Mental health inpatient settings

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Background

This series of investigations was announced by the Secretary of State for Health and Social Care in June 2023, launched in January 2024 and completed in January 2025.

Read the **terms of reference**.

Investigations

Investigation reports:

- Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings.
- Out of area placements.
- Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services.
- Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge.

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Engagement with national partners

We spoke to our national partners across the healthcare system in England, as well as to organisations that represent healthcare staff, patients and families. This was to understand the current landscape in inpatient mental health care.

Organisations we spoke to include:

- care providers
- regulators
- professional bodies
- voluntary and charitable organisations that represent patient and family groups
- members of Parliament (MPs).

This was so we could identify and address the most serious risks to mental health inpatients. Within each investigation area we identified recommendations and other learning that will lead to changes in the safety culture and how safety is managed within mental health services.

Terms of reference

Interim report

Investigation report: Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings

Investigation report: Out of area placements

Investigation report: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services

Investigation report: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge

Feedback

Tell us what you think about these investigations and reports by completing our online feedback form.

Timeline

28 June 2023
Investigations announced by Secretary of State for Health and Social Care.

30 January 2024
Terms of reference published.

12 September 2024
Interim report published.

24 October 2024
Final report published: Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings.

21 November 2024
Final report published: Out of area placements.

12 December 2024
Final report published: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services.

30 January 2025
Final report published: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge.

Safety recommendations

The Shelford Group

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.

NHS England

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.

Department of Health and Social Care

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.

Department of Health and Social Care

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.

NHS England

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.

Department of Health and Social Care

HSSIB recommends that the Department of Health and Social Care includes the documenting of patient, family and carers' wishes and preferences within the Mental Health Bill. This will ensure all patient, family and carer voices are considered in decisions relating to where the patient identifies they would like to be close to, for example the patient's home or a family member, specifically when an out of area placement is needed.

Department of Health and Social Care

HSSIB recommends that the Department of Health and Social Care works across government to review the statutory instruments, business processes and regulations that govern mental health services, social care and housing services impacting on mental health out of area placements and creates a proposal for the future accountability and integration of health and social care. This is to ensure that they are operating to consistent statutory, financial and regulatory frameworks. By addressing system integration and collaboration between health, social care and local authorities will define accountability and reduce or prevent out of area placements.

NHS England

HSSIB recommends that NHS England reviews and updates its inpatient children and young people's mental health services specifications and commissioning guidance to ensure they support developmentally appropriate, needs-based transitions. Any changes to service delivery will require a review of funding lines to enable successful implementation.

NHS England

HSSIB recommends that NHS England reviews and revises its guidance and policies to ensure consistency regarding the language used for age ranges (for example children, young people, young adults and adults). This is to support a consistent approach to healthcare delivery that aligns services and mitigates gaps.

Care Quality Commission

HSSIB recommends that the Care Quality Commission work with the Department of Health and Social Care to understand prioritisation for assessing transitions in mental health care within Integrated Care System assessments. Any subsequent work should include the development of a methodology to identify the challenges described in the investigation report relating to

transition from inpatient children and young people's mental health services, to adult mental health services. This is to improve the safety, quality and consistency of transitions across England.

Department of Health and Social Care

HSSIB recommends that the Department of Health and Social Care works across government to identify opportunities to support closer cooperation between local government, education and health systems for the safe and effective transition of young people into adulthood. This is to ensure alignment, equity of access, and clear responsibility and accountability for their health, education and social support that spans the ages of 16 to 25. Cross governmental work would be supported by the adoption of consistent language for age ranges of children, young people, and adults.

NHS England

HSSIB recommends that NHS England provides guidance regarding communication of essential safety and risk mitigation information when patients transition from inpatient children and young people's mental health services due to reaching transition age. This is to safeguard vulnerable people and may include how to share information with families and carers, health and social care providers, and third sector organisations.

Department of Health and Social Care

HSSIB recommends that the Department of Health and Social Care works with NHS England and other relevant stakeholders, to clarify national expectations for meaningful and restorative learning from patient safety events and deaths in mental health services. This is to ensure effective learning is supported through processes that provide high-quality and transparent investigations within a culture of compassion.

NHS England

HSSIB recommends that NHS England works with other stakeholders to define the term ‘therapeutic relationship’. This is to support building trust and compassionate relationships between staff and patients from admission to inpatient settings through to discharge, to improve patient outcomes.

NHS England

HSSIB recommends that NHS England, working with other relevant national bodies, develops guidance on how to reduce and respond to non-anchored ligature risks. This will help staff to support people who attempt to hurt themselves with non-anchored ligatures and improve patient safety whilst maintaining a therapeutic environment.

Department of Health and Social Care

HSSIB recommends that the Department of Health and Social Care creates a national oversight mechanism that supports co-ordination, prioritisation and oversight of safety recommendations to implementation across the system. This is to ensure that recommendations from public inquiries, independent patient safety investigations and other patient safety investigation reports, as well as prevention of future death reports from inquests, are analysed and monitored and reviewed until their implementation using a continuous quality improvement approach to learning.

Department of Health and Social Care

HSSIB recommends that the Department of Health and Social Care working with NHS England, and other relevant stakeholders, develop a comprehensive, unified data set with agreed definitions for recording and reporting deaths in mental health services to include deaths that occur within a specific time period after discharge. This will support any revisions required to the current NHS

England Learning from Deaths Framework. The creation of a comprehensive, unified data set would enhance system-wide visibility, co-ordination and collaboration, reduce duplication of effort, and maximise the impact of improvement work through strategic oversight.

