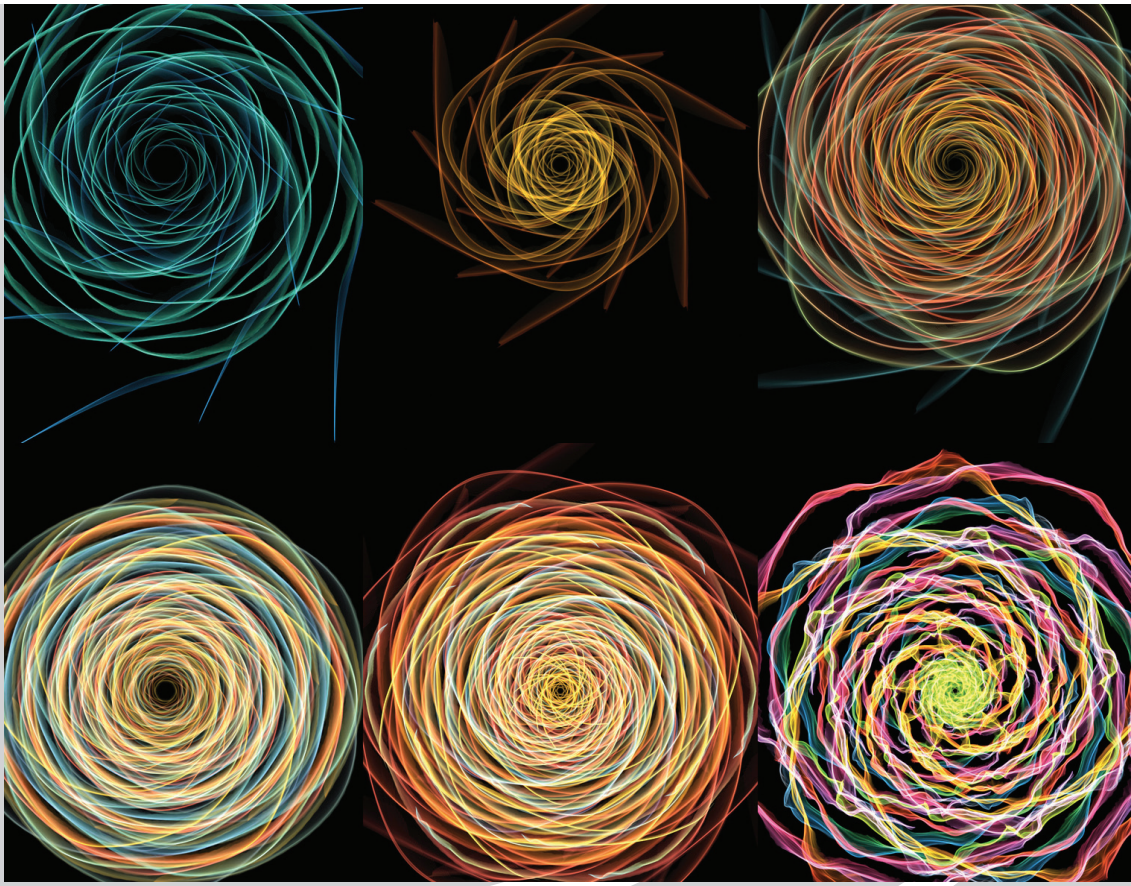
Mental Healthcare in Young People and Young Adults REPORT 1

A review of the quality of care provided to young people and young adults with mental health conditions presenting to acute general hospitals or mental health inpatient facilities



NCEPOD

Improving the quality of healthcare

Mental Healthcare in Young People and Young adults: REPORT I

A review of the quality of care provided to young people and young adults with mental health conditions presenting to acute general hospitals or mental health inpatient facilities

A report published by the National Confidential Enquiry into Patient Outcome and Death (2019)

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The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent body to which a corporate commitment has been made by the Medical and Surgical Royal Colleges, including the Royal College of Psychiatrists, Associations and Faculties related to its area of activity.

The Child Health Clinical Outcome Review Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.

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Appendices 1-5 do not form part of the main report – please use the links to open as a separate document

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Introduction

In 2013 the Royal College of Paediatrics and Child Health published their *'Overview of Child Deaths in the Four UK Countries'* report.[1] This report highlighted that 30-40% of 13-18 year olds, who died, were affected by mental health, learning difficulties or behavioural conditions. The reports presented here are a natural follow-on to this work, to look in detail at the mental healthcare provided to children and young people from the unique perspective of the overlap between physical and mental healthcare, the quality of physical and mental healthcare provided and how patients with mental health conditions use healthcare services. The overarching aim of this study was to identify areas of care that can be improved for all children and young people aged between 11 and 25 years (up to their 26th birthday for REPORT I and up to their 25th birthday for REPORT II).

The study focused on patients with three common mental health conditions and one behaviour: eating disorders, depression, anxiety and self-harm. The conditions /behaviour were chosen as exemplars of the whole spectrum of mental health conditions and behaviours, whilst recognising that there would be differences in incidence, common age for presentation and associated guidelines. However, the common issues between the different groups allowed a useful examination of the pathways of care for children and young people aged 11-17 years and 18-25 years (up to their 26th birthday for REPORT I and up to their 25th birthday for REPORT II), including the interface and transition between child and adult healthcare and the access to appropriate and timely input from specialist crisis and general hospital mental health liaison services.

REPORT I presented here provides an in-depth qualitative overview of patients aged 11-25 years (up to their 26th birthday) who were admitted as an inpatient to an acute general hospital, or mental health facility, either via an emergency department or via referral from a community mental health team or primary care. It summarises the findings from across the UK, from clinical questionnaires and multidisciplinary case note reviews, to highlight improvements in clinical care.

REPORT II which can be accessed using the hyperlink focuses on an analysis of routinely collected national datasets for patients aged 11-24 years (up to the 25th birthday) and how they used healthcare services over a ten-year period between 2004 and 2014. This report provides a population overview that could not be achieved from the review of clinical data in REPORT I. It helps to set the scene by supporting the qualitative findings with 'big data' from the four UK countries and completes aspects of the pathway that could not be achieved through case note review.

Since the case acquisition and data collection points (spring 2016 and 2004-2014 respectively) and the analysis and drafting of this report in early 2018 there has been a lot of focus on young people's mental health, and changes are already underway. The provision of mental healthcare varies across the four UK countries and each service provider will need to assess the service they provide against the recommendations made here to identify where to focus their quality improvement plans.

England

Since the study began there have been significant changes in England in both policy and delivery. *'Future in Mind'*[2], *'Five Year Forward View for Mental Health' (FYFVMH)*[3] and subsequent implementation programmes have seen improvements in service development, joint working and access to mental health care. The *'NHS Long Term Plan'*[4], published in January 2019, commits to the continued investment to expand access to community-based mental health services and commits to a new approach for young adult mental health services for people aged 18-25, to support the transition to adulthood.

For children and young people (CYP) under 18 years of age, Clinical Commissioning Groups (CCGs) working with partners across health, social care, the voluntary sector and experts by experience annually refresh whole system *'Local Transformation Plans'*.[5] These plans set out how local services work together to deliver improved outcomes for

children and young people. This includes improved access to treatment, with 324,724[6] children and young people being treated in 2017-18. Access to CYP urgent and emergency mental health care and intensive community support has also improved, with a recent 2018 audit showing that the majority of responding CCGs are offering as a minimum, crisis assessment and brief follow-up appointments. The NHS Long Term Plan states that children and young people experiencing a mental health crisis will be able to access the support they need with a single point of access through NHS 111, 24/7. Every area will have age appropriate, urgent and emergency assessment, intensive home treatment and liaison functions in place.

The NHS has committed that by 2021 all adults over 18 years of age will have access to 24/7 community-based crisis response and intensive home treatment as an alternative to an acute inpatient admission. In addition, all acute hospitals with 24/7 emergency departments will have a liaison mental health team, with at least 50% meeting the criteria for *'Core 24'*.[7] Findings from recent national surveys suggest that the NHS is on-track to meet this commitment, having invested £45m in 71 sites between 2017-2019. There has also been an increase of over 1000 (WTE) staff working in these teams since 2016.

In December 2017 the Department of Health and the Department of Education jointly published a Green Paper *'Transforming Children and Young People's Mental Health Provision'* for England.[8] As well as a proposal for a new waiting time standard for referral times to treatment, which acknowledged the significant differences across areas, other key elements included named leads in every school and college for mental health and wellbeing with links to child and adolescent mental health services (CAMHS) to provide rapid advice, consultation and sign-posting and Mental Health Support Teams for early intervention and on-going help.

In October 2018 the Government made an announcement on suicide prevention which included further measures on support for children and young people including a *'State of the Nation'* report every year on World Mental health Day highlighting trends and issues in young people's mental health alongside their physical health and educational attainment. It committed to providing tools to help schools measure their students' mental wellbeing, building on the commitment to make mental health literacy and resilience a compulsory part of the curriculum.

In November 2018 NHS Digital published the *'Children and Young People's Mental Health Survey'*[9] to examine the prevalence of mental disorders in England, the first since 2004. It showed that in 2017, 12.8% of 5 to 19 year olds had at least one mental disorder, with emotional disorders, such as anxiety and depression, being the most prevalent type of disorder (8.1%). Rates increased with age. Data from this survey revealed a slight increase over time in the prevalence of mental disorder in 5 to 15 year olds from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017.

Wales

'Together for Mental Health'[10] is the Welsh Government's 10 year cross-Government, all-age strategy, to improve mental health and well-being in Wales. The strategy was published in 2012, following significant engagement and formal consultation with key partner agencies, stakeholders, services users and carers. The strategy is supported by a series of delivery plans which encompasses a range of actions, from those designed to improve the mental well-being of all residents in Wales, to those required to support people with severe and enduring mental illness. To ensure progress against the delivery plans a cross-cutting approach has been taken, implemented jointly by partners, including the Welsh Government, health boards, local authorities, third and independent sector, Public Health Wales, police, ambulance and others. Progress against the delivery of the strategy is overseen by the Mental Health National Partnership Board (MHNPB) and seven Local Partnership Boards (LPBs), who provide a public facing statement on what has been achieved within their own area. Key activities since the publication of the 2016-19 *'Together for Mental Health Delivery Plan'*[11] highlighted that progress had been made across all priority areas and the National Partnership Board is currently shaping the core themes for the 2019-2022 delivery plan.

