Assessment of mental health services in acute trusts programme

How are people's mental health needs met in acute hospitals, and how can this be improved?

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Foreword

Physical and mental health care have traditionally been delivered separately. While investment and improvements in mental health services are welcome, physical and mental health services will only truly be equal when we stop viewing physical and mental health as distinct. Services need to be built around all of people's needs and not determined by professional or interest groups.

There is increasing recognition of the importance of integrating services across health and social care. However, this report describes how we frequently still find poor integration between physical and mental health care and how, as a result, people receive poor or disjointed care.

As we raised in our report *The state of health and social care in England 2018/19*, access to mental health care is a particular concern. Often it is the people in most need of urgent mental health care that are not able to access the right care, when they need it, and who then end up in an acute emergency care department. This is often not the most appropriate place for them to be cared for.

Many of the people attending acute hospital emergency departments with physical health needs may also have mental health needs. These people are in a vulnerable position and need to be treated with compassion and dignity. This must be in a way that makes them feel safe and upholds their human rights. In our report, we raise concerns that people with mental health needs are not always receiving this level of care. How well they are treated in an emergency department, or elsewhere in an acute hospital, is often linked to the importance that mental health care is given by the trust board. Acute trusts must do more, but they also need support from mental health trusts to develop better and more integrated approaches to care.

While this report looks at what we found in NHS acute hospitals before the coronavirus (COVID-19) pandemic reached the UK, our findings remain relevant. The issues raised in our report are part of a wider system issue. Commissioners, providers and local authorities all have a role in making sure that people have access to the right services at the right time, and that people's needs are holistically assessed.

Integration of mental and physical health care is not just a matter for acute trusts. When people are admitted to hospital to receive mental health treatment, they need to be reassured that their physical health needs will also be met. As highlighted in our report *Monitoring the Mental Health Act 2018/19*, we are concerned that some people are not getting access to physical health care while in hospital to receive mental health care. This is an area of concern that we will be reviewing in the near future.

Professor Ted Baker

Chief Inspector of Hospitals

Lucy's story

I have had severe mental illness for over 20 years, involving a nine-year inpatient stay and several shorter inpatient stays since then. I have often gone to emergency departments when I'm in crisis and have required surgery for my self-harm injuries.

My experiences in emergency departments have often made my physical and mental health worse. Being acutely psychotic and in pain is hard enough, but the environment of 'safe rooms' in emergency departments often makes this harder. I'm left to sleep on the floor – sometimes for days on end – while waiting for a mental health bed. Often, I don't have access to proper food, aside from sandwiches (which I can't eat as I need a gluten-free diet). My antidepressant medication is stopped suddenly; it's taken away from me when I arrive, and the emergency department don't stock it. This leads to horrendous withdrawal symptoms including nausea, vomiting, tremors, anxiety – and a worsening of my psychotic state.

The attitude of staff at times, too, is hard to deal with. My sense of fear and isolation is made worse by hearing comments such as, "Oh, she's one of those", or even "You'd be better off dead."

There are a few heroes working hard to try and improve the acute hospital experience for patients like me, but often they're a lone voice in a system that doesn't see mental health as a priority. I'm forever grateful to those staff members who have gone above and beyond the call of duty – often in small ways – to make my hospital stays better; those who have negotiated with the hospital kitchens, sometimes late at night so I can get proper food to eat; the medical consultants who have re-started my psychiatric medication, the nurse who hunted for a magazine for me to read while I was waiting in the 'safe room'. Kindness, food, treatment of my pain, and provision of a therapeutic environment make such a huge difference when I'm distressed.

Summary

CQC is committed to making sure that people receive the same high-quality care for their mental health as for their physical health.

Between September 2017 and March 2019, we looked at how well the mental health needs of patients in NHS acute hospitals were being met. Mental health inspectors provided specialist support on 105 acute inspections. They looked at services across acute trusts, including emergency departments, acute medical wards, maternity wards, and children and young people's services.

What we found

Staff we spoke with were generally caring and working very hard in challenging circumstances. However, too often it was the system in which they were working that limited their ability to provide the best possible mental health care to their patients.

People faced barriers in accessing help at a time of crisis

A lack of availability of 24/7 community crisis services meant that patients were often left with no other option than to attend the emergency department. Once in hospital, we found that there was poor coordination and joint working between acute and mental health services, with delays in assessments and securing beds. These delays were made worse by the lack of availability of mental health beds.

Acute trust boards did not always see mental health care as part of the overall provision of care

In acute hospitals, we found that there was often a lack of oversight at board level of the provision of the mental health component of care for patients. Staff were often unclear what the arrangements were for providing specialist assessments – for example, whether they could access a formal psychiatry opinion out of office hours (9am to 5pm). As a result, we found evidence of people waiting for long periods for an assessment.

In emergency departments, patients were not always provided with a safe, therapeutic environment

Every emergency department in acute hospitals should have a dedicated room that is equipped to provide a safe and private environment for psychiatric assessments. This is particularly important for patients whose mental health problems put them at a high risk of harm towards themselves or others. Psychiatric Liaison Accreditation Network (PLAN) standards suggest that these rooms should be free of ligature risks, with a viewing pane, weighted furniture, and an alarm strip or call bell running around the perimeter of the room. However, the safe rooms we saw did not always meet these standards. Even when there was an acceptable safe room available, we found that there were difficulties in keeping all patients safe. We also found that people in crisis were not given information about when they would be seen, or how long they would have to wait for an assessment or admission to hospital.

Acute trusts need to improve staff education and governance of the Mental Health Act

Staff in acute hospitals were often not clear about the legal process for detaining someone in hospital. When they were detaining a person under the Mental Health Act 1983 (MHA), staff were often unclear about roles and responsibilities between acute and mental health trusts. More generally, staff in acute hospitals lacked knowledge about the MHA and how it worked. We also found that there was confusion around the MHA and Mental Capacity Act 2005 (MCA) and when to use which piece of legislation and associated guidance.

Staff feel unsupported and unprepared to meet the mental health needs of their patients

We found that mental health training for staff varied across the acute hospital trusts. Where training was provided, this was often limited to mandatory e-learning that focused on legislation including the MCA and Deprivation of Liberty Safeguards (DoLS), but not the MHA.

Steps to improving practice

System-wide changes:

1. Local authorities, commissioning groups and integrated care providers need to work together to improve cross-sector planning and commissioning, to ensure that all patients have access to the physical, mental and social care they need.
2. Improving system-wide pathways of mental health care requires improved aligned coding and sharing of data.
3. Acute trusts should ensure that service-level agreements (SLAs) are in place with the appropriate organisations to ensure that healthcare records and sharing of information between clinicians is effortless.
4. Commissioners need to ensure that people experiencing a mental health crisis are able to access meaningful alternatives to the emergency department.

