

Developing your project aim

Overall problem/area issue:	There are significant challenges in meeting the need for mental health presentations in the ED.
Your purpose in wanting to improve this (WHY):	To develop and embed; - Clearer interface pathways between ED and MH Services - Policy for those informal or detained patients in ED awaiting a mental health In-patient bed. - Reduce Long Waits in ED or waits for transfer from inappropriate ward admissions - Understand impact, outcomes and experiences of patients who have been exposed to these type of situations (including those accessing ED with none MH presentations) and improve patient experience. - Understanding the impact on staff working (moral injury to staff, considering rates of sickness) within these settings, understanding legal framework for people waiting in ED or on an acute general ward setting. - Develop a process for medical oversight of those patients who are waiting for psychiatric input. - Identify further opportunities for service improvement / Continuity of Care - Data review from what is available across the services including ED attendances and preadmission data, LPS data and patient journey pathways considering health inequalities such as age and gender and use of Restrictive Practise and link to risk (PAR). - Cross reference EPR and Incidents (RRP), are these being captured?
Your proposed SMART aim statement:	By August 2026, we aim to enhance the overall experience of patients, carers, and staff in the Emergency Department (ED) during mental health presentations. This will be achieved by reducing delays in accessing appropriate clinical environments and avoiding unnecessary waits in the ED or acute general hospital settings. The initiative will improve access to crisis care, leading to a reduction in aversive incidents; including restraint, aggression, self-harm, and absconding, as well as mitigating moral injury among staff. We will also strengthen experiential feedback and data collection across the service to inform and advance clinical practice in a meaningful, evidence-led way.
What further scoping or tools will you use to understand the problem further:	A mix of qualitative and quantitative tools as well as some practical ways of engaging with frontline teams, patients, and carers. Real-time Service Data Dashboards: Use live metrics to analyse and monitor attendances, wait times, restraint incidents, staff availability, bed occupancy, and escalation rates. Examples from Diis (LoW, Diagnostics / SMI in Dorset population, Powerbi for LPS to include referral rates, outcomes and discharge data, UHD System data to look at High intensity user data, waiting time data. Query level of data held by SWAST – preadmission data. Any activity data available – 1hr and 24 hr data, MHLI Inpatient TCI lists. Experience-Based Co-Design (EBCD): Engage service users and staff in shaping improvements based on lived experiences. Lived Experience participation within the Service Improvement Plan. 15 steps walkaround. Incident and Datix Report Review: Analyse past critical events for themes related to system failure, decision-making delays, or escalation risks. TCI lists, LoWs, Escalations across the systems due to lack of specialist service availability. Workforce information – sickness, moral injury to staff Staff Feedback Platforms: UHD and DHC to provide anonymous surveys or facilitated focus groups to explore moral injury, burnout, and perceptions of safety. Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs): Capture insights directly from people presenting in crisis (is this a possibility) patient feedback / complaints? Deep Dives to follow patient journeys. Examples – Safewards in ED
What scale are you operating at within the system? (micro, meso or macro) and list the areas involved in your project	MICRO: ED attendances, direct experiences of patients presenting with mental health crises in the ED, Interaction quality, initial triage, environment, wait times and escalation risks. MESO: Flow and Access Metrics, No. of patients waiting for admission to adult acute mental health inpatient beds, Length of Stay (LOS) in ED whilst waiting for transfers or assessment, Discharge pathways from ED to community options.

Project Charter

A simple one pager to help define your project

Problem Statement		Outcomes (what do you intend to achieve from this project, what are the outcomes? What will it improve? How will things be better? Evidence your outcomes are achieved)	
(what is the current problem & why does it need to be improved?)			
An increasing number of individuals experiencing mental health distress are presenting to Emergency Departments (EDs) as their first or only point of access to care, often bypassing community-based services that may more appropriately meet their immediate needs. This trend reflects both a breakdown in community mental health pathways and a reliance on EDs by other services as default “places of safety,” contributing to pressure on acute settings. Patients arrive in EDs via multiple routes, including self-presentation and emergency ambulance conveyance, but it remains unclear whether current triage and referral processes adequately differentiate between those needing inpatient admission and those who could be safely and effectively supported in community alternatives. The appropriateness and consistency of signposting to Mental Health, Learning Disability (MHL) services including crisis care pathways is variable, leading to delays in care, prolonged ED stays, and missed opportunities for early intervention. Existing pathways into inpatient admission or onward mental health care are often opaque, contributing to inefficiencies, patient distress, and moral injury among frontline staff managing frequent escalations. Without a comprehensive understanding of how people access EDs, what alternatives exist, and whether those alternatives are well-communicated and coordinated, the system risks perpetuating reactive care models rather than proactive support aligned to individual needs. This project aligns closely with the UK government's latest reforms particularly the Mental Health Bill 2025 and the 10-Year Health Plan, which signal a major shift toward modernising mental health care delivery, especially within emergency settings. The emphasis on reducing reliance on EDs as default crisis access points, expanding dedicated mental health emergency departments, and strengthening community-based care models reinforces the urgency and relevance of this work. The project will directly contribute to realising these national priorities.		This project will lead to significant improvements in how individuals presenting with mental health needs are supported across emergency and community settings. By August 2026, the work aims to: Ensure timely access to the right care in the right setting, avoiding unnecessary ED attendance and reducing inappropriate admissions. Patients will be supported to access community-based crisis support and mental health services aligned to their level of need, with clear referral mechanisms in place. Deliver transparent and well-communicated mental health pathways, improving signposting for patients and carers, and enabling clinical teams, especially Community Mental Health Teams (CMHT), to direct individuals to appropriate alternatives rather than defaulting to ED as a place of safety. Enhance access to alternative Access Mental health, Crisis Specialist Services in Mental Health as opposed to the ED. Reduce the impact and risks associated with long waits in ED, particularly among patients awaiting inpatient mental health beds. Evidence shows that extended ED stays correlate with elevated distress, poor outcomes, and increased use of restrictive practices. Achieve a measurable decrease in aversive incidents, such as resistance, aggression, absconding, and self-harm, by promoting earlier intervention and avoiding unnecessary escalation in high-pressure environments. Improve staff safety and morale, by reducing moral injury and supporting clinicians more suitable options for care escalation, clear pathways, and shared responsibility across services. Strengthen patient experience and equity of access, using experience, feedback and service data to ensure pathways are appropriate, compassionate, and responsive to individual needs. Evidence of Impact may include: 1. Comparative data on ED attendances for mental health pre- and post-intervention 2. Reduction in ED length of stay for patients awaiting MH beds 3. Increase in referrals directly to MHED or community alternatives 4. Decrease in reported incidents (e.g. Datix data on restraint and aggression) 5. Staff surveys and patient PREMs/PROMs – Lived Experience involvement with Peer Specialists / Dorset mental health Forum to seek and measure patient experience. Community MH access metrics and CMHT usage reports	
In Scope (what will be covered by the project)	Out of Scope (what will not be covered by the project)		
Population: Adults (18+) presenting to ED with mental health concerns. Settings: Emergency Departments, Acute Mental health Services including Liaison Psychiatry Service, Patient flow, Access to Mental health Services – Crisis care, MHRV, and local community services. Focus Areas: Awareness and visibility of community alternatives to ED (e.g. Community Front Rooms, Retreats, Access Wellbeing Hubs, crisis cafes, talking	Children and Adolescent Mental Health Services (CAMHS) Specifically, issues relating to: Referral-to-assessment timelines for CAMHS Community-		