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Health professionals' perspectives of safety issues in mental health services: A qualitative study

Abstract

The study aimed to explore mental health professionals' perceptions of patient safety issues across community and inpatient mental health services.

Fourteen mental health professionals across community and inpatient settings participated in qualitative interviews. Framework analysis, guided by the Yorkshire Contributory Factors Framework - Mental Health, was used to analyse the data.

Safety issues identified by mental health professionals mapped on to 19 of the 21 factors in the Yorkshire Contributory Factors Framework - Mental Health. The factors most frequently mentioned by participants were 'safety culture' which focused on raising concerns, learning from incidents and the influence of targets; 'communication systems' to support effective communication between staff; 'service user factors' including a perceived increase in illness acuity; 'service process' including how patients access and interact with services; and 'staff workload' perceived being as unmanageable.

Mental health professionals consider there to be a broad range of safety issues associated with mental health services. Future research should aim to develop interventions to improve safety focused across the factors raised by professionals.

Key words: Health services research, mental health services, patient safety

Introduction

Preventable patient harm is the leading cause of morbidity and mortality internationally (de Vries et al., 2008), and one in twenty patients experience harm while receiving care in medical settings (Panagioti et al., 2019). For nearly two decades, there has been intense research focus on improving the quality and safety of care by reducing harm from medical error in healthcare organisations (Institute of Medicine, 2000; Lamont & Waring, 2015; Wachter, 2010). Patient safety research has mostly been focused in general hospital settings and has resulted in substantial patient safety developments (Pronovost, Miller & Watcher, 2006; Wachter, 2010). For instance, the introduction of incident reporting systems to understand how and why patients have been harmed at an organisational level (Benn et al., 2009; Pham, Girard & Pronovost, 2013). However, patient safety research in primary care and community settings is lagging behind (Cooper et al., 2018). Likewise, there is a lack of research exploring patient safety issues in mental health services, a unique service where care can be delivered across hospital, community and third sector settings (Berzins et al., 2018; Brickell et al., 2008; D'Lima et al., 2017; Thibaut et al., 2019).

UK mental health services have experienced significant pressures and challenges (Care Quality Commission, 2018). There is a high demand for services and it is estimated that 2.1 million adults accessed specialist NHS services in England in 2018/2019 (Baker, 2020). Waiting times to access services are increasing (The King's Fund, 2018), inappropriate out of area placements in mental health services are common (NHS Digital, 2019), and detentions under the Mental Health Act are

rising (Care Quality Commission, 2018; Smith et al., 2017). Mental health services are perceived to be underfunded (Thomas & Forrester-Jones, 2019) and workforce challenges have grown, for example, the numbers of mental health nurses in England has dropped considerably (Care Quality Commission, 2018). In the UK, in 2017 the Care Quality Commission considered over a third of mental health services inadequate in terms of safety (Care Quality Commission, 2018). Yet the perception of safety issues from perspectives of patients, carers and health professionals remains under researched (Berzins et al., 2018; Thibaut et al., 2019; Berzins et al., 2020).

Of the available research about patient safety in mental health services, much has been confined to identifying and managing individual risks to prevent self-harm, suicide and homicide (Appleby, Hunt & Kapur, 2017; Maguire et al., 2018). Some research has taken a broader approach by considering key stakeholder perspectives on safety issues. Researchers in Canada conducted interviews with 19 health professionals and found that further work is needed to identify clear patient safety definitions, priorities, and strategies for responding to patient safety incidents in mental health settings (Brickell & McLean, 2011). An international Delphi study consulting with expert academics identified research priorities for patient safety in mental health including increasing the understanding of physical health adverse events in mental health patients, identifying environmental factors that support a safe environment and further research investigating suicide prevention (Dewa et al., 2018). A recent review by Thibaut et al. (2019) examined patient safety within inpatient mental health settings. They identified ten areas of safety research within their review including: interpersonal violence, coercive interventions, safety culture, harm to self, safety of the physical environment, medication safety, unauthorised leave, clinical decision making, falls and infection prevention and control (Thibaut et al., 2019).

A recent exploratory survey study collected patient, carer and mental health professional views on the current safety issues in UK mental health services (Berzins et al., 2018). Safety concerns identified included staff competence and poor attitudes, shortage of staff, long waiting times and high thresholds for accessing services (Berzins et al., 2018). This current study builds on this research by taking a qualitative approach to generate a richer understanding of health professionals' views of safety issues in mental health care.

