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NHS England

GIRFT Clinical Operational Standards: Adult Acute Mental Health Urgent & Emergency Care

Standardising best practice to improve patient flow and reduce waiting times in emergency and acute care

April 2026

GIRFT Clinical Operational Standards:
Adult (age 18+) Acute Mental Health Urgent & Emergency Care

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Introduction

The NHS continues to face significant challenges in delivering timely and effective urgent and emergency mental health care. Demand for mental health support is rising, with increasing numbers of people presenting in crisis and requiring immediate assessment, intervention and support. National priorities emphasise the need to reduce long waits for mental health assessment and treatment, improve the timeliness of crisis responses in the community, and ensure that people receive the right care, in the right place, at the right time.

Local audits show that most patients referred to liaison psychiatry also have concurrent medical needs. While an emergency department (ED) should never be the default location for same-day, non-emergency mental health care, EDs remain an appropriate and necessary setting for joint assessment, care and treatment by emergency medicine and liaison psychiatry - provided patients can be discharged or transferred in a timely manner. However, current performance varies significantly across England, and many services face pressures that affect their ability to deliver consistently high-quality, responsive mental health urgent and emergency care.

These challenges are reflected in national data (GIRFT's Summary Emergency Department Indicator Table (SEDIT) for January 2026), where 26% of all mental health presentations now breach 12 hours in ED, with marked regional variation. While some delays relate to mental health pathways, many patients with mental health needs awaiting admission to acute specialties - such as medicine, surgery and orthopaedics - also experience extended stays. These delays harm patient experience and outcomes and place significant pressure on ED staff. Improving this requires shared responsibility across emergency medicine, acute specialties and mental health services to provide suitable clinical environments, co-ordinated inter-specialty decision-making, and equitable access to medical and surgical care.

In response to these challenges, GIRFT has developed these Clinical Operational Standards (COS), which define best practice in mental health Urgent and Emergency Care (UEC). These standards draw upon national policy and guidance, local protocols and expert clinical opinion across crisis, community and acute mental health services. By reviewing current practice against these standards, systems and providers can identify gaps, understand variation and prioritise areas for improvement across the whole pathway.

Progress is already being made: crisis response services continue to expand; 24-hour urgent and emergency mental health services are increasing; and 82% of acute hospitals with a Type 1 ED are now commissioned to the minimum Core 24 standard (8th National Survey of Liaison Psychiatry in England, 2024). Nevertheless, prolonged waits for specialist mental health assessment and delays in accessing inpatient beds remain areas of significant concern. Addressing these issues is essential if we are to deliver a safer, more responsive experience for people in mental health crisis.

The NHS is making meaningful progress across urgent and emergency care, and these mental health Clinical Operational Standards aim to help trusts, systems and partners build on that momentum - ensuring that people experiencing a mental health crisis receive timely, safe, high-quality care wherever and whenever they need it. We need to embed these standards – developed by clinicians, for clinicians and operational teams – before next winter as a minimum standard.

Professor Tim Briggs CBE - ***GIRFT programme lead and National Director for Clinical Improvement, Elective Recovery and UEC for NHS England***

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What are the operational standards?

GIRFT has developed the Clinical Operational Standards (COS) for adult (18+) acute mental health urgent and emergency care to support effective 'front door' care for adults presenting to emergency departments with acute mental health needs. More comprehensive standards for specific disorders and related sub-specialty pathways will be developed in collaboration with key stakeholders.

Based on national policy, guidance and expert clinical opinion, these standards set out care, from deterioration in the community requiring an emergency mental health response through to admission to an inpatient mental health bed.

These standards should be used in conjunction with the UEC Mental Health Winter Action Cards which provide brief, operational prompts designed to help teams turn the wider mental health urgent and emergency care standards into immediate actions at pathway level.

The standards describe how staff are expected to work, including the required actions, responses and associated timeframes needed to deliver optimal patient outcomes.

All clinical and operational staff should be familiar with the standards, and their views should be actively sought and considered. The standards should remain focused on patient care, championed by clinical leaders, and applied in a way that keeps the patient central to all decisions.

How should the standards be used?

