



*Royal College of Emergency Medicine*  
**Quality Improvement Programme**

**Emergency Department**

**Mental Health:  
Self-Harm**

**2025**

**National Report**

## Background

This Quality Improvement Programme (QIP) aims to identify areas for improvement and enhance the standard of care for patients presenting to UK Emergency Departments (EDs) with Mental Health (Self-harm).

The programme ran from 2022/23 - 2025. This report presents the results from Year 3 (January 2025 to December 2025), during which 115 EDs submitted 19,372 patient cases. The full charts for this period can be found in the [MH QIP Full National Results Handout](#).

## Why this QIP matters

### **Statement from Dr Nirmal James, Topic Lead**

The RCEM Mental health (Self-harm) QIP topic team would like to thank all participating ED's for their engagement and contribution, including the feedback provided over the past three years. The QIP is in its 3<sup>rd</sup> and final year, and the final National report summarises the 3 Fundamental standards along with other selected charts from year 3. We have included where appropriate results from year 1 and 2 to show how the QIP had progressed with regards to some of the key standards.

The QIP was primarily designed to address multiple domains of quality in health care for patients with a Mental Health (Self-harm) presentation to an ED such as a full and complete triage and risk assessment. The QIP helped address various facets of care by mapping a patient's journey through the ED and included evidence of compassionate and practical care. We hope the QIP has supported ED Staff to better understand issues around the care of patients presenting with mental health issues and in making iterative changes that have helped improve this care over the past three years

For further information on the clinical standards, methodology, and approach to analysis, please see the [Information pack](#) on RCEM's [Quality Improvement Webpage](#).

## Clinical Standards

The clinical standards set for this QIP are:

- Standard 1

Patients should have a mental health triage by ED nurses/clinician on arrival to briefly gauge their risk of self-harm and/or leaving the department before assessment or treatment is complete.

- Standard 2

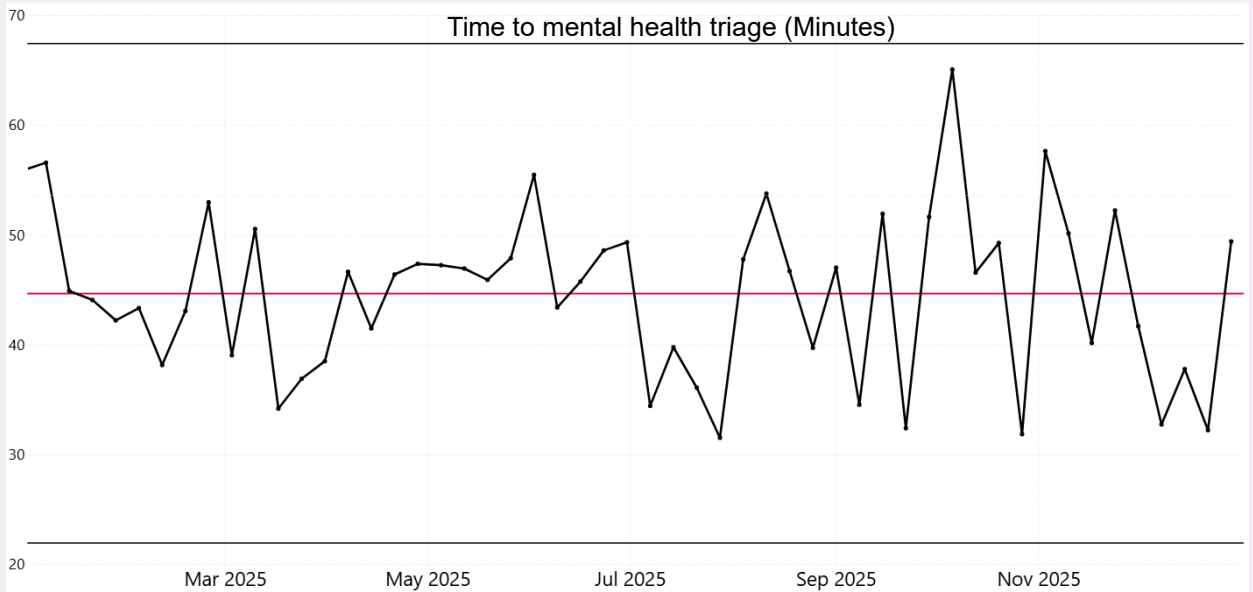
Patients at medium or high risk of further self-harm or of leaving before assessment and treatment are complete should be observed during the whole length of their stay in the ED.