Theoretical framework

The Yorkshire Contributory Factors Framework (YCFF) is an evidence-based framework of factors contributing to safety incidents in hospital (Lawton et al, 2012). A systematic review of evidence exploring contributory factors to patient safety incidents was conducted to inform the development of the framework. It may be used to support identification and prevention of factors that contribute to patient safety incidents (Lawton et al, 2012). Adapted from the YCFF, and used in the current study, the Yorkshire Contributory Factors Framework Mental Health (YCFF-MH) identifies factors contributing to patient safety incidents in mental health services (Berzins et al, 2018). The YCFF-MH includes 21 factors such as external policy context, physical environment, management of staff and staffing levels, individual service user and staff factors, service process and social environment. Factors are displayed in concentric circles in the diagram and organised into the

following hierarchical levels: latent external factors, organisational factors, local working conditions and situational factors. Active failures are central to the framework, along with two cross-cutting factors: communication systems and safety culture (See Figure 1.). The findings are interpreted in relation to this theoretical framework.

<<Insert figure 1 here>>

Aim

This study aimed to explore mental health professionals' perceptions of patient safety issues across community and inpatient mental health services.

Methods

Participants and setting

Fourteen mental health professionals working across community and hospital settings participated in a semi-structured interview exploring participants' views about safety issues in mental health services. The interviews took place via the telephone and were conducted by author (KB), a female, PhD, academic researcher with 20 years experience researching mental health care. Participants were all unknown to the researcher at the time of interview.

Procedure

In a previous, linked study mental health professionals, patients and carers completed an exploratory survey (recruited via Twitter) about the safety of mental health services and indicated as part of the survey if they would like to be contacted to take part in an interview (Berzins et al., 2018). Due to the diversity of experiences and richness of data, interviews with patients and carers are reported elsewhere (Berzins et al., 2020). Recruitment via social media enabled the inclusion of professionals with varied experiences working across mental health services and organisations. Qualitative interviews enabled a more in-depth understanding of safety issues and the relevance of the adapted framework. All participants who took part in the survey were invited to participate in an interview using the email address they provided when completing the survey. . Consent forms and information sheets were attached to the invitation email. Those who responded to the invitation to participate in the interview were recruited to the convenience sample. The aim of the study was reiterated prior to the interview and verbal consent was taken and recorded over the telephone. The interview was audio recorded and transcribed.

Interview

A semi-structured interview guide was developed based on the initial analysis of the previous survey study exploring the same topic (Berzins et al., 2018). The survey questions used in this previous study were developed with input from people with lived experience of mental health problems. The interview questions were broad and not linked to the YCFF-MH. Adaptations were made to the guide as interviews progressed so that pertinent topics were raised with subsequent participants.

The interview began by the interviewer (KB) asking the participant for information about their job role and experience in mental health services, before being asked from their own experience about what they felt were safety issues in services and their experiences of raising concerns about safety. The interview questions were open, and were not framed in terms of the YCFF-MH.

Analysis

Data analysis was conducted concurrently with data collection. Framework analysis (Ritchie and Spencer, 1994) was used to analyse interview data using the YCFF-MH as an initial basis to support interpretation, with scope for the addition of further codes. Framework analysis is viewed as a useful approach when multiple researchers are involved in a project, and to generate a descriptive overview from large datasets (Gale et al., 2013). A decision was made to use the YCFF-MH because it is theoretically based and amended from the YCFF using mental health service users', carers' and professionals' perceptions of patient safety priorities (Berzins et al., 2018). The YCFF was developed using primary research in general hospital settings, but it was not possible to develop a mental health specific framework using the same process as primary data were not available (Berzins et al., 2018).

Authors (AA, KB & GL) familiarised themselves with the transcripts prior to coding by reading through each transcript and writing a summary highlighting the key themes and findings. The summary documents were discussed within the team after which detailed coding was conducted for each transcript supported by NVivo (NVivo qualitative data analysis software, 2018). Although a broadly deductive approach was used whereby the coding framework was based on the YCFF-MH, inductive coding was also conducted on transcripts to provide further contextualisation to the factors within YCFF-MH by producing additional sub-codes. Data could be coded onto more than one YCFF-MH factor. The coding framework was discussed by three researchers (AA, KB & GL) during intense analysis meetings (Sheard et al., 2017) and any discrepancies were resolved.

