Health Services Safety Investigations Body

Investigation report

Mental health inpatient settings: overarching report of investigations directed by the Secretary of State for Health and Social Care

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Theme:
Mental health

Contents

Before reading this report

This report considers the care of people experiencing mental illness and severe mental illness and includes discussion about suicide and dying. Some readers may find the contents distressing. Information about how to access mental health support can be found on the NHS website.

Acknowledgements

Over a period of almost a year the HSSIB team visited more than 40 care areas across 30 mental health care providers and met with numerous patients, families and staff along the way. We would like to thank the many people who contributed to these investigations. 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.

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 overarching report brings together and explores cross-cutting patient safety risks across the individual investigations (the investigations).

The published investigation reports in the series are:

- 'Mental health inpatient settings: creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning' (Health Services Safety Investigations Body, 2024a)
- 'Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults' (Health Services Safety Investigations Body, 2024b)
- 'Mental health inpatient settings: out of area placements' (Health Services Safety Investigations Body, 2024c)
- 'Mental health inpatient settings: supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services' (Health Services Safety Investigations Body, 2024d)
- 'Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge' (Health Services Safety Investigations Body, 2025a).

This report is intended for the Secretary of State for Health and Social Care, healthcare policymakers and organisational leaders to help influence improvements in patient safety. This report has been published at a time when the government is considering long-term plans to radically reform the NHS and is responding to the findings of the 'Independent investigation of the NHS in England' (Darzi, 2024). 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 those settings, such as integrated care boards.

Executive summary

Background

This is an overarching report and the last in a series of HSSIB investigations on the theme of patient safety in Mental health inpatient settings. The aim of this report is to examine patient safety risks identified across the series of inpatient mental health investigations. This report acknowledges that the delivery of mental health inpatient care is complex and influenced by many interacting factors.

This report presents themes that the investigation identified across the published HSSIB investigation reports. It also shares new information that was outside of the terms of reference of specific reports. This report's findings offer opportunities to facilitate improvements in systems, practices and future plans to support patient safety in mental health inpatient settings. Findings may also be applicable to other healthcare services in England.

Findings

Safety, investigation, and learning culture

- There remains a fear of blame in mental health settings when safety events happen. This contributes to a more defensive culture despite staff actively wanting to learn.
- Many recommendations to support learning for improvements in mental health care do not lead to implemented actions. Reasons for this include a lack of impact assessment resulting in unintended consequences, no clear recipient involved in the development of recommendations, and duplicated recommendations across organisations.

System integration and accountability

- The integration of health and social care within an integrated care system currently relies on relationships, with an expectation and hope that they will work well. However, where this is not the case, a lack of clear accountability can result in poor outcomes for people with mental illness and severe mental illness.
- The delivery of care for people with mental illness and severe mental illness is challenging because health and social care services are not always integrated and their goals are not always aligned.

Physical health of patients in mental health inpatient settings

- There are gaps in the provision of physical health care for people with severe mental illness, including inconsistent health checks, poor emergency responses, and misattribution of physical symptoms to mental illness.
- The misattribution of physical symptoms to patients' mental health was observed and had the potential to contribute to worsened patient outcomes.
- National reports, strategies and research have made recommendations to improve the physical health of people with severe mental illness. However, there is evidence that recommendations are delayed in implementation and people continue to die prematurely.
- Integrated care boards lack the required data and the necessary analytical capability to assess disparities in access, experience and outcomes related to the physical health needs of people with severe mental illness.
- There is variation in how the physical health checks are carried out on mental health inpatient wards, with limitations in processes for following up on patients' physical health needs.
- There is variation in the knowledge, skills and experience of staff who undertake physical health checks and in the environments in which these checks take place.
- Patients may not always be supported in terms of health education about their physical health risks and modifiable risk factors, for example smoking, dietary advice and physical activity.

Caring for people in the community

- Integrated care boards cannot consistently draw reliable insights from data at national, system or local level, to optimise and improve services, patient care, and outcomes across mental health pathways of care. This results in variability in service provision which does not always meet the needs of individual patients or local populations.
- Inpatient 'bed days' are taken up by people who no longer need them, because people who are clinically fit for discharge are delayed in being transferred to their home or a suitable residence (appropriate placement).
- Reasons for delayed discharges include issues with housing support and establishing suitable accommodation. This means patients are not always in the right place of care.

- Barriers to discharge affect patient flow and may result in delays in admission for people with severe mental illness. This means they have to be cared for in a community setting while waiting for an inpatient bed.
- There is variation across the country in how drug and alcohol services are provided. The variation does not allow for fair and equitable treatment for all patients.
- Community services are vital to support people to stay as well as possible and to prevent hospital admissions. However, there is variation in community service provision across the country.

Staffing and resourcing

- Staffing and resource constraints in inpatient and community mental health settings impact their ability to provide safe and therapeutic care.
- In inpatient settings, constraints contribute to mental health wards aiming to staff for ‘safety’ but not always for ‘therapy’.
- Challenges for staff include the emotionally demanding nature of their work; this can lead to staff burnout and sickness, and further strain on services.
- There are gaps in mental health workforce planning, particularly in community services where there is no evidence based workforce planning tool to support a standardised staffing establishment setting model.

Digital support for safe and therapeutic care

- A lack of interoperability or integration between digital systems affects the provision of care across mental health, acute and community providers.
- Challenges in securing appropriate funding impacts on the ability of hospitals to integrate and update their digital services and infrastructure.
- Electronic patient record functionality is often not available or does not meet staff needs, and so it is not used. Examples include absent functions for food and fluid balance monitoring and risk assessment of venous thromboembolism (blood clots).
- Challenges in providing and maintaining patient-facing technology, for example televisions and payphones, impacts on the therapeutic environment and the ability of patients to maintain contact with families and loved ones.
- Where technology for monitoring patients had been introduced, implementation has required considerations to ensure it is used appropriately, is patient-centred, maintains therapeutic engagement, and supports patients to feel safe.

Suicide risk and safety assessment

- ‘Doing’ tasks, like ‘ticking’ checklists, overshadow meaningful, empathetic ‘being’ interactions with patients. Open, compassionate conversations that build trust and therapeutic relationships, enabling patients to own their risk while feeling supported, can help mitigate this.
- Investigation processes can contribute to a fear of blame, and subsequently contribute to defensive practices such as checklists and a ‘tick box’ culture. This inhibits open and honest conversations and the ability to put the patient, as their authentic self, at the heart of them.

HSSIB makes the following safety recommendations

Safety recommendation R/2025/063:

HSSIB recommends that the Department of Health and Social Care continues to work with the ‘recommendations but no action working group’ and other relevant organisations, to ensure that recommendations made by national organisations specific to mental health inpatient settings are reviewed. This work should consider the mechanisms that supported or hindered the implementation of actions from these recommendations. This may help the Department of Health and Social Care understand what has worked when implementing actions from recommendations and enable learning about why some recommendations have not achieved their intention.

Safety recommendation R/2025/064:

HSSIB recommends that the Secretary of State for Health and Social Care directs and oversees the identification and development of a patient safety responsibilities and accountabilities strategy related to health and social care integration. This is to support the management of patient safety risks and issues that span integrated care systems.

HSSIB makes the following safety observation

Safety observation O/2025/073:

National bodies can improve patient safety in mental health inpatient settings in England by supporting provider investment in equipment, digital systems and physical environments to enable conditions within which staff are able to provide, and patients can receive, safe and therapeutic care.

1. Background and context

This investigation report is the last in a series of HSSIB investigations focused on Mental health inpatient settings. This section provides background and a glossary of terms is also available at the end of the report (section 5). Further background details can be found in the individual investigation reports.

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' (also referred to as a mental illness) each year (Mind, 2024). A mental illness 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 illness are 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 legislation that covers the assessment, treatment and rights of people where a person is admitted to hospital on a compulsory basis. In this circumstance, 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 reform via the Mental Health Bill 2024 (Department of Health and Social Care, 2025) was being considered by Parliament.

Mental health inpatient care

1.1.3 In England, there are various mental health inpatient services. 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, 2024). The Royal College of Psychiatrists (n.d.) recommends a maximum bed occupancy of 85%. Bed occupancy has consistently been above the recommended maximum of 85% (except during the COVID-19 pandemic) since 2010/11 (Mental Health Watch, 2024).

2. Inpatient mental health settings – cross-cutting patient safety risks

This section brings together and explores the cross-cutting patient safety risks found across the HSSIB individual investigations. These are presented under the following headings:

- Safety, investigation, and learning culture
- System integration and accountability
- The physical health of patients in mental health inpatient settings
- Caring for people in the community
- Staffing and resourcing
- Digital support for safe and therapeutic care
- Suicide risk and safety assessment.