Trust-level changes:

5. All acute trusts need to have a mental health strategy.
6. Mental health care should be considered frequently by the boards of acute trusts.
7. Mental health services in acute trusts should meet nationally recognised quality standards.
8. In emergency departments patients held in safe rooms must be provided with essential food, drink, medicines, and communication with friends and family.
9. Acute trusts should have clear governance processes for administering and monitoring the Mental Health Act 1983, which may be done in conjunction with a mental health trust.

Supporting staff; the role of acute trusts, education providers and Royal Colleges:

10. Training should be provided that gives staff the necessary knowledge, skills and confidence for meeting people's mental health needs.

11. Better mental health care for patients should be provided alongside better support for staff wellbeing.

What CQC will do:

12. We will continue to carry out our regulatory work and ensure we take appropriate enforcement action to help keep people safe and safeguard their human rights. We will also continue to encourage services to improve.

Introduction

In 2011, the coalition government published its mental health strategy *No health without mental health*. This set out the government's plans for improving the mental health and wellbeing of the population. The strategy also described its ambition for delivering high-quality services that were accessible to all.[1] The principle of 'parity of esteem', where mental health is given equal priority to physical health, was then enshrined into law through the Health and Social Care Act 2012.

Since then, the government has increased funding for mental health services, as well as made policy developments, such as the *Five Year Forward View for Mental Health* and the *NHS Long Term Plan*.[2,3]

As an organisation, CQC is committed to making sure that people receive high-quality care for both their physical and mental health care needs across health and social care. In June 2017, following feedback from our consultation on the next phase of regulation, we introduced a new key line of enquiry (KLOE) that looks specifically at whether people's physical, mental health and social needs are holistically assessed.[a] As part of this KLOE, we also look at whether their care, treatment and support are provided in line with legislation, standards and evidence-based guidance.

Between September 2017 and March 2019, mental health inspectors provided specialist support on 105 acute inspections to look at how well the mental health care needs of patients were being met across the trusts in emergency departments, acute medical wards, maternity wards, and children and young people's services.

This report looks at the findings from these inspections and identifies areas where acute trusts, and the wider system, need to improve in order to meet the mental health needs of patients.

While this report was written before the coronavirus (COVID-19) pandemic reached the UK, the findings of our report remain relevant. In some cases, concerns raised in our report may have been made worse by restrictions introduced as a result of the pandemic. Conversely, some changes to practice during the pandemic have improved how patients with mental health needs are cared for in acute settings. As health and care services reassess how to provide services in line with new restrictions, this must include a review of how services work together to appropriately and compassionately care for people with mental health needs.

How did we carry out this work?

To understand more clearly how the mental health needs of patients in acute trusts were being met, we carried out:

- a detailed qualitative analysis from 45 inspections carried out between September 2017 and March 2019

[a] We are using 'mental health needs' in its broadest context to include people of all ages who: go to an acute hospital because of their mental health problem; have a physical health condition along with a known mental disorder; have developed mental health conditions secondary to physical ill-health; have a learning disability and/or are autistic; have dementia or have developed delirium.

- interviews with providers where best practice was being adopted
- a review of the literature and policy reports in this area.

We also held a co-production event with professional bodies, providers of NHS healthcare, policy makers, and Experts by Experience, where we tested the themes emerging from our reports and developed steps to improving practice. In addition, we spoke with some patients and professionals individually about their personal or professional experiences.

What we found

People faced barriers in accessing help at a time of crisis

In our 2018/19 State of Care report we highlighted that, despite policy drives to improve mental health care in the community, some people were still not able to access the care they need when they needed it.[4]

Availability of crisis care in the community

Staff and patients we spoke with told us that they wanted better access to community services, including crisis and home treatment teams and crisis cafés. However, these services are typically open between 9am and 5pm only. We have previously identified the need for better 24-hour support for people having a crisis, particularly between 11pm and 5am. The absence of this can lead to people seeking help from other services, including emergency departments.[5]

We found that doctors and nurses in emergency departments were generally good at recognising patients with mental health needs. In these cases, they used triage questions focusing on self-harm, suicidal intent and mental state. However, they did not always know about the availability of crisis services, and/or were unaware of how to contact these services and what the opening times were. It is vital that both patients and healthcare professionals have easy access to information about alternatives to emergency departments.

For example, Surrey and Bradford have crisis cafés and community wellbeing centres.[6,7] These are run by qualified mental health professionals, in conjunction with peer support workers and offer a drop-in service providing support and signposting to other services, where required. Although these community services are not right for everyone experiencing a mental health crisis, they can help to reduce admissions to both acute and mental health services. In many cases, patients find them a more helpful, therapeutic environment than emergency departments.[8,9]

Some councils have already started providing residents with information about third sector provided community mental health and wellbeing services. CQC encourages other councils and community services to support such initiatives. Healthcare professionals and patients at our co-production event also felt that, in each area, NHS 111 should develop and hold an up-to-date directory of local mental health crisis response and treatment services to enable them to advise patients around the clock.

At the time our inspections were carried out, NHS 111, which is commissioned by local clinical commissioning groups (CCGs), only held a directory of services for physical health services in each area.[10,11] The availability of a comparable directory for mental health and substance misuse services varied hugely across the country. The lack of readily available information left patients unsure of alternatives to emergency departments when in crisis, and hindered the ability of staff in emergency departments and liaison teams to signpost patients to sources of support in the community.

However, as of May 2020, all areas in England now have a 24/7, open access mental health crisis line for all ages. These public facing local helpline numbers are

available on the ‘where to get urgent help for mental health’ page of the new service finder on the NHS website.

Where NHS 111 services are well integrated into community mental health services, the benefits are clear. For example, a 111 first response for mental health scheme in Cambridge and Peterborough reduced visits by patients with mental health needs to the emergency department by nearly one third, easing winter pressures and saving £4.7 million.[12]

Co-ordination of physical and mental health care services

Approximately 80% of patients attending the emergency department with mental health needs also have physical health needs.[13] Our Experts by Experience told us that assessment by a psychiatry team was often delayed because of needing to be ‘medically cleared’ (deemed medically fit) for interview. Many patients also had to wait a long time to be assessed by a member of a psychiatry team because there was no one available. In its *Report of the 4th Survey of Liaison Psychiatry in England*, NHS England reported that 33% of hospitals had 24-hour psychiatry cover.[14]

Effective psychiatry services should make sure that people with mental health needs receive high-quality care while in physical health care settings. They typically offer assessment and treatment for patients across emergency departments. They may also provide a service to inpatient wards and outpatients. However, in 2017 a report by the National Confidential Enquiry into Patient Outcome and Death found that, “only half of those patients who would have benefited from a referral to liaison psychiatry received one from the emergency department.”[15]

Access to these services is complicated by the fact that in some acute trusts the psychiatry services are provided by more than one mental health trust. In these cases, the mental health trust will often decide if they will review the patient depending on whether the patient normally lives in the postcode areas they serve. This can mean that emergency department staff are unsure which psychiatry team to call.

Services for children and young people were less comprehensive than adult services, and were often subject to restrictions that acted as a barrier to care. In some areas child and adolescent mental health services (CAMHS) provided services only for patients up to the age of 16. This meant that 17 and 18-year-olds were at risk of falling through the gap between paediatric and adult mental health services.