- Standard 3

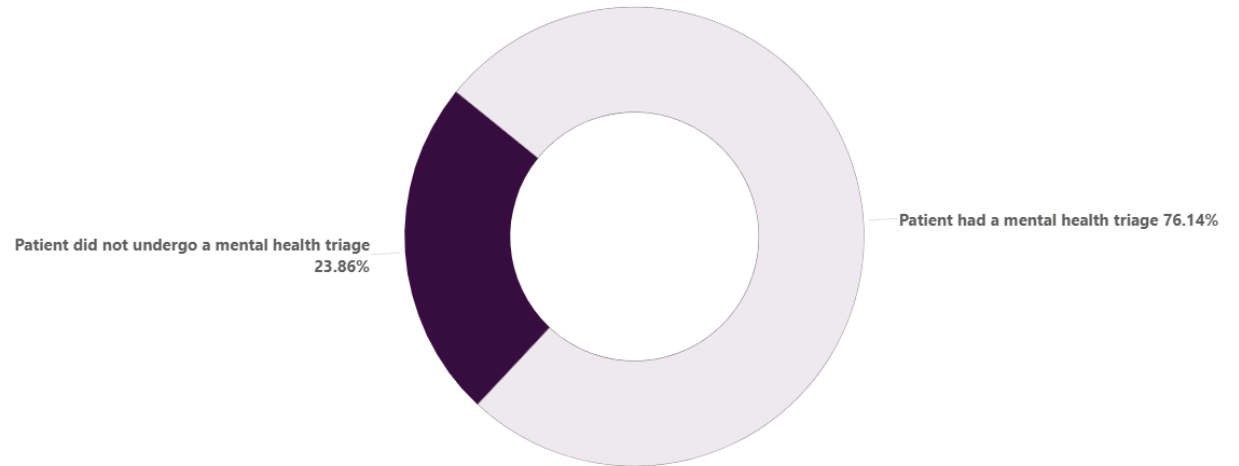
When an ED clinician reviews a patient presenting with self-harm, they should record a brief assessment of ongoing risk, including the type of self-harm, the trigger for the episode, a brief social history, and current thoughts of further self-harm.

## Clinical Standard 1: Mental Health Triage

The data shows that of those patients presenting with a Mental Health (Self Harm) problem, 76.1% underwent a Mental Health triage. This was lower than in year 2 (81.7%) and improved on year 1 (74.6%). The mean time to triage was 45 minutes which was worse than in year 1 (38 minutes) and year 2 (42 minutes). Whilst there be myriad reasons for these changes, they may be reflective of system pressures.



Patients who received a mental health triage

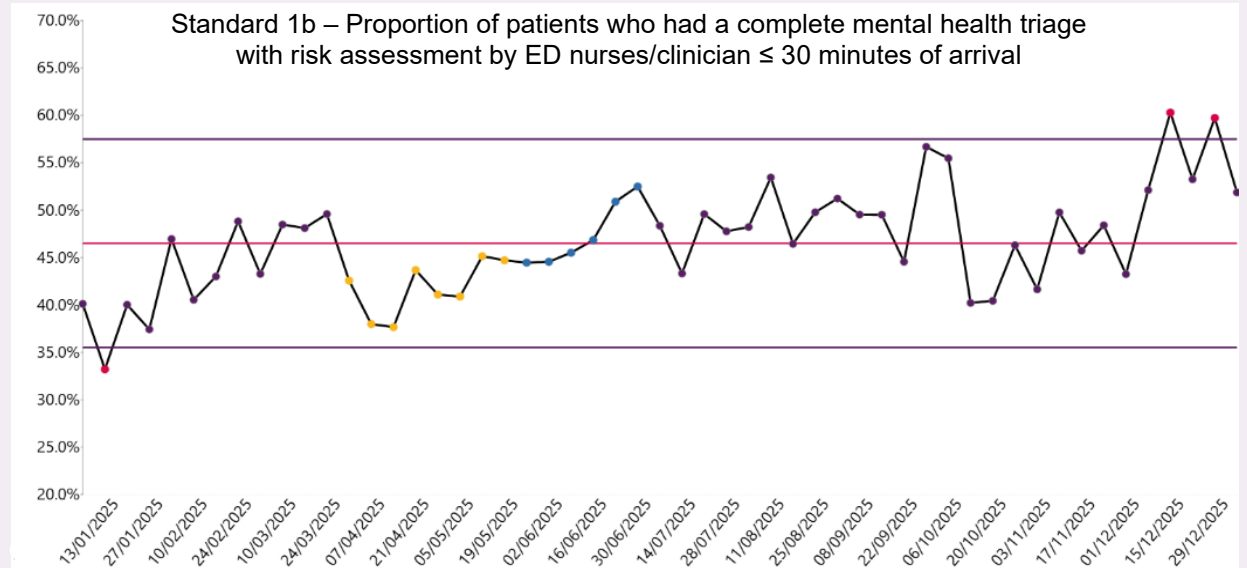
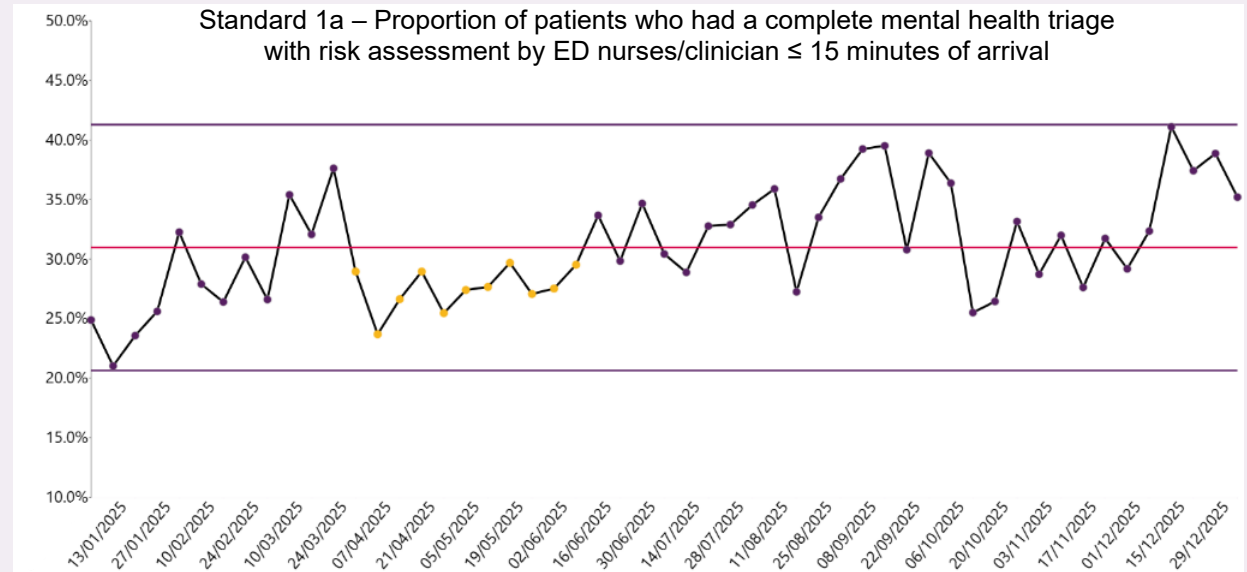