2.1 Safety, investigation, and learning culture

2.1.1 As reported in ‘Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge’ (Health Services Safety Investigations Body, 2025a), when a patient is either seriously harmed or dies while under the care of mental health services, the impact ripples out far and wide. Depending on the type of harm or death there may be multiple investigation processes. At the heart of those investigations are staff, families, and carers who may be experiencing trauma and anguish. The report emphasised that despite a commitment for a ‘just culture’ and ‘restorative learning’, a culture of blame and fear persists. The investigation identified significant gaps between what is said about a safety culture and “what it feels like to really work around here”.

2.1.2 The impact of investigations on health system improvement globally remains challenging and is under researched (Vincent et al, 2017). Further, the negative impacts of adversarial systems, such as those that seek to apportion blame, are increasingly highlighted, and include preventing the dialogue necessary for healing and instead blaming or shaming those involved (Dekker, 2016; Health Services Safety Investigations Body, 2025a; O'Hara and Canfield, 2024; Turner et al, 2020; Wailing et al, 2022). Those involved provide credible information that is crucial to capture and learn from; however, fear can have a counterproductive impact.

2.1.3 Menzies (1960) described these adversarial systems as unconscious mechanisms that organisations develop to protect themselves from psychological discomfort, anxiety, and perceived threats. In mental health care settings, with inherent stressors and risks, these defensive systems can profoundly shape organisational culture, decision making, and ultimately patient care.

Approaches to risk management

2.1.4 Within risk management there is not an expectation to eliminate all risk. NHS England guidance is available for organisations on how to identify and quantify risks of all types, clinical and non-clinical, and assesses priorities for action (NHS England, 2021). In addition there is national guidance on quality risk response and escalation in integrated care systems (National Quality Board, 2022). Other safety-critical organisations, such as some organisations within the airline industry, do not promise to keep people safe – they promise to make certain things safer so that people are less likely to be harmed during their flight. They endeavour to keep safety risks 'as low as reasonably practicable' (ALARP), rather than falsely promising that there will be no safety risk. In brief, reducing risks to ALARP involves weighing the risk against the 'sacrifice' or 'efficiency–thoroughness trade-off' (for example, financial cost, time, loss of productivity, supervision, maintenance) to reduce it (Health and Safety Executive, n.d.; Hollnagel, 2016). The decision process begins with a presumption that the risk reduction measure should be implemented. Applying the ALARP methodology to healthcare means an acceptance that there will always be safety risks and therefore a likelihood of poor outcomes; it is in the mitigation of these risks to be ALARP where real value can be added in the most person centred way feasible within the resources available. This includes a no-blame approach to learning from unintended poor outcomes, and recognition that that poor outcomes can and will happen through inherent and underlying system influencing factors. The term ALARP is not widely recognised or used in healthcare.

2.1.5 When compared to other industries, including industries that have a significant focus on safety, there is an expectation that the NHS will cover ‘all of that which no one can do’ and other industries ‘do not try to do’. Healthcare starts at a different point to other safety-critical sectors; poor outcomes for people may be in the process of already happening in the course of everyday life, through illness, disease, lifestyle factors and injury. While understanding the limitations of what can be achieved for every individual, it is the provision of safe and effective healthcare that helps to mitigate the number, and severity, of these poor outcomes.

Organisational culture

2.1.6 Unhelpful narratives were described by senior leaders in organisations who themselves described “being the naughty child on the naughty step and everyone turns in on you”. The pressure on organisations, particularly following adverse patient safety events, often leads to a defensive posture. This can foster a divisive “us versus them” mindset between leadership and frontline staff, as well as between departments, hindering collaboration and openness to change (Menzies, 1960). As the World Health Organization (2021) puts it: ‘If a culture of blame and fear is dominant in a health organisation, it is quite impossible to have a meaningful programme of patient safety.’ However, the literature is prolific in describing that for staff to learn when things go wrong, an environment of fairness, transparency and learning is required (NHS England, n.d.d; NHS England, 2025a).

2.1.7 'Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge‘ (Health Services Safety Investigations Body, 2025a) gave examples where organisations had been described by families as “defensive”. The investigation was also told during visits about hostility between teams and services when a patient death occurs. This was described by staff as creating a culture of fear in raising concerns, which means staff then do not raise concerns and become an “inactive bystander” when things are going wrong or have gone wrong.

Unintended consequences of safety recommendations

2.1.8 The investigation was told that one of the reasons for not developing a culture of learning from investigations in mental health is the impact of national recommendations being made with “no impact assessment on the recommendations”. The investigation was told by a consultant psychiatrist that not undertaking quality impact assessments before making some recommendations is

“a major factor resulting in the severe loss of therapeutic time per clinician, as they have to fill in so many forms ‘just in case’ for all sorts of things which are rarely, if ever, going to improve outcomes”.

2.1.9 The investigation was told that “whilst recommendations have been made as a way of achieving improvements which individually may seem reasonable, added together over the years there are multiple requirements, some of which have become tokenistic and tick boxing rather than the true spirit of what has been recommended”. This was described as causing “learned helplessness”. An example of this was described in ‘Mental health inpatient settings: creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning’ (Health Services Safety Investigations Body, 2024a) relating to the continued use of outdated risk assessment tools that stratify an individual’s risk of suicide or self-harm as high, medium or low.

2.1.10 The investigation was told that the volume of “tick box induced work”, which had built up because of unintended consequences of actions from previous recommendations, was unhelpful. The impact was described as negatively affecting services, including being less efficient and effective, reducing the number of people who can get access to treatment and/or reducing the quality of treatment available to them. This in turn was described as contributing to burnout, compassion fatigue, vacancies, discontinuity of care and treatment and a higher likelihood of errors occurring as overstretched and exhausted staff slip into learned helplessness.

Barriers to implementation of safety recommendations

2.1.11 HSSIB’s report ‘Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare’ (Health Services Safety Investigations Body, 2024e) highlights national issues related to implementation of recommendations. The investigation was told about barriers to recommendations implementation in mental health services which included that ‘recipients’ of recommendations were not always clear or known. Conversely, the investigation was also told that recommendations were made without involving those responsible for implementing the required actions, or without any agreed understanding of the actions expected to flow from the recommendation and how they might be measured. This was observed at local hospital level between departments, through to regional and national recommendations.

2.1.12 Another barrier to the implementation of recommendations in mental health services was the “duplicity of similar recommendations”. In reports reviewed, which included individual patient safety incident investigations and national reports, it was evident that there were pre-existing recommendations which had been made; however, it was not clear to the investigation what, if any, actions had been taken. In addition, it was not possible to draw conclusions about why previous recommendations had not been implemented, resulting in a layering of similar recommendations.

2.1.13 The report ‘Mental health inpatient settings: supporting safe care during transition from inpatient children and young people’s mental health services to adult mental health services' (Health Services Safety Investigations Body, 2024d) highlighted several recommendations that were made to NHS England in relation to inpatient mental health services, but where NHS England could not provide evidence that actions had been implemented in response. The Thirlwall Inquiry (2024) review report included a table of recommendations from over 30 inquiries that were coded to indicate whether there was evidence to suggest they had been implemented; many had not. This was reported in ‘Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge’ and a resultant safety recommendation was made regarding oversight of recommendations (Health Services Safety Investigations Body, 2025a).

Summary

2.1.14 Patient safety in mental health services requires an overview of what priorities can be delivered to keep people as safe as possible within the real-world constraints of available finance and resource. This includes considering how recommendations to improve patient safety are made and how actions from those recommendations are implemented to enable organisations to learn and keep people as safe as reasonably practicable.

HSSIB makes the following safety recommendation

Safety recommendation R/2025/063:

HSSIB recommends that the Department of Health and Social Care continues to work with the ‘recommendations but no action working group’ and other relevant organisations, to ensure that recommendations made by national organisations specific to mental health inpatient settings are reviewed. This

work should consider the mechanisms that supported or hindered the implementation of actions from these recommendations. This may help the Department of Health and Social Care understand what has worked when implementing actions from recommendations and enable learning about why some recommendations have not achieved their intention.

2.2 System integration and accountability

2.2.1 The investigation heard at varying levels of the health and care system that there was not a clear understanding of integrated care systems (ICSs), integrated care boards (ICBs) and their remits. Two of the inpatient mental health investigation reports (Health Services Safety Investigations Body, 2024c; 2024d) found that ICSs, made up of healthcare (ICBs), social care (local authorities (LAs)), and wider system partners, were not always integrated and there was not clear responsibility and accountability for patient safety risks and issues caused by 'whole system' challenges.

Misalignment of health and social care goals and governance

2.2.2 The investigation into 'Mental health inpatient settings: out of area placements' described that 'LAs are responsible to local government and the local population they serve, while NHS trusts and ICBs are accountable to NHS England through the NHS England regional teams' (Health Services Safety Investigations Body, 2024c). The Department of Health and Social Care informed the investigation that it found the imbalance of rules and regulations and governance across health (ICBs) and social care (LAs) was a significant factor in the challenge to integration. There were integration challenges due to "fundamental" problems with how LAs were governed, and differences in their priorities and those of the NHS, leading to difficulties in providing seamless care across the health and social care system.