At other sites, the mental health team for children and young people would not review children in emergency departments. This meant that staff had to find an acute NHS inpatient bed for the child to be admitted to so that a psychiatric assessment could be carried out.

A lack of integrated computer systems between acute and mental health trusts also caused problems, for example with emergency department staff unable to access the written assessment of the psychiatry team. In other cases, the psychiatry team were unable to see details of the patient’s medical history, or the medicines that had been prescribed by emergency department staff.

However, we have heard examples of good practice at some NHS trusts to improve joint working between acute and mental health services. This included, for example,

the treating doctor in the emergency department and psychiatric team carrying out 'parallel assessments'. This ensured patients received timely care, and that any physical health needs did not delay access to support for their mental health.

Staff told us that where patients needed to be admitted to an inpatient psychiatry ward they were frustrated by the number of phone calls they had to make to secure a bed. In some cases, the lack of continuity of care and complexities in communication between commissioners, local authorities, acute and mental health partners left patients and relatives experiencing a sense that no-one was prepared to take responsibility for their care. Where there were no agreed ways of working, this had an impact on the quality of care patients received. This included, for example, patients being held in the emergency department for many hours before a bed was available.

Availability of mental health beds

As highlighted in State of Care 2018/19, unavailability of a mental health bed, is one of the most common reasons for patients waiting longer than 12 hours from the decision to admit them to actually being admitted to an inpatient bed.[16] At one hospital, the incident list for the emergency department showed that in the previous 12 months, 24 patients waited more than five hours for a bed, 15 of whom waited more than 12 hours. We have written to NHS England to alert them to this finding and other areas of concern.[17]

Under section 140 of the Mental Health Act 1983 (MHA), clinical commissioning groups (CCGs) should work with local authorities to make sure that patients who need urgent care and need to be admitted have timely access to a bed close to home. In our report on how the MHA Code of Practice is being used, we raised concerns about how local authorities were discharging their responsibilities. Our report recommended that:

> *"Local areas, including commissioners, local authorities, police and providers, should work together better to make sure that people receive the right care across organisations, including making sure that people in need of urgent care have timely access to a bed that is close to home, in line with the expectation of section 140 of the MHA."*[18]

Social workers, healthcare professionals and patients at our co-production event told us that CCGs need to take their legal duties to provide access to mental health care more seriously. Where CCGs have merged, for example across integrated care systems, there should be clear lines of accountability to make sure that section 140 of the MHA is adhered to, and that patients in need of inpatient mental health care can be admitted to a local bed.

Examples of effective initiatives

Accessible alternatives to emergency departments: one patient's experience of a crisis café

Louise, 24, talks about her experience of using crisis cafés in her local area of Birmingham.

The mental health trust I'm under, Birmingham and Solihull Mental Health NHS Foundation Trust, is piloting a crisis café some evenings in the week to try to divert people in acute psychiatric crisis from the emergency department. This is run with the support of the charity Mind using one of their wellbeing hubs. There is a mixture of qualified staff (a doctor, nurse, occupational therapist, social worker), together with peer support workers and Mind volunteers.

Police who attend to people who are mentally unwell can bring them to the crisis café rather than A&E. It's a shorter length of time to see qualified staff than in A&E and a quieter, more comfortable waiting area with a small selection of drinks on offer. If the qualified staff have concerns about someone they can either refer them directly to home treatment (without having to get an appointment at the community mental health team, especially if the patient has come from a GP and is not already under secondary services), send to the psychiatric decisions unit or place of safety at the Oleaster Hospital, or be sectioned there if things are that severe.

I personally find it helpful; the wait is shorter and the chairs are more comfortable (I have chronic pain problems and hours on metal chairs in A&E just makes that worse). The layout of the Mind hub at Beechcroft is also much better. I have autism, as well as my mental health conditions, and find A&E waiting rooms a total sensory and social overload. At the crisis café I can sit by myself in a quiet area, near the waiting room, so I have reduced sensory input but am still visible to staff.

Currently the crisis café is only open three evenings a week until 10.30pm. I don't know if they'll continue it after the end of the pilot scheme, but I hope they do. It's much better for me to go there and know that I can talk to someone and get the help I need straight away.

Working together across sectors: 'Big Room' and high intensity user projects

Staff from the emergency department at Imperial College Healthcare NHS Trust hold a weekly 'Big Room' meeting to discuss emergency mental health pathways with representatives of medical and nursing staff from the acute trust, psychiatric liaison teams, registered mental health nurses, security, police, paramedics and a social prescriber. Held at lunchtime, the meeting gives staff the chance to discuss new policies, and progress in quality improvement projects.

The meetings begin with one or two patient stories – to make sure that patients are at the heart of discussions – and operate on a 'flat hierarchy' basis. This encourages everyone to contribute to the discussion, whatever their level of seniority. The introduction of these meetings has improved collaboration with other local partners in the emergency care pathway, as well as introducing a programme of quality improvement projects.

One such project has focused on improving care for people who have attended the emergency department more than six times in six months (high intensity users). These patients are often of low socio-economic status and have multiple medical, psychiatric and social disorders.

Working with West London NHS Trust, staff at Imperial carry out a home team visit, where appropriate, to understand the health and social care reasons that have led to the person going to the emergency department. The home visit is carried out by an emergency department consultant, liaison psychiatry consultant and a social

prescriber, who then develop a care plan for the individual. Up to six one-to-one visits were provided for each patient on the frequent attender programme.

In a group of 30 patients supported through the frequent attender programme, the total number of attendances to the emergency department reduced from 482 to 375 in the seven months pre and post-intervention – a 22% reduction. Furthermore, when these patients do go to the hospital, the development of tailored care plans makes sure that they are not subject to unnecessary investigations when seen out of normal working hours by staff who may be unfamiliar with their psychosocial and health background.

Establishing a separate mental health ambulatory unit

We recently published a support tool for emergency department clinicians and includes practical solutions to support good, efficient and safe patient care. The following example is taken from that tool.

Patients presenting to the emergency department, and then referred to the mental health liaison team, all received a rapid initial contact. If the patient was medically suitable, they were transferred to a separate area within the psychiatric unit. This was on the same site but in a different building. The mental health liaison team approved the transfer. Thus they avoided acutely unwell patients being transferred there. This provided an area where the lower risk mental health patients were able to wait. The area was a less crowded and calmer environment. It was staffed by mental health support workers. Patients who needed psychiatric admission did not wait long within the emergency department. The teams involved felt this improving flow, patient experience and patient safety. Patients were more closely observed. And they were less likely to abscond before their full assessment.

Cross-sector planning and commissioning: The pan-London compact implementation group (CIG)

The pan-London compact agreement between London's mental health and acute NHS trusts, local authorities, clinical commissioning groups, NHS England and NHS Improvement, London Ambulance Service and police services, was published in June 2019.[19] This aims to improve access to mental health inpatient services in London by specifying minimum service standards and key stages along the patient pathway, with clear lines of responsibility and escalation processes. It also details the reporting requirements needed to ensure up-to-date information on bed capacity and service pressures.