## Clinical Standard 1: Mental Health Triage continued

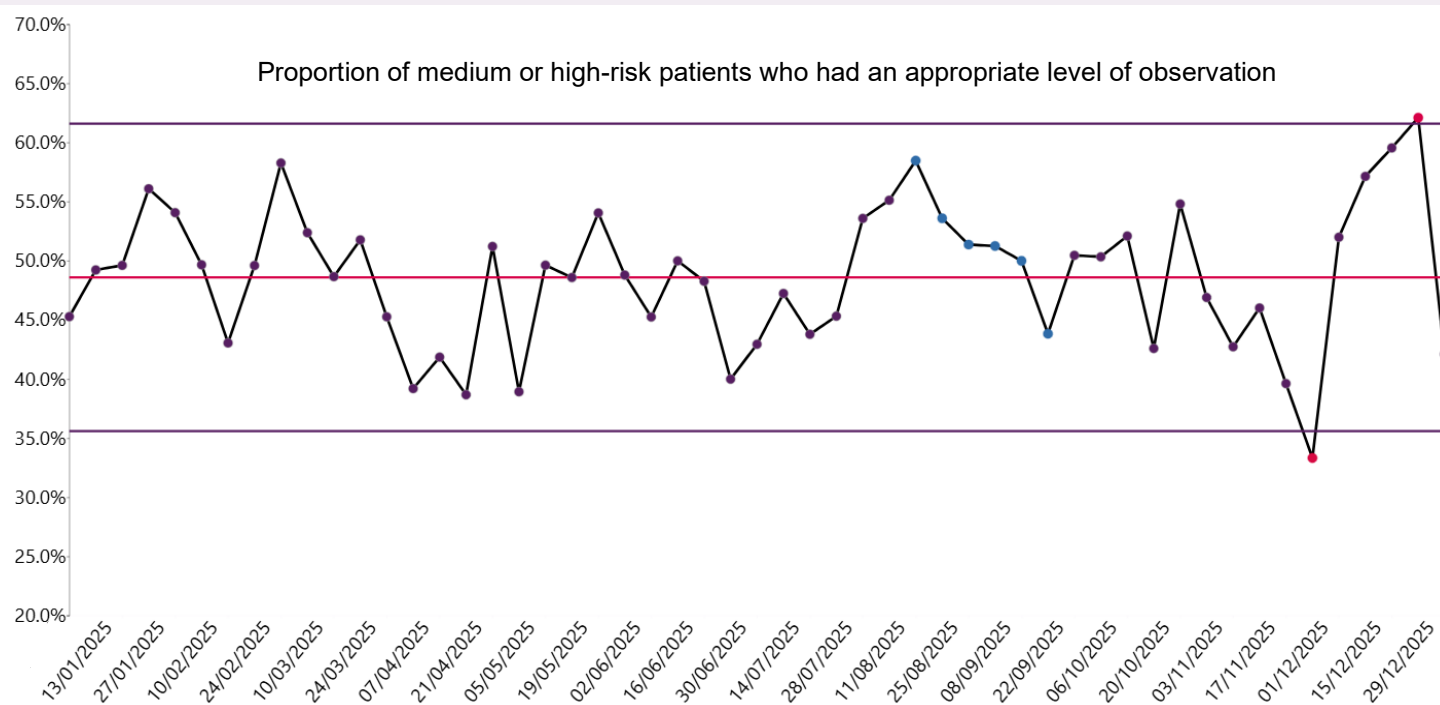
The percentage of patients receiving a Mental Health triage within 15 minutes of arrival in ED has remained largely unchanged at 30.7% compared to year 2 (31.1%). However, a small improvement of 1.4% has been seen in the percentage for those receiving a Mental Health triage within 30 minutes of arrival in year 3.

### Recommendations:

- Continue to focus on improving the time from attendance to triage which is vital to the identification of those patients at risk of self-harm and the risk of absconding before being reviewed by a clinician.
- ED's should follow their local policy when triage is delayed due to high volumes of patients.



## Clinical Standard 2: Proportion of medium or high-risk patients who had an appropriate level of observation (good evidence of continuous or intermittent observation, interaction or care)



An average of 48.6% of patients at medium or high risk of self-harm and absconding were appropriately observed during their ED stay. This represents an improvement on year 2 (42.8%) and a vast improvement on year 1 (29.1%).