Scotland

Scotland's children and young people's mental healthcare is delivered through 14 Health Boards which are part of Health and Social Care Partnerships. This provides a variable degree of integration at children's services level, with considerable variation in local funding. Over the past couple of years there has been sharing of best practice and the development of community intensive treatment teams which has allowed the adolescent inpatient units to reduce the length of stay and improve access to beds.

All the actions from the 2017 *'Mental Health Strategy'*[12] relating to children and young people, the *'Rejected Referrals Audit'*,[13] *'Audit Scotland'* report[14] and the *'Programme for Government'* in 2018[15] have been brought together in the newly established Children and Young People's Mental Health and Well-being Taskforce. This has been jointly commissioned by Scottish Government and Convention of Scottish Local Authorities (COSLA) to take a whole system approach to children and young people's mental health. It will bring together input from partners across a range of sectors and will focus on services for children and young people aged 0-25 years and will run until the end of 2020. This will build on the national multi-agency approach underpinning all children's services in Scotland; *'Getting It Right For Every Child (GIRFEC)'*[16]. There are four strands of work focusing on, generic, neurodevelopmental, specialist services and for those children and young people at risk. There will be accompanying work on the development of the workforce, improving data quality and the promotion, prevention and support for mental health within schools. This work will be supported by the established training and workforce development within NHS Education Scotland (NES), data collection by the Information Statistics Division (ISD) and the Mental Health Access Improvement Support Team (MHAIST) hosted by Healthcare Improvement Scotland.

Northern Ireland

The policy for child and adolescent mental health services (CAMHS) in Northern Ireland is stated in the *'Child and Adolescent Mental Health Services - A Service Model'* issued by the Department of Health in July 2012.[17] The model outlined an integrated approach that addressed equity, accessibility and early intervention. Transformation of CAMHS based on the implementation of the *'Stepped Care Model'* is a 'work in progress'. All Health and Social Care Trusts in Northern Ireland have seen the consistent establishment of Primary Mental Health Teams, Crisis Resolution and Home Treatment Teams and the development of a single point of entry to support effective service responses provided at the right time and right place and based on needs.

The developments in CAMHS have been consolidated through publication of the co-designed and co-produced care pathway for CAMHS – *'Working Together: A Pathway for Children and Young people through CAMHS'*[18] published in March 2018. The pathway sets out the journey through CAMHS from referral, through to treatment and discharge/ transition and the standards to be expected along that journey of care. A further important achievement is the revision to the CAMHS Minimum Dataset which now captures demand, need, activity outcomes and experience. Improvements to information systems continue to ensure consistent data returns across the region. The current data shows a sustained increase in demand and an increase in the percentage of children and young people being accepted (80% acceptance across the region for 18/19).

A key priority is the establishment of a Managed Care Networks for acute CAMHS to address the difficulties of providing support to young people presenting in crisis. The purpose of the network is to develop standardised approaches and consistency of care to improve service responses across key service interfaces such as secure care, forensic care and youth justice. The Managed Care Network is designed to bring the acute service response into a single system of care, delivered locally which supports a consistent approach as well as more timely access for support and advice. It is also important to note that the first ever prevalence study of children and young people's mental health in Northern Ireland is underway and publication of this may be anticipated mid-2020.

Executive summary

STUDY AIMS

The primary aims of this study were to:

- Assess the quality of mental healthcare provided to people aged 11-25 (up to their 26th birthday) years
- Examine the interface between different care settings
- Examine the transition of care from child to adult health services

METHOD AND DATA RETURNS

Patients with an eating disorder, depression, anxiety or who self-harmed, aged 11-25 years and who were admitted as an inpatient to a general hospital or emergency mental health facility between 8th February and 20th March 2016 were included. These pathways of care were chosen to examine the quality of physical and mental healthcare when accessing secondary care services. This aspect of the study is therefore not a sample of all children and young people accessing mental health services, but reflects a small sample of the whole population aged 11-25 with mental health conditions. By reviewing this sample of patients it was a test of a discreet pathway where policies and procedures for their care would be expected to be embedded. It also allowed assessment of what information, from the patient's wider mental healthcare, was available to secondary care staff. This did mean that there was a second sample of data that was smaller still, as it was a sample of a sample, nevertheless it enriched the data when used as part of the wider sample. Data were collated from a number of sources to allow the aims to be met.

1. **Clinical peer review using questionnaires and case notes – UK wide**
   Questionnaires were sent to the general hospital and mental health lead clinicians who were caring for the patients in the study. Copies of case note data were then requested along with contact information of community mental health teams. If information on the community teams were received then they were contacted with a questionnaire and a similar case note request. These questionnaires and case notes had all patient identifiers removed and were then reviewed by a multidisciplinary group of clinicians to assess the quality of care provided through a semi-structured questionnaire.

   10,999 patients were initially identified, 1,460 patients were sampled using the preset criteria. 191 patients were excluded which resulted in a sample of 1,269 patients

Within the stratified sample, 1,269 patients were selected for inclusion:

- Acute general hospital admissions – up to 3 patients per hospital: n=710
- Mental health inpatient admissions – up to 3 patients per hospital: n=434
- Patients coded for an eating disorder – up to 3 per hospital: n=125

2. **Organisational survey – UK wide**
   An organisational questionnaire was sent to acute general hospitals and mental health facilities where mental healthcare may have been provided, either with on-site or off-site services. 251 questionnaires returned with data that could be used.

Key messages ▸ *LINK TO KEY MESSAGES IN REPORT II*

	Key message	Key findings
1	Mental healthcare was not given the same level of importance as physical healthcare in general hospitals	• 106/491 (21.6%) patients did not have their existing mental health history recorded in the general hospital case notes at the initial assessment • 310/318 (97.5%) patients had adequate physical health monitoring plans made on the ward compared with 148/285 (51.9%) patients who had adequate mental health monitoring plans made • General health clinicians reported a lack of clarity as to who was leading the mental healthcare in 50/403 (12.4%) patients
2	General hospital staff were not receiving enough support from mental health professionals in the general hospital setting, particularly with regard to risk management	• 55/209 (26.3%) patients experienced a delay in the first assessment by a mental health professional in a general hospital • 47/56 (83.9%) patients had issues with physical health monitoring on the general hospital ward due to their mental health condition • General health clinicians stated that the patient's mental health condition impacted on the management of an acute medical condition for 64/449 (14.3%) patients • The peer reviewers were of the opinion that the problems in monitoring would have been avoidable through better training (21/43; 48.8%) and patient care (52/67; 77.6%) • Mental health nurses were available to routinely support the care of 11-25 year old patients with mental health conditions when they were admitted to a general hospital in 74/116 (63.8%) hospitals • 68/246 (27.6%) general hospital case notes reviewed highlighted a delay in response by mental healthcare to a referral, and the delay had an impact on the quality of both the physical and mental healthcare in 36/60 (60.0%) patients • The initial mental health assessment resulted in the formation of a collaborative risk management plan in 102/153 (66.7%) patients

KEY MESSAGES – LINK TO KEY MESSAGES IN REPORT II *(continued)*

	Key message	Key findings
3	Planning for the transition of care from child to adult mental health services, particularly in secondary care was not always done well	• 22/101 (21.8%) hospitals (general or mental health) had no framework to facilitate continuity of patient care at the point of transition from child to adult mental health services • Of the hospitals with on-site mental health services it was reported in only 46/96 (47.9%) that designated professional leads for transition were in place: - 26/58 (44.8%) hospitals where 11-17 year olds were treated - 20/38 (52.6%) hospitals where 18-25 year olds were treated • Only 23 patients had evidence that transition was occurring or had occurred in mental healthcare within the previous two years and there had been problems with transition planning or implementation in 6/20 (30.0%) patients (unknown in 3). The most common issues were delay in identifying a named clinician and/or acceptance into an adult service
4	Clinical information related to patients with known mental health conditions was not always communicated at the interface between healthcare providers or between the multidisciplinary clinical groups caring for the patient	• Less than half of all hospitals were reported as being a member of a clinical network of care* for people with mental health conditions (106/251; 42.2%) • At the time of arrival and/or admission to the general hospital, the admitting general health team were only able to access community mental health notes and summaries for 47/226 (20.8%) patients • The clinical notes from the general hospital setting were available to the admitting mental health inpatient team for 22/48 (45.8%) patients • Peer reviewers found evidence of adequate communication with the patient's wider multidisciplinary team in 161/280 (57.5%) of general hospital case notes reviewed • Communication with patients and other agencies was described overall as 'good' in 85/310 (27.4%) general hospital case notes reviewed, and in 53/310 (17.1%) it was described as 'poor' or 'unsatisfactory'. This seemed to be a particular problem for patients aged 11-17 years where in 35/53 (66.0%) communication was rated 'poor' or 'unsatisfactory'

* *A clinical network of care was defined as "linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services working together in a coordinated manner"*

Recommendations

These recommendations have been formed by a consensus exercise including all those listed in the acknowledgements.

	Recommendations	**Who should action**
SUPPORT IN ACUTE GENERAL HOSPITALS TO ENSURE PARTITY OF ESTEEM FOR PATIENTS WITH MENTAL HEALTH CONDITIONS		
1	Develop and promote national guidance outlining the expectation required of general hospital staff in the care of children and young people with mental health conditions. Guidance should include: a. Training relevant to their role in the assessment, formulation and management for aspects of mental health conditions, including familiarity with specific terminology and language b. Routinely taking a physical and mental health history c. Undertaking and acting on simple and appropriate mental health risk assessments d. When and how a referral to mental health services should be made and what the content should be	• *Royal Colleges - RCPsych, RCP, RCPCH, RCN, RCEM and Specialty Associations* • *Executive Boards for Mental Health and for Physical Health and* • *Physical Healthcare Professionals for the implementation* *Supported by* • *Health Education England* • *Medical Training Bodies* • *NHS Improvement* • *Care Quality Commission* • *General Medical Council*
2	Nominate or appoint a clinical lead for children, and young people's mental health in all acute general hospitals to: a. Promote the integration of physical and mental healthcare b. Lead on implementation of existing training initiatives and future national guidance c. Identify staff training requirements in acute general hospitals to meet the needs of children and young people with mental health conditions d. Ensure policies and procedures are in place to provide: i. Continuity of care between general and mental health services ii. Care during transition from child to adult mental health services e. Promote the use, and regular review, of an agreed joint care and risk management plan between general and mental health, which is integrated into the nursing plan when patients who require inpatient mental healthcare are temporarily accommodated on a general hospital ward f. Promote clear documentation and monitoring of mental health history, mental state examination and management plans	• *Executive Boards for Physical Health* *Supported by* • *Physical Healthcare Professionals* • *Mental Healthcare Professionals for Adults and Children & Young People* • *NHS Improvement* • *Regulators*