Managing cross-agency risk and accountability

2.2.3 The report 'Mental health inpatient settings: supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services' (Health Services Safety Investigations Body, 2024d) described how 'Health, social care, local authorities and education do not always work together in a consistent and integrated way to support positive outcomes for young people who are transitioning from inpatient CYPMHS to AMHS'. It also said that there is currently 'no clear responsibility and accountability for children and young people's health, education and social support that spans their transition from

childhood to adulthood'. The report further considered that although it is the intention that Care Quality Commission (CQC) provides an oversight function from its ICS assessment activities, including for integration and patient transition between services, there is no mechanism for holding a specific body to account for challenges identified. The House of Commons Committee of Public Accounts (House of Commons, 2023) has reflected similar integration accountability concerns. Since the publication of the report, and due to organisational changes across the healthcare landscape, CQC work on ICS assessment activity has been paused for at least six months.

2.2.4 The investigation explored CQC ICS assessments with the Department of Health and Social Care. It was discussed that findings of these assessments could be shared with organisations that have responsibility for their individual part of an ICS. For example, this could be NHS England for ICB issues, or the Ministry of Housing, Communities and Local Government (MHCLG) for local authority issues, where individual organisational accountability mechanisms can then be employed. However, it remains unclear how patient safety risks and issues at the boundaries of, and integration across, parts of a system could be effectively addressed by an organisation (NHS England or MHCLG) that does not hold accountability or have suitable levers to ensure the 'whole system' is truly integrated and working well, and that goals for people are aligned.

2.2.5 HSSIB has found across several investigations that ICBs are unable to fully mitigate healthcare risks when contributing factors are outside their control and sit across the wider ICS. However, guidance states that ICBs should be 'accountable for effective management of healthcare risks' (National Quality Board, 2022). HSSIB has seen examples where the NHS has been impacted by poor patient flow and suboptimal patient journeys that have resulted from poor health and social care integration, both in mental health care and across the wider healthcare system. The NHS Confederation (2024) stated that 'flow-related issues are best addressed through collaboration within and beyond the health service'. Although 'collaboration' occurs, it is unclear how ICBs can be accountable for managing healthcare risks that result from challenges in the provision of sufficient LA-funded social care support to allow efficient and safe discharge from inpatient care. Health and social care integration issues and their impact on flow and patient harm, as found in 'Harm caused by delays in transferring patients to the right place of care' (Healthcare Safety Investigation Branch, 2023), continue unresolved.

2.2.6 During engagement with the Department of Health and Social Care, it was highlighted that social care could also be impacted by challenges with healthcare delivery. Delays in accessing healthcare mean additional support may be required

from LAs, for example, for people with mental illness who are being supported by social services and LAs and are not able to access timely mental health care because of challenges with capacity and/or resources.

2.2.7 The investigation engaged with the Department of Health and Social Care to explore accountability across ICSs. It highlighted that the individual parts of a system (health, social care, and system partners) understand their responsibilities and accountabilities through statutory duties, and broader duties, to work as partners. The intention of ICSs is to bring together system partners to co-operate and co-ordinate, build relationships, and ensure their systems work together effectively. The Department of Health and Social Care highlighted that system partners work together jointly to design and commission services through planning processes, joint strategic needs assessments and forward plans, with a mutual accountability of partners working together to commit to meeting the needs of their population. The investigations identified examples of where these relationships have worked well to enable strategic planning for the delivery of services across health and social care in ICSs. However, HSSIB has seen limited evidence of where these relationships have enabled resolution of risks or issues that are impacting the safety of patients in a responsive and dynamic 'real-time' way across a system, with clear and defined system safety accountabilities.

2.2.8 Although there is a statutory duty for system partners to work together, this does not mean they always work well. HSSIB investigations have shown there is significant variance in how different ICBs and LAs work together across England, and how providing individualised and holistic care for people with mental illness is challenging because ICBs' and LAs' goals are not always aligned. Challenges are often not related to an issue within either health or social care individually, but across their boundaries; there is no clear system-level accountability for health and social care integration challenges that result in poor outcomes for people. Two safety recommendations from HSSIB's inpatient mental health investigations (R/2024/043 and R/2024/050**)** were made to the Department of Health and Social Care in relation to system integration and accountability. Other HSSIB investigation reports (Healthcare Safety Investigation Branch, 2023; Health Services Safety Investigations Body, 2025b) have also made related safety recommendations (R/2022/196, R/2022/197, R/2023/240, R/2025/057).

Summary

2.2.9 The integration of ICBs, LAs, and wider system partners within ICSs is vital to managing risks and issues across the health and care system and delivering positive outcomes for patients, families, and carers. The Department of Health and

Social Care wants to ‘ensure appropriate accountability arrangements are in place so that the health and care system can be more responsive to both staff and the people who use it’ (Health and Care Act, 2022).

2.2.10 However, the accountability arrangements described by the Department of Health and Social Care to the investigation are for individual parts within a system, rather than for the integration of the health and care system as a whole, which is where HSSIB has identified challenges and impacts on patient safety. The integration of partners within systems currently relies on relationships, with an expectation and hope that they will work well. However, when they do not work well, when goals for people are not aligned, and when this contributes to poor outcomes, there remains no clear accountability.

2.2.11 The safety recommendation below is made to address the health and social care integration accountability issues found in HSSIB’s mental health investigations and, as described, also found during HSSIB investigations across other areas of healthcare.

HSSIB makes the following safety recommendation

Safety recommendation R/2025/064:

HSSIB recommends that the Secretary of State for Health and Social Care directs and oversees the identification and development of a patient safety responsibilities and accountabilities strategy related to health and social care integration. This is to support the management of patient safety risks and issues that span integrated care systems.

2.3 The physical health of patients in mental health inpatient settings

2.3.1 Across each of HSSIB’s mental health inpatient care investigations, the physical health of people experiencing mental illness and severe mental illness was considered. Deterioration of physical health was reported in ‘Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults’ (Health Services Safety Investigations Body, 2024b) and a safety observation and safety recommendation were made.

Parity of esteem

2.3.2 The disparity between mental and physical health services, and the aim of ‘parity of esteem’ – that is, giving equal value to physical and mental health – have been considered through many national reports, strategies and research (Department of Health and Social Care, 2011; Department of Health, 2014; Royal College of Nursing, 2023). Reports have consistently highlighted the treatment gap, with individuals with severe mental illness receiving less preventative care and treatment for chronic physical illnesses. Subsequent initiatives, such as the Five Year Forward View for Mental Health (NHS England, 2016) and the NHS Long Term Plan (NHS England, 2019), sought to reduce rates of premature death among people with severe mental illness who often die 15 to 20 years earlier due to preventable physical conditions. However, a National Audit Office (2023) review found that most ICBs lacked sufficient data to assess disparities in people’s access, experience, and outcomes.

2.3.3 Despite clear commitments, challenges remain in achieving parity of esteem. The report of the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) (2022) highlighted barriers such as inadequate mental health nurse training in physical health, the separation of psychiatry from other medical specialties, and a lack of proper equipment in mental health inpatient units. NCEPOD told the investigation that the Royal College of Psychiatrists was going to use the NCEPOD report findings to update its ‘Standards for inpatient mental health services’ (2022) guidance. There was no other evidence of action taken as a result of the NCEPOD report and its recommendations. The Royal College of Nursing (RCN) report Parity of Esteem: 5 years on (2023), based on a survey to establish members’ views on mental and physical health equality in care settings, found that despite some positive examples of services providing necessary support, physical health settings often fall short in meeting the mental health care needs of patients. In addition their report cites that ‘people with mental ill health are not having their physical health well managed’.

2.3.4 Recent data from the Office for Health Improvement and Disparities (2023) reported that over 130,000 adults with severe mental illness in England died prematurely (before the age of 75) between January 2020 and December 2022, often due to preventable conditions like respiratory diseases. The Royal College of Psychiatrists (2024) has called on the government to increase access to physical health checks through additional services such as community health hubs, better integration of physical and mental health services, and more support for marginalised groups. However, the investigation has heard concerns by some organisations that following the consultation on changes to the GP Contract for 2025/26, targets around physical health checks for people with severe mental illness have been removed from the operational and planning guidance (NHS

England, 2025b), as well as the retirement of the Quality and Outcomes Framework (QOF) indicator incentivising the completion of physical health checks in general practice (NHS England, 2025c).

2.3.5 The investigation reviewed the HM Treasury (2024) 'Treasury minutes progress report' in which it was reported that:

'The Major Conditions Strategy will highlight the importance of seeking closer alignment and integration between physical and mental health services … The strategy will recognise that one aspect of ensuring parity of esteem between mental health and physical health services is funding decisions that ensure every ICB has a sufficient sized and skilled workforce … The department is developing a Mental Health Policy Tool to support government policymakers to take mental health and wellbeing impacts into account and address disparities when designing new policies.'

