# The Royal College of Psychiatrists: Membership survey on local capacity

## Survey findings for England

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## 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

Guaranteeing patient safety and improving patient flow are priorities of the College; providing high quality therapeutic care relies on local capacity to ensure patients have timely access to services.

We continue to observe the impacts of historical and recent de-prioritisation and underinvestment of mental health care:

- Last month, the Health Services Safety Investigation Body (HSSIB) published a report outlining the need for a patient safety strategy to ensure the delivery of safe and therapeutic care[1].
- 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, accounting for over half of the PFD reports where lack of mental health resources came up as an issue[2].
- The Care Quality Commission (CQC) also published a survey in April 2025 highlighting the extent of the waiting list crisis among community mental health services[3].

A survey was sent to the RCPsych membership to gather their experiences of local inpatient capacity pressures over the last year and whether such issues affected their decisions about the admission, treatment and discharge of patients. The survey findings further compound the challenging conditions under which psychiatrists and mental health professionals are working to attempt to consistently deliver safe and therapeutic care.

Overall, 860 members across England participated in the survey and a total of 1,440 free text box responses were received[i].

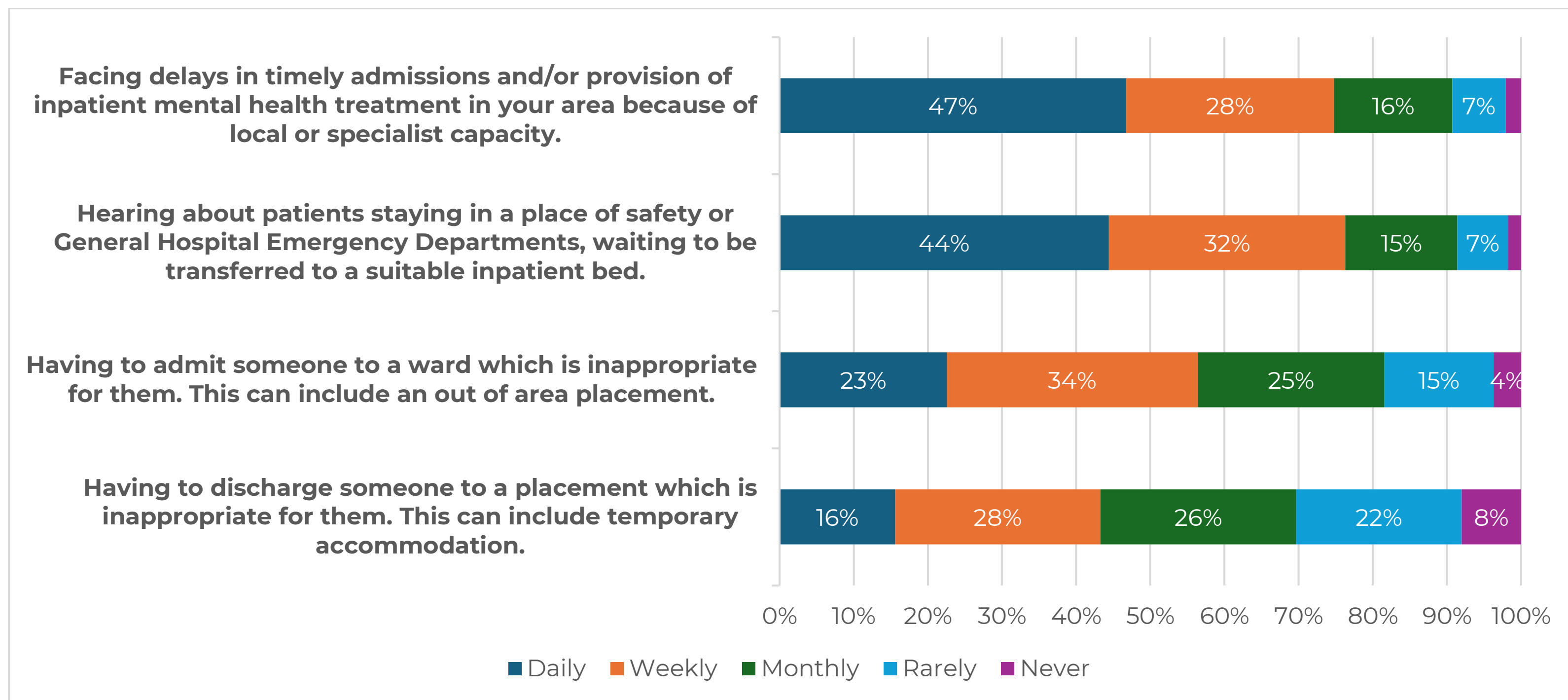
[i] The RCPsych surveyed members across the UK on this topic – the total response rate was 6.3% (1,012 members participated in the survey, after filtering out any members who are not currently practising or are not based in the UK. This was out of 16,166 members who were recorded on the RCPsych membership database as 'working'). The survey was open from 3 February to 2 March 2025 and the average time it took participants to complete the survey was 12:04 minutes.

