing multiple business cases for capital funds that were not successful and that this was resource intensive (see also NHS Providers, 2023b). Mental health providers also felt they could not compete against bids from the physical/acute healthcare sector, particularly when funds had already been received to eradicate dormitories in mental health settings. National stakeholders were aware of similar concerns around prioritisation of funds to the acute sector and described limited national guidance for this process. NHS England told the investigation that they recognised their role in supporting ICBs through capital guidance and were looking to strengthen this for 2025/26. NHS England have also tasked ICBs to develop ‘joint capital resource plans’ to include ‘site development strategies’ and the identification of further funds to bid for (NHS England, 2024g). The investigation heard challenge from ICBs that these plans felt “bureaucratic” when there was limited capital funds available.

3.3.3 The DHSC told the investigation that the health service had been “undercapitalised”. Fiscal policies and efforts to reduce the national debt had contributed to this. The DHSC was aware that built environments in the NHS presented challenges. However, because accountability for the management of capital funds was devolved to ICBs and providers, there was limited awareness at national level of the highest-risk areas and therefore overall capital needs. Stakeholders told the investigation that more capital funds were required to address the challenges relating to NHS built environments.

3.3.4 At the time of writing, a spending review was awaited. The ‘Independent investigation of the NHS in England’ had also highlighted the challenges faced by NHS providers from current capital rules and the difficulties faced raising funds to make urgent safety improvements (Department of Health and Social Care, 2024a). Providers told the investigation that long-term budgets were needed to help with longer-term planning of their built environments, especially for large projects and major improvements to support therapeutic care and safety; this need was also highlighted by NHS Providers’ (2023b) review of the NHS estate. The investigation was told that the previous government had considered ‘health infrastructure cycles’ that might support longer-term funding of estates projects; these had not been taken forward.

3.3.5 In summary, the investigation found that built environments for mental health inpatient care contributed to patient harm and did always support therapeutic engagement and care. Some physical environments also increased staffing requirements and, as noted in 2.3.24, the working environment was a factor that influenced workforce recruitment, retention and safety. While limited capital funds was one contributing factor, other factors included unclear prioritisation processes for building and improvement works, limited national awareness and oversight of built environment issues across the country, and budget/capital funding cycles that did not allow for long-term planning for works. The following safety recommendation has been made in relation to mental health inpatient settings in line with the scope of this investigation and requires consideration in line with broader policy decisions around inpatient bed numbers and the long-term workforce. The investigation believes the safety recommendation is also applicable to built environments of the wider NHS.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/039:

HSSIB recommends that the Department of Health and Social Care, with input from stakeholders including NHS England, identifies the short-, medium- and long-term requirements of NHS mental health built environments to ensure they enable delivery of safe and therapeutic care to patients, and create a supportive working environment for staff. This is to support the development of a strategic and long-term approach to capital investment and prioritisation for NHS built environments.

HSSIB proposes the following safety response for integrated care boards

Proposed safety response ICB/2024/009:

HSSIB suggests that integrated care boards: 1) ensure system-level infrastructure strategies clearly reflect the risks across their mental health inpatient built environments, and 2) ensure prioritisation of capital funding is equitable across different healthcare settings in a geographical area.

3.3.6 The investigation heard about the specific challenges faced by secure settings relating to accessing capital funds. At the time of writing, Provider Collaboratives (see 1.1.7) for medium/low-secure services were not part of capital funding pathways via ICBs. There were longer-term plans to integrate Collaboratives into ICBs, but the investigation was told that this was unlikely to facilitate easier access to capital funds due to a lack of resource for additional services. For high-secure settings, the investigation was told that there were limited routes available to access capital funding for large projects, new builds or refurbishments. While the inpatient population in high-secure settings is small compared to wider mental health services, patients pose a ‘grave risk of harm’ to others (Department of Health and Social Care, 2019). As per 3.2.2, stakeholders had significant concerns about the specific risks associated with high-secure services and that in the future some estates may not be able to keep patients, staff and the public safe.

3.3.7 High-secure services are nationally commissioned by NHS England. The DHSC and NHS England told the investigation that there was no separate or specific process for capital funding of high-secure services. This meant any funds would need to be sought from the finite and already oversubscribed capital allocation to the NHS which would be unable to meet the needs of the high-secure estates. At the time of the investigation, the issue was described as “unresolved” and complex. Some national stakeholders were unaware of the concerns around the high-secure estate and access to capital funding.

3.3.8 According to the ‘service specifications’ for adult high-secure services, the ‘Secretary of State for Health has a duty’ to provide hospital accommodation and services for people who require high security and that this needs to be in a ‘safe and therapeutic environment’ (NHS England, 2024c). In summary, the investigation found some parts of the high-secure estate were unable to provide a safe and

therapeutic environment. Further concerns were identified about longer-term implications for patient, staff and public safety, with barriers to accessing capital funding to support future estate development.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/040:

HSSIB recommends that the Department of Health and Social Care undertakes assessment of the capital requirements of the built environments across high-secure services in England and develops plans to ensure the long-term safety of patients, staff and the public.

