Health Services Safety Investigations Body

Terms of reference

Mental health inpatient settings

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Theme:
Mental health

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Introduction

Terms of reference (TORs) for the Secretary of State (SoS) mental health (MH) directed investigations.

Engagement and stakeholders across all investigations

Across all HSSIB investigations there is a requirement for engagement with patients, families, carers, as well as local and national organisations. To ensure the patient voice is represented, HSSIB routinely works in partnership with the charitable sector to help generate, coordinate and support focus groups as well as patient advocates.

As each investigation progresses, different mechanisms will be employed to ensure the patient voice is integral to our report. HSSIB can also be contacted directly by any patient, carer or family member who want to share a story about the mental healthcare received.

Proposed investigation 1

SoS topic: How providers learn from deaths in their care and use that learning to improve their services, including post-discharge.

Proposed investigation 1: Learning from inpatient MH deaths, and near misses, to improve patient safety.

Proposed investigation terms of reference.

This investigation will look across NHS and independent sector providers to:

TOR 1

Examine the mechanisms that capture data on deaths (and near misses) across the MH provider landscape, including up to 30 days post discharge.

Approach

- Effectiveness of current mechanisms for learning from deaths.
- What are the agreed definitions for deaths in MH inpatient services.
- Does the data on MH inpatient deaths capture contributory physical health conditions?
- How is the patient MH care pathway considered if someone dies as an inpatient
- How are deaths once discharged from linked to care provided as an inpatient?
- Who needs/collates this data and for what function?
- How are protected characteristics and disadvantaged groups identified within the data?
- Understand and consider whether the sexual safety of a patient within a mental healthcare inpatient environment has contributed to the death.

TOR 2

Examine local, regional, and national oversight and accountability frameworks for deaths in MH inpatient services.

Approach

- How does management and leadership provide oversight functions.
- What are the accountability mechanisms, at each layer, for learning from deaths and near misses.

TOR 3

Understand how providers ensure timely and effective investigations.

Approach

- What investigation resources are available across providers and how well are they trained?
- How are recommendations received, and appropriate actions implemented/ enforced? I.e. PFDs etc.
- How are providers/systems tested, post implementation of actions taken, in response to recommendations?
- How people who use the service, and families, are involved in investigations.

Proposed investigation 2

SoS topic: How young people with mental health needs are cared for in inpatient services and how their care could be improved.

Proposed investigation 2: The provision of safe care during transition from children and young person (CYP) to adult, inpatient mental health (MH) services.

Proposed investigation terms of reference.

This investigation will look across NHS and independent sector providers to:

TOR 1

Determine and understand age related considerations for CYP and adult inpatient MH services.

Approach

- Understand policy and guidance that influences MH inpatient services in consideration of age.
- Understand how both CYP and adult inpatient MH services are commissioned in consideration of age, and how the needs of people are considered and maintained during transition.
- Consider variations across providers and regions in the provision of inpatient MH services, when considering the age of people that use them.

TOR 2

Consider how approaches to the transition between CYP and adult inpatient MH services are evaluated to support the recovery of people that use them.

Approach

- How are people that transition from CYP to adult MH inpatient services appropriately supported in their recovery. Consider varying models, including research and trials, to determine how safe outcomes guide policy, service commissioning, and provision.

- How are people, and/or their carers, that use MH services able to contribute to, and influence, the design and delivery of transition between CYP and adult MH inpatient services.

Proposed investigation 3

SoS topic: How out-of-area placements are handled.

Proposed investigation 3: Impact of out of area placements on the safety of MH patients.

Proposed investigation terms of reference and approach.

This investigation will look across NHS and independent sector providers to:

TOR 1

Identify factors which contribute to the use of out of area placements.

Approach

- Understand current length of stays in out of area placements.
- What the factors are which lead to people being placed out of area.
- Identify any factors which may have contributed to an increase in the use of out of area placements.

TOR 2

Evaluate how the needs of local MH inpatient service users are identified by ICBs/Trusts and how this enables appropriate local provision.

Approach

- What is the policy. What are the agreements in place. How are OOA placements driven by safe appropriate care (for example specialist services) rather than bed (lack of) availability. Why is there variation in numbers of beds per head across areas.

- How are inpatient MH beds, a critical but limited resource, appropriately managed. How are they protected for patients with the most significant need. How are planned, as opposed to reactive, acute placements managed.
- How do commissioners use patient outcome evidence to determine levels of NHS provision of inpatient MH care requirements. How is this balanced against commissioning private provision.

TOR 3

Consider how local providers maintain oversight of their patients that are out of area, including how they support patients to return to appropriate services within their local area.

Approach

- What are the responsibility/accountability mechanisms for local providers when their patients are receiving MH inpatient care out of area.

Proposed investigation 4

SoS topic: How to develop a safe, therapeutic staffing model for all mental health inpatient services.

Proposed investigation 4: Creating the conditions for staff to deliver safe and therapeutic care – workforce, relationships, environments.

Proposed investigation terms of reference.

This investigation will look across NHS and independent sector providers to:

TOR 1

Examine the factors which impact on providers' ability to safely staff their mental health inpatient wards.

Approach

- Consider system-wide factors including staff availability, recruitment, retention, work and task type.

- Consider the mitigators used by providers to support safe staffing, including the use of locum and agency staff.

TOR 2

Examine the conditions on mental health inpatient wards in which staff work, and the impact conditions have on the delivery of safe and therapeutic care.

Approach

- Take a system-perspective to consider design of organisational and local workplace systems, processes and environments.
- Likely to include consideration of organisational workforce management/ scheduling/training, organisational policies and processes.
- To specifically include consideration of digital design, interoperability and transfer of information, and the design of physical work and care spaces, impact on sleep for patients and observations.
- Outcomes may be considered specifically, such as the need for restraint, attempts at self-harm, and being fit for discharge.
- Understand and consider whether the sexual safety of staff and patients within a mental healthcare inpatient setting has been considered and ensured.