

2.15 I have set out what I consider to be the key features of the RCUK mental health quality standards¹⁵ – these are my independent opinions (I have not commented on every single section or standard):

a. Introduction and scope:

- i. 'staff are trained and updated regularly to a level of proficiency appropriate to each person's expected role'. This allows some local determination regarding what level of training specific staff need. The standards do not differentiate between registered and non-registered clinical staff. This is important in my opinion as in the past several years there has been increasing use of non-registered staff in clinical roles in all healthcare settings. The Kings Fund report, Mental health 360: workforce¹⁶, published in 2024 stated that for adult mental health services in 2012/13, the skill mix of adult acute wards comprised 60% registered nursing staff and 40% support (i.e., non-registered) staff and this had reversed by 2022/23. In addition this report stated that there were 13,300 nursing vacancies in NHS mental health services in September 2023, and for mental health inpatient settings there was increasing reliance on bank and agency staff – these issues had made it increasingly difficult to recruit and retain staff.
- ii. 'Resuscitation Council UK recognises that the standards in this document may provide challenges for some mental health services and the organisations that are responsible for providing them. Intentionally, these standards are aspirational in certain areas.'
- iii. The guideline defines terms as: '1. 'MUST' has been used when the consensus is that the standard promotes normal practice and is obligatory. '2. 'SHOULD' has been used when the consensus is that the standard promotes normal practice.' '3. 'RECOMMENDS' is used when the consensus is that the standard promotes best practice.' In document 'must' has been used 105 times, 'should' has been used 36 times, and 'recommends' only 6 times, i.e., most of the standards are considered as normal practice and obligatory.

¹⁵ Resuscitation Council UK Quality Standards: Mental health inpatient care (Published May 2014; last updated May 2020). Available at <https://www.resus.org.uk/library/quality-standards-cpr/mental-health-inpatient-care> [accessed 10 September 2026].

¹⁶ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce> [accessed 11 September 2026].

- iv. 'Resuscitation Council UK recommends that each mental healthcare organisation considers the implications of these standards and makes suitable arrangements to develop the capabilities that are required. Organisations should consider training some staff selected from within the organisation to a higher standard than is required generally so that they can undertake the actions that are necessary and/or cascade training within their facilities. Additionally, organisations could establish a suitable service level agreement with acute healthcare services that are sufficiently close geographically; ambulance services; or external training organisations. Mental healthcare organisations may require a combination of arrangements.' This recognises that some mental health inpatient units are on an acute hospital site with a hospital resuscitation team that responds to the universal 2222 call number used by acute hospitals, and gets an immediate predetermined response usually within about 5 minutes of a team with several members with the skill set to provide advanced life support – these resuscitation ('crash') teams will usually respond to any life threatening emergency including cardiac arrest. Response times in mental health inpatient units may be longer than on acute wards as the unit will often be in remote and unfamiliar buildings separate to where resuscitation team members are usually working, and security arrangements can make entry difficult. Many units however are not on an acute hospital site and call an ambulance with a 999 call – calls are handled and triaged based on the information provided by the caller and the call response determined by the category – this requires a discussion and triage process – cardiac arrest is a category 1 response with an average expected response time target of 7 minutes, and 90% of calls to be responded within 15 minutes. Some mental-health settings on acute hospital sites will also call an ambulance as the sites are large and the mental health unit is remote from the hospital. In many settings, and in particular those relying on an ambulance service response, the expert help will arrive too late to change the outcome – this is because most resuscitation measures work best when used early, i.e., within minutes.

- b. Section 1: Resuscitation Committee / service structure: this section of the Standards sets out the need for a resuscitation service structure with a resuscitation lead and potential stakeholders, and terms of reference, and the need for financial support to maintain the service. The standard states 'Every organisation must have an identified board member who is responsible for resuscitation services'. This was required in England by Health Services Circular 2000/028¹⁷, which stated that Chief Executives must ensure that 'a non-executive Director of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework'. This was changed in 2021 by NHS England in 'Enhancing board oversight: a new approach to non-executive director champion roles'¹⁸ to a 'new approach' – this states in Annexe 2 (section 3) that resuscitation issues to be 'overseen through committee structures. Trusts should use their discretion to determine the relevance of each issue to their trust. It should be noted that there will be many other important issues not included in this guidance that trusts should also have oversight of' and 'The Quality Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board.'
- c. Section 2: Resuscitation Officers: this sets out the need for at least one person to have a lead role in implementing the standards including training, equipment, and incident review, and the requirements for the role.
- d. Section 3: Training staff:
 - i. 'All healthcare staff must undergo resuscitation training at induction and at regular intervals thereafter to maintain knowledge and skills.' Most settings will aim for annual updates with a period of grace (e.g., 6 months).
 - ii. 'Training must be to a level appropriate for the staff members' expected clinical responsibilities.' This means individual units can decide who to train to which level of training. Staff should be trained according to what they are expected to do as part of their clinical role as opposed to their specific clinical role, or whether they are registered or non-registered. Therefore, in my opinion, there is no reason why a non-

¹⁷ NHS Executive. Health Services Circular 2000/028 - Resuscitation Policy.