New builds and the New Hospital Programme

3.3.9 The investigation visited several new-build estates for mental health inpatients where the design of the sensory and therapeutic environments had been informed by user perspectives of patients and staff. Sensory considerations included how design could reduce the potential adverse reactions of patients to aspects such as noise and light. The investigation found limited data available to demonstrate that the new environments had positively influenced patient outcomes, but it was the view of providers and patients that they had many therapeutic benefits.

3.3.10 Other providers told the investigation of their requirements for new buildings or a whole hospital to meet patient and staff needs. However, applications for funding, including to the NHS New Hospital Programme, had been unsuccessful. The investigation met with representatives of the New Hospital Programme who described how limited funding and unforeseen issues, such as reinforced autoclaved aerated concrete (RAAC), had influenced decisions about which hospitals would be built. The Programme acknowledged that there may have been more focus on acute (physical health) hospitals rather than mental health hospitals, particularly in light of the national strategy to move to more community-based mental health care and because of demands on acute hospital services.

3.3.11 The New Hospital Programme recognised the widespread needs of the built environments across the NHS, including in mental health. Its representatives described 1) that the available funding did not allow for all needs to be met, particularly in light of increasing building costs, and 2) not knowing how best to design a mental health inpatient setting to meet the goals of treatment and the

needs of patients and staff. They said there were limited best practice principles for design, particularly in the context of changing patient needs, increasing recognition of the importance of the sensory environment, and increasing use of technology to support care. At the time of writing, the government had stated that it planned to conduct a review of the New Hospital Programme as it needed to be realistic and fully costed.

3.3.12 There is a Health Building Note (HBN 03-01) for the design of adult acute mental health settings (Department of Health, 2013) and further guidance is available for secure settings (for example Department of Health, 2010; NHS England, 2023d). The investigation was told by stakeholders that HBN 03-01 is outdated and that there is limited evidence around best practice standards to inform future updates. Providers shared some insights into what they had learnt from recent new builds, including the need to focus on sensory environments that did not feel restrictive, while ‘over designing’ for durability as people are getting stronger.

3.3.13 Providers also told the investigation that they wanted guidance on which technological solutions to incorporate into the design of their built environments. Various technological solutions were seen in use, including door-top alarms, cameras and observation systems, but providers had differing views on their benefits and use varied. Specific to cameras and patient observation systems, the investigation heard contrasting perspectives about their benefits and drawbacks. From a patient perspective, concerns related to privacy, consent and governance, worsening of psychological distress and negative influences on therapeutic relationships. The investigation did not specifically examine the role of cameras or monitoring technology further.

3.3.14 In summary, to support future design of built environments for mental health care, there is a need to identify best practice principles for design. Associated research would benefit from considering the experiences of providers, staff and patients, and take input from experts in human factors and ergonomics. Design principles will also need to align with future models of care and workforce plans as described in section 2. In the meantime, NHS England told the investigation that HBN 03-01 is part of a series of HBNs that are currently under review for update. The findings of this investigation may provide intelligence to support update of that HBN.

HSSIB makes the following safety observations

Safety observation O/2024/036:

Those involved in healthcare research can improve patient safety by seeking to understand the design principles for mental health inpatient settings that underpin safe and therapeutic care. Research should include consideration of sensory environments, the role of technology, and the changing needs of patients.

Safety observation O/2024/037:

Those involved in the design of new and upgraded built environments for mental health inpatient settings can improve patient safety and the delivery of therapeutic care by involving relevant stakeholders in design processes. Stakeholders include people with lived experience (patients and staff) and experts in human factors and ergonomics. Any design should also consider the changing needs of patients.

4. Safe and therapeutic care – social environments and organisational factors

This section summarises the investigation's findings in relation to its second aim (see 1.4.2) with a focus on the wider therapeutic social environment and the organisation of care, and their impact on safe and therapeutic care.

4.1 Therapeutic social environments

4.1.1 The investigation observed how the 'social environment' influenced therapeutic engagement and care. A therapeutic social environment was heard to be one that enables formation of therapeutic relationships between staff and patients; provides a space where patients feel safe and included; and supports meaningful activities, interaction and self-reflection. The investigation also saw how local leadership and decision making influenced the social environment.

Creating a therapeutic social environment

4.1.2 The investigation saw and heard how the built components of an environment alone did not create a space that was therapeutic and in which patients could feel ‘psychologically safe’. Staff described how a therapeutic “social” environment was fundamental when seeking to support patient and staff interactions. Staff also told the investigation about the importance of appropriate relational boundaries when engaging with patients.

4.1.3 Relational boundaries are the professional and personal rules that support safe and effective therapeutic relationships. There are risks to patients and staff where boundaries waver outside of professional limits (Royal College of Psychiatrists, 2015) and the investigation was told how this could lead to the forming of non-therapeutic relationships. Managers in secure settings shared work undertaken around ‘boundary breaches’ and described factors that contributed to breaches, including staff inexperience, increasing numbers of young and newly qualified staff, an imbalance of male and female staff, limited experienced supervision, and individual attitudes. Overfamiliarity with patients may also increase the risk of breaching boundaries.