## Survey findings

### Question 1: 'In the last 12 months, how often have you experienced the following events?'

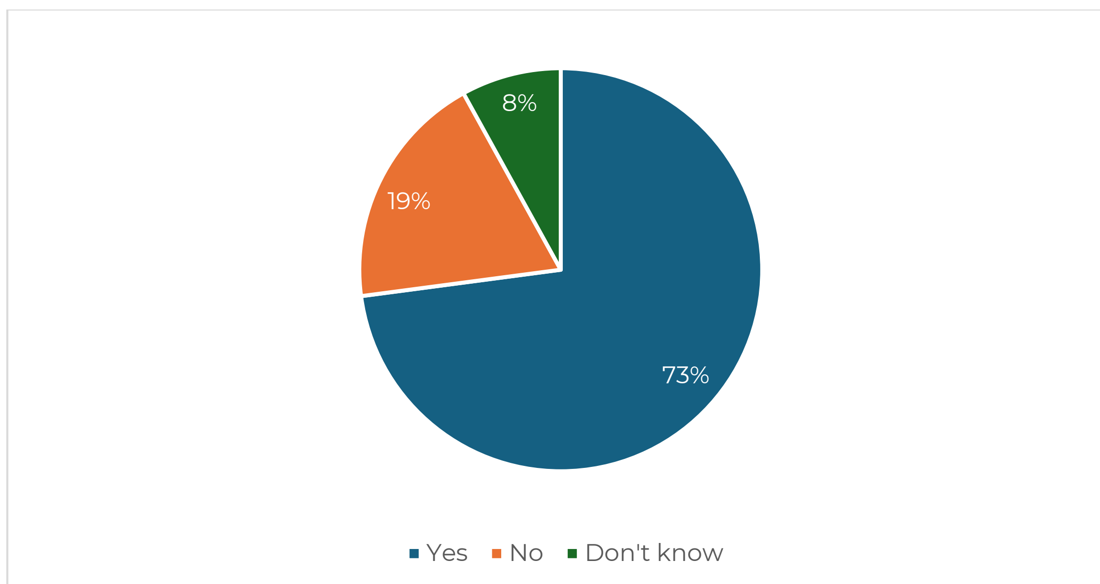
Members were asked how frequently they experienced certain local capacity pressures while delivering inpatient care in the year to February 2025:

- Almost half (47%) of the respondents based in England faced daily delays in timely admissions and/or provision of inpatient mental health treatment, because of issues with local or specialist capacity. Over a quarter (28%) experienced this on a weekly basis, with only 2% never experiencing this.
- 44% of respondents heard daily about patients staying in a place of safety or in General Hospital Emergency Departments (EDs) while waiting to be transferred to a suitable inpatient bed. Almost a third (32%) experienced this on a weekly basis and only 2% never experienced this.
- Over a third (34%) of respondents in England had to admit someone to a ward which was inappropriate for them, including out of area placements, on a weekly basis. The second greatest proportion of respondents (25%) reported doing this on a monthly basis, while 4% of respondents never did this.
- 28% of respondents had to discharge someone to a placement which was inappropriate for them on a weekly basis (including temporary accommodation), followed by 26% who did so on a monthly basis. 8% of respondents never did this.



### Question 2: 'Do you ever feel you have to make a decision on admission or discharge which is based on something other than the patient's clinical need and best interests?'

Almost three quarters (73%) of respondents located in England 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. 8% of respondents did not know.




### Question 3: 'If 'yes', please describe where this pressure is coming from.'

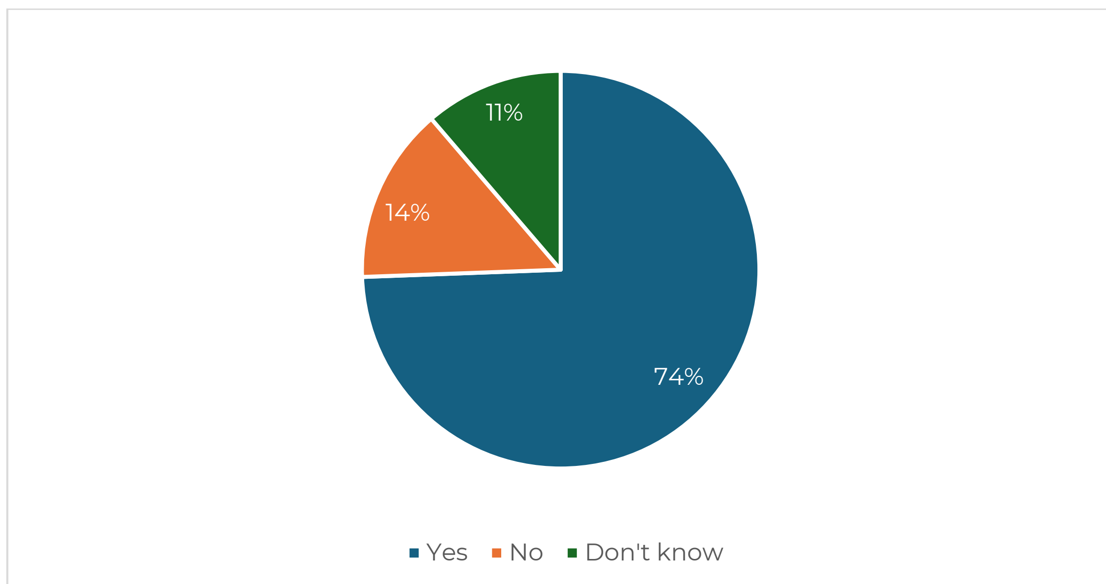
The respondents who did feel they had to make a decision on admission or discharge as a result of external pressures, rather than the patient's clinical need and best interests, **were asked to describe where such pressures were coming from**. 610 written responses were received (a response rate of 97%) and can be grouped into the following themes:

- A substantial proportion of respondents described pressure coming from **insufficient and unsuitable local inpatient provision**. Many respondents cited issues with bed capacity and availability, i.e. how there were insufficient numbers of inpatient beds to meet admission demands. This often leads to delayed urgent admissions and the reliance on Mental Health Act (MHA) assessments and formal admissions as the only means of accessing inpatient services.
- Many respondents reported **concern and pressure from bed management teams** – for example, from bed/operational managers, trust managers, patient flow teams, and clinical directors – to:
  - Meet key performance indicators (KPIs) for bed occupancy and availability levels.
  - Discharge patients as early as possible, even if they are still unwell, and clear beds so other patients can be admitted.
  - Conversely, several members were instructed to hold off on admitting new patients and to re-review any patients who had already been assessed as needing an informal admission.
- A substantial proportion of members reported **a lack of cohesion with external partners**, such as acute trusts, integrated care boards (ICBs), social care services, care homes, and local authorities etc, who also lack capacity. This in turn can create conflicting priorities.
- Many members mentioned **a lack of alternative and appropriate community provision**, including:
  - Alternative, appropriate 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.
- **High rates of patient readmission** were reported by members, with pressures to discharge patients prematurely and a lack of community provision leading to their subsequent return.
- Some members mentioned **mental health professionals being at overcapacity due to a lack of commitment to workforce retention and recruitment**, contributing to low staff morale, burnout, and higher rates of staff sickness absence.
- Some members raised **financial and funding issues** as the main source of pressure.
- Several members mentioned receiving **pressure from patients** or **carers and families**, i.e. competing patients with differing levels of need who require admission.

### Question 4: 'In your opinion, are decisions about admission or discharge ever made which compromise patient care and safety?'

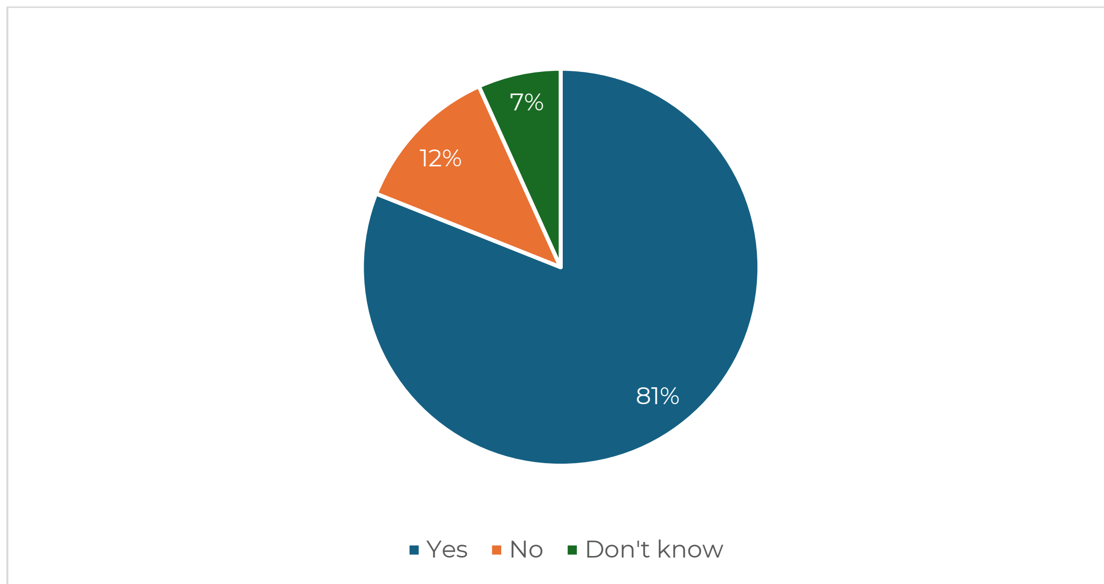
Almost three quarters (74%) of respondents located in England were of the opinion that such decisions made about admission or discharge have compromised patient care and safety. One in ten (11%) respondents did not know.



**Question 5: 'Have you experienced or witnessed 'moral injury' indicators amongst healthcare workers when making admission or discharge suitability decisions in the context of local capacity pressures?'**

The following definition of moral injury was provided to members: '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).

The majority (81%) of respondents working in England have experienced or witnessed 'moral injury' indicators amongst healthcare workers when making admission or discharge suitability decisions in the context of local capacity pressures. 7% of respondents did not know.




