Briefing from the Royal College of Psychiatrists

Assessment of, and solutions for, improving local mental health care capacity

About the Royal College of Psychiatrists

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom. We work to secure the best outcomes for people with mental illness, intellectual disabilities and neurodevelopmental conditions by promoting excellent mental health services, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.

Introduction

This briefing provides an overview of the results of RCPsych's 'Local Capacity Survey' and proposes evidence-based solutions to the challenges psychiatrists continue to face in their delivery of care.

The RCPsych recently surveyed their UK-based membership asking about their experiences over the past year of local inpatient capacity pressures and how these have affected their decisions about patient admission, treatment and discharge. 1,012 members participated in the survey, 860 from England – in the year to February 2025:

- Almost half (47%) faced **daily delays in timely admissions and/or the provision of inpatient mental health treatment**, because of issues with local or specialist capacity.
- 44% heard about patients **waiting for transfer to a suitable bed**, while **staying in a place of safety or in General Hospital Emergency Departments (EDs)**, on a **daily basis.**
- Over a third (34%) **admitted someone to a ward which was inappropriate for them**, including out of area placements, on a **weekly basis**.
- 28% of respondents **discharged someone to a placement which was inappropriate for them every week** (including temporary accommodation), followed by 26% who did so on a **monthly basis**.
- The majority (81%) have **experienced moral injury themselves or witnessed 'moral injury'[1] indicators amongst healthcare workers** when making admission or discharge decisions in the context of local capacity pressures.
- Almost three quarters (73%) felt they **had to make a decision on admission or discharge as a result of pressure from external factors, rather than the patient's clinical need and best interests**.
- A similar proportion (74%) are of the opinion that **such decisions made about admission or discharge have compromised patient care and safety**.

The results were shocking yet expected and are indicative of decades of underinvestment and lack of prioritisation. While the NHS Long Term Plan, Mental Health Investment Standard and Health and Care Act 2022 have all been welcome interventions, they help outline the inconsistent and often fragile nature of mental health investment and prioritisation. Meanwhile, we continue to observe the impacts of this failure to take the opportunities to improve mental health care:

- **HSSIB published a report** in May 2025 outlining the need for a patient safety strategy to ensure the delivery of safe and therapeutic care, learning from previous investigations.
- **CQC published a survey** in April 2025 highlighting the extent of the waiting list crisis.
- In January, the **Government failed to include mental health care in the Elective Care Reform Plan** – denying millions of patients the funding and prioritisation required to access timely care.
- Last year **the Darzi Review** highlighted that the NHS is failing to meet the promises of the Constitution, and as a result, patients are suffering; 1 million people were waiting for mental health services in April 2024.

[1] Moral injury is understood to be the strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code, for example, when healthcare staff feel their workload is such that they deliver care of a standard that falls well below what they would usually consider to be good enough (Williamson et al, Lancet Psychiatry 2021).

When read alongside our survey results, we can appreciate the challenging conditions under which psychiatrists and mental health professionals are working to try and consistently deliver safe and therapeutic care.

Key messages from our members

When asked where the decision-making pressures on admissions/discharges based on factors other than patients' clinical needs and best interests come from, members answered:

- **Insufficient bed availability to meet demand**. This often leads to delayed urgent admissions and reliance on MHA assessments as the only means of accessing inpatient services.
- **High rates of readmission due to pressure to discharge patients** before they are clinically ready and their subsequent **return due to a lack of community provision** (including crisis care).
- Concern from bed management teams **pressured to meet bed occupancy KPIs**.
- A **lack of cohesion with external partners**, who also lack capacity, creating conflicting priorities.
- A **lack of appropriate community provision**, including:
    - alternative care and accommodation to safely discharge patients to
    - crisis resolution and home treatment teams to allow people to stay in the community
    - community mental health services to keep people well and avoid the need for inpatient treatment
- **Mental health professionals at overcapacity due to a lack of commitment to workforce retention,** contributing to low staff morale, burnout, and higher rates of staff sickness absence.

Providing clinically led, evidence-based solutions

Members were also asked to provide **potential solutions** to allow psychiatrists to make decisions based entirely on patients' clinical needs and best interests. These recommendations require cross-system collaboration and collective implementation; no one aspect of the health system alone can reverse the worsening trends:

1. Improve community capacity

Community provision has a dual purpose:

- supporting people to live well, preventing mental ill-health and ensuring those with a mental illness can – where safe – avoid admissions and live fulfilling lives
- supporting transitions from inpatient settings to the community in a timely fashion, to ensure continuity of care

Hospital admission can be part of the care pathway for those with more severe and complex mental illness. However, where possible, avoiding hospital admissions requires the provision of psychological therapies, accessible to those with mild and moderate to severe or more complex conditions. **Dedicated funding must continue to be provided for Talking Therapies to improve capacity and reduce waiting times**.

It is estimated that 1.5% of people with complex mental health difficulties equate to one third of the cost – often through costly inpatient, and sometimes unnecessary, admissions. **The HEARD study** outlines the importance of creating **a clear pathway that makes the most efficient use of community and inpatient resources for those with the most complex or severe needs**. What these therapies look like in practice should be determined by local specialised commissioning; however, there needs to be better national guidance. **Aligned with the approach to Talking Therapies, dedicated national funding must be provided to ensure commissioners have the capacity to provide.**

Assertive outreach teams to maintain contact with those who find it most difficult to engage with services are essential for keeping people well in the community.