A definition of parity of esteem was formalised by the Department of Health and Social Care and NHS England in 2024 (Department of Health and Social Care, 2024a). The definition emphasises equal access, evidence-based care, and patient experience for people using mental health services.

Supporting physical health in mental health inpatient settings

2.3.6 Across HSSIB's mental health inpatient investigations, concerns were raised around staff having the knowledge, skills and experience to recognise when a patient's physical health is deteriorating. Factors that contributed to this were highlighted in individual reports (Health Services Safety Investigations Body, 2024b; 2025a). The investigation was told of examples of patients going into respiratory and cardiac arrest and requiring resuscitation where there were delays in starting treatment and issues relating to familiarity with equipment. Some staff described that they "panicked" and had concerns about knowing what to do in some emergencies, resulting in delays in calling for an ambulance and starting basic life support. The Nursing and Midwifery Council (NMC) standards of proficiency for registered nurses (2018) was available for use in curricula by approved education institutions (AEIs) from the end of January 2019. Mental health nurses are expected to be proficient in recognising and responding to a patient whose physical health is deteriorating as per the NMC standards. The investigation was told by the Royal College of Nursing (RCN) that, "as with all clinical interventions, where nurses may not readily practice certain physical health interventions, ongoing training and education through CPD and simulation, should be available".

2.3.7 Within ‘Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults’ (Health Services Safety Investigations Body, 2024b), managers described the value of physical healthcare teams attending the ward. However, they were concerned that the inpatient ward teams were over-reliant on them and had become deskilled. The investigation identified serious incidents of harm and coroners’ reports to prevent future deaths, where the physical deterioration of patients had not been recognised or responded to.

2.3.8 The Royal College of Psychiatrists’ (2022) ‘Standards for inpatient mental health services’ requires a physical health review to be started within 4 hours of a patient’s admission as an inpatient, or as soon as is practicably possible, and completed within 1 week, or prior to discharge. However, it is reported that these reviews are not consistently implemented, with 41% of patients missing key assessments (Royal College of Psychiatrists, 2024). The investigation spoke to staff on wards about physical health checks and at all sites visited there was a specific physical health check room. In addition, some services had a room for use if a patient suffered an acute deterioration of their physical health. Some services described having a registered general nurse who would visit the ward on a regular basis to undertake physical health checks. In other services, the physical health checks were done by mental health care nurses and support staff.

2.3.9 The investigation was told by staff that physical health checks include measuring a patient’s weight, taking their blood pressure and blood glucose level, which would be recorded in a patient’s medical record. However, there was variation in how often these checks would be done. Most organisations said they would do these when the patient was admitted or shortly after admission. The investigation did not see any specific outcomes as a result of these checks, for example, what advice would be given to a patient who was very overweight or who was a known heavy smoker.

2.3.10 The HSSIB investigations observed that patients who smoked but were not allowed to leave the ward may be offered alternatives to cigarettes, including vapes. Patients who were able to leave the ward would repeatedly do so for a cigarette. Impacts of long-term smoking on a person’s physical health was a consideration for staff who stated that patients who smoke are “typically given more time off the ward to do that”. The investigation spoke to staff about smoking and opinion varied on whether patients should receive health advice about their smoking habits and the promotion of healthy living.

2.3.11 Physical health check rooms were observed by the investigation and included equipment to check someone's blood pressure and blood glucose levels, urinalysis sticks, weighing scales, machines to analyse heart rhythm (ECG machines), and emergency life support equipment. Many of these rooms appeared to be well managed and maintained and staff were able to describe the equipment and its use. However, some environments for the physical health check were observed by the investigation to be cluttered and appeared to be more like a store cupboard with equipment that may be needed to assess someone's physical health.

Impact of mental health inpatient care on physical health

2.3.12 The investigation was told by families that medication to treat their family member's severe mental illness had caused significant physical health issues, including weight gain. Weight gain was a common issue shared and it was described that this had made their family member feel worse. One parent of a child who had died described that after being admitted to an inpatient setting, their daughter had experienced sudden weight gain and was not undertaking any physical activity. The parent described how they had noticed their daughter becoming increasingly breathless on exertion and experiencing dizzy spells. In addition to their daughter's holistic health needs not being fully supported, she also had an acute physical health condition which was later diagnosed as a venous thromboembolism (VTE – a blood clot) which required medication. A VTE is a recognised complication of obesity and reduced mobility (Thrombosis UK, n.d.). The parent described their daughter having limited access to physical activities on the ward, while being able to order takeaway food frequently. A subject matter advisor told the investigation that, 'being aware of likely side effects and taking prompt action to manage them and to help the person better manage them so they are prevented or mitigated from the outset is as important as recognising and responding to physical deterioration of patients'.

2.3.13 The investigation was told by staff and people with lived experience that having supported conversations about physical activity, nutritional support, smoking cessation, alcohol and substance addiction, financial welfare and safer housing, whilst an inpatient may help people understand factors that are within their control and that they can influence. The investigation observed local initiatives, such as social prescribing and the use of wellbeing mentors and peer support workers being implemented. However, the investigation was told there were limitations in what they could offer. These limitations were particularly described in terms of support in finding suitable housing and support in obtaining employment due to the "discrimination and stigma" associated with mental illness and this stigma continued to pose challenges. The investigation repeatedly heard

statements such as, “discrimination can limit access to education, employment, housing, and other opportunities, further marginalising individuals and hindering their personal growth”. The most recent community mental health survey (Care Quality Commission, 2025a) reported that ‘no help or advice was offered to 69% of people in finding work, or 67% in support for financial advice or benefits’. In addition it was reported that ‘39% of respondents did not receive support for physical health needs, but they would have liked this’.

2.3.14 The investigation observed that staff would include physical activity as part of therapeutic interventions. This included attending the gym or a dance class. Access to the gym was reported to have helped a patient reduce his weight, which had helped improve his diabetes (Health Services Safety Investigations Body, 2024b). The importance of having therapeutic physical activity and gym access on inpatient mental health wards 24 hours a day seven days a week was shared by many people including staff and patients. However, the availability of physical activities was limited because there were not enough staff, or staff did not have the required competencies.

2.3.15 In secure settings where patients stayed for a long period of time, there was evidence of active one-to-one conversations to encourage patients to consider modifiable risk factors for poor physical health, such as smoking, diet and physical activity. However, this was not always observed in other mental health inpatient settings such as acute inpatient wards.

2.3.16 The investigation is aware of multiple coroners’ prevention of future deaths reports related to physical health checks and staff’s knowledge and experience in inpatient mental health settings. One example is a man who died from a blood clot; he had had a history of blood clots and had reduced mobility while an inpatient on a mental health ward. One of the coroner’s findings was that insufficient consideration was given to the patient’s reduced mobility because of diagnostic overshadowing (see 2.3.16). Another example referred to the administration of medication to sedate a patient whose health then deteriorated. The patient’s deteriorating condition was not recognised and there was a delay in getting medical help and in calling the paramedics.

Diagnostic over shadowing

2.3.17 The investigation was told by many people about the risks of ‘diagnostic overshadowing’ in people with mental illness. Diagnostic overshadowing has been described in research as the ‘process by which physical symptoms are misattributed to mental illness’ (Hallyburton, 2022; Jones et al, 2008). The

investigation heard examples where patients with mental illness had been admitted to a physical health hospital due to worsening physical health; however, attempts to fully understand the physical issue had been limited. For example, a patient with a swollen abdomen and stomach pains was admitted to a physical health hospital only to be discharged. Then, some hours later, the patient had to be readmitted. The patient had a perforated bowel; however, staff told the investigation that the acute hospital staff were focused on the patient's anxiety and challenging state of mind rather than the physical health reason for their transfer. Similar scenarios were shared about people being transferred from a mental health inpatient ward to an acute hospital setting and their symptoms being missed or misunderstood because of the focus on their mental illness overshadowing their physical symptoms.

2.3.18 'Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults' (Health Services Safety Investigations Body, 2024b) identified incidents where diagnostic overshadowing was a potential contributory factor, and the stigma around having a mental illness was repeatedly described. 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.

2.3.19 The investigation was told there is disparity in people with mental illness accessing screening programmes and that to combat this a targeted approach by providers is needed. In some services this issue was described as improving, but variability remains. The investigation was told that a targeted approach requires joint working between staff who work in mental health, public health, and physical health; however, this is currently based on relationships rather than more formal structures and mechanisms.

Data on premature deaths

2.3.20 In 2021 the All-Party Parliamentary Group on Mental Health highlighted that to deliver on the commitment in the Five Year Forward View for Mental Health (NHS England, 2016) to prevent poor physical health outcomes for people with severe mental illness, a national measure for reducing premature death, with targets to hold services to account, was needed (Health and Social Care Committee, 2021). It was recommended that NHS England and Public Health England should ensure mortality data (data on death rates) is published at local and regional levels, and that local plans setting out how to meet reduction targets, including rolling out social prescribing in every primary care centre, be put in place. The investigation

met with social prescribers and mental health workers and found there was variability in how their role was implemented in primary care and community mental health services.