Safety observations

Creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning

- Organisations can improve patient safety by taking a person-centred approach to biopsychosocial assessments and safety planning and stop asking for evidence of risk assessment tools that stratify an individual's risk of suicide or self-harm as high, medium, or low risk.
- Organisations can improve patient safety by ensuring that a person centred approach to biopsychosocial assessment should be offered for all patients who have contact with mental health services, when a patient has an episode of self-harm or suicidal thinking, every time they make a transition between mental health services, and at key important times in the person's life. This is line with current guidance from the National Institute of Health and Care guidance.
- Organisations can improve patient safety by involving 'digital experts' in their electronic patient record system improvement projects. This will support any digital configuration and infrastructure changes required to record person-centred approaches to psychosocial assessments and safety planning.
- Organisations can improve patient safety by listening to and communicating with patients, their families and carers, about the safety and wellbeing of people who have self-harmed and/or are expressing suicidal thoughts. It is important that this involvement starts from the point of a patient's admission through to their discharge from inpatient mental health wards and during follow up.

Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings

- 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.

- 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.
- 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.
- 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.
- 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.

Out of area placements

- NHS organisations can improve patient safety by maintaining clinical and welfare oversight and responsibility for patients being treated in an out of area placement. This can ensure harm is minimised and that patients are returned to their sending hospital as soon as possible.
- Mental health inpatient services can improve patient safety by offering advocacy to all mental health inpatients at the point of admission, and ensuring that the patient's decision about whether or not to have an advocate is continually reviewed as their treatment continues and needs may change. This can ensure that patients' needs and views are taken into account by health and social care staff when decisions about their care are being made, particularly when in an out of area placement.

- Crisis resolution and home treatment teams can improve patient safety by joining quality networks for crisis resolution and home treatment teams and could consider using continuous clinical reviews of mental health acute inpatients. This can ensure that appropriate patients are discharged early and could maximise acute care bed availability for patients in the community who are at high risk because of their mental health problem, and reduce the need for out of area placements.
- Health and social care organisations can improve patient safety by working together and embedding mental health social workers from the local authority in mental health acute hospitals. This can ensure that patients' holistic health and social care needs are considered throughout their acute mental health admission and on into the community, and improve efficiency of working, patient flow and discharge and reduce the use of out of area placements.
- Mental health services can improve patient safety by reviewing their community mental health services to see if they meet the needs of their population with the aim of keeping as many people as possible out of inpatient services and thus preventing the use of out of area placements.
- Healthcare services can improve patient safety by conducting assessments for neurodevelopmental conditions such as autism and attention deficit hyperactivity disorder, where it is safe and clinically indicated, at the earliest opportunity when a person is in contact with community and acute mental health services. This can ensure that patients are put on the appropriate pathway early. This can prevent harm that may be caused by receiving inappropriate treatment and reduce admissions to mental health inpatient settings, thus reducing the need to use out of area placements.

Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services

- Providers of inpatient children and young people's mental health services can improve patient safety by ensuring there is not a blanket approach to safeguarding mitigation measures based on a person's age, and that mitigation measures are individualised and based on behaviours and risks.
- Children and young people's mental health services and adult mental health services can improve patient safety by having more aligned thresholds and criteria to access care, and improved data sources to inform decision making. This is to support closer alignment of services and mitigation of

gaps, and to enable more seamless care pathways from childhood to adulthood.

- Mental health providers can improve patient safety by adopting a consistent approach to involving and informing young people, and their families and carers, about how care decisions and the sharing of care information change when young people reach 18. This is to support a consistent and proactive approach to seeking young people's wishes, and enabling a shared understanding between staff, young people and their families and carers.
- Inpatient children and young people's mental health services can improve patient safety by ensuring that young people, families, and carers are involved, informed and prepared as possible for the young person's next place of care. This may require increased levels of engagement with partner inpatient adult mental health services to support a full understanding of the differences that will be encountered.

Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge

- Integrated care boards and organisations that provide mental health care can improve patient safety by working together to support the facilitation of cross-organisational investigations and learning. This should be achieved in a way that enables people involved in an investigation to come together to share perspectives and build relationships to enable learning. This may provide opportunities for effective and meaningful organisational learning and facilitate reparation and trust-building for everyone involved.
- Organisations that provide mental health care can improve patient safety by adopting a comprehensive person-centred care approach that prioritises the individual needs, preferences and rights of each patient. This approach should ensure consistent access to meaningful therapeutic activities, actively involve families in care planning and decision making, and create supportive environments tailored to the sensory and emotional needs of neurodivergent individuals.
- NHS boards can improve patient safety by supporting their non-executive directors (NEDs) with responsibility for quality and safety to attend NED-specific training on quality of care and patient safety. This may include modules on compassionate leadership, the importance of psychological safety, safety science in investigations and techniques for supportive challenge. By fostering these skills, NEDs can better understand the

complexities of healthcare delivery, engage meaningfully with staff, and ensure that patient safety and quality care remain at the forefront of their governance role.

- Integrated care boards and organisations that provide mental health care can improve safety by involving people with lived experience and family carers in coaching for executive leaders. This could include creating learning networks within provider collaboratives. By embedding these roles, executive teams and non-executive directors would receive direct insights from those with personal experience of mental health services, helping them to co-produce learning from deaths and drive improvements in care.

Safety actions

Creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning

- NHS England, working with the National Collaborating Centre for Mental Health, is identifying 10 organisations to lead work to co-produce personalised approaches to safety planning in inpatient services. The learning will be shared through national learning networks. This is expected to be complete by March 2026.
- NHS England is producing national guidance on Safety Assessment and Safety Planning, specifically relating to person-centred safety assessment and planning, to support organisations in complying with the National Institute for Health and Care Excellence guidance ‘Self-harm: assessment, management and preventing recurrence’. This is expected to be complete in April 2025.