The findings were not sent to participants prior to publication. Interviews covered a wide range of topics; saturation was difficult to judge as it was felt from prior experience that a sample of this number of participants could produce rich data, particularly when an area was underexplored. All researchers were experienced academic researchers educated to PhD level, KB (female) and JB (male) research mental health services, AA and GL (both female) research patient safety.

Results

Thirty-six mental health professionals expressed an interest to take part, fifteen responded and fourteen were interviewed. Participants were based in the UK. Ten females and four males participated. Years of experience ranged from 5 to 32 years with an average of 18 years of experience. Participants were nursing managers (5), registered mental health nurses (3), pharmacists (2), psychologists (2), an occupational therapist, and a social worker.

Interviews lasted between 28 and 82 minutes with a mean length of 55 minutes. The data mapped onto 19 of the 21 factors of the YCFF-MH, which is not unexpected given that the YCFF-MH was adapted from the YCFF which was largely based on evidence from the healthcare professional perspective (Lawton et al., 2012). Those factors not identified in the data were: *design of equipment and supplies* and *equipment and supplies.* The five YCFF-MH factors most frequently mentioned by participants are described below in descending order alongside a definition of each factor (Berzins et al., 2018; Lawton et al., 2012) and illustrative quotes. We present a summary of this information for the remaining fourteen factors in Table 1.

Safety culture

Definition: organisational values, beliefs and practices that support the management of safety and learning from error (Berzins et al., 2018; Lawton et al., 2012).

Discussions related to safety culture centred around three areas: the differing perceptions of safety; raising concerns and learning from incidents; and the influence of targets. Participants described differences in how safety is perceived in hospitals compared with the community. In hospital settings, there was a sense that safety related mostly to the immediate physical safety of patients, for example, a person harming themselves, whereas in the community the concept of safety was viewed as more subtle and related to triggers, such as difficulties with a relationship, and early warning signs, for example, no longer taking medication.

"…They'll [inpatient wards] be thinking of safety in relation to physical damage to yourself. On wards, they do use a lot of that terminology about safety and risk, whereas in the community I think people are probably a bit more subtle on how they talk about things. They'll talk about relapse triggers and early warning signs, but that's probably as medical as it gets."

ID40 Occupational Therapist

There was variation in the recognition of safety concerns in different settings, for instance, safety concerns were more likely to be perceived within wards with higher levels of acuity. The resources available to wards were felt to have an influence on reporting concerns, one participant suggested that patients may be less likely to speak up about safety concern as they may perceive less scope for staff to respond to their concern.

"I think stuff must go on that isn't reported. And I think it probably depends upon the level of security and again the staffing levels. I think it's more likely in high secure that things would be ticked up. But in medium and low secure maybe not so much."

ID53 Social Worker

A number of participants talked about instances when they had raised concerns and reported incidents but had not received a response from services. When incident investigations had been conducted these had often resulted in the same or similar outcome as previous ones. Participants felt that organisations were not learning from incidents, regardless of level of seriousness. The perceived end result of numerous investigations had been new recommendations or amendments

to existing policies that health professionals struggle to recall. Responding to concerns and complaints in an open, transparent manner may encourage health professionals to raise concerns and allow for a culture of learning from incidents.

"It comes down to the culture and being able to demonstrate to people about how the organisation will respond to anybody raising a concern. If that's seen to be dealt with in a very fair, open, transparent way you would like to think that it would reassure folk that actually there's a genuine interest in this from a patient safety perspective and it's about what we can improve rather than seeking to, sort of, blame the individuals at the centre of it."

ID69 Mental Health Service Manager

One participant questioned whether health professionals would continue to report incidents if they receive no meaningful response. There was a perception that health professionals not employed on permanent contracts, such as agency staff, may be unlikely to speak up about safety issues or report incidents because they fear that they will not be booked to work again.

"That's an issue in our organisation, people feeling that there's a, kind of, discrimination, if you're from one profession you get treated differently…where you're using bank and agency staff, that sometimes they feel fearful about speaking out about what they see, because it might affect them being booked."

ID69 Mental Health Service Manager

Interestingly, many participants stated that health professionals encourage patients to raise concerns if they felt unsafe, as this is perceived as a more effective way of receiving a response from the organisation:

"When it's been really risky, it's been because of the various factors which haven't been able to be managed because they've also been short-staffed, so they [staff] always will encourage people to make a complaint."