### Recommendations:

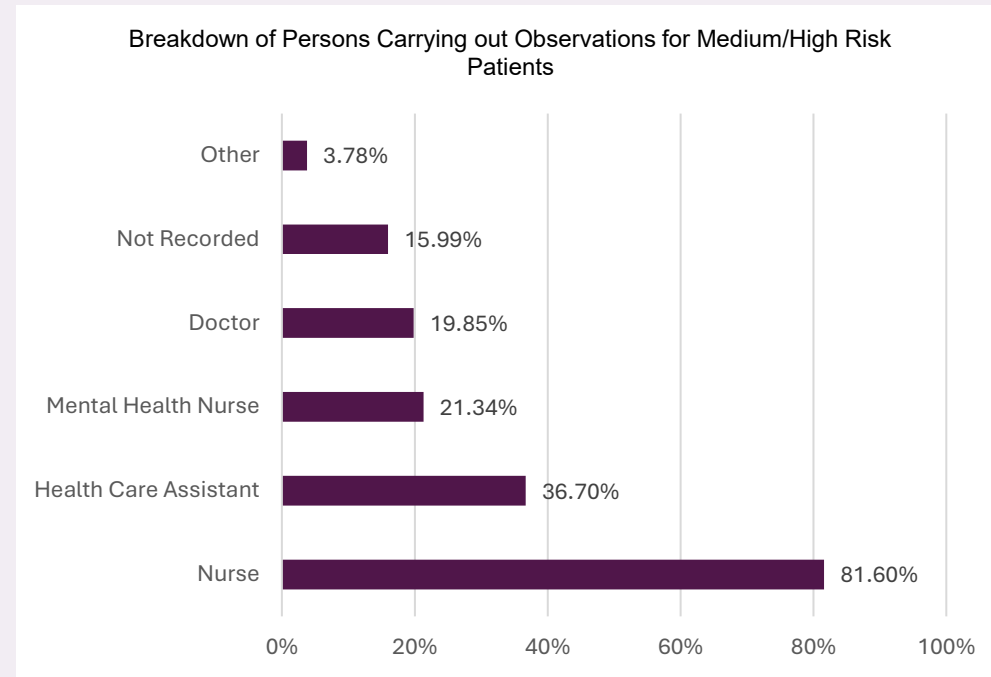
- Trusts should ensure there is a policy in place that relates to the continuous observation of medium and high-risk patients, including standardised recording of interactions to maintain patient safety.
- The need for enhanced observation should, where possible, be highlighted automatically, via alerts embedded in electronic patient records.

## Clinical Standard 2: Persons carrying out observations for patients at medium or high risk of further self-harm or leaving before assessment or treatment completion

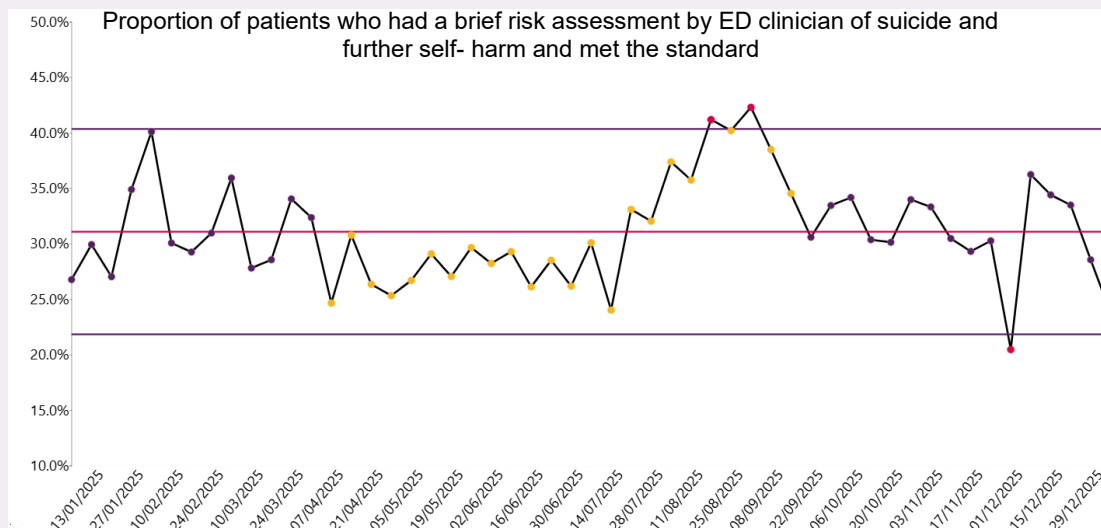
In relation to the 'Person' classification (observer of/accompanying the patient) the medium or high-risk patients, the results show a similar picture to year 2 with most observation being undertaken by Nurses or Healthcare Assistants. The percentage of patients being observed by Doctors or Mental Health Nurses are similar. It should be noted that the 'other' category includes staff such as Police Officers where a patient is brought to the ED for example, under a Section 136 of the Mental Health Act. The overall percentage is more than 100% as there were multiple observers recorded across different groups.

### Recommendations

- A culture of collective responsibility should be encouraged.
- Novel solutions like empowering third-party agencies to assist with observations of these patients have been successful in some departments.
- Employing dedicated mental health nurses would enable better patient care.