	Recommendations	Who should action
MENTAL HEALTHCARE IN THE ACUTE GENERAL HOSPITAL SETTING – ASSESSING RISK, TREATMENT AND PATIENT SAFETY		
3	Ensure children and young people admitted to acute general hospitals have prompt access to age-appropriate general hospital mental health liaison/crisis services when needed. These services should: a. Be staffed by clinicians fully trained in the specific needs of the age groups cared for b. Provide access to timely assessment, treatment and risk management during their episode of care, including those presenting in crisis both in or out of hours c. Enable general hospital staff to provide: i. Appropriate and safe care of patients with a mental health condition on an inpatient ward ii. Care for children and young people where psychosocial factors affect physical illness presentation, treatment compliance and/or safeguarding d. Facilitate access to a range of psychological and psychosocial interventions based on a full mental health assessment and clinical formulation e. Work with general hospital staff to plan the patients mental healthcare needs upon discharge f. Involve children, young people and carers in agreeing and communicating after-care interventions and risk plans	• *Commissioners* • *Executive Boards for Mental Health and for Physical Health* *Supported by* • *Physical Healthcare Professionals* • *Liaison Psychiatrists* • *Mental Healthcare Professionals for Adults and Children & Young People*
CONTINUITY OF CARE DURING TRANSITION FROM CHILD TO ADULT MENTAL HEALTH SERVICES		
4	Use NICE Guideline 43 – *'Transition from Children's to Adults' Services for Young People using Health or Social Care Services'* to support patients with mental health conditions during transition between child and adult physical and mental health services	• *Physical Healthcare Professionals* • *Liaison Psychiatrists* • *Mental Healthcare Professionals for Adults and Children & Young People* • *Commissioners*
5	Ensure continuation of mental health care within and across service providers, particularly at the transition from child to adult services including: a. The use of documented and joint care pathways b. The use of clinical networks of care* c. Auditing against national standards locally	• *Mental Healthcare Professionals for Adults and Children & Young People* • *Physical Healthcare Professionals* • *General Practitioners* *Supported by* • *Commissioners – local* • *Executive Boards for Mental Health and for Physical Health* • *Regulators*

** A clinical network of care was defined as "linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services working together in a coordinated manner"*

	Recommendations	Who should action
JOINED UP CARE AND COMMUNICATION BETWEEN ACUTE GENERAL AND MENTAL HEALTHCARE		
6	Develop local clinical network arrangements between acute general health and mental health services to work more closely on: a. Identifying and remedying gaps in local care pathways to provide high quality mental healthcare in all settings b. Ensuring patient care records are effectively shared between care providers c. Considering whether there is sufficient capacity in inpatient mental health facilities to allow timely local admission d. Ensuring access to co-ordinated psychological and pharmacological interventions	• *Executive Boards for Mental Health and for Physical Health* *Supported by* • *Local and National Commissioners* • *Primary Care* • *Third Sector Providers and Social Care* • *Care Quality Commission* • *Service Users* • *Providers of Local Transformation plans in England*
7	Ensure mental health risk management plans are clearly available in all general hospital patient records for patients admitted with a current mental health condition. If a plan is not needed then this should also be recorded	• *Physical Healthcare Professionals* • *Mental Healthcare Professionals for Adults and Children & Young People* *Supported by* • *Executive Boards for Mental Health and for Physical Health*
8	Utilise electronic patient records to improve record sharing between mental health hospitals and general hospitals within and outside the NHS. In the absence of electronic records, patients should not be transferred between the hospitals without copies of all relevant notes accompanying them and could be encouraged to carry a 'patient passport' outlining an agreed care plan	• *Executive Boards for Mental Health and for Physical Health* • *Physical Healthcare Professionals* • *Mental Healthcare Professionals for Adults and Children & Young People* *Supported by* • *Commissioners*

	Recommendations	**Who should action**
9	Provide children and young people with mental health conditions an opportunity for private confidential discussions with physical and/ or mental health professionals where they are seen in an emergency department or ward within an acute general hospital or mental health facility. This should include a psychosocial assessment leading to an agreed, documented crisis and coping plan given to the patient	• Physical Healthcare Professionals • Mental Healthcare Professionals for Adults and Children & Young People Supported by • Executive Boards for Mental Health and for Physical Health • Service User Groups
10	Document the competence and capacity of children and young people to be involved in decision-making and also to give their consent to treatment or an admission	• Physical Healthcare Professionals • Mental Healthcare Professionals for Adults and Children & Young People Supported by • Executive Boards for Mental Health and for Physical Health

1

Method

STUDY ADVISORY GROUP

A study advisory group (SAG) was formed to steer the study development. The multidisciplinary group comprised the following specialties:

- Child and Adolescent Mental Health Services (CAMHS)
- Counselling
- General practice
- Health and social wellbeing improvement
- Liaison psychiatry
- Medicine – general and emergency
- Nursing
- Paediatrics – acute and community
- Patient representative
- Psychology
- Social work

The role of the group involved developing the aims of the study, identifying the areas for review and determining how to undertake the study to capture information relevant to the areas identified for review. The preferred method would have been to identify patients prospectively in the community and through Child and Adolescent Mental Health Services and follow their various healthcare pathways, including access to inpatient hospital care. However, it was not possible to identify patients this way so a pragmatic decision was taken to identify patients though hospital coding and trace their pathways of care out into the community and across physical and mental healthcare providers. It was recognised by the SAG that this only identified a select group of patients who were accessing secondary care, but nonetheless it also identified a group of patients who would test the mental healthcare provided to patients admitted to general health hospitals and the care provided to patients admitted in an emergency, either to an acute general hospital or mental health facility. It also reflected the findings of the report by the Royal College of Paediatrics and Child Heath from which this work stemmed.[1]

STUDY AIMS AND OBJECTIVES

The specific aims of this study were to assess:

- The quality of care provided to 11-25 year olds with mental health conditions
- The interface and joint agency working between different care settings for this group
- The transition of mental healthcare between child and adolescent services

Clinical objectives

To gain an in depth view of the care received by patients by assessing:

- History taking and recording of a mental state examination
- Risk assessment, including the appropriate use of risk assessment tools
- The identification of comorbidities
- When relevant, emergency department (ED)/emergency medical unit care; including the management and referral of those with self-harm minor injuries, consent, confidentiality and facilities for 11-25 year olds
- Multidisciplinary care, including handover and communication
- Treatment planning and delivery
- Care pathways; including emergency services, community assessment and access to community services
- Discharge or transfer planning including follow-up arrangements

Organisational objectives

- To review access to services, including pathways of care and clinical leadership
- To review how services are delivered, including multidisciplinary care, outreach clinics and co-location of services

PARTICIPATION

National Health Service acute general hospitals and mental health facilities, in England, Scotland, Wales and Northern Ireland were expected to participate, as well as public hospitals in the Isle of Man, Guernsey and Jersey. Within each hospital a named contact referred to as the NCEPOD Local Reporter acted as a link between NCEPOD and the hospital staff, facilitating case identification, dissemination of questionnaires and data collation.

STUDY POPULATION

Inclusions

Patients included in the study met the following criteria:

- Aged 11-25 years inclusive. This age group was chosen by the SAG as it started at the point of an educational transition and covered the transition period from child to adult services
- One or more diagnosis of depression, anxiety, an eating disorder or self-harming behavior. The diagnostic categories included were chosen to provide a breadth of conditions and a behaviour that would test the whole system of care in general health and mental healthcare (Table 1.1)
- Admitted as an inpatient to an acute general hospital or mental health facility between 00.00 Monday 8th February and 23.59 Sunday 20th March 2016 inclusive.

Exclusions

Patients who were subsequently identified not to have a mental health condition following sampling were excluded from the study.

Patient identification

Patients were identified in two ways for this part of the study to ensure that emergency attendances as well as admissions were identified and admissions via the ED as well as CMHT and CRHTT were also identified to complete the picture.

1. Prospective data collection

During the two week data collection period (Monday 7th March – Sunday 20th March 2016) the Local Reporter was asked to prospectively record the details of all patients who presented to the ED (or equivalent) as a result of self-harm, anxiety, depression or an eating disorder. Acute general hospitals and mental health facilities were included, as were urgent care centres and minor injuries units. Data collection included patients who arrived to the facility as an emergency (not via community mental health teams (CMHT) or crisis resolution and home treatment teams (CRHTT). This data collection was used to record the wider number of emergency attendances of patients who may not have been admitted, and therefore would not have been recorded on a patient administration system and identified retrospectively. The purpose of collecting these data were to show the whole pattern of patients attending the hospital during and being able to match them with the retrospective admission data where relevant.

Table 1.1 Included ICD 10 diagnostic codes

Anxiety and depression	F06 F30 - F39 F40 - F45; F60; F93	Organic, including symptomatic, mental disorders Mood (affective) disorders Neurotic, stress-related and somatoform disorders
Eating disorders	F50	
Self-harm	X60 - X84 Y10 -Y34	Intentional self-harm Event of undetermined intent

▶ *(SEE APPENDIX 3 FOR MORE DETAIL)*

2. Retrospective data collection
The second stage was a retrospective identification of patients three months following the close of the prospective data collection. Local Reporters in both acute general hospitals and mental health facilities were asked to identify patients who were **admitted** during the study period, using the listed ICD10 codes. This may have included some of the same patients from the prospective data collection, but could also have included patients referred via CMHT and CRHTT, not just those arriving through the emergency acute health pathway.

SAMPLING STRATEGY

Up to six patients per hospital were initially sampled for inclusion in the questionnaire and peer review process as follows:

- Mental health inpatient admissions – up to 3 patients per hospital
- Acute general hospital inpatient admissions – up to 3 patients per hospital
- 2 patients staying 3 days or longer
- 1 patient staying 2 days or shorter
- Up to 3 patients per hospital with an eating disorder – to ensure a high enough sample to review

▶ *LINK TO KEY FINDING 13 IN REPORT II*

DATA COLLECTION

A. Clinical peer review using questionnaires and case notes

Questionnaires – phase 1
A questionnaire was sent to the named clinician caring for the patient at the time of the general hospital admission (where applicable). This questionnaire collected data on the care provided during the general hospital admission.