ID40 Occupational Therapist

Finally, the influence of different metrics and ratings were highlighted. For example, targets were said to be often focussed on achieving positive Care Quality Commission ratings, as opposed to the quality of professionals' interactions with patients.

"We're not measured on what experiences we've given to a patient or how we've looked after a patient during that day. We are measured on purely admin things and therefore that's where people target and I'm guilty of it myself."

ID64 Registered Mental Health Nurse

Communication systems

Definition: the effectiveness of the processes and systems in place for the exchange and sharing of information between staff, patients, groups, departments and services. This included both written (eg. documentation) and verbal (eg. handover) communication systems (Berzins et al., 2018; Lawton et al., 2012).

This factor encompassed a broad range of issues, but discussions around care planning and systems in place to support communication between staff were dominant, and there was a degree of overlap with the factor *support from central functions*.

Patient files and notes were not always readily available to staff in different teams, staff were often described as working in 'silos', depicting difficulty with communication within and external to mental health services. Participant suggested that information governance could often restrict communication:

"… The fact that we are so desperately convinced that we've got to retain these boundaries between GPs, and secondary care, and tertiary care, and, you know, information governance is paramount. Actually, I'm not sure it is. I really do think that if we could sort this out in a different way, and manage access to each other's information, so that we can get some kind of algorithms running, actually, our patients would be very much better off for it."

ID64 Registered Mental Health Nurse

However, participants noted that in some instances particular information (e.g. about traumatic events) was not relevant for all staff to see, even within the same organisation, highlighting potential negative consequence of fully integrated notes:

" So, there's a problem that we have integrated notes and that everybody uses them…so I've got a bit of an issue about what's been written in the notes…maybe this is because of my background, psychologists used to be able to have like process notes which I keep separately anyway, because when people are disclosing really traumatic events. You don't want them to be read by the OT [Occupational Therapist]. Where it is completely irrelevant in the intervention…"

ID59 Psychologist

How care plans were developed and used was viewed as important in terms of safety. Participants suggested that care plans could be improved by not only developing them with patients, using their terminology, but attempting to use them to manage safety according to the patient's preferences. This was not thought to be a feature of current practice:

"…Yeah, it's how you use them [care plans], because I suppose service users might feel, 'I've expressed what is helpful when I become distressed or unwell, this is what we should be trying', but then if we say, 'Oh well, we've spent time making this, but actually because you're sectioned, if it gets to a certain point, then we'll decide and we can restrain you for your safety' and it's, like, 'Oh well, what's the point in me doing it?'..."

ID61 Pharmacist

Participants described instances where a communication system or mechanism that was useful in terms of safety had disappeared over time as practice had changed, with teamwork becoming less prominent:

"We used to have a community meeting every morning and… we'd ask people how they were and what we thought was happening. We were really well trained in group processes and my biggest concern is that we don't have…most of our nurses now are not trained as team players…"

ID54 Mental Health Service Manager

Service user factors

Definition: those features of the patient that make caring for them more difficult and therefore more prone to error. These might include abnormal physiology, language difficulties or clinical symptoms.

Individual service user factors were dominated by the perceived increase in acuity of illness observed by health professionals over recent years. Those admitted to hospital were experiencing serious mental illness, but also more co-morbidity of physical health problems and substance misuse:

"Our service users that come into our beds particularly are sicker. They're sicker from a mental health perspective, but they're sicker from a physical health perspective, they're more acute."

ID77 NHS Manager

This acuity was also present in patients living in the community:

"They're not seen as frequently as they could, I mean we don't have any beds anyway…if somebody is really at crisis, it takes a lot to get an admission nowadays. So, we're managing people at much higher risks in the community than ever before. So, you know, people who are kind of actively suicidal in the community..."

ID45 Psychologist

These seriously ill people could have many risks to their safety, yet health professionals often had no information about their background and needs prior to a crisis admission.

Service process

Definition: includes both gaining access to and discharge from services, for example, not being able to access crisis care or being discharged from hospital before feeling suitably recovered (Berzins et al., 2018; Lawton et al., 2012).

The threshold to qualify to receive treatment from mental health services was perceived as being much higher than previously. Health professionals described long waiting lists to receive treatment and large numbers of seriously unwell people are in the community waiting for treatment. Professionals were encountering patients for the first time when they were acutely

unwell because of the delay in accessing services, limiting the potential for earlier interventions and avoiding crisis situations.