## Clinical Standard 3: Proportion of patients who had a brief risk assessment by ED clinician of suicide and further self-harm and met the standard (4 out of 4 elements)



In the third and final year of the programme, the national mean for patients meeting the full fundamental standard (all four required elements) was 31.1%. The mean has remained static over the course of the 3 years.

There is a period of improvement between August and October where performance peaked above 40%, but this was followed by a sharp decline toward the end of the year, likely reflecting winter system pressures.

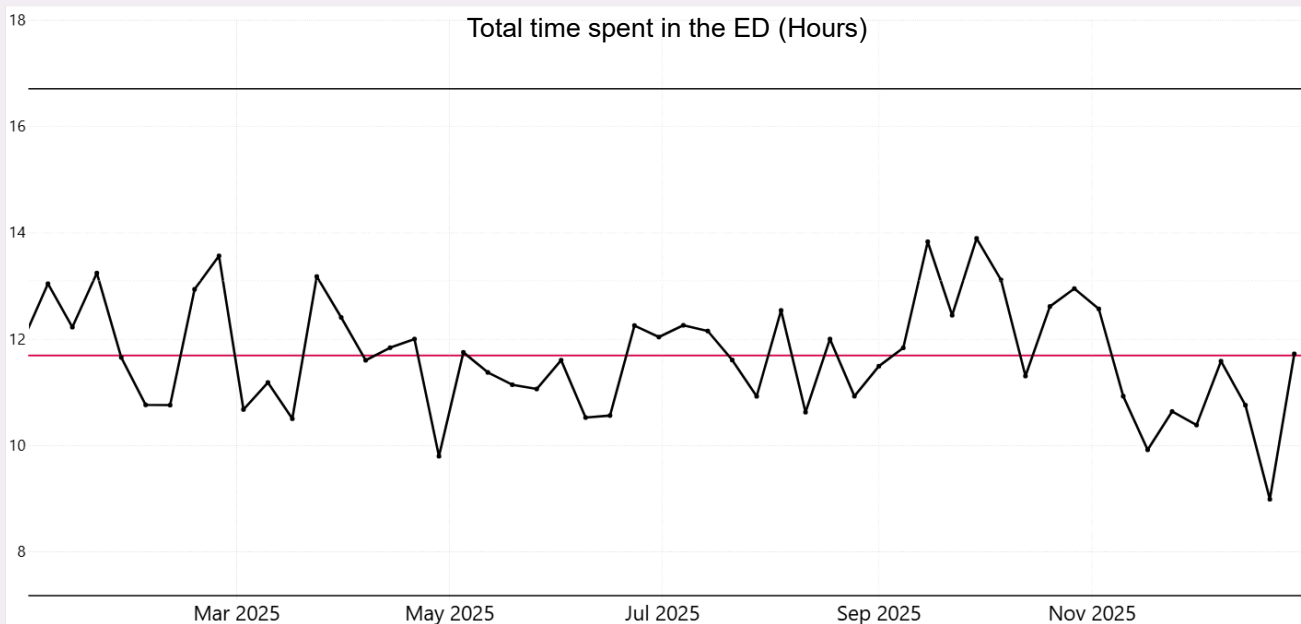
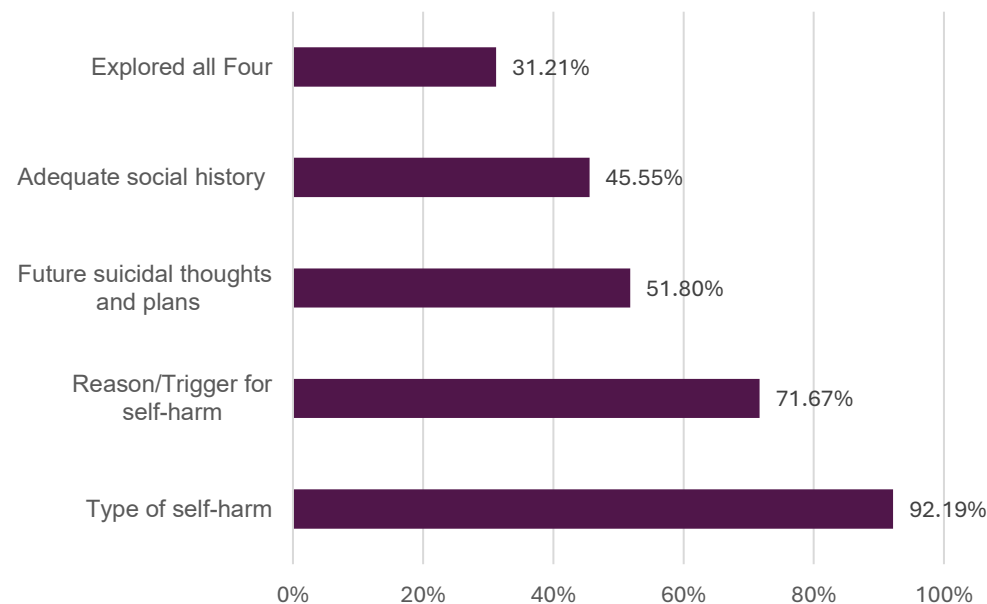
Clinical Standard 3: Proportion of patients who had a brief risk assessment by ED clinician of suicide and further self-harm and met the standard (4 out of 4 elements)

The data reveals wide variation in the completion of the individual elements of the risk assessment. Whilst there is good recognition of the 'type of self-harm' being documented (92.2%), other critical areas of risk are not quite as well documented. The reason or trigger for self-harm was documented in 71.67% of cases; future suicidal thoughts and plans in 51.8% of cases and less than half of cases had an adequate social history taken (45.6%).