Where it could be identified and where applicable a questionnaire was sent to the named clinician caring for the patient at the time of the mental health facility admission. This questionnaire collected details about the care provided during the mental health inpatient admission.

Both of the above questionnaires also served to identify:

- *The details of the clinician who undertook the **mental health assessment in the general hospital (general hospital mental health liaison services)*** Where it could be identified that the patient had a mental health assessment undertaken in the general hospital during their admission, a questionnaire was subsequently sent for completion by the relevant service who undertook that assessment.
- *The clinician who was responsible for the **mental healthcare in the community** in the two-year period prior to the admission under review (where applicable)* This community mental healthcare questionnaire was then sent to the community clinician when the patient was under the care of a community clinician, or had been under the care of community mental health services in the two-year period prior to the admission under review.

Questionnaires – phase 2
Following identification of the contacts for mental health inpatient care, mental health assessment or community mental health services, questionnaires were disseminated. This meant that the number of questionnaires included in this sample would be lower as it was a sample within a sample.

Case notes
Copies of case note extracts were requested for the current admission, where applicable;

- Acute general hospital care
- Notes of mental health assessment in the general hospital if conducted by general hospital mental health liaison services or equivalent team
- Mental health inpatient care
- Community mental health notes (two years prior to the current admission)

Clinical peer review

A multidisciplinary group of peer reviewers were recruited to peer review the case notes and associated clinician questionnaires. The group of peer reviewers comprised: psychiatrists (including child and adolescent and adult psychiatrists); paediatricians (including specialist paediatricians); emergency medicine physicians; psychologists; occupational therapists; physicians; nursing (mental health and general) and general practitioners.

After being anonymised with respect to patient identifiable information, each case was reviewed by at least one case reviewer within a multidisciplinary group. At regular intervals throughout the meeting the Chair allowed a period of discussion for each reviewer to summarise their cases and ask for opinions from other specialties or raise aspects of the case for discussion.

To standardise the peer review process, peer reviewers used a semi-structured electronic questionnaire and were encouraged to enter free text commentary at multiple points.

The overall quality of care of each case was summarised using the NCEPOD grading system:
Good practice: A standard that you would accept from yourself, your trainees and your institution.
Room for improvement: Aspects of **clinical** care that could have been better
Room for improvement: Aspects of **organisational** care that could have been better
Room for improvement: Aspects of both **clinical** and **organisational** care that could have been better
Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution
Insufficient data: Insufficient information submitted to NCEPOD to assess the quality of care

B. Organisational survey

An organisational questionnaire was sent to all Trusts/ Health Boards where 11-25 year olds with mental health conditions may have been cared for. Data collected included information around pathways of care, policies and protocols in place and standard communication. The organisational questionnaire was split into two questionnaires:

- To collect data on the organisation of care for people aged 11-17 years
- To collect data on the organisation of care for people aged 18-25 years

DATA ANALYSIS

The data from all questionnaires received were electronically scanned into a database. Prior to any analysis taking place, the data were cleaned to ensure that there were no duplicate records and that erroneous data had not been entered during scanning. Any fields that contained data that could not be validated were removed.

Following cleaning of the quantitative data, descriptive data summaries were produced. The qualitative data collected from the peer reviewers' opinions and free text answers in the clinician questionnaires were coded, where applicable, according to content to allow quantitative analysis. The data were reviewed by NCEPOD Clinical Co-ordinators, a Clinical Researcher and Researcher Assistant to identify the nature and frequency of recurring themes. All data were analysed using Microsoft Access™ and Excel™ by the research staff at NCEPOD.

As well as descriptive data, case studies have been used throughout this report to illustrate particular themes.

Data sources

Throughout the report data is presented from different sources to give an overall picture of care. Data sources in the text, tables and figures are labelled as:

- General health clinician questionnaire/ general health clinicians
- Mental health inpatient clinician questionnaire/ mental health inpatient clinicians

- Mental health assessment in general hospital (general hospital mental health liaison services) questionnaire/ mental health assessment clinicians
- Community questionnaire/ community mental health clinicians
- Peer review assessment form/ peer reviewers' opinion
- Organisational questionnaire/ organisational data

INFORMATION GOVERNANCE

All data received and handled complied with all relevant national requirements, including the Information Commissioner's Office (NCEPOD Z5442652), the NHS Act 2006 (15/CAG/0210), the NHS Code of Practice and Public Benefit and Privacy Panel for Health and Social Care (for NHS Scotland). As anonymous data were requested ethical approvals were not required, approvals from the data providers for each individual country was. Each member of the team completed Medical Research Council (MRC) Research Data and Confidentiality e-module training for National Statistics.

The findings of the report were reviewed by the Study Advisory Group, NCEPOD Peer Reviewers, NCEPOD Steering Group members including Clinical Co-ordinators, Trustees and Lay Representatives.

POSITIVE PRACTICE FINDINGS – HIGHLIGHTED THROUGHOUT THE REPORT

- 259/283 (91.5%) cases had an entry in the general hospital medical notes made by the mental health professional – p39
- 215/247 (87.0%) entries in the general medical notes by mental health professionals were sufficiently detailed – p39
- 255/272 (93.8%) patients had a clear action plan outlined and agreed following initial assessment - p39
- 326/430 (75.8%) patients had mental health services involved in discharge planning – p41
- 412/460 (89.6%) patients had a clear written discharge plan – p42
- 39/42 (92.8%) hospitals had a process of support, rapid liaison, shared decision-making with colleagues in Tier 4 services – p43
- 87/102 (85.3%) hospitals had an emergency mental health pathway specifically for 11-25 year olds in crisis – p36
- General hospital based mental health liaison teams provided crisis services for 18-25 year olds in normal working hours in 33/39 (84.6%) hospitals and out of hours in 35/42 (83.3%) hospitals – p36
- 64/67 (95.5%) general hospital notes and 65/67 (97.0%) mental health notes reviewed had a risk management plan recorded – p39
- Following assessment in the community: – p71
  - A case co-ordinator or named lead clinician was allocated in 85/93 (91.4%) patients
  - The patient was reported to be involved in a care planning and review process in 87/96 (90.6%) cases and the patient's family involved in 84/97 (86.6%) cases
  - The patient's care plan was reported to contain:
- Their management and recovery plan in 76/81 (93.8%) cases
- Their risk management plan in 77/83 (92.8%) cases
- A crisis management plan in 75/83 (90.4%) cases
- 61/72 (84.7%) patients were provided with a copy of their care plan
  - 64/78 (82.1%) of 11-25 year olds were seen within six weeks of referral to community mental healthcare – ▶ *APPENDIX 2*

STUDY LIMITATIONS

There were some specific issues encountered:

- Not all NHS healthcare providers participated in this study, however data were examined from all UK countries to ensure wide representation
- Private inpatient providers, in the main, did not participate, but based on the sampling criteria it should not have impacted on the sample or the report findings which was based heavily on the general hospital stay
- Mental healthcare providers were less willing to take part than general healthcare providers, with concerns around sharing copies of patient records
- Case notes received were not always complete and lack of cross-service notes meant that parts of the pathway of care were harder to obtain

- Although NCEPOD did request electronic medical records as well as those on paper, it was not always easy for the peer reviewers to work out what information would have been accessible to the clinician at the point of patient presentation to the hospital
- Response rates from community mental healthcare was lower than would have been hoped for, although the sample for this cohort was already smaller as clinicians had to be identified through the general hospital clinician questionnaire or case notes – the same for general hospital mental health liaison services
- Organisational questionnaires were completed at Trust/Board level – therefore it may not have been easy to provide single answers that were representative of organisation of care in all hospitals or parts of the hospital
- There was some confusion as to whether Trusts/Health Boards provided mental health services on-site or not – some indicated they did when these services may have been provided by another Trust/Board through a shared agreement

2

Data returns and sampled study population

PROSPECTIVE DATA IDENTIFICATION

Prospective data were collected over a two week period on 7,014 patients who had an emergency attendance either at a general hospital emergency department or a mental health facility. Of those, 439 patients were excluded because they did not have one of the included mental health conditions. There were 6,222 emergency attendances from 5,285 patients (where an NHS number was provided) (Table 2.1). Within this group 5,347 attendances were to a general or combined hospital Trust/Health Board and 875 were to a mental health facility.

Table 2.1 Number of emergency attendances

	Number of patients
1 attendances	4,561
2 attendances	584
3 attendances	98
4 attendances	28
≥5 attendances	14
Subtotal	**5,285**
NHS number missing	353
Total	**5,638**

Source: Hospital coding

Within the emergency attendance data, 1,828/5,276 (34.6%) patients were male and 3,448/5,276 (65.3%) were female. Ages ranged from 11 to 25 years. The median age for females was 18, and for males 20 years.

▶ *LINK TO CONDITIONS OF INTEREST IN CONTEXT: INPATIENTS IN REPORT II*

RETROSPECTIVE DATA IDENTIFICATION AND STUDY SAMPLE

Using the patient identification methods outlined in Chapter 1, retrospective data were collected over a six-week period on a total of 10,999 patient admissions to a general hospital or mental health facility (Figure 2.1), of which 503 (312+191) patients were subsequently excluded, the majority of which was because of incorrect coding.

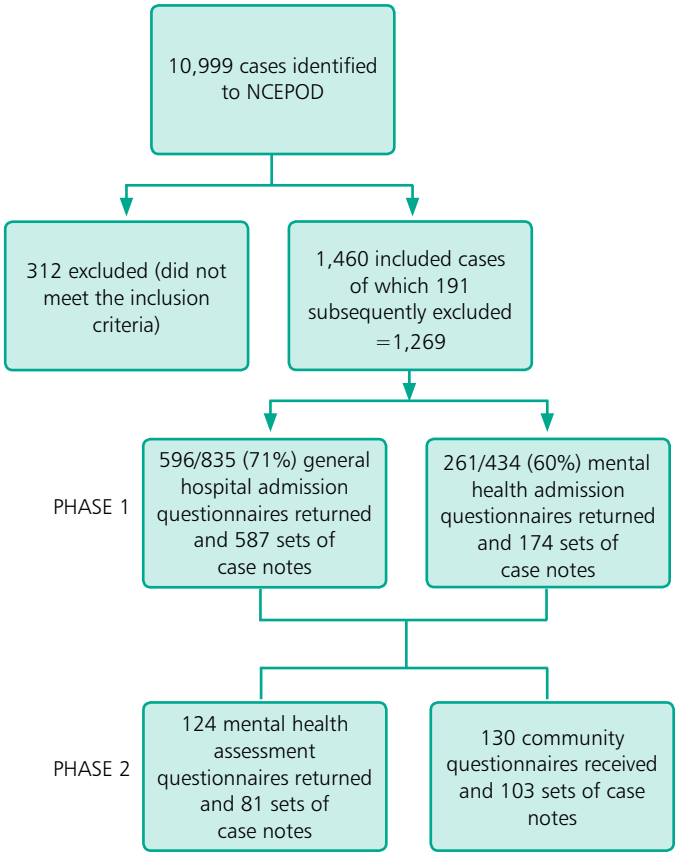


Figure 2.1 Data returns

N.B. Denominators throughout the report will change depending on data source and the number of responses given – 'not answered' questions are omitted from the denominator.