**Question 6: 'What solutions should be implemented at a local, regional, or national level to allow you to make decisions based entirely on the patient's clinical need and best interests?'**

Members were then asked to **provide potential solutions** that should be **implemented locally, regionally or nationally**, to allow psychiatrists to **make decisions based entirely on patients' clinical needs and best interests.** 830 written responses were received (a response rate of 97%) and can be grouped into the following themes:

- A large proportion of respondents suggested **improving the provision of social care, community mental health services and supported accommodation** to prevent the need for inpatient admissions and to reduce delayed discharges – their recommendations included:
    - Making more step-down options available and expanding appropriate placements to facilitate discharge from hospital, which are adequately funded and situated locally in the population. These could include supported short-term placements, day hospitals, and crisis and respite houses.
    - Improving the provision, capacity and safety of community mental health services to reduce the pressure on inpatient staff, prevent instances of delayed discharge, and enable admission avoidance. Members particularly suggested improving community services for people with intellectual disabilities and severe mental illness.

    - Improving substance misuse services, including providing supported living arrangements with integrated drug and alcohol services and the capacity to take dual diagnosis.
    - Ensuring there are specific pathways for homeless people to access safe accommodation; for example, specialist ring fenced provision for rough sleepers with mental illness, who have years of untreated illness and huge barriers to receiving care.
- Many respondents expressed the need for **sufficient local inpatient provision**, i.e. properly resourced local inpatient beds for all ages to improve patient flow, address patient needs, and meet demand.
- Many members also advised **adopting a system-wide approach**, where inpatient services, community mental health teams, social care services, local authorities and GPs share ownership of care and joint responsibility for safe discharges. Significantly more robust working partnerships with a better-informed social care provision could reduce length of stay, and facilitate a safe, sustainable and appropriate discharge from hospital back into the community.
- Many members suggested there be **improved, optimal infrastructure and resourcing within mental health services** to facilitate patient care pathways – some of their suggestions included:
    - Providing more resources to core community mental health teams to reduce unsafe practices around admission and discharge, prevent relapse, improve patients' physical and mental health, improve social engagement, and prevent the need for further inpatient treatment.
    - Having more psychiatrists available in community mental health teams.
    - Improving estates and IT infrastructure, thus making clinical decision-making easier and quicker.
    - Streamlining and lessening the burden of documentation and administrative work for clinicians, allowing more time for patient care.
- Several members also recommended **improving certain patient pathways** – some of the suggestions include:
    - Making inpatient pathways clearer with robust support at the points of admission and discharge (e.g. crisis resolution and home treatment).
    - Bridging the gap and bolstering the transition from mental health liaison inpatient services to community services, to ensure consistency and continuity of care. Members also suggested having clear, robust, multidisciplinary-team-(MDT)-facilitated and consultant-led care pathways available in the community. A member also highlighted the need for collaborative care and the co-production of service pathways.
    - Implementing improved and robust management pathways of care and community treatment for people with personality disorders and complex emotional needs. Members specifically cited that improved local services that bridge the gap between inpatient admission and crisis teams for patients with emotionally unstable personality disorder (EUPD)[2] should be implemented. Members also mentioned the need for more guidance around admitting people with EUPD to better guide decision-making, particularly around the values and harms of admission in this group.

[2] Members referred to EUPD in their responses, which we recognise is an alternative name for borderline personality disorder (BPD). In the latest diagnostic criteria, personality disorders are organised by severity and traits, but the College understands that many people were diagnosed under the previous criteria and that current treatment pathways are still relevant to these previous terms.

- A reimagining of how mental health services can better meet the needs of people with neurodevelopmental conditions – current inpatient settings, pathways and services are rarely well suited, leading to greater risk of comorbid mental illness, high levels of restrictive practices, problematic discharge, and unnecessary prolonged admission.
- Many members mentioned potential solutions involving **the psychiatric and wider mental health workforce**, including:
    - Improving psychiatric and community staffing levels to reduce workload, enable staff to respond sooner, and improve staff morale.
    - Addressing staff moral injury and burnout, and providing better support for the psychiatric workforce, including reviewing pay/banding. This in turn will improve recruitment and morale, reduce staff sickness and absence levels, and reduce the need to hire locum psychiatrists.
    - Implementing strong mentorship programmes for staff.
    - Increasing national training posts for psychiatrists.
- A substantial proportion of respondents also suggested **improvements to decision-making processes** regarding patient admission and discharge – recommendations include:
    - Placing patient-needs at the centre of decision-making, rather than KPIs. Ensure any KPIs are patient-centred and reflect improvements in patient outcomes. Putting ethnical practice rather than operational priorities at the heart of decision-making.
    - More improved, transparent communication between staff and managers.
    - Staff involved in the direct and relational care of the patient should have the responsibility to make admission/discharge decisions in the patient's best interests.
    - Some members believe bed management interference should be removed from clinical decision-making processes – there should be more clinical autonomy over bed management and clinician-led decision-making.
    - Some members also think there should be proper accountability and transparency around admission/discharge decisions made by bed managers.
    - Trusts should be prevented from setting targets regarding the number of discharges per week – these targets could lead to further patient safety issues.
    - A few members suggested there should be training for bed managers to ensure the way they communicate requests for clinical review does not coerce doctors, especially more junior ones, to take decisions that could compromise patient safety.
- Many respondents mentioned **investing more into mental health services**, including:
    - Addressing the national shortage of inpatient beds; sufficient funding should be allocated to allow for people to be safely cared for within inpatient settings.
    - Ring-fenced funding for the recruitment, retention and training of psychiatric staff across ICBs.
    - Better allocation of funding between physical and mental health provision.
    - Investment in novel treatments to reduce the need for inpatient treatment.
    - Investment in community mental health services, so that teams are more able to care for people with severe mental illness and thus reducing the need for admission.
    - Additionally, more funding for social care services.
- Some members suggested that **national bodies should acknowledge the critical shortfall in local service capacity**. Members also suggested that local mental health services and ICBs be transparent with patients about local capacity pressures. Members