2.3.21 In relation to mortality data at local and regional levels, 'Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge' (Health Services Safety Investigations Body, 2025a) referred to the Department of Health and Social Care commissioned Mortality Data Working Group, which has identified actions to address gaps and drive improvements in the data on deaths. In addition, HSSIB made a safety recommendation (R/2025/056) regarding the development of 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.

Summary

2.3.22 Acknowledging the national reports, literature, guidance, advocacy and policy, and recommendations made to try and guide health service efforts, people who have a severe mental illness have a greater risk of poor physical health and of dying prematurely compared with the general population (De Hert et al, 2011; NHS England, 2016; Prince et al, 2007; Public Health England, 2018; Reilly et al, 2015; Thornicroft, 2011). Recommendations that have been made nationally remain relevant and their impact has yet to be fully understood.

2.3.23 The investigation into mental health inpatient settings found gaps in physical health care, including inconsistent health checks, poor emergency response, and the misattribution of physical symptoms to mental illness. Medication side effects, limited access to screenings, and poor co-ordination between mental and physical health services had the potential to contribute to worsened patient outcomes. While national recommendations have been made, people with severe mental illness continue to face higher risks of poor physical health and premature death.

2.4 Caring for people in the community

2.4.1 A theme throughout the HSSIB mental health inpatient investigations was the importance of community services and the challenges they face. The investigation did not explore these issues in depth as they were outside the remit of the direction from the Secretary of State for Health and Social Care and the subsequent terms of reference in each individual investigation. However, we did identify variation in how community mental health services were delivered across the country.

Impact of patient flow and discharge on community mental health delivery

2.4.2 There is a national aspiration in England to support more people with mental illness and severe mental illness in the community (NHS England, n.d.a). The upcoming NHS 10 year plan gives an opportunity to consider this aspiration. However, the HSSIB investigations found that many inpatient ‘bed days’ are taken up by people who no longer need them because of delayed discharges – that is, delays in transferring people who are clinically fit for discharge to their home or a suitable residence (appropriate placement) in the community.

2.4.3 Inpatient and community mental health staff told the investigation that the challenges around discharge contributed to poor patient flow, and can result in people with serious mental illness being cared for in the community because there are no beds available in an inpatient setting. They said that caring for more unwell patients in the community also creates additional pressures where, because of limited resources, staff are unable to support people with less acute mental illness, which can lead to their deterioration.

2.4.4 The investigation observed how the NHS England mental health discharge initiatives (NHS England, 2022) were being implemented in mental health inpatient settings. During observation visits, two challenges with the initiatives were identified; staff were struggling with identifying an expected discharge date with subsequent discharge to ongoing care, and pressure to discharge patients as early as possible.

2.4.5 The investigation heard about the importance of integrated pathways for continuity of care, as reflected in national reports. The investigation heard from inpatient and community mental health staff that it is vital for patients who are being discharged to community care that there are appropriate treatments and therapies available to keep those people and the public safe. Published statutory guidance on discharge from mental health inpatient settings (Department of Health and Social Care, 2024b) states that ‘there should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge’ to be able to give the appropriate treatment and support in the community to those who have been discharged.

2.4.6 The Parliamentary and Health Service Ombudsman (2024) published a report that stated:

‘We must not overlook patient safety in the transition from inpatient to community care and beyond … Unsafe discharge potentially leads to poorer outcomes for patients and the risk of repeated cycles of readmission: a revolving door in and out of services.’

The individual HSSIB investigation reports have highlighted the poor outcomes associated with poor discharge planning.

2.4.7 ‘Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge’ (Health Services Safety Investigations Body, 2025a) highlighted issues with the push for discharge to free up beds against the time taken to understand if medications are having the required and intended effect. Teams were trying to support treatment in the community but staffing, resourcing, variation in treatment and therapies, among other challenges, meant that not all patients could get the treatment or support they needed (Health Services Safety Investigations Body, 2024b).

Variation in health and social care community services

2.4.8 The investigation heard that community services are set up differently across the country depending on the experiences of the staff in those services. The investigation heard from some senior mental health staff that services are not commissioned against a structured review of what their local community needs. Staff recognised there may be variation across the country in terms of what services are needed, depending on many factors including culture and socioeconomic factors.

2.4.9 The investigation heard that another reason for variation is the lack of data available to service commissioners, ICBs and local providers. In addition, the availability and skills of staff to interpret data to make informed decisions about what services are needed for their local population was variable. The investigation was told by local leaders across mental health services that they cannot consistently draw reliable insights from data at national, system or local level, to optimise and improve their services, patient care and outcomes. This results in variability in service provision which does not always meet the needs of the local population. The investigation was told that that the digital fundamentals need to be in place to support drawing reliable insights from data at national, system or local level, to improve outcomes. The investigation was told by a subject matter advisor that “It is important that data is transparent and that variance is properly explored to make sure best uses are being made of available resources for each community.”

2.4.10 HM Treasury's (2024) 'Treasury minutes progress report' contains an update on the NAO report (2023) related to the NAO's recommendation in data and information and how the quality and completeness of data on mental health services, including cost of services and patient outcomes, might be improved. The Department of Health and Social Care told the investigation that improving data quality is a key priority for it and for NHS England. 'Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge' (Health Services Safety Investigations Body, 2025a) provided further evidence of work being carried out on data quality.

2.4.11 The investigation heard from several community and inpatient teams that there are different therapies for people in the community, but many of these are not the full psychological therapies recommended by NICE (Mind, n.d.; NHS England, n.d.b). In addition, therapies were not always delivered according to trauma-informed principles or adapted appropriately to support people with a mental illness and co-existing neurodivergent condition. Many staff said that the community mental health service offer may not be appropriate to keep people well and in some cases may be more harmful to people if they receive the wrong type of therapy. The investigation was told by NHS England that there is no national focus, (including a requirement to collect data), on access to evidence based care, particularly NICE recommended psychological therapies for people with severe mental illness. NHS England informed the investigation that 'current national data suggests that less than 3% of patients seen by community mental health teams, receive two or more sessions of an evidence based therapy.' As a consequence, the majority of patients are missing out on treatments that could significantly improve their outcomes and reduce hospital admissions.

2.4.12 In January 2025, the NHS England '2025/26 priorities and operational planning guidance' (NHS England, 2025b) was released with the purpose of 'improving access to timely care' while allowing 'greater control and flexibility' in funding and resources at a local level. This guidance reduced the number of national targets from 31 to 18 to give 'focus and clarity' (NHS Confederation, 2025). However, several mental health priorities were removed, including:

- increasing access to adult community mental health and maternal mental health services
- ensuring that people with severe mental illness or a learning disability receive a physical health check
- increasing dementia diagnosis. (Patient Safety Learning, 2025)

2.4.13 In addition to specific community mental health services, staff in community settings also described how “robust” drug and alcohol (D&A) services are vital in ensuring that people’s mental illness does not escalate or deteriorate, and can help prevent a mental health crisis needing inpatient treatment. The investigation heard that many people with a mental illness use D&A services as a means of coping, which may represent a key aspect of their life that they are able to “control”. However, there is significant variation across the country in how D&A services are provided. Staff said that as the services are “mostly voluntary” they are not accountable to patients if they are unable to deliver a service.

2.4.14 A further challenge in the community related to interactions between health and social care, including LA housing. “Simple cases” of discharge from inpatient settings to community settings were described as “challenging enough”; however, for “more complex” discharge cases, such as when a person has been in an out of area placement (OAP), it was heard that challenges significantly increase. For example, a patient from the north west of England was sent to an OAP in the south east of England because there was not a bed locally for them. When they are ready for discharge they may wish or need to be discharged to a new area, because returning to their originating area may be unhelpful or cause a relapse in behaviours leading to deteriorating mental health. In this case the ‘sending’ OAP hospital will be dealing with at least one other inpatient setting, possibly several community health care settings and multiple social care and LA settings. The investigation heard there is significant concern, across staff in community and inpatient mental health care provision, that no one is “aligning” these services across settings and areas of the country, so that people get the appropriate care and support for discharge and transitions between services.

Summary

2.4.15 Challenges in delivering safe and effective community mental health services were seen, impacted by two different discharge scenarios: delayed discharges and/or the pressure to discharge people early. Supporting and enabling improved flow and discharges at the appropriate and safe time for individual patients, would help mitigate the risk associated with community mental health teams supporting more unwell patients because they are waiting for an inpatient bed or are discharged early.

2.4.16 Community services are vital to support people to stay as well as possible and prevent hospital admissions. The investigation heard about challenges relating to mental health commissioning and community therapy provision, but also

variation in voluntary services and local authority and social care delivery across England. The area of community mental health may be the subject of further work by HSSIB.