Where there was an NHS number provided, the admission data included 10,154 admissions for 8,992 patients as there were a number of patients who had multiple admissions (Table 2.2). These data also included patients who were transferred from one hospital to another during the study period.

Within the stratified sample, 1,269 patients were selected for inclusion:

- Acute hospital admissions – up to 3 patients per hospital: n=710
- Mental health inpatient admissions – up to 3 patients per hospital: n=434
- Patients coded for an eating disorder – up to 3 per hospital: n=125
- 276/1,269 (21.7%) were male and 990/1,269 (78.0%) were female
- Ages ranged from 11 to 25 years and the median age for females was 18 and for males was 20 years (Figure 2.2).

Table 2.2 Number of admissions

	n
1 admission	8,128
2 admissions	682
3 admissions	130
4 admissions	26
≥5 admissions	26
Subtotal	**8,992**
No NHS number	342
Total	**9,334**

Source: Hospital coding

Reasons for admission

▶ *LINK TO CHAPTER 4 IN REPORT II*

Admissions both to general hospital and mental health inpatient care were greatest for self-harm. More patients with an eating disorder were admitted to a general hospital, and more patients with anxiety and depression to a mental health hospital. However, it is important to remember a number of patients were admitted with multiple mental health conditions, and there were also a number of transfers from the general hospital to a mental health facility, and so patients may have fallen into a number of these groups (Table 2.3).

▶ *LINK TO TABLE 2.4 IN REPORT II*

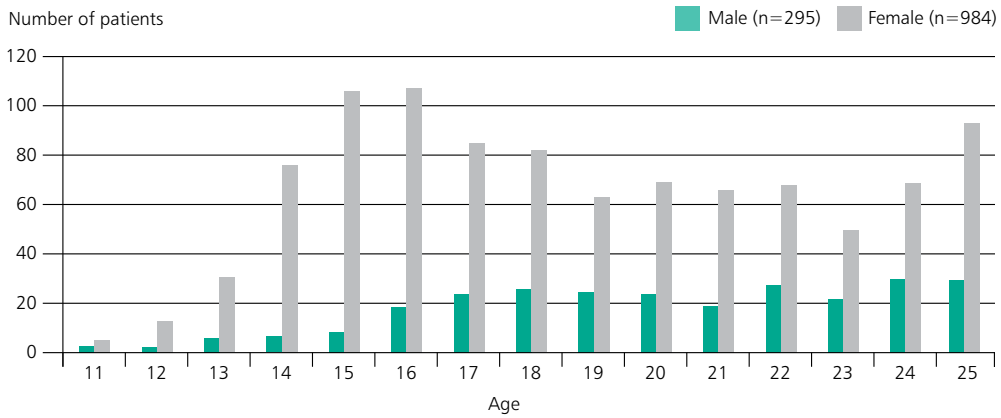


Figure 2.2 Age and sex of the study population
Source: Hospital coding – all UK

Table 2.3 Diagnostic reason for admission to a general hospital

	Mental health inpatient care		General hospital inpatient care	
	n	**%**	**n**	**%**
Eating disorder	42	21.5	125	29.8
Anxiety disorder	29	14.9	44	10.5
Depressive disorder	51	26.2	57	13.6
Self-harming behaviour of ideation, or significant risk of self-harm	159	81.5	273	65.2
Subtotal	**195**		**419**	
Not answered	19		99	
Total	**214**		**518**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal* *Source: General health clinician questionnaire*

Mode of admission

Table 2.4 shows the mode of admission in the general hospital. The 'other' admissions included direct admission to a ward following a referral from primary care or an outpatient department.

Table 2.4 Location on arrival at the general hospital

	n	**%**
Emergency department	378	73.7
Clinical assessment unit	37	7.2
Emergency assessment unit	13	2.5
Surgical assessment unit	9	1.8
Other	76	14.8
Subtotal	**513**	
Not answered	5	
Total	**518**	

Source: General health clinician questionnaire

Organisational questionnaires

There were 140/249 (56.2%) organisational questionnaires received from hospitals in which people aged 11-17 were cared for, of which 65/140 (46.4%) provided mental health services on-site and 75/140 (53.6%) had no mental health services on-site. A further 111/249 (44.6%) organisational questionnaires were received from hospitals in which people aged 18-25 years were cared for, of which 48/111 (43.2%) provided mental health services on-site and 63/111 (56.8%) had no mental health services on-site.

▶ *LINK TO KEY FINDINGS IN CHAPTER 3 IN REPORT II*

3

Mental healthcare in acute general hospitals

▶ *LINK TO CHAPTER 4 IN REPORT II*

This chapter considers the presentation of patients with a mental health condition to a general hospitals and the pathway of care thereafter.

ADMISSION TO A GENERAL HEALTH HOSPITAL

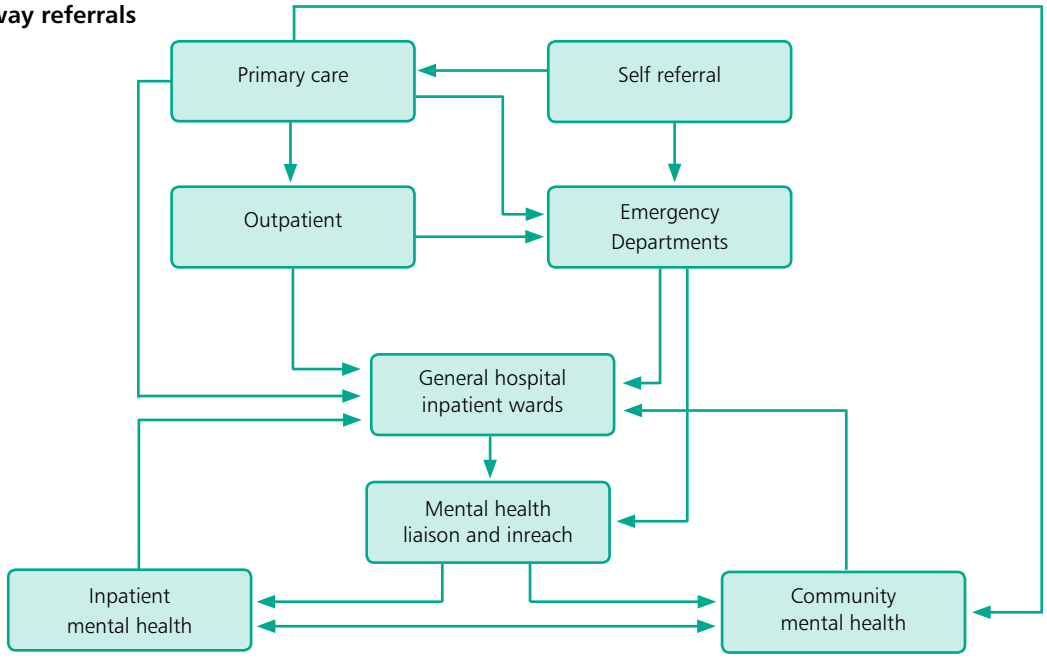
Within the study sample patients with mental health conditions accessed the general hospital for a number of purposes and the pathways of care often overlapped:

- There were patients presenting in crisis often with a self-harm presentation who had varying degrees of mental health condition and physical healthcare needs. Many of these patients were admitted for brief periods of time primarily for safeguarding and psychosocial assessment
- There were patients with a diagnosed mental health condition who were referred for physical healthcare monitoring and stabilisation
- There were patients who were admitted for physical healthcare who had a pre-existing mental health condition, or where psychosocial risk becomes apparent during the course of their care
- There was also a group of patients who had been directed to general hospital emergency department as the location for out of hours or urgent response mental health services

This complexity meant that not only must general hospital staff have knowledge and training about the mental health risks and needs of patients attending the general hospital, but also they must understand the local configuration of mental health services, referral processes, likely response times and additional resources available.

Figure 3.1 summarises some of the various referral pathways that were reviewed as part of the admission.

Figure 3.1 Pathway referrals



3

Arrival at the hospital

The majority of patients in the study were admitted to a District General Hospital (DGH) (356/489; 72.8%) (Table 3.1).

Table 3.1 Type of hospital the patient was admitted to by age

	11-17 years		18-25 years		Subtotal	Not answered	Total
	n	%	n	%	n	n	n
District general hospital <500 beds	105	42.0	88	36.8	**193**	2	**195**
District general hospital ≥500 beds	90	36.0	73	30.5	**163**	2	**165**
University teaching hospital	49	19.6	73	30.5	**122**	2	**124**
Specialist paediatric tertiary centre	4	1.6	0	0.0	**4**	0	**4**
Other speciality hospital	1	<1	5	2.1	**6**	0	**6**
Independent hospital	1	<1	0	0.0	**1**	0	**1**
Subtotal	**250**		**239**		**489**	**6**	**495**
Not answered	9		12		**21**	2	**23**
Total	**259**		**251**		**510**	**8**	**518**

Source: General health clinician questionnaire

Table 3.2 Gender and age group of the study population on arrival at the general hospital

	11-17 years		18-25 years		Not answered	Total
	n	%	n	%	n	n
Male	31	12.0	58	23.2	4	**93**
Female	228	88.0	192	76.8	0	**420**
Subtotal	**259**		**250**		**4**	**513**
Not answered	0		1		4	**5**
Total	**259**		**251**		**8**	**518**

Source: General health clinician questionnaire

The majority of patients where a general hospital questionnaire was returned were female; when looked at by age, 31/259 (12%) patients aged 11-17 years of age were male, and this increased to 58/250 (23.2%) patients in the 18-25 age group (Table 3.2).