think it is important to have a wider national understanding of the pressures in mental health services.

- A few members also suggested that it would be useful **to understand the mental health needs of local populations** through improving data collection and using demand forecasting to understand and project the number of beds and levels of staffing needed locally.

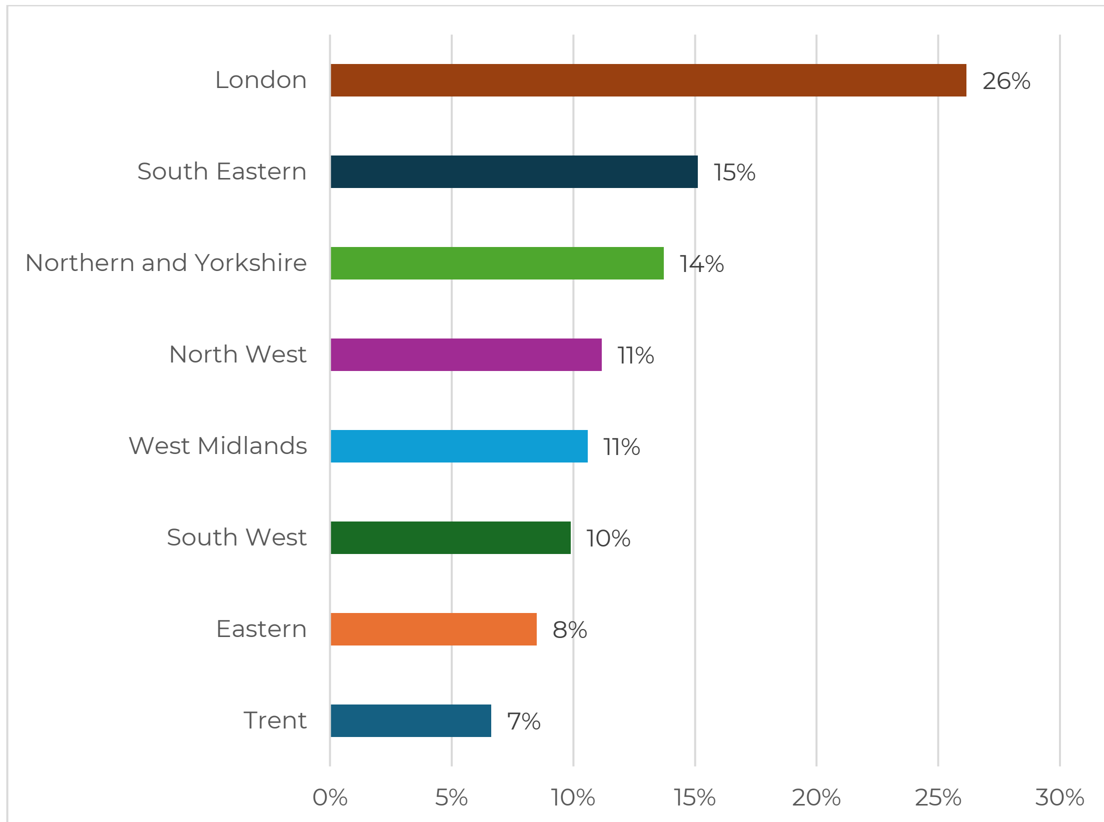
These recommendations require cross-system collaboration and collective implementation; no one aspect of the health system alone can reverse the worsening trends.

## Membership details and demographic information

Members were asked a range of questions relating to their grade, sub-specialty, and experience.