4.1.4 Through visits to different providers the investigation got a sense of different social environments and how they influenced psychological safety. On some wards there was evident proactive engagement between staff and patients, and patients approached staff to talk about their needs and concerns. On other wards the investigation was told by patients that the focus was “medication” and that staff did not listen to patient concerns. **Vignette L** describes the investigation’s initial impressions when visiting two adjacent wards to demonstrate the different environments.

Vignette L.

Ward 1 – Some staff were attempting to encourage a patient who was described as “threatening” to have medication. Other staff were in the staff area of the ward. Other patients sat alone in communal areas which were dilapidated with broken fixtures. Patients described fearing being put in seclusion, describing it as “hell”.

Ward 2 – Most patients were in the communal area listening to music and chatting with the staff who were sat with them. All staff were in the patient areas engaging with patients. The ward was clean and tidy. Staff and patients seemed cheerful and were approaching each other to converse.

Summary of the investigation’s observations, adult setting.

4.1.5 Managers described a willingness among their staff to engage therapeutically with patients in a kind and compassionate way; the investigation observed this in practice in multiple providers. The investigation also saw examples where efforts had been made to develop therapeutic social environments through patient-centred activities (see figure 4) and approaches to develop psychological safety. Examples included a ‘community space’ in an older-adult inpatient setting that could be adapted to become a shop, hairdresser or entertainment venue; and a ‘therapeutic community’ in a specialist service for adults with personality disorders. The therapeutic community model values relationships and participation, and encourages a culture of enquiry. The investigation joined a morning ‘community meeting’ that all patients were expected to attend. This involved a patient-led discussion of how they were feeling, what factors had the potential to trigger thoughts of wanting to self-harm, and mechanisms to help them cope with and manage these thoughts. Patients encouraged each other to take responsibility for their actions in an environment of psychological safety. Research suggests that approaches such as this have supported positive outcomes for particular patient groups (for example Eckerström et al, 2019).

Figure 4 Pictures showing examples of local efforts to create therapeutic social environments (pictures: investigation’s own). Sensory room (left) and outdoor community space (right)

4.1.6 Managers also described other factors that influenced the creation of therapeutic social environments. Factors included the presence of an experienced leader, a multidisciplinary belief in the therapeutic approach to care, and where a ward is equipped with the necessary resources to support all patients. In contrast, managers described that a ward with 20 patients together did not enable therapeutic relationship formation, contributed to an environment that had the potential to “heighten emotions”, and could lead to a group effect where behaviours changed. The Royal College of Psychiatrists (2011) has recommended that general adult inpatient wards should not exceed 18 beds as otherwise they feel ‘institutional’ and ‘less safe’. Providers described that it was challenging to reduce bed numbers because of capital funding issues (see 3.3.1) and demands on services.

4.1.7 In summary, the investigation found that many factors contribute to the therapeutic environment and the development of therapeutic relationships. The investigation heard about the importance of psychological safety and saw several examples of local efforts that created feelings of safety and therapy. Further examples of a therapeutic social environment will be described in HSSIB’s future ‘learning from deaths’ investigation in the series on mental health inpatient settings.

4.2 Organisational factors

4.2.1 The investigation identified how other ‘organisational factors’ influenced patient safety and therapeutic care. These factors included organisational decision making to create caring and inclusive environments, local supporting infrastructure for care (other than built environments), cross-provider integration of care processes, and other wider factors.

Decision making – mixed-sex wards

4.2.2 The investigation’s visits to providers identified several with mixed-sex wards. The investigation spent time in these environments and explored the local reasons why mixed-sex wards continued to exist despite NHS England’s expectation for providers to ‘have a zero-tolerance approach to mixed-sex accommodation’ (NHS England and NHS Improvement, 2019). NHS England’s (2019) guiding principles to single-sex accommodation describe the need to prioritise safety, privacy and dignity of all patients, and include that decisions to mix patients should be based on their clinical condition and not on ‘constraints of the environment or convenience of staff’.

4.2.3 Where mixed-sex wards existed, managers described factors that influenced the decision to continue the use of these wards. Factors included demand and capacity, a lack of commissioned inpatient beds for women, geography where there was a small number of wards to provide care for a local population, and built environment limitations that prevented adaptation to allow structural changes to respond to demand. However, managers also recognised the potential risks mixed-sex wards created, including in relation to sexual safety (**Vignette H**, 2.2.30). Managers described particular concerns about the safety of women on mixed-sex wards and that women are disproportionately affected by violence, including sexual and domestic. To support the mitigation of risks to all patients, providers described seeking to meet patient preferences about their accommodation if bed availability allowed, and the creation of separate accommodation areas and women-only day rooms.

4.2.4 The investigation heard repeated concerns from national stakeholders about the persistence of mixed-sex wards in mental health services. They described how their existence did not align with national expectations and were not supportive of standards in support of patient safety (see 2.2.33). They also described how a lack of privacy and dignity for patients influenced their care and recovery.