"…Nine times out of ten when they're picking up a case it's a case of somebody who's in an absolute mess, rather than picking somebody up who's in a bit of a mess... So the treatment we then do with them takes so much longer because they've got into such a mess by the time you see them."

ID58 Occupational Therapist

There was a sense that patients who do not speak up about their treatment needs stay on waiting lists for treatment for longer:

"And it means the people who are less risky or the people who are the quietest or the people who you don't hear from or the people who've got no-one to advocate for them wait longer and longer."

ID58 Occupational Therapist

Participants perceived that a higher proportion of people were being detained under the Mental Health Act while in the community and in some cases this may occur as a means of getting the person an inpatient bed:

"I mean, when I started we maybe had about 50/50 detained, informal now I have...the proportion of detained is much much higher, it's very hard to get a bed as an informal patient."

ID64 Registered Mental Health Nurse

Participants perceived that previously health professionals were more likely to know patients and their history, preferences and needs. Service process as it is currently, often meant patients attended services far from where they live and were moved within services, e.g. between wards.

Staff workload

Definition: the level of activity and pressure on time during a shift.

Workload was often perceived to be unmanageable, especially by frontline staff. Nursing staff could often be driven to be task-orientated and feel pressured to complete whatever they had been assigned:

"Nurses 'do', nurses do, we do, we do, we do and we don't push back and if you do push back, yeah, well…but also I think there's a peer pressure that, you know, if the task has been given to you, that you achieve it this shift."

ID54 NHS Manager

Health professionals often described working additional unpaid hours as a result. Unmanageable workloads were perceived as a safety issue that should be routinely recorded as such:

"…The people who are doing unpaid overtime should at least be recording it… as a matter of service safety. I think some people maybe [don't] do that because they think it's their fault…but you've got people who've done this for years who know that they're good at their job but it's just not possible to fit it all in."

ID40 Occupational Therapist

This way of working was seen as contributing to increased risk for patients:

"Yes, I very strongly feel that because you miss things as a professional if you haven't attempted to form a proper supportive relationship with someone…You've not had time to get to know their families, their networks. Then inevitably you miss clues and you miss opportunities. It places people at risk not just of serious incidents happening but also a risk of their quality of life, not being supported in the way that it should be."

ID81 Social Worker

<<Insert table 1 here>>

Discussion

In this study, mental health professionals talked about their perceptions of patient safety issues across community and hospital mental health services. The topics participants discussed were consistent with the majority of YCFF-MH factors suggesting that the YCFF-MH may be a useful theoretical framework to interpret professionals' perceptions of safety issues in mental health settings. This extends a previous survey study by reporting contributory factors in more detail (Berzins et al., 2018). Professionals focused most on issues related to safety culture, communication, service user factors, service process and workload. These findings aligned with the research priorities for patient safety in mental health identified by Dewa et al. (2018), for instance, understanding environmental factors that support safety. This was explored within the social and physical environment factors of the YCFF-MH. These findings also overlap with those from a systematic review by Thibaut et al. (2019) who identified ten research categories in inpatient mental health settings. Two of the categories directly overlapped with factors within the YCFF-MH: safety culture and physical environment. Some of the remaining research categories fell in to broader factors within the YCFF-MH, for instance, interpersonal violence within social environment. We use a broader approach by exploring factors derived from a general care setting (YCFF) (Lawton et al., 2012) and their relevance to mental health (YCFF-MH) that would not necessarily be identified in a review of patient safety in mental health care.

Professionals who worked in the community focused not only on physical safety, but also on more subtle elements of safety, such as, triggers and early warning signs of relapse.
They described the approach to safety in the community as focused less on the medical model. This reflects previous findings on patient's perceptions of safety in the community (Berzins et al., 2020). Although, Coffey et al. (2017) found that risk assessment and care planning in the community is conservative, and patients are often not involved. Previous research revealed that it is difficult

for patients to raise concerns (Berzins et al., 2020), and we have found this is also the case for professionals, particularly temporary (bank/agency) staff who make up a large proportion of the workforce. Where professionals raised concerns and reported incidents they may not receive a response from the organisation. A more transparent procedure for raising concerns was advocated by professionals to encourage a culture of learning. Participants felt quality metrics influenced the organisations attention. As such, some focussed on achieving metrics rather than quality interactions with service users, possibly due to a lack of time and resource and a need to provide the organisation with this target information. Professionals acknowledged that they are driven by targets but that it was vital to have the patient perspective, even though what patients value may be difficult to measure. This is highlighted by Farrelly et al. (2016) who found professionals questioned the clinical appropriateness of patient choices, creating a barrier to shared decision making.