- Operational teams and clinicians should work together to assess whether their service is delivering the care and behaviours described in the standards.
- Acute care teams should identify any gaps and collaborate with specialty teams to ensure the standards are implemented.
- Successful implementation of the standards requires engagement and support from the trust executive team.

How can the standards be embedded?

Having a written document alone is not enough. The standards should be used as a framework during the induction of new staff and included in annual updates for existing staff. They should become part of routine practice so that they are recognised as normal daily interactions. Senior staff can reinforce this by modelling the expected behaviours, particularly during periods of pressure or stress, to demonstrate what good practice looks like.

We need to embed these ways of working over the next six months as standard practice, certainly before next winter. They should represent 'how we do things here every day'. This can no longer be optional.

This document outlines key areas for improvement and should be read alongside the Red Tape Challenge report, which sets out the wider changes needed across the NHS to reduce bureaucracy and increase the time clinicians can spend on direct patient care.

Contents

The Clinical Operational Standards

Deteriorating community patients and those at risk of admission

Patients requiring an emergency response

Patients in the emergency departments of acute hospitals

Mental health inpatient flow

UEC MH Winter Action Cards 25-26

Clinical Operational Standards - Emergency Care pathways

Case Studies - Mental Health Improvement Support Team Network - Futures

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Clinically deteriorating community patients and those at risk of admission

Many patients whose mental health deteriorates are already under the care of community mental health services. To support deteriorating patients on community caseloads, the following standards should be adhered to:

1. Community services must have a clear process (e.g. through a daily team meeting or emergency duty system) to identify patients who are clinically deteriorating. Patients identified as at risk of admission must receive an urgent face-to-face response within 24 hours, alongside an urgent MDT discussion led by a senior (Tier 2) or expert (Tier 3) clinical decision-maker, as clinically appropriate.

2. Clinically deteriorating patients or those frequently using emergency departments must have co-produced, multi-agency (e.g. ambulance, NHS 111, and non-health agencies as appropriate) care and crisis plans reviewed and shared in written form. The plan must include diagnosis, biopsychosocial formulation and interventions to improve mental health and prevent relapse, and actions to respond to emerging crisis and risks. Crisis plans must be recorded on a system accessible 24/7 to mental health urgent and emergency care services and the patient and their carers/family should have a copy as appropriate.

3. Clinically deteriorating patients must receive regular medication reviews by their prescriber, including a review of concordance. Teams must ensure depot medication is tracked so it is administered as prescribed. Deteriorating patients under a Section 17A Community Treatment Order (CTO) of the Mental Health Act, must receive an urgent assessment of the need to 'recall' in line with relevant guidance (e.g., NICE NG53, MHA Code of Practice).

Tiers of clinical decision makers

Tier 1: Resident doctors and Band 6 mental health practitioners and above (not including Tier 2 and 3 decision makers)

Tier 2: Specialty psychiatrists, specialty registrars (ST4-ST6) and non-medical consultant grade mental health practitioners

Tier 3: Consultant psychiatrists, specialist psychiatrists, non-medical consultant mental health practitioners who are prescribers and/or non-medical approved clinicians.

MHA Code of Practice

NHS Clinically-led Review of Access Standards

RCPsych Accreditation for Community Mental Health Services

NICE Guidance NG53

Clinically deteriorating community patients and those at risk of admission (continued)

4 Admission of a patient with a predictable course of deterioration, whether informal or under the Mental Health Act, should be timely rather than as a last resort. This may prevent escalation of risk and a prolonged admission. Senior (Tier 2) or expert (Tier 3) clinical decision-makers should consider nature and not only degree when assessing the threshold for admission under the Mental Health Act.

5 Care plans for co-morbid substance misuse must be developed jointly with Co-occurring Substance Use and Mental Health Disorders (CoSUM) services. Patients with co-morbid substance use must not be excluded from crisis support services.

6 Clinically deteriorating patients must have their support needs reviewed though a Care Act assessment, and an assessment of carers needs where appropriate. Both assessments must be repeated at least annually, or more frequently if clinically indicated.

7 If a clinically deteriorating patient does not attend appointments, staff must take an assertive approach to follow up, including liaising with appropriate agencies (e.g. social services, housing, criminal justice system) and seeking collateral information from family and carers, as appropriate, taking into account the principles of the Triangle of Care and Confidentiality: NHS Code of Practice.