4.2.5 In summary, the investigation found mixed-sex wards in mental health inpatient settings with multiple factors contributing to their continued existence, including bed availability, commissioning, and capital funding in relation to the built environment. Managers acknowledged the associated risks with mixed-sex wards but also described some benefits. Benefits included the flexibility to meet the specific preferences and needs of some patients, and some staff and patients described these wards as more representative of the “real world” and so had a therapeutic element.

Decision making – creating inclusive environments

4.2.6 While exploring decision making around the accommodating of patients in mental health inpatient settings, a recurrent concern raised by staff across providers was how to accommodate patients with specific needs, preferences and histories in ways that maintained a safe and therapeutic environment for all. Specifically, the investigation was told about concerns meeting the needs and preferences of patients who may identify as a different gender to their registered sex at birth, or who may not identify with a specific gender. In line with national guidance on same-sex accommodation (NHS England and NHS Improvement, 2019) staff described wanting to accommodate patients as per their preferences and

‘according to their presentation’. However, they also described that the context of mental health inpatient settings made applying national guidance difficult in some circumstances.

4.2.7 Staff described how decisions of where to accommodate patients who are transgender and non-binary required consideration of the individual circumstances of the admitted patient and all other patients on a ward. For example, the investigation met a patient who was registered male at birth, identified as female, and was accommodated on a male ward; the provider described the patient’s circumstances that created complexity in deciding where to accommodate them while trying to meet their preferences and needs, and also while maintaining their safety and the safety of others. Any patient may have previous traumatic experiences (see 2.2.30) and/or may have relevant current/historic criminal convictions. The principles of therapeutic care include avoiding putting patients in positions that may re-traumatise them.

4.2.8 A review by the National Survivor User Network (2023) found that provider policies and attitudes towards patients who are transgender and non-binary varied, and people faced ‘discrimination and harm … from staff and other service users’. The investigation heard from national stakeholders that there was “misunderstanding and misinformation” about caring for patients who are transgender and nonbinary. Concerns about ‘getting it right’ have been influenced by challenging public debate, previous political messages, and negative responses to national reports (Cass, 2023). At the time of writing, the NHS Constitution was undergoing its 10-year review which included additional considerations in relation to sex and gender (Department of Health and Social Care, 2024c); the investigation heard from several stakeholders that they were not in support of proposed changes to the Constitution.

4.2.9 Providers described wanting support to help them consider how best to accommodate and care for patients who are transgender and non-binary within the complexities of mental health inpatient settings, including secure settings. Stakeholders described national guidance as “outdated” and lacking in consideration of the specifics of mental health inpatient settings. Several national stakeholders agreed with the need for greater support for providers to help ensure all patients are cared for safely and therapeutically. Other stakeholders disagreed with the need for guidance and that instead high-quality patient-centred care for all is required.

4.2.10 In summary, the investigation found variation in how providers approached the accommodation of patients who are transgender and non-binary. The investigation also found that mental health inpatient providers wanted support when making decisions about how best to accommodate and care for patients who are transgender and non-binary alongside the needs of other inpatients. While the investigation recognises that the care of all patients should be patient-centred, providers had specific concerns around the care of patients who are transgender and non-binary. Due to those concerns, the safety recommendation below referring to ‘guiding principles’ has been made.

4.2.11 The investigation was told that any guiding principles to support care should consider the risk assessment of all patients, rather than assuming that a patient who is transgender and non-binary would pose an inherently greater risk to others compared to other patients. The investigation did not identify specific incidents through its evidence collection where a patient who was transgender and non-binary had harmed another patient in a mental health inpatient setting. The Equality and Human Rights Commission (2022) further told the investigation that a blanket policy is unlikely to be the best way to support equality and that a set of principles which can be flexibly applied may be beneficial. Any support must be informed by trans-led organisations and by people with lived experience, including patients and staff in relevant settings, and requires implementation by a workforce that is trauma informed and inclusive towards LGBTQ+ considerations (LGBT Foundation, 2024).

HSSIB makes the following safety recommendation

Safety recommendation R/2024/041:

HSSIB recommends that NHS England, working with relevant stakeholders, develops guiding principles for providers of mental health inpatient care to support local decision making when accommodating patients, including patients who are transgender and non-binary. This is to ensure a provider’s equality and human rights obligations are considered, and all patients are cared for in environments where they feel safe and that are therapeutic.

4.2.12 The investigation’s focus on the care of patients who are transgender and non-binary was a result of concerns raised by providers. The investigation recognises that all patients should be cared for through a person-centred approach which values privacy and safety, and barriers to care exist for many people. The

investigation also recognises that other barriers to care are faced by patients who are transgender and non-binary and heard about patients being refused access to hormone medication during inpatient stays particularly when self medicating, and limited availability of support while awaiting care for gender dysphoria (Grassian, 2022).