In terms of communication systems, problems remain with some professionals using paper notes and where electronic systems are used, these are often very difficult to navigate. Mental health service notes are often not available to those outside of the trust, for instance in primary care, as they often used a different IT system. There are existing facilities for safety that could be better used, such as, care plans. This is consistent with previous findings that care planning and personalisation is variable across sites (Simpson et al., 2016). More effective sharing of some information relating to safety is required. Although it is acknowledged that not all professionals needed to see all of a patient's information so there is a balance to strike.

There is a resource issue, impacted by understaffing and unsafe staffing affecting safety (Baker, Canvin & Berzins, 2019). A number of previous studies have highlighted that inadequate staffing hinders safety of both service users and staff (Jones & Gregory, 2017; Riahi, Thomson & Duxbury, 2016). A study by McKeown et al. (2018) found that inadequate staffing was linked to the use of restrictive practices, such as physical restraint, because staff are less able to implement alternative interventions. Violence and aggression is associated with substantial economic cost to the healthcare service (Kline & Lewis, 2018; NHS, 2010), and the use of physical restraint to manage it creates serious patient safety concerns (Brophy et al., 2016; Mind, 2013).

The thresholds for intervention across mental health services have got higher affecting safety (Berzins et al., 2018), and detention under the Mental Health Act may be the only way for people to receive inpatient services. The increased acuity of people when they first come into contact with services hampers the ability to collect preferences from patients when they still have capacity (by developing safety plans, care planning, and involving families). A previous study highlighted that patients felt they benefitted from being involved in the development of safety and care plans (Coffey et al., 2017). A higher threshold for contact in to services means that patient histories are less likely to be known, and without knowledge of people's individual context, it can be harder to keep them safe. The heavy workload of professionals' means that they do not know patients and this may further compromise the safety and quality of care.

The YCFF has informed numerous patient safety interventions and provided them with a theoretical underpinning. For instance, the YCFF has been used in practice to support patient safety incident

investigation by providing a framework for questions to ask professionals involved in an incident to gain an in-depth understanding of factors that caused the incident[1].

[1] See: https://www.improvementacademy.org/tools-and-resources/the-yorkshire-contributory-factors-framework.html

The YCFF has also informed a measurement to capture patient perspectives of safety used within an intervention to relay patient feedback to staff for improvements (Lawton et al., 2017). These examples provide an idea of how the YCFF-MH may be used as a tool to support patient safety intervention development in mental health settings.

Factors within the YCFF-MH not commented on by professionals related to equipment and supplies. The safety landscape in mental health services, and indeed in all services, has been radically changed by the COVID-19 pandemic. Personal protective equipment is now a crucial part of ensuring safety in mental health care. Also, using remote consultations to access services may further impact on isolated, or digitally exclude groups.

Relevance for clinical practice

The use of the YCFF-MH to collect and report quality and safety data should be explored by mental health services. The framework could be used to ensure that when safety interventions are being developed, a broad range of contributory factors are examined rather than locating the problem within one domain. The utility of the framework could be enhanced by sub-dividing factors that include numerous aspects of contributory factors. For example, service process encompasses both admission and discharge two very different parts of the service process that could be further nuanced based on the findings of the current study.

Organisations should consider the approach they use to manage professionals' concerns and complaints regarding safety to ensure that processes are open and transparent, professionals feel listened to and that their concerns have been effectively acted upon. An organisational culture of learning from incidents as opposed to an individual blame culture was important. As well as improving processes to encourage professionals to report safety concerns, feedback about patient safety should be actively sought from professionals by the organisation.

Strengths and limitations

A strength of this study was the use of the YCCF-MH as a theoretical framework. Contributory factors identified within each level of the framework were discussed by participants. This highlights that interventions developed around these contributory factors have the potential to improve safety in mental health services.

This was a small-scale, exploratory study producing preliminary findings. The sample included a range of mental health professionals in terms of work setting and length of experience, although there were a lack of psychiatrists, and social media (Twitter) was used to recruit participants. As

such, there may be bias in the sample and the findings may not represent the views of all mental health professionals. There were factors that remained unexplored, and some factors had a small number of codes associated with them. The collection of further data is warranted and could enrich the understanding of these factors. Participants were recruited to take part in the interview after participating in an online survey about safety. It may be those who had negative experiences were more likely to participate, although these people may have more to contribute that those who had not had these experiences.