The work of the CIG has greatly improved understanding of the level and nature of hospital attendances by patients experiencing mental health crisis, and the resulting innovative partnership services have led to a safer, more efficient and improved experience for patients. In August 2019, the 27 London acute emergency departments carried out an audit of people going to the emergency department. This found that 72% of attendances were outside working hours (9am to 5pm), with a high proportion of people living alone and with problems that included self-harm, suicide attempts, depression and alcohol misuse.

Work between the CIG, mental health trusts and the London Ambulance Service has enabled the deployment of Mental Health Joint Response Cars, with a specialist crew (paramedic and registered mental health nurse) attending relevant 999 and 111 calls to see and treat more patients on site and reduce people being taken to emergency departments. Mental health nurses have also been working in clinical hubs, supporting calls to 111 and 999 by providing specialist advice and support to ambulance crews, and patients over the telephone.

Collaborative working across services has enabled examples of good practice, such as these, to be shared and introduced in other centres, leading to a rolling programme of quality improvement.

Acute trust boards did not always see mental health care as an integral part of patient care

Leaders in acute trusts play a key role in monitoring how well their services meet people's mental health needs. As part of our well-led inspections, we look at whether trust leaders have a clear vision and strategy that aims to deliver high-quality care for all patients, including people with mental health needs. Having a specific mental health strategy can help the integration of physical and mental health services.

Strategies for improving the provision of mental health care in acute trusts needs to extend beyond crisis care in the emergency department. A good strategy will recognise the need to integrate mental health care into acute inpatient wards and outpatient clinics.

Figures from the Liaison Psychiatry Survey of England suggest that of the acute trusts that have psychiatric liaison services linked to emergency departments, around one-third also have some psychiatry or psychology provision linked to other acute services, such as in diabetes, stroke care or oncology.[20] However, the provision of these additional services is patchy. Without a clear board-level commitment to integrated physical and mental health care across all services, the sustainability and impact of such initiatives is easily lost.

Where trusts recognised the importance of mental health care as an integral part of care there were clear action plans with named clinical leads. Trusts such as King's College Hospital in London, Oxford University Hospitals, Guy's and St Thomas' in London (see 'examples of effective initiatives') have made mental health a topic discussed at board level. Where psychiatry is provided by a mental health trust there is sharing of data on coding, admissions and activity between trusts. Where psychiatry is provided 'in house' by the acute trust, as in Oxford, mental health is an integral part of board discussions about a wide range of clinical topics. These initiatives have helped to achieve integrated care and parity of esteem for patients' mental and physical health care needs.[21,22]

The sharing of patient stories, such as at King's College Hospital's mental health board meetings, is a powerful way to focus attention on this area. Our Experts by Experience also suggested that acute trusts could benefit from developing patient participation groups, to hear more of the voice of those using their service and to co-produce quality improvement projects.

While some acute trusts commission and fund their own psychiatry service, most use service level agreements (SLAs) to commission services from mental health trusts,

so that there is an agreed level of service provision. Boards have a key role in making sure that these SLAs meet the needs of their local populations so that people receive the right care and support in a timely way.

However, in some trusts there was no in-house provision and also no clear SLA between the acute trust and the mental health trust. This meant that staff were sometimes unclear whether they could access a formal psychiatry opinion out of hours (9am to 5pm). In other cases, patients waited for long periods in the emergency department for an assessment. At one district general hospital we visited there was no board oversight for mental health care, and the SLA extended only to psychiatry cover for the emergency department, not inpatient wards. This unsatisfactory situation is unlikely to be an isolated one. The most recent figures from the *Report of the 4th Survey of Liaison Psychiatry in England* show that 110 out of 175 liaison psychiatry services provide a service only to emergency departments and emergency admissions, and 117 out of 175 do not have a 24/7 service.[b]

Examples of effective initiatives

King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust

South London and Maudsley NHS Foundation Trust provides psychiatric liaison services to King's College Hospital NHS Foundation Trust. The trusts have a service level agreement that sets out the details of service level cover.

Each month the trusts hold a joint mental health board meeting with representatives from the security team, safeguarding, emergency department, physicians, occupational health, commissioning, and patient representatives. This board reviews statistics on admissions, discharges, reviews by the liaison psychiatry team, waiting times, patient flow, and use of the Mental Health Act. In addition, it discusses joint commissioning arrangements as well as initiatives to improve the wellbeing and mental health of staff.

Support and leadership provided by the joint mental health board has improved the integration of mental health care into the acute trust in a number of practical ways, including the development of a new alcohol care team, securing sustainable funding for integrated care models, mental health training for staff, and development of joint policies, for example for rapid tranquilisation.

Oxford University Hospitals NHS Foundation Trust

Oxford University Hospitals NHS Foundation Trust views mental health care as integral to the delivery of physical health care. It is committed to making sure that all its patients receive care for their emotional health and wellbeing regardless of whether they have a formal mental illness diagnosis.

The Psychological Medicine directorate at the trust provides a fully integrated psychiatry and psychology service, with 14 consultant psychiatrists, and over 60 clinical psychologists working as members of acute specialty teams. For example, the paediatrics service has two consultant psychiatrists and 20 clinical psychologists.

[b] NHS England, *Report of the 4th Survey of Liaison Psychiatry in England*, July 2019

They enable ongoing specialised care for children and adolescents and their parents with emotional distress as well as medically unexplained symptoms, such as abdominal pain and mental illnesses requiring medical care such as anorexia nervosa. Similarly, the neurosciences department is supported by two dedicated neuropsychiatrists and nine neuropsychologists. They are integrated into specialist neurosciences multidisciplinary teams to deliver inpatient and outpatient services for patients with acute and long-term neurological conditions.

The integrated nature and scale of the psychological medicine service improves patient outcomes, enhances patient experience and allows it to give face-to-face teaching to acute staff on psychological and psychiatric care of patients, as well as supporting these staff in their work by their regular presence on wards. This innovative service shows that full integration of physical and mental health care, with benefits for both patients and staff, is achievable in an acute trust.[23]

Patients were not always provided with a safe, therapeutic environment

While waiting for or having treatment, patients at risk of self-harm need to be assessed in an environment that is private, appropriate for their needs and minimises the potential for them to injure themselves. Many emergency departments had a 'safe room' that met the standards of the Psychiatric Liaison Accreditation Network (PLAN) (see below). Among other expectations, the standards state that a safe room should be free of ligature risks, with a viewing pane, weighted furniture, and an alarm strip or call bell running around the perimeter of the room. However, in several departments we visited, the safe rooms did not meet these standards.

Psychiatric Liaison Accreditation Network (PLAN) standards

Coordinated by the Royal College of Psychiatrists, PLAN is a joint initiative involving representatives from the colleges of Emergency Medicine, Nursing and Physicians, as well as Mind and representatives of people who use services and carers. The PLAN standards specify the expected standards for liaison psychiatry teams across a range of areas, including the provision of staff training.[24] We look at whether teams have PLAN accreditation as part of our inspection process.