Infrastructure – digital and technology

4.2.13 In this report, 'digital' refers to the use of technology to access and transfer clinical information about patients. 'Technology' includes the software and hardware used by staff to facilitate care. The investigation identified that technology (or lack of it) had contributed to patient harm where it created barriers to accessing patient information. Similar findings have also been highlighted in other settings by HSSIB (2023a; 2024c). The investigation did not consider technology for patient communications with others such as family, but did hear about the importance of technology being available (where appropriate) to support social contact as part of therapeutic care. This was of particular importance when patients were admitted to a unit far away from their homes. 'Out of area placements' will be considered in a future HSSIB investigation in its series on mental health inpatient settings.

4.2.14 The investigation identified incidents with technology where poor usability of electronic patient records (EPRs) had not supported decision making (**Vignette B**, 2.2.6) and lack of interoperability between different digital systems meant staff did not have access to information held in other EPRs (**Vignette M**). A lack of technology to support care planning also contributed to incidents, for example where paper charts were used to monitor patients (**Vignette G**, 2.2.25).

Vignette M. The patient was found in cardiac arrest. An inquest identified that blood test results had been available at another hospital 24 hours before the patient's collapse. The results had not been communicated and showed a low potassium level in the blood which was concluded to have contributed to the patient's death.

Summary based on a report to prevent future deaths, adult setting.

4.2.15 Staff in providers also told the investigation that their EPRs did not facilitate good person-centred safety assessment, care planning with patients and carers, or handover of patient information. HSSIB's interim report 'Learning from inpatient mental health deaths and near misses: assessment of suicide risk and safety

planning’ also highlighted how some EPRs still required staff to categorise patient risk assessments despite recommendations suggesting the need to move away from this type of risk stratification.

4.2.16 The investigation saw that EPRs were rarely used for handover of patient information between staff at change of shift. Staff said that this was because of the usability issues and because of limited numbers of devices (tablets and laptops), slow and unreliable hardware, and poor Wi-Fi. This meant handovers were often verbal and relied on ‘paper’; this had led to some patient information being lost. The investigation identified incidents where information loss had contributed to harm and deterioration of patients’ health.

4.2.17 Digital teams in providers recognised the issues with usability and interoperability of their EPRs. Due to design limitations, different providers’ EPR systems had grown and they did not have a standardised ways of storing clinical information resulting in variability. Projects to implement updated EPRs faced barriers due to limited funding and inability to release clinical staff for user input into configurations. One provider described having “no capital funding for digital” for the next year.

4.2.18 The investigation met with NHS England and heard that while most mental health inpatient providers had EPRs, the usability of these systems was poor. As part of NHS England’s digital transformation work there are plans to launch a programme to improve the quality of EPRs in mental health settings. National stakeholders described the need for providers to prioritise “digital infrastructure” to ensure it is able to support patient care, for example by having reliable technology. Investment in digital infrastructure has been shown to reduce lost work time, improve staff satisfaction and potentially reduce harm to patients (Zhang et al, 2022).

4.2.19 In summary, the investigation found that technology in mental health inpatient settings did not always facilitate the delivery of safe and therapeutic care. Part of the NHS England’s (2023b) Long Term Workforce Plan is to ‘reform’, which includes embracing technological innovation. This will be unachievable without addressing fundamental underlying digital infrastructure issues, some of which were found in this investigation. This finding has contributed to the safety recommendation in 2.3.57.

HSSIB makes the following safety observation

Safety observation O/2024/038:

Providers of mental health inpatient care can support patient safety by evaluating and addressing local barriers to the effective use of technology to support patient care, including through gaining insights from people with lived experience (patients and staff) and ensuring the digital infrastructure is available, usable and reliable.

4.2.20 The NHS's plans for digitisation also offer the opportunity to identify where traditional paper-based approaches can be digitised to support patient care. One potential opportunity highlighted in this investigation was for the monitoring of food and fluid intake. Patients had been harmed when monitoring had not recognised that their health was deteriorating, the potential for complications (**Vignette G**, 2.2.25), or risks associated with receiving nutrition after prolonged starvation (refeeding syndrome). Staff described how paper charts did not support them to identify problems and therefore they often relied on dietitians. However, as explored in 2.3.19, limited availability of dietitians meant ward staff needed to be able to effectively monitor and respond to concerns about food and fluid intake.

Cross-provider care

4.2.21 'Cross-provider care' is where mental health inpatients require care from other healthcare providers – for example, for a physical health condition. The investigation identified patient safety incidents where limited integration of care across providers had been a contributing factor. Patient harm had occurred as a result of delays referring a patient or transferring their care, or because of limited access to specialist services. Harm from delayed follow-up of investigations undertaken at a different provider is described in **Vignette M** (see 4.2.14).

4.2.22 The need to transfer a patient to another provider for physical healthcare was a recognised need of mental health inpatient providers. Providers also stated their view that the number of transfers was increasing due to increasing patient acuity. Transfers were resource intensive and put patients, staff and the public at risk. Patients may be transferred to non-therapeutic environments with ligature risks and from where they could abscond. Transfers from secure settings also needed to consider factors such as a patient's criminal offence and security, and often required multiple staff for escort. These staffing requirements affected staffing numbers, particularly in emergency transfer situations.