¹⁸ <https://www.england.nhs.uk/publication/enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles/> [accessed 21 August 2026].

registered member of clinical staff should not undertake Immediate Life Support training. ILS-level training is already completed by people in non-clinical roles outside healthcare, including some police officers and members of the Armed Forces, who have no clinical registration and, unlike a healthcare assistant, have no day-to-day exposure to patients.

- iii. 'This training must include use of an 'early warning scoring' system to identify deteriorating patients, including use of an escalation protocol to ensure early and effective treatment of patients in order to prevent cardiac arrest. The scoring and escalation system must be the same as that used in actual clinical care. Use of the National Early Warning Score (NEWS) is recommended for these purposes. Use of paediatric early warning scoring systems is recommended for practice with children.' NEWS was launched by the Royal College of Physicians in 2012, and NEWS2 in 2017. Each measured vital sign (pulse, blood pressure, respiratory rate, oxygen saturation level, need for oxygen, consciousness, temperature) is given a score from 0 to 3 based on how far it is from the normal range, and these numbers are added together for a total score. The total score determines the escalation in care required (e.g., increased frequency of vital sign measurement, review by a doctor, calling an ambulance or resuscitation team).
- iv. 'Resuscitation Council UK's Immediate Life Support (ILS) course is recommended as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion. This guidance recommends that clinical staff in each mental health inpatient facility should receive regular update training in physical health skills in addition to ILS in response to an assessment of need undertaken by each organisation.' This follows NICE (National Institute for Health and Care Excellence) Guideline NG10, Violence and aggression: short-term management in mental health, health and community settings (Published 28 May 2015)¹⁹. This replaced NICE CG25, Violence, The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (February 2005). Of

¹⁹ NICE Guideline NG10 – Violence and aggression: short-term management in mental health, health and community settings, 28 May 2015. <https://www.nice.org.uk/guidance/ng10> [accessed 11 September 2026].

note the 2005 guidance specifically stated the RCUK ILS course, whereas the 2015 NICE guidance used the generic term 'immediate life support' such that the training required in this document can in effect be determined locally.

- v. 'According to Resuscitation Council UK guidelines, training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. Training and facilities must ensure that, when cardiorespiratory arrest occurs, all clinical staff can, as a minimum:
- recognise cardiorespiratory arrest;
 - summon help;
 - start CPR;
 - attempt defibrillation, if appropriate, within 3 minutes of collapse using an automated external defibrillator or manual defibrillator.'
- This guidance is in line with the core guidance for all clinical settings. This 'within 3 minutes' target is specific for a shock to be delivered.
- vi. 'All staff must know how to summon help and be aware of the protocol for the settings in which they work. This could be dialling 999 or a standard telephone number within the organisation. We recommend that this should be a common national number, 2222, as recommended by the National Patient Safety Agency.' This needs to be determined locally – the RCUK quality standards document does not cover the issue of staff in standalone units having to know the location of the unit, and how to get into the unit via locked doors. This is a problem owing to a number of factors. Firstly, staffing often relies on agency staff who are not familiar with the unit. Secondly, for 999 calls staff have to know the precise address, the closest access and parking for an ambulance and the entrance for ambulance staff. In addition the caller may be in an office away from the patient and will not always be able to answer all the triage questions asked by the 999 ambulance call-handler/dispatcher such as; age, and whether they are breathing normally. This has been an issue for cases I have reviewed for inquests – solutions include having action cards that include location details and having cordless internal office phones that enable the caller to walk to the patient's location. Finally, mental health inpatient settings may have

a number of locked doors between the entrance and the patient. A unit specific system needs to be in place for resuscitation teams/ambulance crews to rapidly access the patient, and ensuring all staff, permanent and temporary, are aware of it.

- vii. 'A variety of methods to acquire, maintain and assess resuscitation skills and knowledge can be used for annual updates of all staff, (e.g. life support courses, simulation training, in-house training, mock-drills, 'rolling refreshers', e-learning, video-based training/self-instruction). The appropriate methods must be determined locally. Training materials such as Lifesaver (www.life-saver.org.uk), developed by Resuscitation Council UK, or very brief videos aimed at members of the public may be appropriate for non-clinical staff. 'Hands-on' simulation training and assessment is recommended for clinical staff.' 'A system must be in place for identifying resuscitation equipment for which staff require special training, such as defibrillators and emergency suction equipment.' Ideally training should take place with colleagues from the same clinical teams using the same equipment that exists in the workplace – this is not commonly done, such that often the first time a group of individuals works together in an emergency is an actual resuscitation attempt. This is an issue for all clinical settings as they require a large number of both permanent and temporary staff to provide a 24/7, 365 days a year clinical service. There are a large number of staff permutations and not all can attend training at the same time. Mock drills or actual patient events are the few times staff will work together during a resuscitation attempt. This makes the need for standardised guidelines, training courses, and equipment more important as everyone irrespective of if they have trained together should be working to the same plan.
- viii. 'Specific training for cardiorespiratory arrests in special circumstances (e.g. for children of all ages who have collapsed, patients who are secluded or subject to restraint, and patients who have suffered blood loss) must be provided for medical, nursing and other clinical staff in the relevant specialties.' This acknowledges some of the potential medical emergencies that might occur.