In 162/518 (31.3%) patients admitted to a general hospital, additional complicating risk factors associated with mental health conditions were identified at presentation to hospital. The most common risk factors were:

- Social care involvement for a safeguarding concern in 54/162 (33.3%) patients
- The patient was a looked after young person or care leaver in 22/162 (13.6%) instances
- Substance misuse in 47/162 (29%) patients

The majority of patients arrived via the emergency department (ED (378/513; 73.7%), with just 59/513 (11.5%) through the admissions unit (paediatric or adult) and on the 76/513 (14.8%) classified as 'other'. 62 patients went direct to the ward. The majority of patients attended hospital from their usual place of residence (368/503; 73.2%) for which 298/368 (81.0%) this was the family home. This was also reflected in the routine national data presented in REPORT II. A further 38/503 (7.6%) patients arrived from another NHS hospital. Where it could be seen in the case notes, 300/366 (82%) patients arrived with someone accompanying them and in 253/295 (85.8%) cases where it was documented, this was a family member, friend or partner. However, in a number of case notes reviewed this information was not known or not recorded.

▶ *LINK TO EMERGENCY DEPARTMENT ATTENDANCES IN REPORT II*

In this study sample 196/292 (67.1%) patients were under the care of a community mental health team at the time of admission, and 223/325 (68.6%) patients had been under the care of a mental health team at some point in the two years prior to admission. Only 44/500 (8.8%) patients were referred to the general hospital by community mental health; the majority of patients self-referred (268/500; 53.6%) with a further 69/500 (13.8%) patients referred by primary care (SEE APPENDIX 2 FOR MORE DETAIL).

▶ *LINK TO CHAPTER 3 IN REPORT II*

A referral letter was present in the case notes of 89/113 (78.8%) patients referred from community mental healthcare or via primary care. In 83/89 (93.3%) it was reported by the NCEPOD peer reviewers to have contained at least adequate information about the patient's mental health condition.

Where it could be ascertained from the referrers' perspective, Table 3.3 shows that the community mental health clinicians identified the most frequent factors leading to presentation at hospital as:

1. A change in risk status in 42/82 (51.2%) patients
2. Patient non-compliance with their treatment plan in 27/82 (32.9%) patients
3. A change in social or family circumstances in 19/82 (23.2%) patients

Table 3.3 Factors that led to an admission in patients who were receiving current mental health treatment

	Mental health community clinicians		Mental health inpatient clinicians	
	n	**%**	**n**	%
Change in risk status	42	51.2	47	42.0
Patient non-compliance with treatment plan	27	32.9	40	35.7
Change in social or family circumstance	19	23.2	26	23.2
Precipitating event (e.g. trauma or loss)	15	18.3	22	19.6
Patient non-response to evidence based treatment plan	13	15.9	24	21.4
Patient disengagement from treatment plan	12	14.6	34	30.4
Family/carer non-compliance with treatment plan	11	13.4	12	10.7
Substance or alcohol misuse	9	11.0	22	19.6
Treatment plan Inadequate	4	4.9	6	5.4
Other	21	25.6	19	17.0
Subtotal	**82**		**112**	
Not answered	2		0	
Total	**84**		**112**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*

Source: Community mental health clinician questionnaire

Safeguarding

On an organisational level, where a response was received, it was reported that 223/225 (99.1%) hospitals were aligned with local safeguarding for child protection/adult safeguarding team(s) (131/132 (99.2%) caring for 11-17 year olds and 92/93 (98.9%) caring for 18-25 year olds). However, only 78/132 (59.1%) hospitals in which care was provided to 11-17 year olds, and 53/93 (57.0%) hospitals in which care was provided to 18-25 year olds, reported there to be a lead clinician with a specific responsibility for liaison with the child protection or adult safeguarding team(s) about children and young people with mental health conditions.

CASE STUDY 1

A young homeless woman of 19 years was brought to the emergency department complaining of abdominal pain and vomiting. She gave a history of having been treated in Child and Adolescent Mental Health Services for Anorexia Nervosa. No notes about this were available. No cause for her symptoms was identified. She was admitted to an adult medical ward for observation and referred for a mental health assessment. While this was awaited she refused to take any food and fluids. When confronted about this, she took her own discharge and was given details of a local organisation for the support of the homeless, and the telephone number of the local social care department.

Peer reviewers questioned whether this young person's situation was fully understood by general hospital staff before her discharge. No mental health notes were available and no mental health assessment had been undertaken. There was no record of any additional information being sought about her past mental health conditions or current social circumstances. The cause of her current physical symptoms was not clarified. There was no record of staff consulting social care services adult safeguarding teams, nor reference to local safeguarding procedures being followed or planned mental health review.

Initial assessment at arrival

Initial assessments were most commonly conducted in the ED (442/507; 87.2%) as this was where the majority of patients arrived. In line with this, the specialty team performing the initial assessment was also emergency medicine (206/395; 52.2%). Assessments were also made by paediatricians (83/395; 21%), general medicine (66/395; 16.7%) or surgery (40/395; 10.1%). In 227/384 (59.1%) patients the initial assessment was conducted by a nurse or junior doctor (basic grade or junior specialist trainee). This variation reflected the routine systems of triage within the ED. The peer reviewers found that the seniority and competence of clinicians was appropriate for this initial assessment in 238/243 (97.9%) of the case notes reviewed. In most cases the patient's mental health condition was recorded but there were 34/264 (12.9%) patients for whom it was not.

In 157/491 (32%) patients a physical as well as a mental health condition was recorded as present at the initial assessment, and 79/176 (44.9%) patients had physical health conditions which required urgent medical and/or nursing attention, often for treatment for a drug overdose, lacerations secondary to self-harm or management of the effects of starvation secondary to an eating disorder.

Previous mental healthcare admissions to a general hospital

▶ *LINK TO RE-ATTENDANCE TO THE EMERGENCY DEPARTMENT IN REPORT II*

From the cases reviewed it could be seen that there were 173/435 (39.8%) patients whose attendance at the hospital was the first presentation of their mental health condition. In 238/438 (54.3%) cases reviewed the patient had been admitted to hospital within the previous two years, and 121/226 (53.5%) patients where it was documented in the case notes, a mental health condition, with or without associated physical health issues, had been the reason.

Of the 124 patients who had been to the same hospital with a mental health or self-harm issue within the previous six-months the outcome of that presentation had resulted in 56/106 (52.8%) patients, where it was known, being referred for mental health review under an outpatient or community mental health service and 12/106 (11.3%) patients admitted to an inpatient facility. This finding was consistent with that seen in re-attendance data presented in REPORT II.

Recording of mental health history

A full mental health history was recorded in the general hospital case notes at the initial assessment of 385/491 (78.4%) patients (regardless of the route of admission), 106/491 (21.6%) patients did not. There were 196/292 (67.1%) patients who were known to be undergoing active treatment with mental health services at the time of admission but in only 76 patients was there a current mental health formulation or management plan available to staff. At the time of arrival and/or admission, the admitting team were only able to access community mental health notes and summaries for 47/226 (20.8%) patients. This reflected the known fact that mental health records are not widely shared between different service providers, even within the NHS.[19]

Recording of medication for mental health conditions

▶ *LINK TO ANTIDEPRESSANT AND ANXIOLYTIC/HYPNOTIC PRESCRIPTIONS IN PRIMARY CARE IN REPORT II*

Psychotropic medication prescription was part of the mental health treatment for 187/330 (56.7%) patients. Most commonly this included an antidepressant or anxiolytic. Acute discontinuation of such prescribed medicines is known to be associated with major side effects. Medication of any type was discontinued in 27/235 (11.5%) patients. In 6/27 (22.2%) patients, appropriate reasons were recorded (e.g. a drug had been used for self-harm in overdose).

ADMISSION TO A GENERAL HOSPITAL WARD

▶ *LINK TO TREATMENT SPECIALTY IN REPORT II*

Whilst 357/510 (70%) patients in the study were aged between 11 and 20 years, only 6 patients (1.2%) were admitted to a specific adolescent ward. More commonly and appropriately patients aged 11-17 years were admitted to a paediatric ward (193/496; 38.9%) (Table 3.4).

CASE STUDY 2

A 14 year old patient was admitted to a general hospital paediatric ward with swallowing difficulty and gagging secondary to anxiety. This had been a recurrent problem since the age of 9 and the patient had seen several paediatricians as an outpatient for help and advice. There had also been multiple emergency attendances to the same hospital over the previous six months and despite urgent GP referral the patient had not yet been seen by CAMHS professionals. On this occasion the consultant paediatrician documented that after a discussion with the general hospital mental health liaison services there would be an appointment to see CAMHS for an initial assessment three weeks later.

Peer reviewers commented that inpatient admission may accelerate CAMHS referral but that GP referrals may wait considerably longer. Paediatricians commented that they often felt that navigating a complex system to make an urgent referral was extremely difficult and that they had little or no contact with mental health colleagues except on-call.

Table 3.4 Specialty of the ward the patient was admitted to

	n	%
Emergency department observation unit	40	8.1
Assessment unit	64	12.9
Paediatric ward	193	38.9
Adolescent ward	6	1.2
Adult medical ward	90	18.1
Adult surgical ward	40	8.1
Other	63	12.7
Subtotal	**496**	
Not answered	22	
Total	**518**	

Source: General health clinician questionnaire

CASE STUDY 3

A 15 year old with known attention deficit hyperactivity disorder, depression and history of severe self-harming behaviour was admitted directly from school to a large emergency department in a children's hospital. The patient underwent an excellent assessment of mental state. The documentation and early input from CAMHS on-site also demonstrated a high standard of care. It was felt that the patient needed an inpatient mental health stay to manage the acute crisis but was then discharged from this within two days with a clear follow-up plan.

Peer reviewers were impressed with the high quality of overall care and documentation on this occasion.

Time to first physical health assessment following admission

The Royal College of Paediatrics and Child Health and the Royal College of Physicians of London have set standards which state that patients in acute general healthcare should be seen by a senior clinician within 14 hours of acute hospital admission.[20,21] Where timings were recorded in the case notes, the first medical review by a doctor of any grade after admission was not within 14 hours of arrival in 21/317 (6.6%) patients (Figure 3.2). According to general hospital clinicians, 41/446 (9.2%) patients experienced a delay in their first physical health assessment following admission.