4.2.23 The investigation explored opportunities to reduce the need to transfer patients. In acute situations managers thought most transfers were appropriate, enabling access to care that was not available on site. However, they also acknowledged that some transfers may be taking place because of under-confidence of ward teams to care for physical health issues. Where providers had introduced physical healthcare teams and registered nurses (adult) to wards (see 2.3.17) some had seen fewer transfers.

4.2.24 For less time-critical situations, depending on the setting, patients were transferred for specialist outpatient appointments and primary care services. In some locations arrangements had been made for specialists to visit the mental health provider on a regular basis or as needed. This was beneficial as it provided access to care, reduced workforce demands and mitigated some risks. Cross-provider arrangements varied across different regions. Barriers influencing their setup included relationships between providers, integration of processes including technological, data sharing arrangements, and questions around funding. Where arrangements had been agreed, these barriers had been overcome.

4.2.25 In summary, the investigation found that limited cross-provider pathways of care created barriers to some patients receiving the physical care they needed, and increased demands on the workforce to support transfers. There may be opportunities to bring some services to patients in mental health inpatient settings to reduce the need for transfers; this also has implications for patient and public safety. The role of integrated care boards (ICBs) puts them in a position to support the formation of these cross-provider pathways.

HSSIB proposes the following safety response for integrated care boards

Proposed safety response ICB/2024/010:

HSSIB suggests that integrated care boards: 1) work with mental health inpatient providers to identify patient needs that require input from other providers and agencies, and 2) facilitate cross-provider working arrangements between mental health, acute and primary care providers to minimise the need for transfers of care unless clinically necessary.

4.2.26 The investigation did not explore cross-provider working on discharge of patients to the community, or cross-agency working such as with the police, local authorities or social care. However, the investigation heard about the importance of

integrated pathways for continuity of care and good working relationships, as reflected in national reports. For example, the Care Quality Commission's (2024b) 'special review' following the killings of three people in Nottingham highlighted concerns that align with what the investigation heard, including that 'transferring between inpatient care and crisis care into community care was difficult, and that services did not always ensure continuity of care'.

4.2.27 The investigation saw examples of good multi-agency working. These included multiagency care planning to support patients experiencing emotionally unstable personality disorder in the community with short admission to hospital only if required, and following violent incidents or allegations of a sexual nature on wards. However, the investigation also saw how a lack of collaboration contributes to harm. For example, the investigation identified a report to prevent future deaths where a patient at high risk of suicide had absconded from an inpatient setting. The police were contacted but formed a different perception of the patient's level of risk which influenced their involvement. The patient was found dead around 24 hours later.

4.3 Wider factors

4.3.1 'Wider factors' refers to further aspects that influence the ability of providers to deliver safe and therapeutic care; some of these may be beyond the individual ability of a provider to influence. Due to the terms of reference, several wider factors were outside of the scope of this investigation. These wider factors have been summarised for context and recognise that delivery of mental health inpatient care needs to be considered with acknowledgement of its position within the wider health and care system, and of the influence of cultures on the quality of care. The 'Independent investigation of the NHS in England' also highlighted several of these wider factors (Department of Health and Social Care, 2024a).

4.3.2 The investigation heard about and identified evidence of the following factors which influenced the ability of mental health inpatient providers to deliver safe and therapeutic care to patients:

- limited availability of crisis services and an overall reduction in inpatient mental health beds (see The King's Fund, 2024a)
- limited availability/access to community mental health services, outpatient psychiatric care and social care (see Rethink Mental Illness, 2024)
- under-resourcing of services for patient groups including older adults, people with dementia, people with personality disorders (see Royal College of

Psychiatrists, 2020b), people with a learning disability (see Health Services Safety Investigations Body, 2023b) and people with autism.

- under-recognition and action to address avoidable health inequalities in mental health. For example, the Centre for Mental Health (2020) highlighted that ‘black adults are the least likely ethnic group to report being in receipt of medication for mental health, or counselling, or therapy’ and ‘85% of older people with depression receive no NHS support’.

Influence of culture on care

4.3.3 Throughout the investigation, stakeholders provided insights into past and present cultures surrounding mental health care. In this context ‘culture’ refers to the values and beliefs that influence the care of patients and support for staff. Culture is a recognised component of the Safewards model (see 1.2.9) and NHS England (2024a) has set out commitments to ‘create conditions where patients and staff can flourish’.

4.3.4 Stakeholders expressed concerns that limited long-term investment in inpatient services had led to normalisation of lower quality care in some providers. Coupled with the workforce challenges described in section 2, this had the potential to create the conditions for the workforce to use more restrictive practices with patients. Stakeholders were worried that mental health services may be becoming more restrictive again following years of effort to reduce restriction. They also described how beliefs and attitudes may influence who is detained under the Mental Health Act (1983); NHS statistics have highlighted how detention rates of black and black British people were over four times higher than those of white people (NHS Digital, 2022).