Liaison psychiatry services meeting the required levels of quality for an acute hospital, based in urban or suburban areas with a busy emergency department would be expected to have 'core 24' staffing levels.

The NHS Long Term Plan has committed to ensuring that all acute hospitals will have mental health liaison services that can meet the specific needs of people of all ages, with 50% of mental health liaison services meeting the 'core 24' quality and staffing standards by 2021.[25]

Emergency department staff told us that they often had difficulties in keeping all patients safe, even when there was an acceptable safe room available. For example, they told us that there would often be more than one patient who was judged to be at risk to themselves (or potentially others). In these instances, where a safe room was already in use, staff told us that they would attempt to place patients in a bed where they could be easily observed by clinical staff.

While safe rooms could provide a safe physical environment, our Experts by Experience told us that they were often not therapeutic environments. They described some rooms as resembling a 'prison cell' with bare walls, a mattress on the floor, and harsh lighting 24 hours a day. They also described not having access to a phone to contact friends or family, and having limited access to food. As illustrated in Lucy's story (page 4), this environment, together with the noise of the emergency department and sudden withdrawal of their medicines, could make their mental and physical health worse.

Patients told us that not being given information about when they would be seen, or how long they would have to wait, could cause further distress. Others described how being assessed multiple times – first at triage, then by a succession of different nurses and doctors – was also unsettling and tiring. On some occasions, we heard that the distress caused by being in an inappropriate environment, was made worse by the attitudes of staff, who referred to patients by their presentation such as "the overdose in bed 4" rather than by their name.[c]

Such poor standards of care could amount to breaches of a patient's human rights. For example, Article 3 of the Human Rights Act 1998 outlaws "inhuman or degrading treatment" and Article 8 protects a patient's right to respect for their private and family life.[d]

Outside of the emergency department, we found instances on acute wards where ligature risks had not been removed, putting patients with mental health needs at risk. However, some trusts had recognised these risks and provided rooms and bathroom facilities that were designed with ligature-free equipment and fixed furniture to reduce risks to patients and staff. CQC's brief guide on ligature risks was updated in March 2020. In addition, we wrote to NHS mental health trusts in August 2020 to emphasise the importance of identifying and mitigating ligature risks.

Some trusts had also tailored the environments of wards for patients with dementia. This included adding reminiscence décor, making the ward layout simple and easy-to-navigate, and introducing enhanced care trollies that contained a variety of activities as a diversion for patients who were agitated.

Where patients had been assessed as being a risk to themselves, trust policy was typically one-to-one observation by a registered mental health nurse. However, we are also aware of instances where one-to-one supervision has been with a security guard, which is not appropriate.

Examples of effective initiatives

Working with patients to improve safe rooms

Imperial College Healthcare NHS Trust has worked with an architect and people who use services to design a safe room meeting PLAN standards. The room has walls painted in calming colours, a secure window overlooking a courtyard area, and a ceiling light that provides images of the sky to match the time of day. Patient feedback has already demonstrated that people find this new environment therapeutic. In one incident, a person with severe anxiety was admitted to the newly

[c] REF FOR QA – mentioned by Lucy at the coproduction event

[d] Human Rights Act 1998

designed safe room. During this time her heart rate dropped from 140bpm to 70bpm as her anxiety reduced. In a later interview, she recalled how the design of the room and skylight helped to provide her with a sense of calm:

"I don't know how long I was there… time started to slow down really nicely…I focused on the skylight, I imagined the night sky when I do astronomy."

Acute trusts need to improve staff education and governance in relation to the Mental Health Act 1983

Being acutely unwell, psychotic, or in pain is a distressing experience for any patient, but can be even worse for people whose liberty is restricted. Patients receiving health care in an acute hospital while detained under the Mental Health Act 1983 (MHA) typically have one-to-one observation, and any personal items that pose a safety risk to them or others should be removed. This needs to be carried out in line with the legal framework of the MHA and guidance set out in the MHA Code of Practice.

Many acute trusts are registered with CQC to provide the regulated activity of "assessment and admission of people using the MHA." This means the acute trust is responsible for the oversight, management and support of staff in adhering to the MHA, but we found that staff understanding and application of the MHA was poor. This could put patients at risk and in some cases was breaching their human rights.

When a person needs to be detained while in an acute hospital, staff need to be clear about what the legal process is for this. The MHA and its Code of Practice state that when a person is detained they must be informed of their rights under the MHA. Staff are also legally obliged to complete the paperwork required to detain a patient under the MHA, and share this with the relevant MHA administrator, usually a designated individual with responsibility for collating the paperwork.

Most but not all acute trusts delegate this service to the mental health trust that they have a service level agreement (SLA) with. In such cases, we would expect that the mental health trust lead on the administration of the MHA. However, our inspectors found that in some trusts, there were no joint operating policies between the acute and mental health trust for managing MHA paperwork. One emergency medicine consultant we spoke with in an acute trust reported that submitting an incident reporting form was the only way to keep track of the numbers of patients detained under the MHA.

Inspectors found that governance in this area, as well as staff understanding of the application of the MHA was poor. They found that there was often confusion between the MHA and the Mental Capacity Act 2005 (MCA). For example, at one hospital we visited the charge nurse in the emergency department thought patients could be held for 72 hours, and a social worker could then complete a Deprivation of Liberty Safeguards (DoLS) assessment retrospectively. In our report *Monitoring the Mental Health Act in 2018/19*, we highlighted the urgent need to update the codes of practice for the MHA, the MCA and DoLS to provide clear guidance for professionals on these complex interface issues.[26]

At another emergency department, a senior nurse asked a member of the hospital security team to wait with a patient to prevent them from leaving. Guidance issued by the Royal College of Emergency Medicine states that security staff can only be

asked to restrain or forcibly bring a person back to an emergency department under the MCA if they have a mental disorder and lack capacity to consent to or refuse care. In an emergency where there has been no chance to assess the patient's capacity, or if they do not lack capacity, the use of common law to restrain and detain a patient may also be appropriate when they are judged to pose a high risk of harm to themselves or others.

It is good practice for emergency departments to develop a clear policy for handling situations such as this, particularly where security staff are involved. Where restraint is considered, it should be a last resort, where less restrictive measures have not been effective. If a patient has been restrained in an emergency situation it should then be considered whether assessment is required for consideration of detention under the MHA or the DoLS provided under the MCA.

We found other incidents where paperwork had either not been completed or had not been sent to the correct MHA administrator. Not following these processes can result in a person being detained unlawfully and is considered a serious breach of their human rights. We take these breaches seriously and have taken enforcement action where standards of care in relation to the use of the MHA have been inadequate.