- ix. 'Members of mental health resuscitation teams that have specific involvement in resuscitation, particularly team leaders, require a level of training beyond that provided by local ROs [resuscitation officers]. These people should be encouraged and supported to attend nationally recognised courses, such as the Advanced Life Support (ALS) course.' I am uncertain if this actually happens – mental health inpatient units have varying levels of doctor cover over a 24-hour period and some doctors may have done an ALS course during their training, such that those who are relatively new to psychiatric training have the most up to date experience in resuscitation.
- e. Section 4: Preventing cardiac arrest: this section outlines the Chain of prevention which refers to staff education, monitoring of patients (NEWS), recognition of the need for escalation of care, calling for help, and the response to the call for help. These quality standards emphasise the need to escalate care when there are concerns and ensuring an appropriate senior response occurs.
- f. Section 5: Resuscitation teams and/or responding personnel.
 - i. This section covers some of the issues I have already addressed including how to call for help. It sets out the skills that staff should be able to deploy prior to ambulance arrival.
 - ii. 'The staff who respond immediately must have the following minimum skills:
 - competent delivery of CPR;
 - defibrillation (automated external defibrillation);
 - basic airway interventions, including bag-mask ventilation and/or supraglottic airway;
 - skills required for immediate post-resuscitation care.The following skills are strongly recommended:
 - intravenous cannulation (as determined by local policy and clinical need);
 - intraosseous access (as determined by local policy and clinical need);
 - drug administration (as determined by local policy and clinical need).'These issues are mostly covered on the RCUK ILS course. Staff would not be able to learn intravenous access on the ILS course as it is a skill

that takes time to acquire, such that only those who are inserting intravenous cannulae and giving intravenous drugs on a frequent basis for other clinical reasons would be able to insert an intravenous cannula in an emergency and give drugs and fluids. The main drug for cardiac arrest is adrenaline. This is why these are left to be determined locally as they may not be feasible in many settings. This does mean that settings need to ensure that those staff who are most likely to provide the immediate response have RCUK ILS training as this teaches the skills that are immediately required to help prevent cardiac arrest or treat cardiac arrest when it occurs.

- iii. 'Ideally, the role of team leader in a resuscitation team should be undertaken by a person who is a current Advanced Life Support (ALS) provider or has equivalent training. Immediate Life Support (ILS) providers (or those with equivalent training) can also lead the team while waiting for more skilled help to arrive.' The standards list the skills required to lead the team which include documenting events. An area of improvement for settings would be to have a scribe to document what is happening in real time and if necessary, using a checklist to prompt actions during the resuscitation.
- g. Section 6: Resuscitating children in mental health inpatient units. These focus on the need for expertise in caring for children, and having the correct sizes of equipment. The standard includes 'The designated responding staff must have knowledge about the equipment and doses of drugs (the availability of which should be determined by local policy) that children require. They must understand the differences in causes of, and treatment required by cardiorespiratory arrest in children as compared with adults'. This is because nearly all cardiac arrests will be secondary arrests in children. This is not too dissimilar to adults for mental health settings although adults are also prone to primary cardiac arrest.
- h. Section 7: Resuscitation in special circumstances. This section states 'Organisations must have policies and procedures in place for resuscitation in special circumstances (e.g. blood loss due to trauma, suffocation, application of a ligature to the neck and hanging, self-harm, seclusion, rapid tranquillisation, etc.)'.
- i. Section 10: Resuscitation Equipment. These lists are based on the equipment required to deliver the interventions required that the staff are capable of

undertaking and will if needed lead to improved outcomes. There are specific adult and paediatric lists equipment and drug lists:

- i. There is further information for calling for help ' All settings must have a means of calling for help (e.g. landline telephone [internal or external], mobile telephone with reliable signal, or alarm bell).'
- ii. The lists require a local risk assessment including considering 'patient group (e.g. adults, children), incidence of cardiac arrest, training of staff, and access to expert help'.
- iii. The need for equipment lists and checks to ensure availability when needed – the frequency of checks is determined locally as in many settings the equipment and drugs are in sealed bags/boxes and the checks only need to be done if the seal is broken to use the equipment or drugs, or the equipment expires, batteries need changing, or drugs expire. In settings where there are a relatively few cardiac arrests equipment will be changed as items expire and this determines the frequency of checks.
- iv. 'The precise availability of equipment and drugs should be determined locally. The lists include a suggestion on the immediacy with which equipment and drugs should be available:

Immediate - available for use within the first minutes of cardiorespiratory arrest (i.e. at the start of the resuscitation)

Accessible - available for prompt use when the need is determined by the resuscitation team.'
- v. The standard also states consulting local experts to ensure appropriate equipment is available as the lists are non-exhaustive. Many items will depend on local policy and staff training based on a risk assessment.
- vi. Finally, I note that RCUK has already given evidence on the issues of disparity between the adult and paediatric lists.