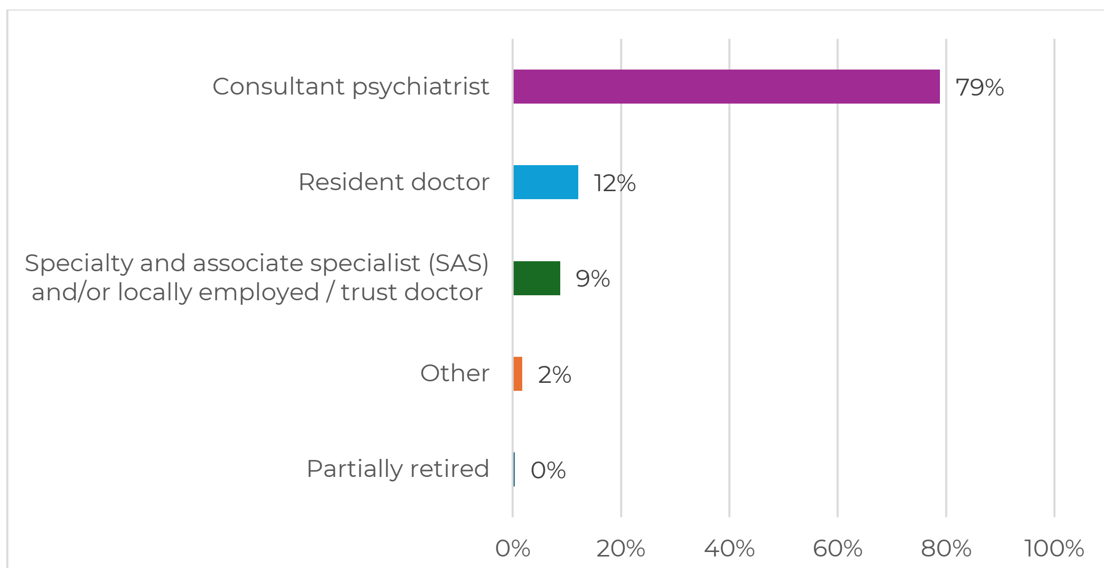
*'What is the geographical location of your employer?'*

In total, 860 (85%) of all respondents work in England. Among the respondents who are located in England, over a quarter (26%) are based in London, 15% in the South East, and 14% in Northern & Yorkshire. Less than 10% of respondents are located in the Eastern and Trent divisions, with 8% and 7%, respectively.



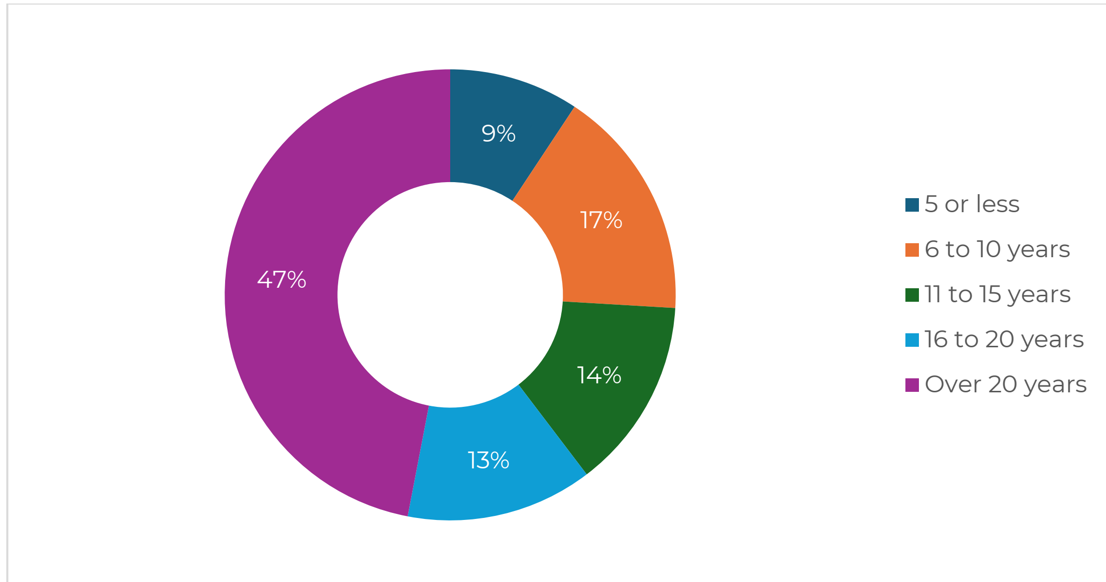

*'What option best describes your role as a doctor?'*

The majority (79%) of respondents from England are consultant psychiatrists, 12% are resident doctors, and 9% are specialty and associate specialist (SAS) or locally employed (LE) doctors.