On our inspections we also found issues with staff knowledge of the need for capacity documentation for consent forms, and DNACPR (do not attempt cardiopulmonary resuscitation) forms. Patients have a right to be informed and involved in decisions about their treatment. Our inspectors saw several examples where the DNACPR form stated that the patient did not have capacity to engage in the discussion regarding CPR, but there was no evidence in the notes that a formal capacity assessment had ever been carried out. It is not clear whether this reflects a lack of training, or simply an omission on the part of clinical teams.

Examples of effective initiatives

South London and Maudsley NHS Foundation Trust[27]

Background: In 2018, the trust board agreed a new approach to the oversight and monitoring of the Mental Health Act 1983 (MHA). This was to make oversight of the MHA 'business as usual' to make sure that the use of the MHA, as well as quality of care, is monitored routinely in monthly trust quality and performance reviews. The trust board approved a new Mental Health Law Committee Terms of Reference with two key aims:

1. To achieve 100% compliance with the MHA, CQC regulatory standards and the Code of Practice.

2. To provide least restrictive and 'appropriate' high-quality care, delivered with a focus on promoting equalities and human rights.

The Mental Health Law committee is presented with information on:

- local population profiles and how local diverse populations accesses services
- local patterns of detention and pathways into care
- compliance with the MHA, CQC regulatory standards and the Code of Practice

- the people who are detained at the service including equalities characteristics, social and risk determinants, whether they are new to the service and the nature of their mental illness
- whether care delivered is least restrictive and of high quality.

The Mental Health Law committee also strengthens multi-agency partnership working by having representatives from local partner organisations as members. People who use services and carers are also invited to committee meetings to feedback to members on their experience.

Staff feel unsupported and unprepared to care for their patients' mental health needs

In order for staff to provide high-quality care for their patients' mental health needs, they need to receive appropriate training.

We found that mental health training for staff varied. Where training was provided, this was often limited to mandatory e-learning that focused on legislation including the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), but not the Mental Health Act 1983 (MHA).

The lack of training on mental health care meant that clinical staff lacked both competence and confidence to provide it. As a result, they relied heavily on support from psychiatry teams for mental capacity assessments, ethical issues and treatment of patients. In some cases this was appropriate, but in some medical teams there was a culture that viewed patients' mental health needs as "outside their remit".

We also saw discharge summaries routinely requesting depression screening to be carried out by GPs on discharge. While it is not clear whether this was due to a lack of confidence on the part of the medical teams, or a lack of time, it is a concerning finding. We would expect that medical teams should be able to have a holistic conversation with patients who are worried or showing signs of depression. Where appropriate, clinicians should ask about symptoms of depression and seek advice from psychiatry teams if required.

Research has repeatedly shown that physical health outcomes are poorer, and the risk of suicide is increased, where depression, anxiety and other mental health conditions are not dealt with. Furthermore, the lack of engagement with a patient's mental health needs is likely to prolong their length of stay and increase the potential for readmission.[28]

Nursing staff on wards and in emergency departments told us that the lack of relevant training on mental health care left them feeling unprepared to care for their patients effectively. Paediatric nursing teams we spoke to in some emergency departments reported that they had no training on how to care for young people who self-harmed and autistic people and/or people with a learning disability.

As a result, nursing staff working on the observation unit attached to an emergency department reported feeling as if they had been "thrown into the deep end" and felt unsupported in caring for patients with mental health needs. Staff at another trust reported relying on carers and families for advice and information on how best to care for patients with a mental health condition or learning disability and/or autistic people.

Nurses told our inspectors that they wanted more face-to-face training on how to give better support to these patients. Evidence suggests that face-to-face training is better at helping staff to gain the confidence they need to put knowledge into practice.[29,30]

We did visit some trusts where this had been implemented. One trust had provided dedicated mental health training for nurses working in the emergency department, and mandatory face-to-face training for nurses on conditions including dementia, learning disabilities and autism. The introduction of link nurses for mental health, learning disabilities, dementia and safeguarding also helped with providing support and training for nurses on wards.

Another trust had funded protected time for the liaison psychiatry team to provide dedicated training sessions for junior doctors, mental health awareness training and scenario-based sessions in the hospital simulation suite. Staff on medical wards who had attended gave positive feedback for this training and the effect this had on improving their own knowledge and skills.

Professionals we spoke with at our co-production event felt that the bulk of training should be pre-registration, embedded into the undergraduate curriculum for all clinical staff, with regular updates as part of continuing postgraduate professional development. Where staff have specialist roles in acute trusts, such as in emergency departments or on wards caring for patients with dementia, training should be tailored to support these specific roles. Similarly, specialist training should be provided to pharmacists to make sure that acute trusts have access to at least one dedicated pharmacist, 24 hours a day, with expertise in the use of medicines to treat mental health conditions, as well as access to medicines when required for patients who need them.

Our Experts by Experience told us that training for staff in emergency departments should also include non-clinical staff, such as emergency department receptionists and security staff, in order to improve communication skills and promote a compassionate, non-judgemental attitude.

Examples of effective initiatives

King's Health Partners

As part of the Integrating Mental & Physical Healthcare: Research, Training & Services (IMPARTS) programme, patients attending the outpatient department at King's College Hospital and Guy's and St Thomas' Hospital in London answered some simple mental health screening questions on an iPad. A high, or significant change in score can be used by the healthcare professional at their appointment as a prompt to ask about mental wellbeing, with a range of interventions as appropriate, from just checking the patient is okay, to more intensive psychological, psychiatric or social support. This was implemented in a variety of outpatient clinical pathways including allergy, dental, orthopaedics and haematology services.[31]

As of January 2020, IMPARTS had screened 25,185 patients in total at King's College Hospital since 2011 and 16,886 patients at Guy's and St Thomas' Hospital. In total 78,127 individual screenings had taken place across both trusts, including IMPARTS, with 4,049 identified with probable major depression at King's College Hospital and 4,683 with anxiety symptoms. A review of the IMPARTS programme

demonstrated that web-based screening is acceptable to patients, feasible to implement in routine clinical practice and effective at identifying psychological problems that might otherwise be missed.[32]

One team shared how IMPARTS had made a difference to their patients:

"One patient fell down a flight of stairs and fractured her tibia, fibula and crushed ankle. After prolonged and unsuccessful treatment attempts, she was referred to the limb reconstruction unit at King's College Hospital. The nature of her injury, the lack of progress in treatment, and the impact on her daily life had resulted in an episode of depression. She completed the IMPARTS screening that flagged these issues to her medical team. She received a psychiatric assessment and cognitive behavioural therapy. Her mental health and quality of life improved as a result."

The IMPARTS programme also offers a five-day mental health skills course for non-mental health professionals. Evaluation of this course shows that it improved the knowledge and confidence of non-mental health clinicians in dealing with mental health conditions in patients presenting primarily with physical health conditions.

Conclusion and next steps

Staff we spoke with were generally caring and working very hard in challenging circumstances. Several expressed frustration at not being able to do more to recognise and support the mental health needs of their patients, but too often it was the system in which they were working that limited their ability to provide the best possible care for patients with mental health needs.