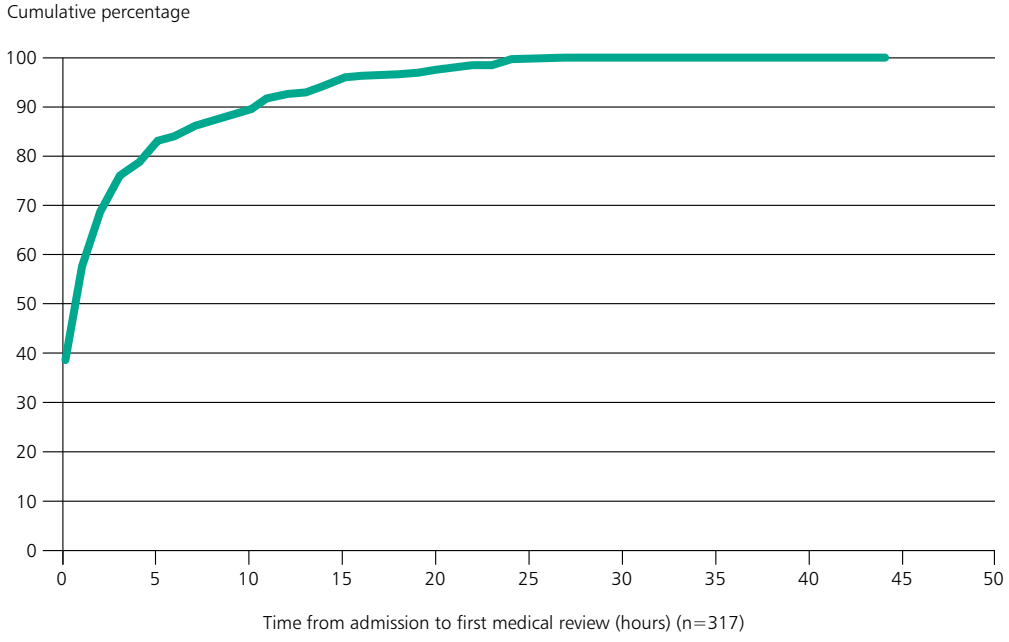


Figure 3.2 Time of first review from time of admission

Source: General health clinician questionnaire

Where it was recorded, the assessments were conducted by a basic grade, junior specialist trainee or nurse in 218/415 (52.5%) cases reviewed. It would have been appropriate for a more senior member of a specialty team to see the patient thereafter to confirm diagnosis and provide a clear management plan. In only 240/313 (76.7%) cases reviewed was a consultant review recorded in the case notes. In 191/232 (82.3%) of these cases this review was within 24 hours, but in only 97/232 (41.8%) was it was within 14 hours (Table 3.5).

Table 3.5 Time from admission to first consultant review

	n	%
< 14h	97	41.8
< 24h	94	40.5
< 48h	23	9.9
< 72h	6	2.6
>72h	12	5.2
Subtotal	**232**	
Unable to answer	8	
Total	**240**	

Source: Peer review assessment form

Peer reviewers reported a substantial delay in consultant review for 26/229 (11.4%) patients. They also summarised what they believed the value of consultant review had been when it had occurred (Table 3.6). This included:

- Confirmation of diagnosis in both physical and mental health
- Initiating referrals
- Making changes to treatment or a management plans

The physical health consultant who saw the patient for their first review was also responsible for the patient's ongoing physical healthcare in 318/431 (73.8%) instances. Specialists from paediatrics (168/411; 40.9%) and acute general medicine (106/411; 25.8%) were the most likely to provide this leadership role.

Table 3.6 Impact of the first consultant review

	n	%
Physical health diagnosis made or confirmed	132	58.7
Investigations initiated	100	44.4
Changes to treatment or management plan initiated	83	36.9
Mental health service referral initiated	72	32.0
Mental health diagnosis made or confirmed	51	22.7
Competency/capacity assessment carried out	10	4.4
Social care service referral initiated	9	4.0
Other	41	18.2
Subtotal	**225**	
Unable to answer	15	
Total	**240**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Peer review assessment form

Mental health conditions/behaviour at admission

▶ *LINK TO CHAPTER 4 IN REPORT II*

Many patients had more than one presenting mental health condition/behaviour on admission and a total of 352 patients had 538 documented mental health conditions (Table 3.7).

Table 3.7 Mental health condition at presentation

	n	%
Deliberate self-harm - overdose/ingestion of drugs, alcohol, harmful substances	176	50.0
Eating disorder	85	24.1
Suicidal ideation	78	22.2
Depression	75	21.3
Deliberate self-harm - cutting/other	63	17.9
Acute anxiety state	29	8.2
Other	32	9.1
Total	**352**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Peer review assessment form

The data here do not represent a national pattern as the sampling strategy for the study, described in Chapter 1, had already biased the inclusion criteria. However, in the study sample, ingestion of drugs and/or alcohol was approximately 2.5-3 times more common than physical self-harm related to cutting or trauma and suicidal ideation was a feature in 78/352 (22.2%) of the case notes reviewed. However the national picture of service use reflected in more detail from the analysis of the routine national data in REPORT II.

CASE STUDY 4

A 17 year old girl with learning difficulties was admitted via the emergency department of her local district general hospital after taking an overdose of an 'over the counter' laxative. She had a history of severe depression, bulimia and self-harm and was already under CAMHS. Mental healthcare was arranged to commence after discharge with an urgent appointment secured with CAMHS the next day.

Whilst this young person seemed to have good follow-up arrangements in place, peer reviewers commented that her mental health plan was unavailable to admitting clinicians. There was no assessment made about her current suicide risk, with reliance on CAMHS follow-up the next day. There also appeared to be no identifiable key worker to assist with transition to adult services given that she was likely to need longer term follow-up and care.

For 243/477 (50.9%) patients there were significant physical health consequences which arose directly as a result of the patient's mental health condition. Table 3.8 provides more detail about these. The consequences of self-harm dominated the reason for admission with 59/231 (25.5%) patients requiring toxicology monitoring and 76/231 (32.9%) toxicology management. There were also patients with serious secondary effects of starvation in those with an eating disorder, the most common of which were electrolyte imbalance and low heart rate. Where there were presenting physical health issues which occurred directly as a result of the patient's mental health condition, 18/231 (7.5%) patients required intensive care support.

▶ *LINK TO INTENSIVE CARE ADMISSIONS FOR SELF-HARM IN REPORT II*

Table 3.8 Physical health issues arising due to the patient's mental health condition

	n	%
Overdose requiring toxicology management	76	32.9
Overdose requiring toxicology monitoring	59	25.5
Trauma secondary to self-harm	28	12.1
Electrolyte imbalance	26	11.3
Low pulse rate (<50/minute)	26	11.3
Low blood pressure (SBG <85mmHg)	22	9.5
Hypoglycaemia (CBG <4mmol/L)	18	7.8
Dehydration	12	5.2
Oesophagitis	2	<1
Other	71	30.7
Subtotal	**231**	
Not answered	12	
Total	**243**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: General health clinician questionnaire

CASE STUDY 5

A 22 year old young man with poorly controlled asthma, severe depression and addiction took a large overdose of a mixture of paracetamol, antidepressants, alcohol and methadone. He was found in the bathroom of his home 12 hours later having aspirated and sustained a severe burn and muscle damage to his calf from lying next to a radiator overnight. After a 10 week stay in intensive care, during which he had renal replacement treatment and a below knee amputation he was seen by mental health professionals and transferred to inpatient care for treatment for his depression.

Peer reviewers commented on the severity of the physical health issues both acutely and in the long-term for this young man. Whilst it was impossible initially for him to be seen in intensive care as he was fully sedated and ventilated, he was then extubated for several weeks before a psychiatrist assessed him. During this time there were issues with patient refusal which made day-to-day care extremely difficult and might have been better managed if mental health input had been sought and obtained sooner.

Chronic physical health conditions at admission

Chronic health conditions in children and young people are on the rise and are well known to be associated with psychological stress which in turn impacts on both mental and physical wellbeing and recovery.

There were 109/518 (21.0%) patients who were known on admission to have ongoing chronic physical health issues which was noted when they presented with a mental health condition. The most common of these were chronic asthma and diabetes (Table 3.9).

Table 3.9 Chronic physical health comorbidities

	n	%
Chronic asthma	23	21.1
Diabetes	15	13.8
Epilepsy	6	5.5
Arthritis	4	3.7
Chronic neurodisability	4	3.7
Other	67	61.5
Subtotal	**109**	
None	374	
Not answered	35	
Total	**518**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*

Source: General health clinician questionnaire

Medical history and mental state examination at admission

A medical history was recorded in the patient's general hospital notes in 297/332 (89.5%) cases peer reviewed at admission to a ward. Peer reviewers stated that the history description was adequate in only 181/297 (60.9%) cases reviewed. There was a record of the patient's mental state in only 140/322 (43.5%) general hospital case notes reviewed and peer reviewers found a formulation of differential diagnoses in just 233/313 (74.4%) cases.

Consent, competence and mental capacity

Current NHS guidance states that children under the age of 16 may consent independently to most interventions provided they have sufficient competence to do so. In children and young people, 16 years and over, the law is broadly similar across the UK and the term mental capacity is generally employed.[22-26]

Suffering from a mental health condition does not mean that a child or young person lacks the ability to participate in decision-making. However, there may be situations which arise where it is appropriate to document and specifically test their competence or mental capacity. It is best practice to document consent or at least agreement to investigation or treatment as part of this process. If the person lacks mental capacity it may be possible for health professionals to still deliver care. This may be based on the fact that it is in the best interests of the patient and involving parental consent (if the person is under their liberty) or to use the powers derived from the Mental Health Act The law varies slightly with age across the different countries of the UK, but best practice is that children and young people should be enabled to actively participate in decision-making in matters relating to their health as soon as they are deemed competent/have capacity to do so.[26]

In 12/128 (9.4%) hospitals from which a response was received, there was no specific policy for consent in children and young people. Fewer hospitals in which 11-17 year olds were cared for had a specific policy or used proforma templates to facilitate mental capacity assessment as compared with 18-25 year olds (79/122; 64.8% vs. 88/94; 93.6%). (Table 3.10).

Table 3.10 Organisational policy and proformas for use in the assessment of mental capacity

	11-17 years		18-25 years	
	n	%	n	%
Yes	79	64.8	88	93.6
No	43	35.2	6	6.4
Subtotal	**122**		**94**	
Not answered	18		17	
Total	**140**		**111**	

Source: Organisational questionnaire

Peer reviewers stated that competency/capacity was documented in the general hospital case notes for only 103/309 (33.3%) patients. When the ages of the patients were looked at it was just as likely that the patient was under the age of 16 years as older. Whilst numbers were much smaller, assessment of competency/capacity seemed to be more routine where people were being cared for in inpatient mental health and these assessments were recorded for 76/106 (71.7%) patients across all age ranges (SEE CHAPTER 4). This might be explained by a more seriously ill cohort of patients being admitted for inpatient mental health care and/or the need for more challenging therapeutic options to be delivered. It may also be that mental health professionals are more familiar with the practice of using assessments of competence and mental capacity in relation to decision-making for children and young people and documenting this information.