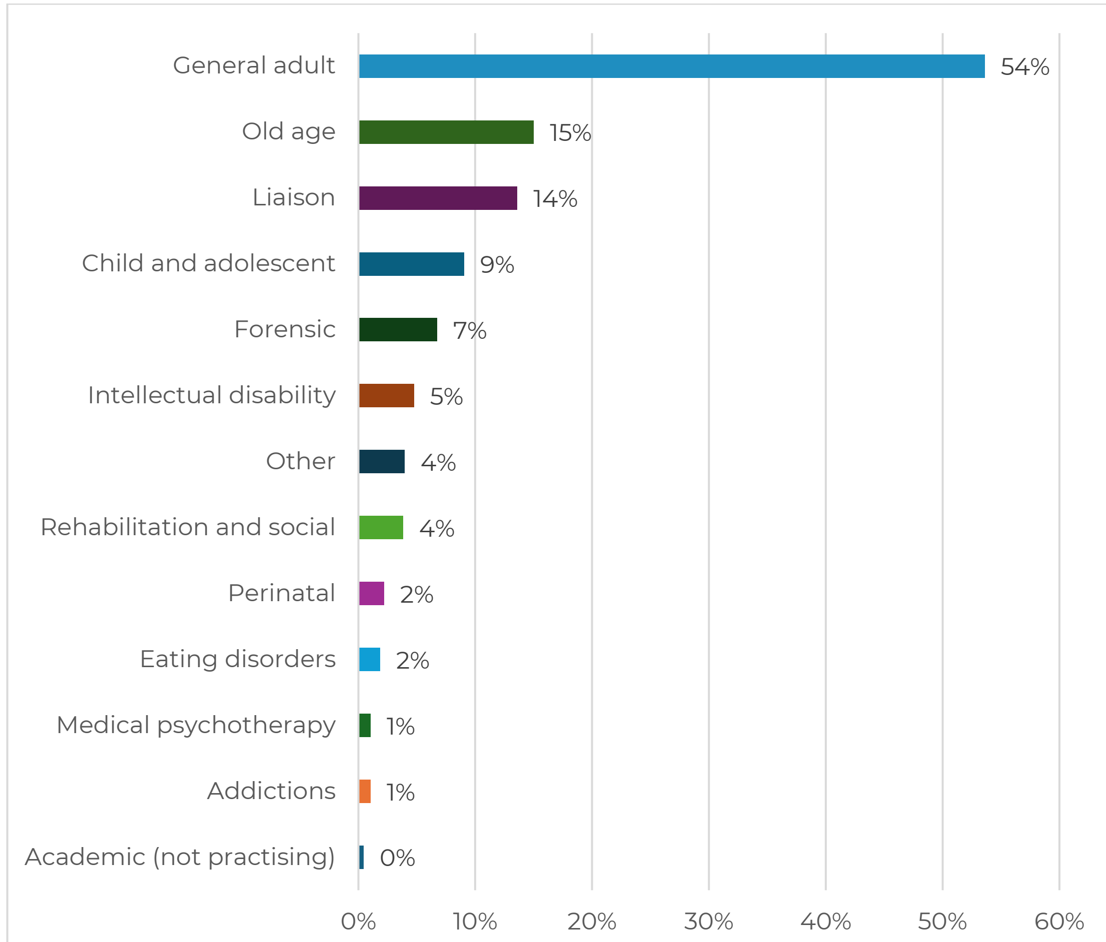
*'How many years have you practised?'*

Just under half (47%) of respondents based in England have practised psychiatry for over 20 years, with 17% practising for 6 to 10 years, 14% for 11 to 15 years, and 13% for 16 to 20 years. The smallest proportion (9%) of respondents have been practising for 5 years or less.



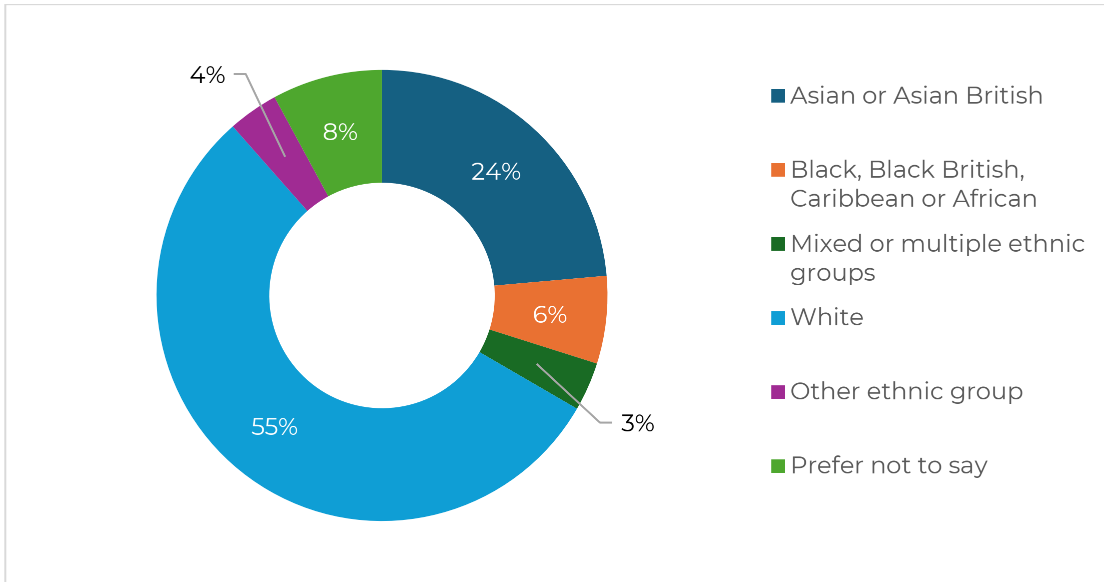

*'What specialty are you currently practising in?'*

More than half (54%) of respondents based in England specialise in general adult psychiatry, followed by old age psychiatry (15%) and liaison psychiatry (14%). Only 1% of the respondents each practise addictions psychiatry and medical psychotherapy.