We have highlighted in earlier publications how there is a lack of appropriate community provision to support patients experiencing a mental health crisis.[33] It was similarly evident from these inspections that patients were frequently left with no other option than to attend the emergency department to seek care, even if it was not always suitable for their needs. Supporting acute trusts to improve the mental health care of their patients is not something that can be done in isolation, it requires a system-wide response that ensures better community provision to support patients at a time of crisis, and also on discharge from hospital admission.

Where high-quality leadership for better mental health in acute trusts was lacking, we saw how there was more likely also to be a lack of appropriate training to support staff and poor working relationships between acute and mental health trusts. This meant that patients' mental health needs were not seen as a priority in the same way that their physical health conditions were. In some cases, patients with mental health needs were entirely disregarded and seen as "someone else's problem" – whether that was their GP, the psychiatric services or even the police.

High-quality care must encompass both patients' physical and mental health needs. The focus of improvement should be on providing integrated high-quality, compassionate, effective care at each interaction with health services and not just one of "passing the patient through the system" to meet targets. Quality improvement initiatives in this area should engage frontline staff, as well as the views of patients, in order to improve staff compassion, knowledge, and patient care.

We hope that the external stakeholders we spoke with will support this work, recognising that there is 'no health without mental health' – and that this applies equally to both patients and staff. Several studies have shown that a poor workforce culture and burnout leads to compassion fatigue and compromises the care of patients.[34]

Acute trust boards have a responsibility for the wellbeing of their staff. As part of our well-led inspections, we look at staff wellbeing and organisational culture, including access to breaks, rest facilities, and supervision.

We welcome commitments from organisations including the General Medical Council, Nursing and Midwifery Council, Health Education England, the Royal College of Physicians, the Royal College of Emergency Medicine, the Royal College of Psychiatrists and the Royal College of Nursing to review specialty curricula and postgraduate training pathways, conferences and events to ensure parity of esteem between mental and physical health. We also recognise ongoing commitments from NHS England and NHS Improvement in providing mental health care in both acute and mental health trusts.

As part of the Assessment of Mental Health Services in Acute Trusts programme, we will continue to develop our regulatory framework in this area. We have embedded prompts related to mental health into core service and well-led inspection

frameworks. These are aligned with the Psychiatric Liaison Accreditation Network (PLAN) standards and will remain in the inspection framework.

We also outline 11 steps that we recommend providers, clinical commissioning groups and local authorities take to improve the quality of care for people with mental health needs, and work towards achieving parity of esteem.

Steps to improving practice

System-wide changes:

1. **Local authorities, commissioning groups and integrated care providers need to work together to improve cross-sector planning and commissioning, to ensure that all patients have access to the physical, mental and social care they need.**

   Providers need to work together to ensure that people's physical health, mental health and social care needs are holistically assessed, with a seamless provision of care that minimises delay and duplication. We encourage acute, mental health and primary care providers to use available quality improvement tools and examples of good practice to collaborate. The views of patients should be incorporated into suggested initiatives for improvement.

   In order to achieve the best possible outcomes for patients within the resources available, system-wide improvement initiatives need to be undertaken based on good quality informatics that best identify population needs and opportunities for improvement. These improvement initiatives should be adequately resourced at the most appropriate level, including pan region, Sustainability and Transformation Partnerships (STP)/Integrated Care Systems (ICS), clinical commissioning group (CCG) and local authority. The pan-London compact is an example of an effective region-wide collaboration at STP/ICS level that is demonstrating measurable change and improvement.[35]

   Those organisations (CCGs) with accountability under Section 140 should also fulfil their legal duties under the Mental Health Act, to ensure that patients requiring an inpatient bed can be admitted close to home.

2. **Improving system-wide mental health care requires improved aligned coding and sharing of data.**

   At present, one of the barriers to improving mental health care across systems is the lack of consistent high-quality data. Ensuring that mental health care is joined up between primary care, secondary care and mental health services requires coding to be centred around the person, not the organisation. The same codes should apply in primary care as they do in emergency departments and secondary care. Better data on numbers of patients and their mental health needs will enable better planning and commissioning of resources.

   NHS Digital, professional bodies and chief clinical information officers from acute, primary care and mental health should continue to work together to ensure aligned coding across sectors is applied nationally, to ensure the focus is on patient pathways. This is essential for coordination and efficiency of care,

oversight on population health needs, and pathways-based regulation across integrated care systems.

3. **Acute trusts should ensure that service-level agreements (SLAs) are in place with the appropriate organisations to ensure that healthcare records and sharing of information between clinicians is effortless.**

   Where appropriate, healthcare professionals involved in a patient's care should have access to all records, including details of; allergies and intolerances, medicines, test results and care plans as well as medical and psychiatric history, to ensure better continuity of care, particularly when patients are transferring between community and inpatient services.

   At a system-wide level, there should be compatible electronic patient record systems giving staff the necessary access to records detailing contact that patients have with mental health care services across organisations. Where this is not available, staff contracts and smartcards must be enabled to ensure that liaison staff have access to primary care, acute, community and mental health records. We would expect NHS trusts and publicly-funded independent providers to work together to reduce barriers in information sharing. This is essential for provision of safe, high-quality care, and CQC will continue to monitor this as part of the inspection process.

4. **Commissioners need to ensure that people experiencing a mental health crisis are able to access meaningful alternatives to the emergency department.**

   For many patients, the emergency department is not the most appropriate place for them to access care during a mental health crisis. It was also apparent from our series of inspections that care for mental health patients in many emergency departments was not of a standard that we, as a regulator, expect to see. This was a theme voiced by patients at our co-production event, some of whom have found community services, where available, more helpful in a crisis (see Louise's story, page 12).

   In line with the NHS Long Term Plan, integrated care systems should ensure there is better access to, and resourcing of crisis care in the community, home treatment teams, and support of third sector organisations.[36] Community mental health care should be available around the clock, so that patients in crisis can access care in a timely manner, in a setting that best meets their needs.

Trust-level changes:

5. **All acute trusts need to have a mental health strategy.**

   Trust boards need to provide leadership and oversight of the mental health care of people using their services. This should be guided by a clear mental health strategy, co-produced with both experts in the provision of mental health care to the physically ill and patients, carers and families. There also needs to be clear accountability for provision of psychiatric services and administration of the Mental Health Act. This may be done in house or through a service level agreement with a mental health trust.

As a regulator, we would expect to see evidence that clear arrangements for integrated mental and physical health care are present in areas of high demand, such as emergency departments, oncology, liver and alcohol-related services, pain clinics, trauma and maternity services. Arrangements should include plans for improving mental health care across all wards and outpatient clinics, with named clinical leads and timescales for action.

6. **Mental health care should be considered frequently by the boards of acute trusts.**

   The mental health strategy should be regularly reviewed at acute trust board meetings, with named leads having accountability for turning the strategy into action and improving standards of care. Trusts that regularly discuss mental health care at board meetings have shown significant improvements in the care of patients with mental health needs.[37,38] CQC will continue to review board-level commitments to improving mental health care in acute trusts.