The cumulative percentage is greater than 100%, as patients may have had more than one risk assessment element documented.

The failure to capture a social history and future intentions in more than half of the patient cohort is a significant barrier to meeting the standard of "exploring all four" (31.2%).

Brief Risk Assessment Breakdown by Element



Total Time Spent in the Emergency Department

During the lifetime of this QIP there has been a slight deterioration in the time patients spend in the ED from an average of 11 hours in year 2 to 12 hours in year 3. Throughout 2025 duration times for patients in ED fluctuated between 9 and 14 hours.

**Recommendations**

- Streaming of appropriate patients direct from triage to Adult Psychiatric Liaison Services.
- Increasing capacity and efficiency of Adult Psychiatric Liaison Services that will support timely assessments.
- Reviews by mental health teams should begin as early as possible, ideally alongside physical treatment.

## Parallel Assessment

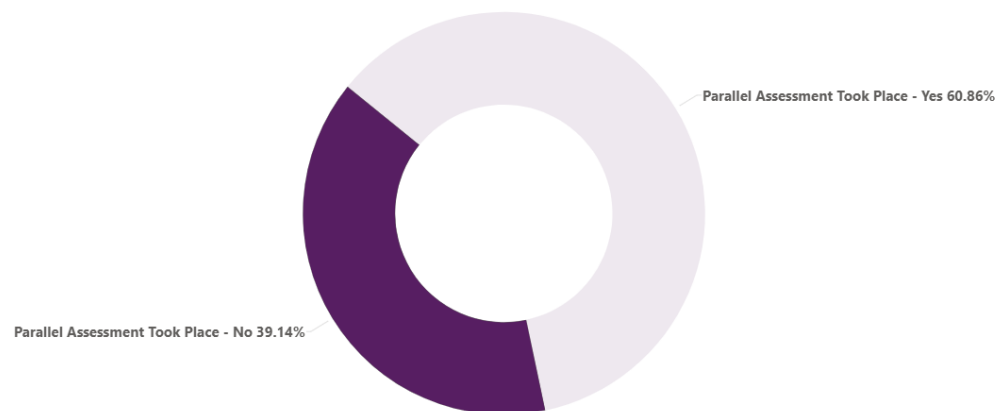
60.9% of patients who met the criteria for a parallel assessment (where a patient receives a mental health and physical health assessment at the same time), received one which demonstrates an improvement from year 2 (56.4%) and year 1 (55.9%). However, this data suggests that more improvement is necessary to facilitate parallel assessment.

There has been a decline in the time taken for patients to be reviewed by Adult Psychiatric Liaison Services following referral (152 minutes). In year 2 this was 140 minutes and year 1, 39 minutes.

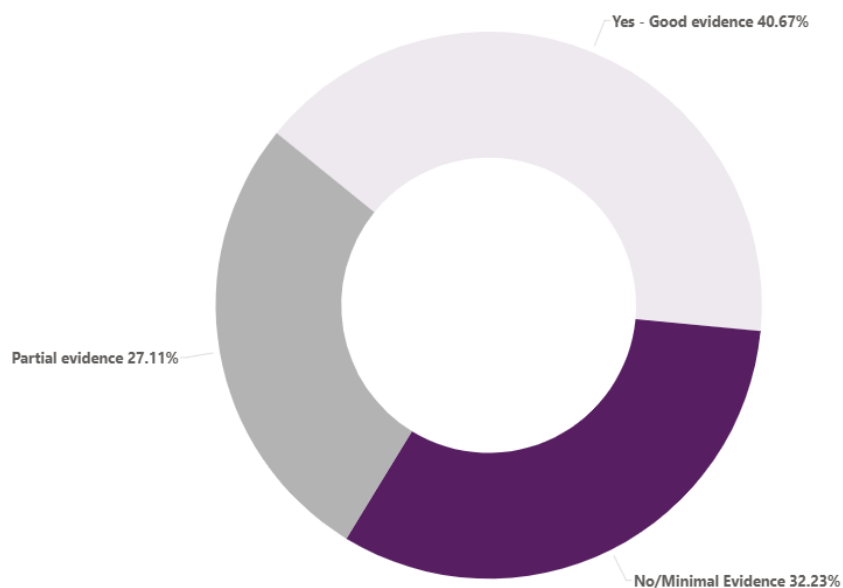
### Recommendations

- A culture of collaboration needs to be fostered between EDs and Adult Psychiatric Liaison Services to facilitate parallel assessment of patients.
- Awaiting medical clearance prior to review by Adult Psychiatric Liaison Services should only be in exceptional cases where the medical presentation takes priority.

Percentage of patients that had or did not have a parallel assessment if they were eligible for one



## Evidence of compassionate and practical care



Evidence of compassionate and practical care for patients presenting with mental health needs was recorded in 40.7% of cases. The data shows an improvement on year 2 (38%) and year 1 (30%) and leaves room for further sustained focus on improving care for this group of patients.