2.5 Staffing and resourcing

2.5.1 The investigation heard from staff across inpatient and community mental health services about staffing and resource constraints which impacted on their ability to provide safe and therapeutic care. The State of the Provider Sector 2024 survey (NHS Providers, 2024) gave useful insights related to where workforce or wider/systemic factors had a potential impact on the likelihood of patient safety incidents. It reported that 'Over two in five (42%) of respondents were very worried or worried about their trust having the right numbers, quality and mix of staff to deliver high quality healthcare currently' and a majority were concerned about the 'current level of burnout (75%) and morale (78%)' among staff. The report went on to say that 9 in 10 mental health trust leaders were worried about their capacity to meet demand over the next 12 months.

2.5.2 The investigation heard from providers in inpatient settings that wards aimed to staff 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 numbers for staff such as allied health professionals and psychological professionals.

2.5.3 The investigation was told by the Royal College of Nursing that "the mental health nursing workforce in England is experiencing crisis-levels of workforce shortages and retention issues, with staff experiencing high levels of stress and burnout due to increased workload and high demand for services". The investigation considered vacancy rate data as at December 2024 and NHS England (2024) reported that the full-time equivalent (FTE) vacancy rate for mental health nursing had the highest vacancy rate at 16.1%, compared to 6.1% for acute nursing. The Royal College of Nursing told the investigation that "pushing a continuing focus on parity of esteem may help to raise the profile of the crisis for mental health nursing, by highlighting to integrated care systems the importance of including a specific focus on mental health care when approaching workforce planning, forecasting, and resource allocation".

2.5.4 Staff told the investigation that staffing and resourcing in community services could be a challenge. This was not necessarily due to high number of cases, but because of the traumatic nature of the work being undertaken. Staff in crisis resolution and home treatment teams (CRHTTs) said that they were supporting very unwell people in the community and that their teams were at “breaking point”. Many staff become unwell due to the nature of the work, putting additional strain on the remaining staff, and ultimately affecting the support to unwell people in the community. They said that this meant that not all people got the mental health support they needed, resulting in their condition deteriorating which could lead to a hospital admission.

2.5.5 Senior mental health nurses working in the community told the investigation that the “real challenge” was at the acute end of the mental health pathway when people become so unwell that they need inpatient care: “the front door”. They said that there are not enough staff with the right skills to treat people when they are becoming acutely unwell in the community, with the aim of preventing them from needing inpatient treatment. The investigation was told that some staff have moved from acute settings into higher banded roles in the community, but that they did not always have the knowledge, skills, and competence to care for people in a community setting.

2.5.6 The investigation heard that in-reach services from CRHTT and community mental health teams are trying to work more closely with social care providers. They said that this is to support discharge to the community and ongoing management of patients to keep them well. They said that the whole team (including health and social care) needed to function as one to ensure the right support was available at the right time. The whole team includes the voluntary and charitable sector, provision of rehabilitation beds, services supporting transition from hospital to home, and drug and alcohol services.

2.5.7 The Care Quality Commission (CQC) (2019) states that ‘There is no mandated standardised national guidance or approach that providers have to follow for setting nurse staffing levels’. However, NHS England (n.d.c) guidance provides a framework for calculating staffing numbers at a local level. Both the CQC and NHS England guidance are inpatient setting specific and do not apply to community mental health services. The investigation was told that whilst there is no evidence based workforce planning tool for community mental health to support the establishment setting process, the National Quality Board Guidance (2018) provides a process for staffing decisions within community mental health. The investigation was also told that NHS England has commissioned the National Quality Board to undertake

staffing guidelines for inpatient and community mental health settings, including mental health nurses. At the time of writing, the standards and procedures are not yet published.

2.5.8 ‘Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults’ (Health Services Safety Investigations Body, 2024b) found evidence to suggest that patients are more unwell and the range of patients’ needs may have changed in mental health inpatient settings. In addition, it was reported that there may be under-recognition of how physical health needs contributed to acuity. A safety recommendation (R/2024/037) was made that the Shelford Group, which provides and oversees the Mental Health Optimal Staffing Tool, reviews and updates the tool on a regular basis following collection of recent data from mental health inpatient settings.

2.5.9 A report by the National Audit Office (2023) focused specifically on how ambitions had been met to increase access, capacity, workforce and funding for mental health services and recommended that:

‘DHSC and NHSE [the Department of Health and Social Care and NHS England] should publish a longer-term mental health workforce recruitment and retention strategy and a costed plan, that reflects the volume and skills required to meet future service ambitions … The strategy should include how they will work with ICBs on local workforce development, recruitment and retention.’

In response to the National Audit Office recommendations, a detailed response was provided by the Department of Health and Social Care (2024a) in a letter to the Chair of the Public Accounts Committee, which sets out several interventions targeted at the mental health workforce.

Summary

2.5.10 The investigation identified gaps in mental health workforce planning, including in community services, where there is no standardised staffing model. Senior community mental health nurses highlighted the difficulty of supporting patients with mental illness before they reach crisis levels due to a lack of skilled staff. Efforts to improve care co-ordination between crisis teams, social care, and voluntary organisations were noted as necessary for better patient outcomes.

2.5.11 The investigation found that staffing and resource constraints in both inpatient and community mental health services significantly impacted the ability to provide safe and therapeutic care. This mirrors national data; for example, the 2024 NHS Providers survey highlighted widespread concerns, with over half of

respondents worried about having the right staff numbers and skills, and a majority expressing concerns over staff burnout and morale. Mental health staff described challenges caused not only by staffing levels but also the emotionally demanding nature of their work, leading to staff burnout and sickness and further strain on services.

2.6 Digital support for safe and therapeutic care

2.6.1 Each of the HSSIB mental health investigations considered digital factors that influenced the delivery of safe and therapeutic care. ‘Digital’ referred to the use of technology to deliver patient care and the supporting infrastructure and processes. ‘Technology’ referred to the software and hardware used to support care. The following subsections summarise digital and technological themes found across the investigations.

Consistent access to clinical information

2.6.2 Up-to-date and complete clinical information is required to support care continuity and decision making about patient care. The investigations found that clinical information about patients may be stored in different locations, both in electronic and paper formats, and that the right information may not always be accessible at the right time for staff. Challenges with accessing information were seen and heard to contribute to patient harm, both mental and physical.

2.6.3 From a mental health perspective, investigations demonstrated where sharing of information between services during transitions of care had been lost. This degraded patient trust in healthcare processes and meant decisions about care were not always made with full consideration of patients’ needs and wishes. These issues were specifically seen in ‘Mental health inpatient settings: supporting safe care during transition from inpatient children and young people’s mental health services to adult mental health services’. The resulting patient experiences had the potential to re-traumatise young people by repeatedly having to share their histories (Health Services Safety Investigations Body, 2024d).

2.6.4 From a physical health perspective, and in addition to the challenges described in 2.3, difficulties were seen accessing information when patients had received input from physical healthcare teams, both within a mental health hospital and when via a separate acute or primary care provider. Information was not always accessible, or shared, to support co-ordinated care across different providers. In one example a patient was found in cardiac arrest and blood test results available at

another hospital 24 hours before had demonstrated anomalies that were not visible to staff in the mental health hospital (Health Services Safety Investigations Body, 2024b).

2.6.5 During its observations in high-secure settings, the investigation heard about barriers to making referrals to NHS physical healthcare services were also heard (Health Services Safety Investigations Body, 2024b). At one high-secure hospital, physical healthcare staff described how their electronic patient record (EPR) system did not link to wider external NHS systems and so they were unable to use certain functionality, including that for making electronic referrals for physical healthcare. This resulted in a need for “paper referrals” to some specialists which had delayed care.

2.6.6 The investigations’ findings demonstrate issues with the integration of care across multiple providers and with the digital interoperability between different technology systems. This was particularly apparent when multiple providers were required to co-ordinate the physical care of patients. HSSIB has previously suggested that ICBs work with providers to identify patient needs that require input from other providers and agencies, and facilitate cross-provider working arrangements (see ICB/2024/010 – Health Services Safety Investigations Body, 2024b). HSSIB has also launched further work considering patient safety issues related to EPRs with potential consideration of digital interoperability between clinical systems (Health Services Safety Investigations Body, 2025c).

Design of digital systems for care delivery

2.6.7 In several of the mental health hospitals visited, staff described difficulties using EPRs to support patient care. Difficulties included finding information stored in EPRs about patients, frustration with the speed and downtime of EPRs due to old hardware and poor Wi-Fi, and outdated functionality based on superseded guidance. The investigations described how the design of EPRs had contributed to patient harm through not fully supporting decision making. Examples included where a patient was able to go on unescorted leave and where the undertaking of associated risk assessments was based on outdated guidance (Health Services Safety Investigations Body, 2024b).