4.3.5 Stakeholders also gave examples of scenarios where assumptions were being made about patients because of their mental health problem. The investigation identified incidents where ‘diagnostic overshadowing’ (misattribution of a physical problem to a mental health problem) was a potential contributory factor, and the stigma around having a mental health problem was repeatedly described. Assumptions reduced opportunities for patients to access and receive care. Stakeholders also described how mental health was not always valued equally to physical health, citing evidence such as the attitudes of some staff and the lack of investment in services.

4.3.6 The investigation also heard about ‘closed cultures’. These cultures have been found in some organisations (see the Independent Review of Greater Manchester Mental Health NHS Foundation Trust, 2024). Closed cultures are those that ‘can lead

to harm, including human rights breaches such as abuse', and services that are more likely to develop these cultures include those where patients are unable to leave or where they are an inpatient for a long time (Care Quality Commission, 2024c). The Equality and Human Rights Commission also told the investigation about the influence of closed cultures on 'blanket restrictions' (where policies restrict a patient's liberty and rights, which are routinely applied to all patients in a setting) and suggested that having a multidisciplinary team (as per section 2) was important to help minimise the risk of "insular" cultures developing among professional groups.

4.3.7 Across the providers visited, the investigation was welcomed and all those engaged with were perceived to be transparent. Some providers recognised the risk of closed cultures and described how they had developed processes to help address risk factors. Other providers had addressed warning signs of closed cultures, including by improving patient involvement in care planning, reducing the use of restrictive practices, and challenging any blanket restrictions. Factors such as high staff turnover, staff shortages, inexperienced leadership, and lack of supervision are risk factors for a closed culture. These factors demonstrate the importance of addressing the workforce issues considered in section 2.

4.3.8 In summary, the investigation found variation in the values and beliefs of individuals and organisations that influenced the delivery of care in mental health inpatient settings. The investigation visited some settings where safe and therapeutic care was evidently a priority. However, the investigation also heard concerns that some engrained beliefs may remain in healthcare that prevent mental health and physical health being valued equally, and that undermine the delivery of safe and therapeutic care to patients.

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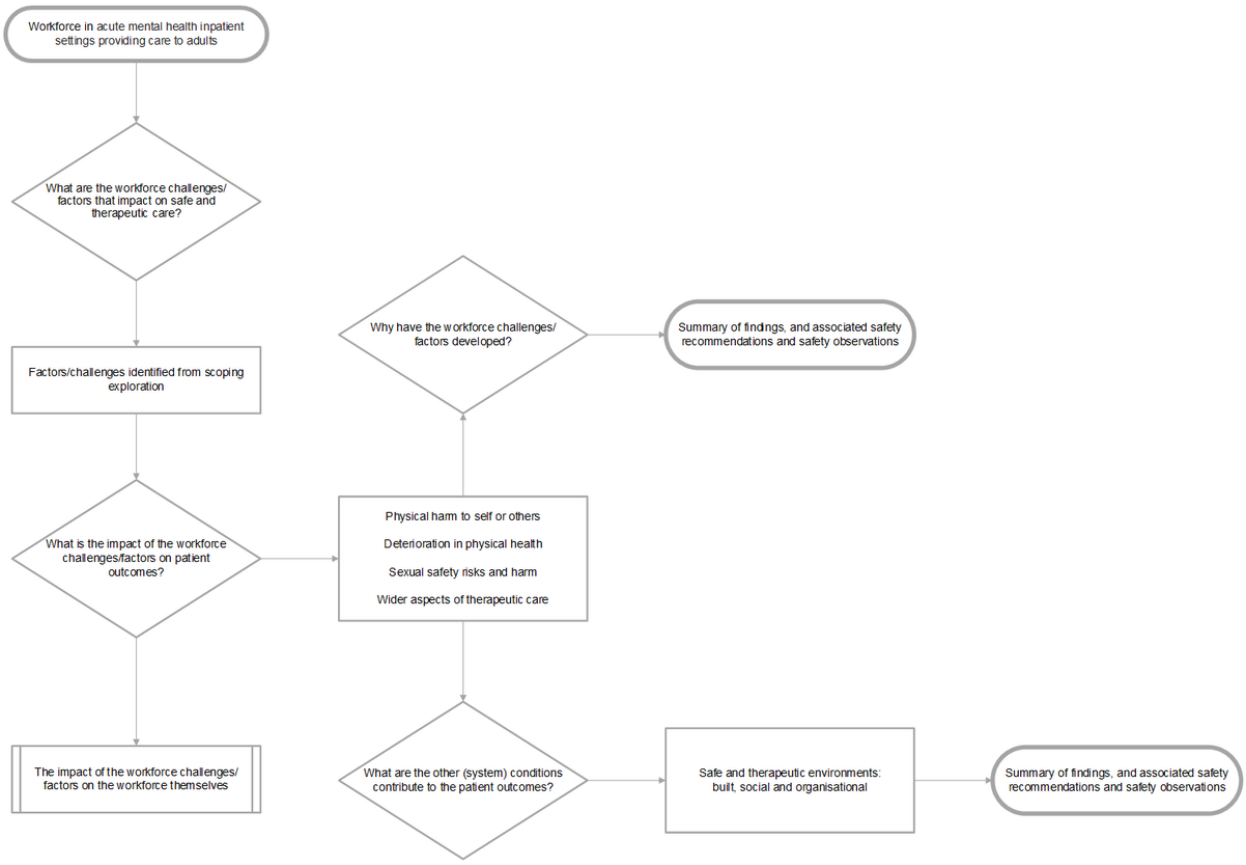
6. Appendix – investigation approach