7. **Mental health services in acute trusts should meet nationally recognised quality standards.**

   Acute trusts need to ensure that there is a suitable, safe and therapeutic environment in which patients can be assessed and treated. We will continue to inspect the provision of mental health care as part of our acute inspections and recognise PLAN accreditation as a hallmark of a service meeting fundamental standards. We also encourage acute trusts to invite peer review of the mental health care they provide**.**

   Trusts must also ensure they comply with the National Patient Safety Alert *Ligature and ligature point risk assessment tools and polices*.[39]

8. **In emergency departments patients held in safe rooms must be provided with essential food, drink, medicines, and communication with friends and family.**

   Facilities for assessment of patients in emergency departments and on acute wards need to promote psychological as well as physical safety. Acute trusts must ensure that patients waiting for assessment in emergency departments have access to food, drink and medicines, as well as means to contact friends and family, if they wish. This is a basic human right, and where patients are deprived of essential medicines, food and drink, we will take appropriate enforcement action.

9. **Acute trusts should have clear governance processes for administering and monitoring the Mental Health Act, which may be done in conjunction with a mental health trust.**

   There needs to be clear contractual and governance processes, for recording serious untoward incidents and the use of the Mental Health Act 1983 (MHA).

   At present, the administration of paperwork in relation to the MHA is usually (but not always) carried out by the mental health trust, via a service level agreement.

Where service level agreements exist, we expect mental health trusts to show leadership in this area, and that the service level agreement is clear.

In line with our strategy, and the recommendations of the *Five Year Forward View*, CQC will continue to monitor the application of the MHA as part of our regulatory work to ensure that the rights of patients detained under the MHA are respected.

Supporting staff – the role of acute trusts, education providers and royal colleges:

10. Training should be provided that gives staff the necessary knowledge, skills and confidence for meeting people's mental health needs.

Training should be provided that equips staff with the knowledge and skills they need to care for their patients' mental health needs. Where possible, this training should be provided face-to-face, and should be refreshed regularly.

Undergraduate and postgraduate curricula should also focus on the competencies needed to deal with the mental health aspects of the care of patients being seen by acute specialties and in acute settings, as well giving healthcare staff the skills and confidence to deal with topics such as self-harm and suicidal thoughts with patients.

We encourage acute trusts and educational establishments to use existing, well-researched training platforms, such as that provided by the Zero Suicide Alliance.

11. Better mental health care for patients should be provided alongside better support for staff wellbeing.

Our inspectors found that staff, particularly in emergency departments, were under a huge amount of pressure, with large numbers of patients to care for, often in the context of limited space, gaps on staff rotas, and the pressure of waiting time targets. Working environments such as these increase the risk of burnout and compassion fatigue, with adverse effects on staff and patients.

The wellbeing of staff should never be forgotten in the drive to improve the mental health care of patients; evidence in the literature shows that burnout has adverse effects on patient safety.[40] CQC recognises that a well-led workplace is one where staff are supported, and we are placing increasing emphasis on the importance of workforce wellbeing and culture as part of our well-led inspections.

As a regulator, we also support and encourage the development and implementation of initiatives designed to improve the wellbeing of all healthcare staff by Health Education England, Royal Colleges, and organisations providing undergraduate and postgraduate training.

What CQC will do:

12. We will continue to carry out our regulatory work and ensure we take appropriate enforcement action to help keep people safe and safeguard their human rights. We will also continue to encourage services to improve.

CQC is committed to ensuring that all providers see mental health care as being just as important as physical health care. Following on from the Assessment of Mental Health Services in Acute Trusts programme, we will continue to develop our regulatory framework in this area. We will take appropriate enforcement action to help keep people safe, and safeguard their human rights – for example, when safe rooms do not meet fundamental standards.

We have already embedded prompts related to the provision of mental health care in core service and well-led inspection frameworks for acute providers. These are aligned with the Psychiatric Liaison Accreditation Network (PLAN) standards and will remain in the inspection frameworks.

When our inspection teams regulate acute trusts, we will look closely at:

- The steps that well-led acute boards are taking to ensure parity of esteem between physical and mental health care provision across the trust.
- Evidence that acute trusts are providing integrated, holistic care, addressing the mental and physical health needs of all their patients – and not just outsourcing all mental health care to mental health trust liaison teams.
- The quality of governance surrounding the use of the Mental Health Act, and when delivered by a mental health trust, the quality of the service level agreement to achieve safe care that protects patients' human rights.
- The quality and content of training provided to acute staff, and how this enables them to meet the mental health needs of all patients in their care more effectively.
- How the views of patients are incorporated into plans for quality and service improvement.
- How safe and therapeutic the care environment is – in both emergency departments and inpatient wards.
- Initiatives to enhance the mental health and wellbeing of staff across the organisation.

In addition, there needs to be better integration of components of care, including greater partnership working across organisations, as well as primary, secondary and tertiary care. In line with the recommendations of the NHS Long Term Plan, CQC will be looking closely at system-level initiatives, and we will seek to recognise examples of outstanding practice where acute trusts have collaborated with community services and mental health trusts to provide mental health care in a holistic, timely manner, in a setting appropriate for the needs of patients.

Appendices

Appendix A: Glossary

Crisis cafés are usually run in partnership between a mental health trust and third sector organisations (such as Mind) and provide care to people experiencing a mental health crisis. They typically operate in the evenings and at weekends, and provide a safe place, in a non-clinical environment where people can drop in and talk to a qualified mental health professional or trained wellbeing worker. Some centres also offer one-to-one therapy, practical support on emotional issues, and hot drinks and food.

Experts by Experience are people who have recent personal experience (within the last five years) of using or caring for someone who uses health, mental health and/or social care services that we regulate.

Mental Capacity Act (2005) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment – for example, some people with dementia. It applies to people aged 16 and over, and the Deprivation of Liberty Safeguards to people aged 18 and over.

Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

A **social prescriber** is usually an occupational therapist or allied health care professional who takes a holistic approach to people's health and wellbeing. They work with people to connect them to community groups and statutory services for practical and emotional support.

Appendix B: Acknowledgements

NHS trusts and providers that have participated in co-production

- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
- Central and North West London NHS Foundation Trust
- Guy's and St Thomas' Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- King's College Hospital NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust (Oxford Psychological Medicine Centre)
- South London and Maudsley NHS Trust
- St George's University Hospitals NHS Foundation Trust
- London Ambulance Service NHS Trust

Organisations representing people who use services who have participated in co-production events

- Choice Support
- Remploy

Other arms-length bodies that have been consulted

- Approved Mental Health Professional (AMHP) leads network
- British Indian Psychiatric Association
- Mind
- NHS Confederation
- NHS England and NHS Improvement
- NHS Providers
- The National College of Policing
- The Race Foundation
- The Royal College of Emergency Medicine
- The Royal College of Paediatrics and Child Health
- The Royal College of Nursing
- The Royal College of Obstetricians and Gynaecologists
- The Royal College of Physicians
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