2.6.8 The investigation heard that the usability and functionality of EPRs in mental health inpatient settings was “poor”, but also that manufacturers of existing EPRs were not developing their products to meet the digital needs of patients and providers. NHS England described that it had developed plans to undertake work to support improvements in the quality of EPRs in mental health settings. However, on

further engagement during the preparation of this report, the investigation was told that the programme had faced challenges due to the limited funding available and the need to prioritise funds elsewhere.

2.6.9 The issues with EPRs in mental health inpatient settings were heard to be under-recognised nationally, with national focus being on digitisation of the acute hospital sector. It was further heard that the lack of parity of esteem is also apparent in the differences between funding allocated to capital projects at national and regional levels (Health Services Safety Investigations Body, 2024b). NHS England told the investigation that a Frontline Digitisation Programme Support Offer existed to support EPR transformation in trusts. NHS England confirmed that all mental health trusts within that Programme had or were implementing an EPR, but that 41 of the 49 trusts had EPRs that did not meet core standards and therefore required transformation work.

2.6.10 Staff described that EPR functionality was often not available or it did not meet their needs and so it was not used (Health Services Safety Investigations Body, 2024b). As an example of absent functionality, the investigation was told about a system where there was no digital support for monitoring food intake and fluid balance (fluid in and out). This contributed to a recognised patient safety risk where patients have been harmed due to malnutrition, dehydration, or increased food intake associated with some medications. A further risk to patient safety was the potential for patients to develop venous thromboembolism (VTE) with subsequent significant harm; there was a lack of EPR functionality to support the assessment of patients' VTE risk.

2.6.11 The HSSIB investigations identified that configuration of EPRs was typically undertaken by the local organisation, with support from product developers. Concerns were shared with the investigation about EPRs being designed and configured without relevant user input to support meeting staff and patient needs. Providers described various factors that influenced their ability to develop their EPRs, including legacy systems that had "grown" without standardisation, workforce issues in digital teams, a lack of capital funding, and an inability to release staff for user testing (Health Services Safety Investigations Body, 2024b). Where providers had 'digital experts', they supported the development of local EPRs to meet the needs of staff, patients and family/carers (Health Services Safety Investigations Body, 2025a).

2.6.12 Local configuration of EPRs has been recognised to potentially contribute to patient safety incidents in other HSSIB investigations. Examples include when sharing critical information in hospital or when patients were being discharged, and

during the integration of electronic prescribing and medicines administration systems into providers (Healthcare Safety Investigation Branch, 2022). Configuration and implementation of EPRs may be considered as part of future HSSIB work in relation to EPRs (Health Services Safety Investigations Body, 2025c).

2.6.13 Investigations also saw where the design of EPRs did not facilitate engagement between patients, families, carers and staff in the use of electronic care plans. Staff described that EPRs did not allow for person-centred safety assessment, care planning with patients and carers, or handover of patient information. This meant patients were not always able to be involved in care planning and therefore were not able to contribute to decisions.

Technology in support of safe and therapeutic care

2.6.14 During the investigations, differing levels of access to patient-facing technology were seen across the providers visited. From a patient perspective, technology included access to televisions, computers and telephones to communicate with family and friends. While the level of access to technology necessarily varied depending on of patients' individual circumstances, when patients were able and allowed to use technology this was not always possible. The investigation saw broken and non-functioning technology, including televisions with poor signal that made them unwatchable and payphones on wards that had been broken for long periods. Patients told the investigations that a lack of access to working technology prevented their connection with the "outside world" and contributed to boredom and frustration. Boredom and frustration in mental health inpatient settings is a recognised problem and may contribute to suicidal ideation, risky behaviours and substance abuse (Marshall et al, 2019).

2.6.15 The lack of access to technology in support of communication, whether it was broken or absent, also meant patients were unable to engage with their families and loved ones. Patients described how limited ability to communicate reduced social opportunities and was not therapeutic. Where patients had been admitted 'out of area' and their families/friends had limited ability to travel to see them, technology for communication was heard to be a "lifeline".

2.6.16 Providers told the investigation that, much like with the challenges faced in improving estates (buildings and physical care environments) (Health Services Safety Investigations Body, 2024b), and the technology for patient care, patient-facing technology was unable to be improved due to a lack of access to funds or

funds being prioritised to address issues with ageing estates and systems that were failing. At some providers, “bids” were seen where the hospital had a charity that provided an alternative source of money to help with small improvements.

2.6.17 Investigations also saw and heard about the use of technology for ‘contactless patient monitoring’ in mental health inpatient settings; depending on the technology, these may be able to monitor information about patients, such as movement and/or some vital signs. Advocates for this technology described evidence that they supported staff to improve safety and provide patient-centred care. They also described how the technology enabled care to be delivered in the most therapeutic way, such as by being able to check the safety of patients at night without waking them. The Care Quality Commission (2025b) have described how observation by staff, particularly at night, is one of the more severe forms of intrusion.

2.6.18 The investigations heard variable views on the benefits and value of these technologies in mental health inpatient settings. Some staff felt they provided a “safeguard” because of the challenges they faced when trying to observe all patients on a ward, particularly when short staffed (Health Services Safety Investigations Body, 2024b). However, others were concerned that the use of the technologies may discourage some staff from actively engaging with patients, which is essential for therapeutic care. From a patient perspective, concerns were heard about privacy and that “being watched” may be traumatising for some patients depending on their histories; in contrast, some patients have reported feeling safer when these technologies were used.

2.6.19 During the investigations, various considerations for implementation of contactless patient monitoring were heard as described below. The investigation was also shown publications to support implementation of specific tools, including ward-level audits to support governance and assurance that technologies are being appropriately used.

- consideration of the role and scope of use of the technology alongside the responsibilities of staff
- engagement with patients to understand their needs and wishes, and an associated consent process
- education of staff, patients, carers and families about its purpose and the privacy of the patient
- consideration of how the data may be accessed and used if an incident occurs

- governance of the technology, including ongoing assurance that it is being used appropriately while ensuring care is patient-centred and therapeutic.

2.6.20 HSSIB did not assess the technology or digital systems used for patient monitoring and it is not HSSIB's role to draw conclusions about specific products for observing and monitoring patients in mental health inpatient settings. Various reports and research provide insights into the use of these technologies from patient safety, privacy and economic value perspectives. While these technologies may have the potential to support improvements in patient care their implementation needs to be carefully considered and managed.

Summary

2.6.21 Interoperable and integrated digital systems have the potential to support improvements in patient safety for physical and mental health. Limited funding available to mental health providers to make improvements in technology and their digital systems was a recurrent issue across the investigations; similar was identified in relation to estates (Health Services Safety Investigations Body, 2024b). The lack of investment impacted on the ability of hospitals to update their digital services and infrastructure. Without appropriate resources, providers will continue to face challenges making digital improvements to mitigate patient safety risks and provide therapeutic care.

HSSIB makes the following safety observation

Safety observation O/2025/073:

National bodies can improve patient safety in mental health inpatient settings in England by supporting provider investment in equipment, digital systems and physical environments to enable conditions within which staff are able to provide, and patients can receive, safe and therapeutic care.

2.7 Suicide risk and safety assessment

2.7.1 The HSSIB (2024a) investigation report 'Mental health inpatient settings: creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning' focused on an ongoing and significant concern related to the continued use of outdated risk assessment tools and scales to predict suicide. The investigation has since considered, across the series of mental health investigations, why such tools

would still be used despite evidence saying they are ineffective. Research indicates that there is often an institutional preference for compliance with strict protocols and tools like risk assessments, despite limited evidence of their effectiveness in preventing adverse events (Menzies, 1960). This over-reliance can reflect a defensive approach where adherence to “doing” (actioning protocols) replaces critical “thinking” and reflective practice around actual patient needs and risks.

2.7.2 The investigation explored why healthcare professionals feel a pull to keep using language and risk assessments associated with high, medium, and low risk. The Royal College of Psychiatrists held webinars to discuss risk assessment; these created spaces for people from diverse backgrounds to discuss the concept.

Conversations about suicide risk

2.7.3 The investigation heard from consultant psychiatrists that there is a desire to make conversations between clinicians and patients about suicide more open and honest, and ultimately therapeutic. One consultant psychiatrist referred to ‘their’ medical school training and stated:

> “I was really frustrated with the way that we were taught to make empathic statements which were being parroted without any actual empathy.”
>
> Consultant psychiatrist insight

2.7.4 People with lived experience told the investigation that they could sense the anxiety and fear, and described a discomfort, when asked about suicide by healthcare professionals.

2.7.5 Staff and people with lived experience talked about the language of suicide and of risk assessment screening questions. People who repeatedly visit mental health services with suicidal thoughts may begin to learn the language healthcare professionals use around suicide risk and get to know the risk assessment screening questions. They may use this knowledge to manipulate the outcome of a risk assessment. A person with lived experience explained it was important for:

> “… professionals to work with them to reduce their risk level, which is about the patient owning their own risk and the healthcare professional having their best interests at heart.”