Figure A summarises the direction the investigation took to examine workforce and workplace conditions in acute mental health inpatient settings that deliver care to adults.

Figure A The investigation's examination of workforce and working conditions



6.1 Evidence gathering

The investigation's findings were drawn from analysis of available intelligence (serious incident investigation reports, preventing future death notices, research and policy literature) and through activities undertaken by HSSIB (observational visits, patient and staff interviews, wider stakeholder interviews and focus groups).

Serious incident reports

The Strategic Executive Information System (StEIS – a national database of serious patient safety incidents) was searched for incidents occurring within 'Mental Health Services' (care sector) between 1 January 2023 and 31 December 2023 (incident dates). Results were refined by clinical area, date of birth and patient type. The data set included 402 serious incidents reported in high-secure settings, 137 in medium/low-secure settings, and 1,016 in other adult mental health settings including those for older adults.

Each report was reviewed by the investigation and a brief summary is provided here:

- High-secure settings – reports related to physical deterioration, patient harm to self, and patient violence or aggression towards others. Incidents associated

with prolonged confinement, sexual safety, and medications were also identified.

- Medium/low-secure settings – reports from across NHS and independent sector providers. Reports related to patient harm to self, absconding and absence without leave, and allegations against staff or other patients. Incidents associated with security, patient violence, and physical deterioration were also identified.
- Adult mental health settings – reports from across NHS and independent sector providers. Reports related to patient harm to self, other injuries and physical deterioration. Incidents associated with patient violence, absconding and absence without leave, staffing, and sexual safety were also identified.

Reports to prevent future deaths

Reports published by HM Coroner were accessed via HSSIB's collation of reports and keyword searches of the Courts and Tribunals Judiciary website. This identified 300 potentially relevant reports made between 2018 and 2024. Each of these was reviewed. Of the 300 reports, 27 related to the investigation's terms of reference including 9 deaths by suicide during inpatient care, 8 inpatient deaths following physical deterioration, and 6 deaths while patients were absent without leave.

Stakeholder engagement

This is one of a series of HSSIB investigations into patient safety in mental health inpatient settings. This meant it was able to draw on evidence from across the four separate investigations in the series. Specific stakeholders engaged with primarily for this investigation are shown in table A and listed below.

Table A Patients and families, providers and regional stakeholders engaged with primarily for this investigation

Patients and families	Inpatient providers/staff	Regional oversight
Patients and patient forums across mental health care providers	Adult (NHS and independent sector)	Integrated care boards
Interviews with people with lived experience	Older adult (NHS and independent sector)	NHS-led provider collaboratives for secure services
	Medium/low secure (NHS and independent sector)	NHS England regional teams

Patients and families	Inpatient providers/staff	Regional oversight
	High secure (NHS)	
	Specialist care for people with personality disorders and a learning disability (NHS)	

The investigation directly engaged with the following national stakeholders and academics as part of the investigation:

- Department of Health and Social Care – estates, capital, research, mental health and offender health.
- NHS England – specialised mental health, office of the chief allied health professional, office of the chief nursing officer, national quality board, workforce and training, digital transformation, research, estates, the New Hospital Programme, and LGBT+ health.
- Service regulators – Care Quality Commission and the Equality and Human Rights Commission.
- Professional regulators – Nursing and Midwifery Council and the Health and Care Professions Council.
- Royal colleges and professional bodies – British Psychological Society, Royal College of Nursing, Royal College of Psychiatrists, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, and The Shelford Group.
- Charities, voluntary and patient/public groups– Mind, organisations representing people who are transgender and non-binary, organisations representing patients and the public.
- Pre-registration education institutions – providing pre-registration mental health, and children and young people nursing courses.
- Academics in – nursing education, sexual safety, healthcare workforce modelling, speech and language therapy, and mental health and dementia.
- Independent sector – Independent Healthcare Provider Network and one large independent sector provider.

Further stakeholders were also engaged with during the consultation phase for this report.

6.2 Analysis of the evidence

The findings presented in this report were identified following triangulation of various evidence sources and following consultation with stakeholders involved in the investigation. The investigation approach was informed by the Systems Engineering Initiative for Patient Safety (SEIPS) to help explore the workplace conditions that influence patient outcomes (see Holden et al, 2013), and risk management frameworks to help understand risks across local, regional and national boundaries.