### Recommendations

- Capturing evidence for compassionate and practical care must be encouraged.
- Explore collaboration with external or third-sector organisations to provide on-site compassionate support alongside ED staff – examples such as on-site Red Cross.
- The implementation of feedback systems involving patients, families, and caregivers can generate valuable insights for healthcare improvement.

## Organisational Data

Across the span of the 3-years, organisational data indicates awareness amongst ED staff has improved due to the mandatory training schedules in hospitals. This includes an improvement in knowledge and understanding of Mental Health issues. Organisational data has shown a reduction in availability of appropriate spaces in which to safely observe and assess patients presenting with a history of mental illness.

	Is there a policy in place for assessing and observing patients at medium/high risk of self-harm, suicide or leaving before assessment and treatment are complete?	Is there an appropriate room available for assessment and assistance of patients with mental health needs? This room should meet PLAN accreditation standards.	Is there an appropriate programme in place to train ED doctors in mental health and mental capacity issues?
Year 1	97.62%	97.62%	83.33%
Year 2	94.12%	92.94%	84.71%
Year 3	96.72%	90.16%	91.80%

### Key Trends in Year 3

- Mental Health Triage

There were 18,867 patient cases included in this 3rd year sample. The data shows that 5.7% fewer patients underwent a mental health triage compared to year 2 data. EDs should review their process for the early identification of patients who present with a mental illness/problem and are at risk of further self-harm and absconding.

- Observations of patients at medium or high risk of further self-harm or leaving before assessment or treatment completion

There has been an improvement from 29% in year 1 to 49% in year 3.

- Parallel Assessment

The year-on-year improvement in parallel assessments may be reflective of an improved understanding amongst ED staff of this clinical intervention and the importance of collaborative working to improve response to patient's needs. However, the focus needs to be maintained to ensure sustainable working practices moving forward.

- Evidence of Compassionate and Practical care

There has been an increase in the capture of evidence to support the delivery of 'compassionate and practical' care from year 1 through to year 3 of this QIP. This evidence capture demonstrates ED staff are providing collaborative, holistic patient care rather than focusing on medical needs alone.

## Conclusion & Recommendations

The RCEM Mental health (self-harm) QIP over the last 3 years has showed an improvement in addressing certain key dimensions of health care quality over the 3- year period. This includes observation of medium and high-risk patients at risk of further self-harm or absconding, parallel assessment and capturing evidence of compassionate and practical care during the patients stay in ED. However, high demand on ED services and overcrowding across the United Kingdom will likely have had an impact on delivery of some of the other key standards of the QIP.

Moving forward the following have emerged as key recommendations from the QIP. For Emergency Departments to maintain focus upon:

- Timeliness and quality of mental health triage
- Quality of risk assessment by ED clinician of suicide and further self-harm (4 key elements)

Hospital Trusts should ensure drug and alcohol liaison service availability in EDs. Overcrowding continues to be an issue. However, steps need to be taken to ensure this does not impact certain key factors like appropriate space and rooms to observe and assess patients presenting with a Mental health (Self-harm) presentation.

## Considerations

RCEM has successfully migrated the QIPs to a new in-house platform, marking an important step forward in how they are delivered and supported. This transition, which began in late 2024, has enabled significant enhancements to the data submission process, including an upgraded and more user-friendly submission form designed to streamline data entry for participating sites.

In addition, from the end of 2025, sites have been able to access interactive dashboards, allowing for clearer visualisation of their data and supporting more timely, informed quality improvement work.

While the transition period did impact data visualisation, we are grateful for the patience and engagement of participating EDs during this time. The Mental Health topic team would like to thank all those involved in developing and implementing the new platform including the sites that were instrumental giving their feedback during the piloting process.

By bringing the platform in-house, RCEM is now better positioned to provide responsive support, continuously improve functionality, and enhance the delivery of the QIPs in the future.

## Support to Improve

- [RCEM Quality Improvement Guide](#) – guidance on PDSA cycles and other quality improvement methods
- [Quality Improvement Skills Training \(QIST\) - HEIW](#)
- [Healthcare Improvement Scotland](#)
- [Understanding SPC charts Dec2018.pdf](#)
- [Quality Improvement Essentials Toolkit | Institute for Healthcare Improvement](#)
- [Mental Health in Emergency Departments – A toolkit for improving care \(RCEM, April 2023\)](#)
- [The Patient who Absconds –Best Practice Guideline \(RCEM, 2024\)](#)
- [Acute Behavioural Disturbance in Emergency Departments \(RCEM 2026\)](#)
- [A Brief Guide to Section 136 for Emergency Departments RCEM Guideline \(RCEM 2025\)](#)

# Appendix 1

## The QIP dashboard

### Using the Dashboard

Users can log into the RCEM QI portal, select the relevant QI topic, and choose their site to view performance graphs aligned to key standards. The dashboard allows users to tailor time periods and review trends over time.