Implications for future research

It may be useful for future researchers to consider the factors raised by professionals in this study when developing interventions to improve safety. In order to develop effective and acceptable interviews, professionals' views should be considered alongside those of service users, carers, as well as third sector organisations who have insight in to the context within which interventions will be implemented. The YCFF-MH factors not spontaneously mentioned by participants warrant further research. When directly questioned about these factors professionals may have valuable insights.

Conclusion

This study addresses the lack of evidence exploring professionals' perception of safety issues in mental health services. The findings show that mental health professionals consider there to be a broad range of safety issues associated with mental health services. Pertinent safety issues highlighted by professionals included the impact of organisational culture on incident reporting and safety, communication systems hindering care planning and sharing of information, and poor access to treatment and services. These areas of concern may be important to consider when coproducing interventions with professionals, service users and carers to improve safety in mental healthcare.

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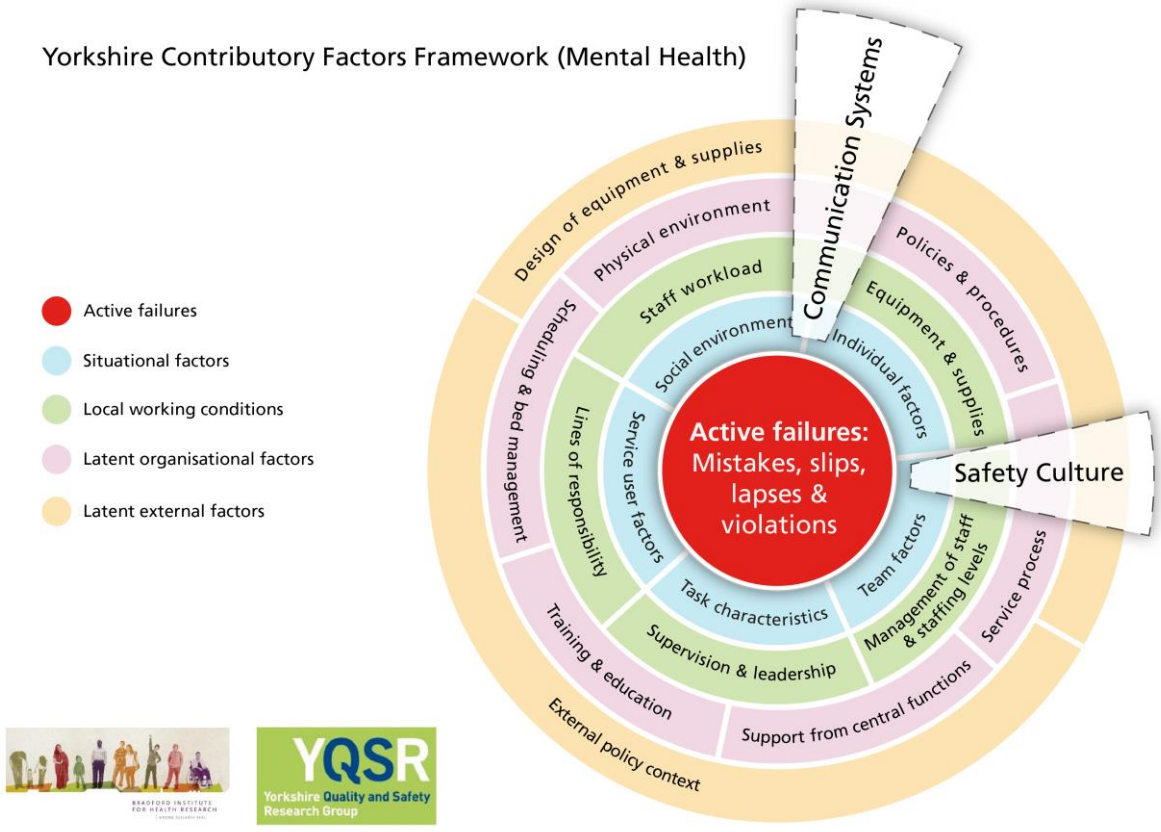

Figure 1. Yorkshire Contributory Factors Framework- Mental Health (Berzins et al., 2020)

Table 1. YCFF-MH factors not featured in main results, with definitions and illustrative excerpts