Person with lived experience insight

Issues with suicide risk categorisation

2.7.6 After the 'Mental health inpatient settings: creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning' investigation (Health Services Safety Investigations Body, 2024a), NHS England (2025d) guidance on 'Staying safe from suicide' was published in April 2025. This guidance makes it clear that categorising patients as low, medium, or high risk is unacceptable because feelings can be very changeable over a short period of time. The guidance is intended to be supplemented by training and quality improvement programmes to support its implementation. The investigation has been advised that this training is currently under development.

2.7.7 A person with lived experience also shared that they knew how to emphasise certain symptoms in order to be taken seriously and be offered a hospital admission. This places patients and staff in very complex decision making positions, described as follows:

> "… you're damned if you do and damned if you don't – if people think that you're too sick then you're going to get detained and your freedom taken away – if people think that you're not sick enough then you're a time waster and you're not deserving of our precious hospital beds, so people learn, I think, to speak the language."
>
> Person with lived experience insight

2.7.8 The investigation was told by staff that sometimes there is an expectation on the patient to reassure them that they can guarantee their own safety, or that they will contact a crisis line if they are feeling suicidal. Staff described this as "falsely reassuring ourselves and treating our own anxiety, and trying to kid ourselves that we can reliably predict that somebody is low, medium, or high risk".

Being with and listening to patients

2.7.9 The importance of "being with" a person and having a conversation rather than completing a checklist was described as important to patients. Patients and people with lived experience also shared that they know a psychiatrist is doing a

checklist in their head and they know when they are being expected to say certain things: “It’s like a game of, you know, psychiatrist bingo.” A doctor referred to a fear of asking difficult questions:

> “I think that as long as we’re scared of the answers that our patients might give us we’re always going to struggle to approach the subject of suicide openly.”
>
> Doctor in training insight

2.7.10 A person with lived experience shared the importance of truly listening and engaging in conversation:

> “… the thing that made the difference was being kind, listening, sitting in the moment holding hope, not trying to change things.”
>
> Person with lived experience insight

2.7.11 As described in ‘Mental health inpatient settings: creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning’ (Health Services Safety Investigations Body, 2024a), the investigation heard examples of patients not being believed. The impact of language such as “you don't really mean that or you’d be dead by now” or “stop saying that, you’ve been saying that for years” was described as trivialising the needs of patients, and in itself creates further harm and despair.

2.7.12 The investigation was told about charities and other spaces run by third sector organisations. For example, the investigation was told about a place where patients have allocated and dedicated time to speak to non-healthcare professionals about their thoughts and feelings. Creating such spaces allows people to have open and honest conversations about suicide where there is not the same anxiety or fear of blame, or need for reassurance, that can happen when such conversations are had with healthcare professionals. The investigation heard examples where people have benefited from that support, time, and kindness.

> “… it is not a science, there isn’t a biological or scientific or some sort of rigorous evidence base behind anything, and all you’re left with is the simplicity of being yourself authentically, simply, kindly, being yourself. It might feel like nothing but it’s actually the most important thing you can do, you can show someone that even if their life doesn’t matter to them, it matters to you caring for them.”
>
> Consultant psychiatrist insight

2.7.13 Staff described how this “fear” affected their work, showing up as defensive practice - that is, ‘ticking all the boxes’ without necessarily putting the patient at the heart of the conversation. The investigation was told that having time to build and foster relationships with patients is very important and was described as being the basis of genuine therapeutic relationships.

> “It’s ‘what you say and how you say it’ which makes a difference to the person on the receiving end … if you can help hold the hope you can offer to help carry the risk, but ultimately it will rest with me, it exists within me and around me. This recognition that someone has the freedom to own their own risk is probably one of the fundamental truths that might shift the way in which people think around this whole area that’s immensely powerful.”
>
> Person with lived experience insight

2.7.14 The investigation considered evidence regarding risk assessment, and how telling a person’s story and background may help people move from making therapeutic care something medicalised to rehumanising the conversations. Methods for teaching and learning about therapeutic relationships was considered very important to changing thinking. This included the importance of healthcare professionals working side by side with people who have lived experience to deliver training, and doing that in a truly co-produced way.

Summary

2.7.15 Language around risk assessment can trivialise patient experiences and instil fear, leading to less honest communication. The HSSIB investigations emphasise the value of open, compassionate conversations that build trust and therapeutic relationships, enabling patients to own their risk while feeling

supported. Co-produced care approaches, and involving people with lived experiences in training, may support the fostering of genuine empathy and connection in clinical practice. Due to the publication of ‘Staying safe from suicide’ national guidance (NHS England, 2025d), no further safety recommendations have been made here.

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4. Appendix: Investigation approach

Stakeholder engagement

This is an overarching report for 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 separate investigations. Stakeholders engaged with are shown in table A and listed below.

Table A Patients and families, providers and regional stakeholders engaged

Patients and families	Inpatient providers/staff	Regional oversight
Patient forums across mental health care providers	Inpatient mental health service providers (NHS and independent sector)	Integrated care boards
Interviews with young people with experience of mental health care	Community adult mental health providers	NHS-led provider collaboratives
Patient and family focus groups across England – arranged via Mind	Interviews with individual staff across England	NHS England regional teams
Targeted focus groups with specific independent charities		Social care teams
Interviews with bereaved families and legal representatives		

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

- Department of Health and Social Care
- Department for Education
- Association of Directors of Children's Services
- National Association for Hospital Education
- Children's Commissioner Office
- NHS England
- service regulators – Care Quality Commission and Ofsted
- royal colleges and professional bodies
- charities
- independent sector – Independent Healthcare Provider Network and independent sector providers.

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

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.

5. Glossary

The terminology in this report has been chosen while acknowledging that there are differing views across organisations and groups.

Accountability (for safety)	The obligation to demonstrate the task achievement and take responsibility for the safety performance in accordance with agreed expectations. Accountability is the obligation to answer for an action (SKYbrary, n.d.a).
ALARP (as low as reasonably practicable)	Generally, risks have to be managed to a level known as ‘as low as reasonably practicable’ or ALARP. This means that the risk must be balanced against the time, cost and difficulty of taking measures to reduce or eliminate the risk (SKYbrary, n.d.b).
Inpatient adult mental health services	General acute (immediate) mental health inpatient services for adults aged 18 to 64 years.
Inpatient children and young people’s mental health services	General acute (immediate) mental health inpatient services in hospital for children and young people up to 18 years. Mental health services for young people up to 25 years provided in residential homes and supported living.
Integrated care boards (ICBs)	ICBs are statutory bodies that carry out several functions that were previously carried out nationally by NHS England. These can include the oversight of patient safety. ICBs facilitate integration between local NHS organisations in their integrated care system.
Integrated care systems (ICSs)	Integrated care systems (ICSs) bring together NHS organisations, local authorities and others for planning services, improving health and reducing inequalities across geographical areas (The King’s Fund, 2022).
Just culture	

	A workplace culture that supports consistent, constructive and fair evaluation of the actions of staff involved in patient safety incident.
Mental health problems (also referred to as mental illness)	Disturbance of a person's mental wellbeing, impairing their ability to function as they would do normally (Mind, 2024).
Outcomes	Results from care and treatments.
Restorative learning	Restorative learning refers to a process that emphasises healing and learning following patient safety events. This approach involves engaging all affected – patients, families, healthcare professionals, and organisations – in a collaborative effort to understand the patient safety event, address the harm caused, and implement changes to prevent future occurrences. By focusing on the human and relational aspects of care, restorative learning aims to repair trust, promote accountability, and foster a culture of continuous improvement.
Restrictive practice/ intervention	Restrictive practice is defined as making someone do something they do not want to do or stopping them from doing something they do want to do, by restricting or restraining them, or depriving them of their liberty (Care Quality Commission, 2023a).
Safety	The framework of organised activities that creates cultures, processes, procedures, behaviours, technologies and environments in healthcare that consistently and sustainably lower risks, reduce the occurrence of an avoidable harm, make an error less likely and reduce its impact when it does occur (International Organization for Standardization, 2023). Activities can include the creation of cultures, processes and procedures, behaviours, technologies, and environments in healthcare (World Health Organization, 2021).
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.
Self-harm	Any behaviour where someone causes harm to themselves; this may be to help cope with difficult thoughts and feelings (Mental Health Foundation, 2022).
Severe mental health problems (also referred to as	Severe mental health problems include psychosis, bipolar disorder, complex emotional needs/'personality disorder' and eating disorders. These diagnoses often occur alongside mood

severe mental illness)	difficulties including depression, anxiety and post-traumatic stress disorder (PTSD) (NHS England, 2024b).
System	The interactions between providers and stakeholders at local, regional and national levels spanning health, social care and education.
Therapeutic care – engagement and relationships	Partnership between staff and patient with shared decision making and recovery-focused goals (Care Quality Commission, 2023b). 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.
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.