WHAT IS THE ISSUE? Safety is important in healthcare. Safety incidents, e.g. a patient falling or mistakes with medication, can happen in any healthcare setting. On mental health hospital wards these safety incidents can also include violence or people harming themselves. Safety incidents can cause physical and psychological harm to patients and staff. They also cost the NHS money. Patients and staff, families, the Care Quality Commission, and the NHS are all worried about ward safety. We know that hospital staff play an important role in keeping people safe. We also know that wards can be less safe when staff become stressed. Staff have different characteristics such as their age, gender and qualifications. We do not know enough about how the characteristics of staff and teams might affect safety on mental health wards.

WHAT DO WE WANT TO DO? We want to find out how the type and number of staff on mental health wards might affect safety incidents. Doing this could improve safety for everyone.

HOW ARE WE GOING TO DO IT? Our project has three phases. Each phase uses different methods. 1. We will look for the published evidence about safety incidents on mental health wards including characteristics of staff and teams. This will help us understand how staff issues may increase or decrease safety incidents on a ward. 2. We will look at hospital records from 50 adult acute mental health wards to find links between the type and number of staff on wards and safety incidents. Next, we will take a close look at five wards. We will choose two that often have safety incidents, two that rarely have safety incidents and one in the middle. On these 5 wards we will ask staff and patients to fill in questionnaires and we will interview some staff and patients. We want to ask staff and patients why they think some wards have many incidents and some have few incidents. 3. When we have gathered all the information, we will suggest changes that we think will improve safety on mental health wards.

HOW HAVE WE INVOLVED SERVICE USERS? Service users have helped us to write this description of our research project. This project came out of discussions with patients and ward staff, and our own experience as mental health patients and/or clinicians. The research team includes a senior expert by experience and co-production specialist. We will recruit a Lived Experience Advisory Group of service users. We will ask the group for help with planning and delivering the research. We will also ask ward staff for advice.

HOW WILL WE SHARE OUR FINDINGS? This research will tell us how best to plan staff teams to make wards safer. We will share what we find out with patients, mental health staff, people who organise and check mental health services, policy makers and researchers. We will do this by writing reports, talking with people at meetings and conferences and online, and making a poster and an infographic. We will also create teaching and learning resources for ward managers and staff. We believe that this research can help to improve safety and well-being for patients and staff on acute mental health wards and other places such as prisons and care homes.