YCFF-MH factor	Definition	Illustrative excerpts
Individual staff factors	Characteristics of the person delivering care that may contribute in some way to active failures.	*"Well, I think people are stressed and people are not practising to the best of their abilities when they're working under that kind of pressure. People become burnt out. They, kind of, survive."* **ID81 Social Worker**
Management of staff and staffing levels	The appropriate management and allocation of staff to ensure adequate skill mix and staffing levels for the volume of work.	*"…For me it's about having a service...that there's enough people there with the right skills to be able to manage or put in place good management plans to keep the population that we serve as safe as we can."* **ID58 Occupational Therapist**
External policy context	The nationally driven policies and directives that impact on the level and quality of resources available to hospitals.	*"…I suppose, the focus on money, budgets and things and so this keeps coming up all the time in discussions on Twitter and things that the money and budgets keep reducing and then the staffing levels are just going down and, sort of, managing that…"* **ID55 Registered Mental Health Nurse**
Supervision and leadership	The availability and quality of direct and local supervision and leadership.	*"There are an awful lot of senior managers and ward managers, who are in post who are not actually very good at their job. I think that's the first thing, they're not very good at managing their personnel and understanding them and bringing them on. They're more interested in the numbers".* **ID63 Psychologist**
Social environment	Concerns about the social aspects of the service environment, for example, lack of activities and other patients' behaviour.	*"…Nurse-led activities for evenings and weekends, it's about building up rapport, doing stuff with patients that isn't just about their illness, creating activities to stop them getting bored and stuff like that."* **ID64 Registered Mental Health Nurse**
Policies and procedures	Formal and written guidance for the appropriate conduct of work tasks and processes.	*"…These are guidelines, there's this government recommendation, are these the safe staffing levels, as a trust we're not meeting the minimum standard of what would be recognised as safe staffing for our population."* **ID58 Occupational Therapist**

Physical environment	Features of the physical environment that helps or hinders safe practice.	*"…Yes, like rooms where people...you can't hear the person talking next door. Where you don't have people barging in, you know, yes, it's how can you disclose and feel safe if the environment isn't secure?..."* **ID45 Psychologist**
Support from central functions	Availability and adequacy of central services in support the functioning of wards and units.	*"…And you think, I'm going to phone their son. Oh, I've not got his number stored, I'll log in, and it takes ages then you realise it's not even showing the number… To me, that's got to a point where it increased risk to me because I was thinking I'd be able to access information and then not being able to…I've now gone back to assuming that I can only access it at the base."* **ID40 Occupational Therapist**
Training and education	Access to correct, timely and appropriate training.	*"…If you don't know what to do with something, you're already going to react negatively internally because you're thinking, 'I know how to deal with bipolar in the extreme, I don't know how to deal with a personality disorder, this is bad news for me'…"* **ID40 Occupational Therapist**
Lines of responsibility	Existence of clear lines of responsibility clarifying accountability of staff members and delineating the job role.	*"…Because they're not recognising they've got to be accountable, and they've got to come up with a plan for how to manage that. I think it's because they are junior and they are inexperienced, even though they're a band seven or eight. And therefore, they don't have the clinical skill set to know what to do with that and take it on…"* **ID61 Pharmacist**
Team factors	Any factor related to the working of different health professionals within a group which they may be able to change to improve patient safety.	*"…When they [teams] don't function, it becomes very siloed…so medics do this, nurses do this, OTs do this, social workers, if you have the luxury of having one, do this…"* **ID54 NHS Manager**
Task characteristics	Factors related to specific patient related tasks which may make individuals vulnerable to error.	*"…If you've got staffing which is changing all the time and you've got agency staff who maybe don't know the patients very well, I just think there's real risks around just not having the information to hand in an accessible way…"* **ID53 Social Work Manager**

Active failures	Any failure in performance or behaviour (e.g. error, mistake, violation) of the person at the 'sharp-end' (the health professional)	*"I had a girl who had absconded once, wearing [removed] Hospital sheets…She went out onto Manchester Parkway and tried to catch a bus and the bus driver shut the doors and said to the whole of the other people in the bus, sorry, I've just got to go for a detour, I'm taking her back to [removed] Hospital"* **ID54 NHS Manager**
Scheduling and bed management	Adequate scheduling to manage patient throughput minimising delays and excessive workload.	*"You have people who are just recovering, just getting better, and you've moved them to sleep over somewhere else and then they break down again".* **ID64 Registered Mental Health Nurse**