- NICE Guideline NG58
- Care Act 2014 Section 9
- Mental Health Act 1983
- Triangle of care and Confidentiality
- Co-occurring substance use and mental health disorders (CoSUM)
- NHS Code of Practice-Confidentiality

Patients requiring an emergency response

If a patient presents with mental health problems and there are risks to their health/safety, or to others, they will require immediate support, assistance and care from urgent and emergency mental health services. These situations must be met with urgent and immediate responses in line with the following standards:

1. NHS 111 #2 (mental health) must be available 24/7, with sufficient capacity to provide a timely response and prevent abandoned calls. Staff must have access to a Directory of Services (DoS), to refer patients to appropriate support in a timely manner, to avoid unnecessary emergency department attendance.

2. The Adult Crisis and Home Treatment Team (CRHT) must provide a face-to-face response **within four hours (24/7)** with the management plan signed off by a senior (Tier 2) or expert (Tier 3) clinical decision-maker **within 24 hours**. CRHT must complete a full biopsychosocial assessment to formulate an urgent and emergency mental health care plan, co-produced with the patient and, where appropriate, their family or carers. This must be reviewed at least **every 24 hours**, or more frequently as clinically indicated, by a senior (Tier 2) or expert (Tier 3) clinical decision-maker.

3. Mental Health Response Vehicles (MHRVs) must be part of a core emergency mental health response to provide appropriate interventions in situ (e.g. active listening, validation) or an onward referral (e.g. to CRHT, or conveyance to crisis cafes, mental health emergency departments), as well as to reduce unnecessary conveyance to emergency departments.

4. Where a patient is detained under Section 136 or 135 of the Mental Health Act, the assessment should take place in a Health Based Place of Safety (HBPoS), which must be **available 24/7**, and identifiable to police through a managed system. Emergency departments should only be used where a HBPoS is not available or physical health care needs are present. Inappropriate use of emergency departments as a HBPoS must be monitored with appropriate operational action.

- Tees, Esk & Wear Valleys NHS Foundation Trust: NHS 111 +2 Case Study
- Mental Health Crisis Care for Londoners: Section 136 Pathway and HBPoS Specification
- RCPsych Practice Guidelines for Crisis Line Response & Crisis Resolution & Home Treatment Teams
- NHSE Mental Health Access & Waiting Time Standards
- The Model ED
- NICE Guidance NG10

Patients in the emergency department of acute hospitals

While an emergency department should never be the default option for non-emergency same day mental health care, most patients with mental health presentations also have concurrent physical health needs. It is imperative that emergency departments, acute hospitals, and mental health services work collaboratively to optimise patient experience and outcomes.

- Liaison outcome measures
- Liaison Side by Side assessment
- Mental Health Units (Use of Force) Act 2018
- NICE guidance- Self Harm
- PLAN accreditation

1. Mental Health Liaison Teams (MHLT) must respond to an emergency department referral within a **maximum of one hour** of presentation. A parallel system of mental and physical health assessment must begin at emergency department reception or triage, including a personalised risk assessment and safety plan to support the patient while they remain in the emergency department.

2. MHLT must complete a full biopsychosocial assessment, co-produce an urgent and emergency mental health care plan **within four hours** of the patient entering the emergency department. Wherever clinically appropriate and safe, the MHLT should also arrange referral, transfer or discharge within this timeframe. The assessment and care plan must be trauma-informed, proportionate and developed collaboratively with the patient and, where appropriate, their family or carers, and must include alternative treatment options such as home-based care, crisis assessment services, or crisis houses. The care plan must be reviewed at least **every 24 hours**, or more often if clinically indicated, by a senior (Tier 2) or expert (Tier 3) clinical decision-maker, particularly where undue delays occur, such as for a Mental Health Act assessment or inpatient admission.

3. Every emergency department must have at least one room suitable for high-risk assessments that meets Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network (PLAN) standards and has appropriate environmental design (NG10). Emergency departments must ensure that patients with mental health needs receive care and treatment in the most suitable and least restrictive environment.