### Benchmarking

Performance is aligned against national averages using a RAG (Red, Amber, Green) rating system:

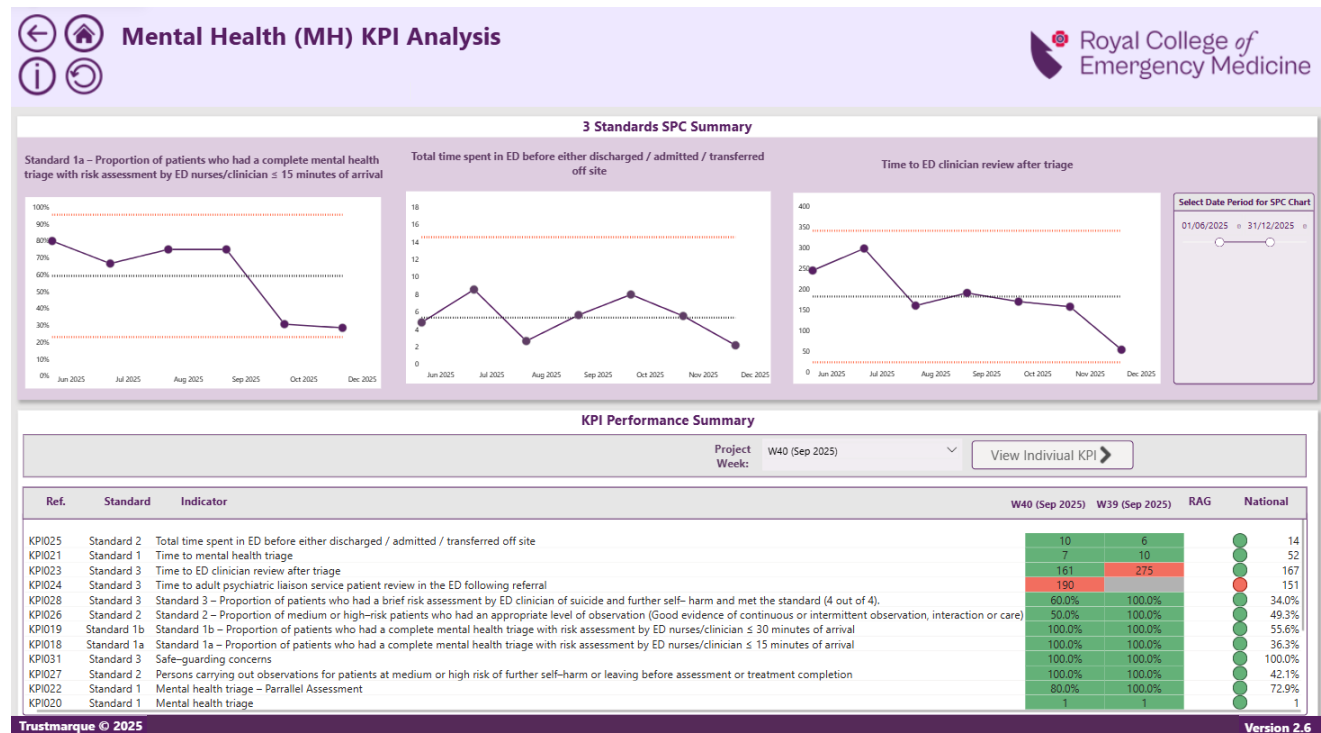
- **Red:** Performance is below the national standard
- **Amber:** Performance is slightly below the national standard
- **Green:** Performance is above the national standard

This allows performance to be quickly assessed and easily compared with national benchmarks.

### Assessing Performance

The dashboard provides charts aligned to national standards that support ongoing performance assessment. These charts allow teams to:

- Monitor processes over time and determine whether changes represent real improvement or normal variation.
- Identify trends (five or more consecutive increases or decreases) and shifts (six to eight consecutive points above or below the centre line).
- Assess whether performance has improved, worsened, or remained stable.
- Understand variation using upper and lower control limits to identify whether a process is stable or showing special cause variation.



## Participating sites

Thank you for taking part in this QIP.

A full list of participant EDs can be found below.

[2025 Mental Health: Self-Harm Participant List](#)

## Authors and Contributors

This report is produced by the Quality Assurance and Improvement Committee subgroup of the [Quality in Emergency Care Committee](#), for the [Royal College of Emergency Medicine \(RCEM\)](#).

The authors of this report were;

Dr Nirmal James, Dr Sasidharan Sameer, Dr Keith McKillop, Joanne Thornton, and Amy Stanton.

## Register for 2026

Registrations for the 2026 RCEM QIPs are now open to all [Type 1 UK Emergency Departments](#). Take part and improve patient care in 2025.

Details of the QIPs running in 2026 and how to take part can be found on at RCEM's [Quality Improvement Page](#).

To register your ED, please complete and submit the 2026 registration form using the QR code or link below.





## Have Your Say

Feedback is essential for RCEM's QIPs and is incorporated in every stage of our programmes.

If you have any queries regarding the report or programme, you can contact RCEM's quality team at [RCEMQIP@rcem.ac.uk](mailto:RCEMQIP@rcem.ac.uk).

If you have feedback on this report or another aspect of the QIPs, please complete the QIP feedback survey using the QR code or link below.

[RCEM QIPs – Your thoughts and Feedback](#)

## Invited Service Reviews

RCEM undertakes reviews of emergency care services at the invitation of NHS organisations. A service review will provide a detailed assessment and key recommendations to support service's improvement at both a clinical and organisational level.

If your trust is interested in the service, please e-mail [Quality@rcem.ac.uk](mailto:Quality@rcem.ac.uk) or complete the invitation form using the QR code or link below

[RCEM Invited Service Review Request](#)





# Emergency Department

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