Community provision must be supported by local **implementation of the Community Mental Health Framework**. This evidence-based, clinically driven, population needs-based approach has helped reduce crisis presentations and referrals to secondary mental health care, and improved patient outcomes. Thus far the Framework has lacked local and national prioritisation to ensure its success – **reissued national guidance would improve implementation**.

Targeted outreach support must be provided in especially vulnerable communities, including to those who are likely to be readmitted, are rough sleeping, face barriers to accessing care, and people with intellectual disabilities and severe mental illness. **Integrated Care Boards (ICBs) and Trusts should work with local Voluntary, Community and Social Enterprise (VCSE) providers to ensure underserved groups have clear links to health services.**

Equally, post-inpatient community-based support can take several forms. Recognising local need, **commissioners should ensure adequate capacity in day hospitals, short-term accommodation, crisis and respite houses, virtual wards and supported housing.**

The 'integrated care' section of this brief details how services can better work together to improve the transition between inpatient and community care.

2. Provision of integrated care

The delivery of high-quality, safe and therapeutic care requires an integrated, holistic approach to patients' health. Fundamentally, **a continuity of care approach is required**; it is preferred by clinicians and patients alike, is known to improve outcomes, and would improve transitions between community and inpatient care.

As the Government focuses on integrating GPs with specialist services through Advice and Guidance, this must be extended to include mental health services to improve patient care – from diagnosis, advice and medication, recognising the proportion of GP presentations which are mental-health related. Aligning services can also aid the implementation of care pathways, particularly for people with personality disorders, complex needs and intellectual disabilities – people who often find it more difficult to access care.

Closer working with GPs will better integrate mental and physical health services, necessary for those living with co-morbidities. **Improved integration between mental health and substance misuse services is also important**; despite the bidirectional relationship between the two, there is often a breakdown in communication as services pass responsibility.

There must be improved relationships between health services, local authorities and VCSE providers. **A key tenet of the Community Mental Health Framework, working more closely with the providers of housing, benefits and other services like social prescribing, can both improve flow, capacity and outcomes**.

3. Improve inpatient capacity

Providing high quality care relies on local capacity to ensure patients have timely access to services. A recent paper looking into the Prevention of Future Deaths (PFD) reports found that the most frequently arising concern among coroners centred on a lack of psychiatric inpatient beds, which accounted for over half of the PFD reports where lack of mental health resources came up as an issue[i].

For some patients, particularly those with severe and enduring psychosis, inpatient admission is part of the care pathway and at times, inpatient care is the most appropriate provision for the acute stage of an episode. A balanced approach to commissioning must support the admission avoidance when people can be cared for in the community, while retaining sufficient capacity so that inpatient services are available when necessary.

ICBs must undertake service capacity assessments to ensure bed capacity meets local demand. In some areas, this may require additional beds, where proportional, to meet population need – **intelligent commissioning.**

Providers should also be **encouraged to share beds with neighbouring trusts to increase overall capacity**, akin to the provider collaborative model (this may additionally help to eliminate inappropriate out of area placements over time).

As the ICB map changes, there is a local and national responsibility to ensure that decision-making structures remain clear – this should be provided in national guidance.

4. Improve workforce capacity

No employee should experience moral injury in the workplace, especially those providing life-changing and life-saving care to others. Improving the capacity of services will reduce this risk, but a bolstered workforce – across inpatient and community settings, is required to deliver any expansion.

An updated Long Term Workforce Plan must be published alongside the 10 Year Health Plan; avoiding the mistakes of publishing a service delivery plan without outlining the workforce requirements, while ensuring the emphasis afforded to mental health services in the Long-Term Workforce Plan is retained.

Alongside this, there are everyday challenges the workforce faces which impact both their professional enjoyment and ability to deliver high-quality care. 'Smaller' yet equally important steps providers can take to improve working environment for the mental health workforce include:

- **Lessening the administrative burden to create more patient time**
- **Improving estates and IT infrastructure to make simple tasks and clinical decision-making easier, and to improve productivity**
- **Providing designated office space and other essentials, as agreed in many job descriptions**
- **Creating mentorship programmes for staff**
- **Providing ring-fenced funding for staff Wellbeing Hubs**
- **Tackling racism, and other types of discrimination, that impacts the ability of staff to feel psychologically and function effectively at work**

Training should also be provided for other health care professionals, including bed managers, to improve their understanding of safe and effective care and how the overuse of KPIs (particularly discharge targets) can negatively impact decision-making. Introducing more meaningful KPIs, for example tracking how many patients are engaged in meaningful activities (work, education, volunteering) months after their discharge, would instead support the delivery of best-practice care.

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[i] DAC Beachcroft. Prevention of future deaths reports in inquests: recurring themes for health and social care. 10 April 2025. Available online: https://www.dacbeachcroft.com/en/What-we-think/Prevention-of-future-deaths-reports-in-inquests-recurring-themes-for-health-and-social-care-2025.