Coding of mental health presentations in the ED

Staff must complete the chief complaint and/or diagnosis field for all emergency department attendances with confirmed or suspected mental health needs for Emergency Care Data Set (ECDS) reporting. If mental health needs are uncertain, the diagnosis must be recorded as suspected. Where an injury is present, staff must complete the injury intent field and code the injury as self-inflicted only when the harm was intentional. Attendances should be recorded as mental health-related only when mental health need is the reason for the visit, not when mental health conditions are incidental.

Patients in the emergency department of acute hospitals (continued)

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4 Emergency departments must provide one-to-one observation by suitably skilled healthcare staff, with the need for observation, frequency of review, medications, and brief interventions jointly agreed by emergency medicine and liaison psychiatry. All interventions must follow least-restrictive practice guidance. Acute behavioural disturbance to be managed in line with RCEM guidance.

5 Before MHLT consider admission, they must assess all community treatment options as part of their gatekeeping function, including seeking telephone advice from a CRHTT practitioner or a Tier 2 senior or Tier 3 expert clinical decision maker. If the decision maker needs to attend in person to advise or provide care, support or treatment, they must attend the emergency department immediately to avoid undue delay.

6 When a decision is made to admit a patient to a mental health ward, staff must clearly formulate the purpose of admission and the criteria for discharge. A hospital bed alone is not a treatment. The rationale must include why alternative settings are not clinically suitable. An initial treatment plan must be outlined on admission and agreed by a senior (Tier 2) or expert (Tier 3) clinical decision-maker.

7 If there is a risk of a 12-hour breach due to, for example, delays in either a Mental Health Act assessment or admission to a mental health inpatient bed, MHLT and/or the acute trust must escalate this through jointly agreed operational and on-call protocols. The patient's treatment should commence in the ED and be reviewed as per Standard 2.

8 Mental Health Trust bed management teams must operate a clear and consistently applied admissions prioritisation protocol, using principles such as those in the NHS Risk Matrix Tool, recognising the significant risks to patient safety and the poor patient experience associated with prolonged waits in an emergency department. Inpatient capacity must be managed in accordance with the Operational Pressures Escalation Level (OPEL) framework.

9 Mental health trusts must routinely monitor and address the key drivers of 12 hour+ mental health emergency department breaches, including delays related to Approved Mental Health Professionals (AMHPs) and Section 12 doctors, using the GIRFT Mental Health Emergency Department Breach Analysis Tool. Data on mental health emergency department breaches, associated incidents and patient experience must be reported to and reviewed by trust boards, with appropriate clinical and operational mitigations implemented in response.

RCEM Absconding Guidance

NHS OPEL Framework

GIRFT 12-hour+ MH ED Breach Analysis Tool

UEC MH Winter Action Cards 25-26

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Mental health inpatient flow

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The lack of available acute admission beds (including Psychiatric Intensive Care Unit (PICU), adult and older adult organic and functional beds) can significantly delay the transfer of patients from emergency departments. To maximise inpatient capacity and minimise these delays, a proactive, flow-focused approach to inpatient care must be adopted, incorporating the following standards:

1. Admission to inpatient care must be purposeful and time-limited, with care and treatment plans linked to clearly defined outcomes that cannot be safely achieved in any other setting. These outcomes must determine criteria-led discharge and the estimated duration of admission.

2. A senior clinical decision-maker (Tier 2) or expert clinical decision-maker (Tier 3) must review care and treatment plans within twenty-four hours of admission.

3. Multidisciplinary team (MDT) formulation and care and treatment plans, including the purpose of admission and criteria for transition into the community, must be available or updated within seventy-two hours of admission.

4. There must be a daily multidisciplinary team (MDT) review focused on progress against the purpose of admission, treatment outcomes, and any barriers to discharge, with named actions allocated and tracked. Red2Green (R2G) principles should be applied to reduce unnecessary 'red days' in hospital.

5. There must be clear multi-agency systems for the escalation and resolution of patients who are deemed Clinically Ready For Discharge (CRFD), with actions allocated and tracked on a daily basis.

6. Early discharge must be facilitated by proactive in-reach from the patient's CMHT and/or CRHT, other relevant community services, in line with the principles of discharge to assess. The patient, family and carers must also be involved in co-producing the discharge plan as appropriate.

7. There must be systems in place to review patients with very long length of stay i.e. >90 days on older adult, organic and functional beds, and >60 days for adults and PICU patients.

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