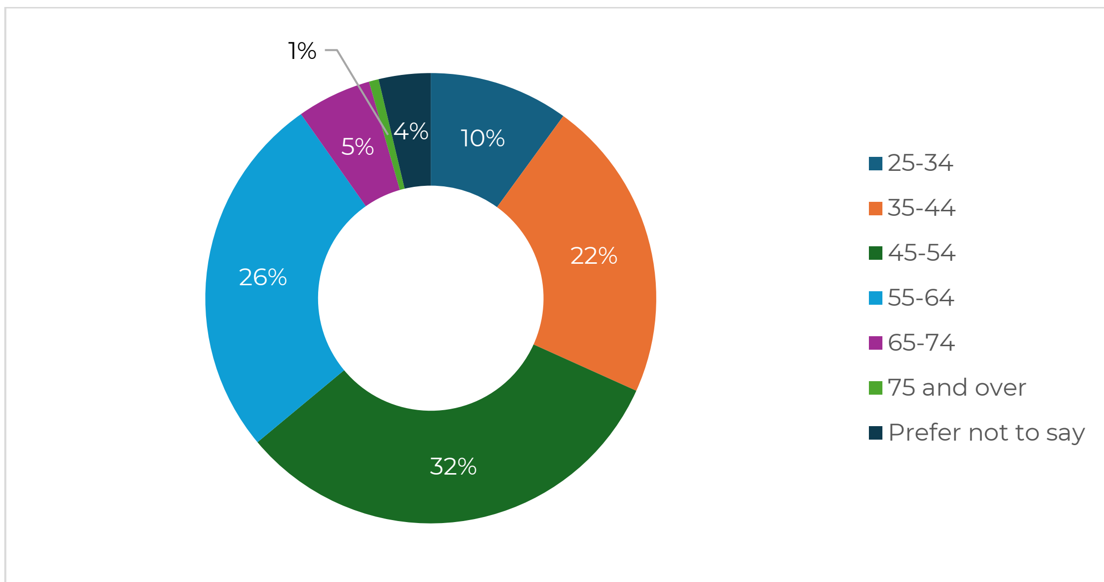
*'What ethnicity do you identify with?'*

Over half (55%) of the respondents in England are White, followed by a quarter (24%) who are Asian or Asian British, 8% who preferred not to say, 6% who are Black, Black British, Caribbean or African, 4% who are from Other ethnic groups, and 3% who are from Mixed or multiple ethnic groups.



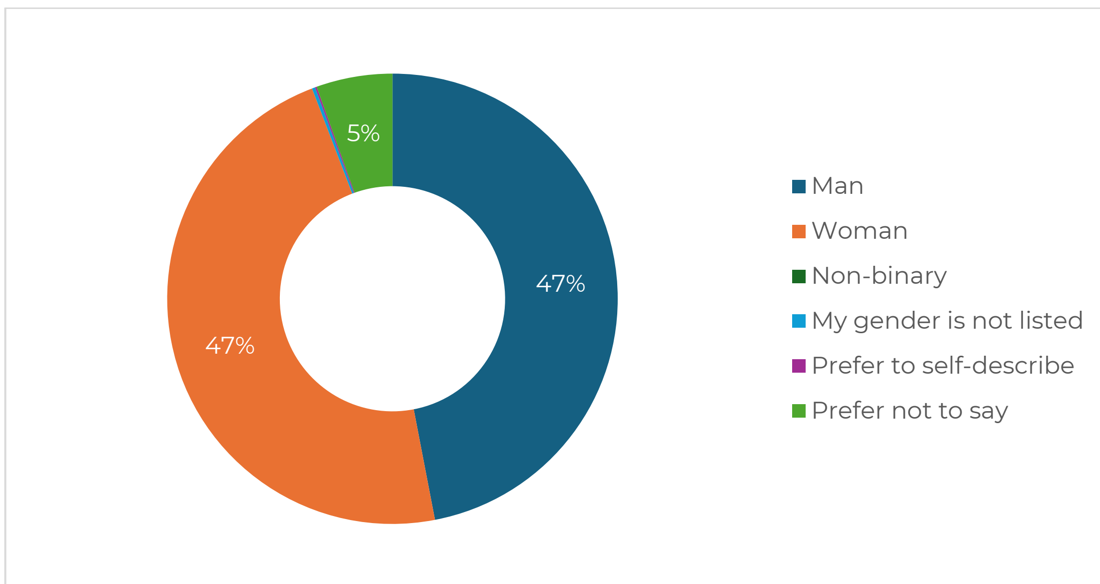

*'What age bracket do you belong to?'*

Almost a third (32%) of respondents based in England are aged between 45 and 54 years, followed by 26% who are aged 55 to 64, and 22% who are aged 35 to 44. 6% of respondents are older than 64 and 10% are younger than 35.



*'Which of the following best describes your gender?'*

An equal proportion of respondents from England are men and women, both with 47%. 5% of respondents preferred not to say.



## References

[1] Health Services Safety Investigation Body. Mental health inpatient settings: overarching report of investigations directed by the Secretary of State for Health and Social Care. 13 May 2025. Available online: https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/fifth-investigation-report/.

[2] 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.

[3] Care Quality Commission. High demand, long waits, and insufficient support, mean people with mental health issues still not getting the support they need. 4 April 2025. Available online: https://www.cqc.org.uk/publications/surveys/community-mental-health-survey.