Mental health professionals were involved in an assessment of competence or mental capacity in 39/93 (41.9%) patients in the general hospital. In 15/35 (42.9%) cases this involved the patient wishing to leave hospital against advice and in 14 cases refusing investigation, treatment or nutrition. The assessment of mental capacity was reported to be have recorded in the general hospital notes in 20/25 (80.0%) cases when this question was answered.

Use of mental health legislation

For 27 patients, the general hospital admission followed a Mental Health Legislation assessment. Where this request originated from was often unclear to general hospital clinicians completing the questionnaires, but for 19 patients the Mental Health Act assessment took place in a general hospital setting. The outcome of the Mental Health Act assessment was a Mental Health Act Assessment Order in 6 patients or a Mental Health Act Treatment Order in 5 patients. Other outcomes for the remaining patients included use of the Mental Capacity Act, a hospital place of safety or emergency department attendance, the Children's Act (Scotland) 1995 or Age of Legal Capacity Act (Scotland) 1991.

Clinical leadership and care co-ordination

When patients are admitted and under the care of more than one team there is a need for clear leadership and care co-ordination. General health clinicians reported a lack of clarity as to who was leading the mental healthcare in 50/403 (12.4%) patients. Furthermore the answer to this question was 'not known' or was not answered for 115/518 (22.2%) patients.

From an organisational perspective there was variability in whether there was a lead clinician of any specialty or team for the care of 11-25 year olds admitted as the result of a mental health condition (114/231; 49.4%). A lead of any specialty was in place to oversee the mental healthcare in 76/129 (58.9%) hospitals providing care to 11-17 year olds, and in 38/102 (37.3%) hospitals providing care to 18-25 year olds. When broken down by whether mental health services were provided on-site or not, a lead was more likely to be in place where services were provided on-site (Table 3.11).

Table 3.11 A lead clinician or team in place for the care of 11-25 year olds admitted as the result of a mental health condition

	Mental health facility				General hospital			
	11-17 years		18-25 years		11-17 years		18-25 years	
	n	%	n	%	n	%	n	%
Yes	55	90.2	20	43.5	21	30.9	18	32.1
No	6	9.8	26	56.5	47	69.1	38	76.9
Subtotal	**61**		**46**		**68**		**56**	
Not answered	4		2		7		7	
Total	**65**		**48**		**75**		**63**	

Source: Organisational questionnaire

Furthermore the nursing requirements were often not considered, and it is known from previous work that paediatric and adult trained general health nurses are unlikely to have been trained in any depth on mental health issues.[27] Organisational data showed that mental health nurses were not always available to routinely support the care of 11-25 year olds with mental health conditions when they were admitted to general health settings (74/116; 63.8%) (Table 3.12).

Table 3.12 Mental health nursing routinely provided to support care

	11-17 years		18-25 years	
	n	**%**	**n**	**%**
Yes	30	44.8	12	24.5
No	37	55.2	37	75.5
Subtotal	**67**		**49**	
Not answered	8		15	
Total	**75**		**64**	

Source: Organisational questionnaire

Delivery of routine ward care and risk assessments

Safe admission of 11-25 year olds with an acute mental health condition, whether or not they also have associated physical health conditions, should include an early and explicit risk assessment made on the ward. This will inform the decision about what level of observation and nursing care is required to ensure their ongoing safety. Peer reviewers believed the delivery of routine ward care was adequate for only 162/286 (56.6%) patients whose cases were reviewed.

Peer reviewers reported that patient monitoring plans made on the general hospital ward for the inpatient stay for physical health were appropriate and adequate in nearly all cases reviewed (310/318; 97.5%), but for mental health only 148/285 (51.9%) patients had an appropriate and adequate monitoring plan (Table 3.13). The overall patient management plan was stated to be satisfactory in only 237/300 (79%) cases reviewed.

Furthermore peer reviewers found gaps in actual physical healthcare monitoring in 98/335 (29.3%) cases where this was recorded. The patient's mental health condition was a clearly documented contributing factor in 47/56 (83.9%) cases. In many cases reviewed the peer reviewers were of the opinion that the problems in monitoring would have been avoidable through better training (21/43; 48.8%) and patient care (52/67; 77.6%) (Tables 3.14 and 3.15).

Table 3.13 An adequate monitoring plan made for physical and mental healthcare

	Physical health		Mental health	
	n	**%**	**n**	**%**
Yes	310	97.5	148	51.9
No	8	2.5	137	48.1
Subtotal	**318**		**285**	
Unable to answer	17		50	
Total	**335**		**335**	

Source: Peer review assessment form

Table 3.14 Factors that would have helped avoid the patient refusing physical healthcare monitoring

	n	**%**
Better training of hospital staff	21	48.8
Mental health assessment in the general hospital	18	41.9
Better communication between staff	14	32.6
Other	16	31.2
Subtotal	**43**	
NA - gaps not as a result of refusal	17	
Unable to answer	38	
Total	**98**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Peer review assessment form

Table 3.15 Management of the patient's mental health condition could have been better whilst they were staying at a general hospital

	n	**%**
Yes	52	77.6
No	15	22.4
Subtotal	**67**	
Unable to answer	31	
Total	**98**	

Source: Peer review assessment form

General health clinicians stated that the patient's mental health condition impacted on the management of an acute medical condition for 64/449 (14.3%) patients. Table 3.16 shows that for 33/42 (78.6%) patients, where details were given, this was due to refusal of care, and in 19/40 (47.5%) patients the management of the physical health condition was delayed. The most common issue was the patient's refusal to take fluids or nutrition (34/42; 81.0%).

Peer reviewers identified that restraint or pharmacological tranquillisation was used in the general hospital context in 9/268 (3.4%) patients but this could not be answered in 135 cases as the information was not provided for review. In 5 cases reviewed peer reviewers identified concerns about how this was implemented.

Table 3.16 Specific issues with day-to-day patient care on general health wards

	Yes	No	**Subtotal**	Unknown	Not answered	**Total**
Refusal to take fluids/nutrition	34	8	**42**	2	20	**64**
Absconding	18	18	**36**	3	25	**64**
Verbal aggression towards staff, patients or family/ carers	17	21	**38**	2	24	**64**
Refusal to take medication	11	18	**29**	4	31	**64**
Refusal to allow routine non invasive procedures	9	20	**29**	5	30	**64**
Physical aggression towards staff, patients or family/ carers	8	23	**31**	1	32	**64**

Source: General health clinician questionnaire

CASE STUDY 6

A 16 year old girl with insulin dependent diabetes was admitted to a paediatric ward after an episode of severe cutting to her forearm. There was a three day delay in a mental health assessment being undertaken and then a nine day delay before she was transferred to a teenage inpatient mental health facility, which was 60 miles away. During this period she refused to eat, self-harmed and absconded several times from the ward. There were wide fluctuations in her blood glucose control. Eventually she received 1:1 nursing.

Peer reviewers commented that the mental health notes in her general health record were very brief. They did not contain a clear risk assessment and there appeared to be no additional mental health input after the initial recommendation for inpatient mental healthcare, despite a prolonged general hospital stay. The peer reviewers also noted that records from the general paediatric team related only to her diabetes care and that it was unclear who was providing a leadership role during the admission.

CASE STUDY 7

An 18 year old young woman with severe self-harming behaviour, including multiple lacerations to her forearm requiring surgical repair, was admitted to an acute medical ward for five days and seen by an adult mental health crisis team. There was a proforma for a risk management plan in her case notes but this had not been completed. Whilst the patient had 1:1 mental health nursing in place the attitude to her risk was inconsistent, and on occasion she left the ward to smoke, without an escort. She was eventually discharged home but her discharge plan was also unclear as to when she would be followed-up by adult mental health services.

Peer reviewers commented about the importance of recording a clear risk management plan whilst patients are in hospital and the need for consistency and professional agreement as to what this means in terms of day-to-day patient supervision and care. They felt there was also a need for a closer working relationship between nurses in mental health and physical health, a common language which all professionals understood and better recording of decisions in jointly held notes.

REVIEW BY GENERAL HOSPITAL MENTAL HEALTH LIAISON SERVICES /CRISIS TEAMS

On an organisational level it was reported that 87/102 (85.3%) hospitals had an emergency mental health pathway specifically for 11-25 year olds in crisis (52/61 (85.2%) for 11-17 year olds and 35/41 (85.4%) for 18-25 year olds).

▶ *(SEE APPENDIX 1 FOR MORE DETAIL)*

In the general hospital setting, crisis services tended to be provided by general hospital mental health liaison teams for 11-17 year olds (32/59 (54.2%) hospitals) in normal working hours and crisis resolution teams (23/42; 54.8%) for 11- 17 year olds out of hours. For 18-25 year olds hospital based mental health liaison team provided services in 33/39 (84.6%) hospitals in normal working hours and out of hours in 35/42 (83.3%) hospitals.

In the general hospital setting the most common route of emergency referral to mental health was via a dedicated on-call mental health liaison service (88/134; 65.7%), the psychiatry team in 50/134 (37.3%), a specified emergency care pathway for all acute mental health referrals in 47/134 (35.1%) and via a specified emergency care pathway for certain conditions in 35/134 (26.1%) hospitals.

General hospital clinicians referred 326/501 (65.1%) of the patients in the study to mental health services during their admission. From the case notes it could be seen that the majority of referrals were made in the daytime (between 8:00 and 18:00) (129/176; 73%).

The reason for non-referral was often unclear. In 124 cases reviewed from patients who attended the ED but who were not referred to a mental health team, the most common singular reason was that the emergency medicine clinician did not consider a referral was required at that stage (Table 3.17).

Table 3.17 Why the patient was not referred to a mental health team

	n	%
The emergency medicine clinician did not consider it was required	39	38.2
No age appropriate mental health service was available	13	12.7
Other	60	58.8
Subtotal	**102**	
Unable to answer	22	
Total	**124**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Peer review assessment form

Referrals to mental health services were made primarily by medical and nursing staff, with varying levels of seniority. They originated in the main from emergency medicine (59/211; 28.0%), paediatrics (100/225; 44.4%), and general medicine (42/225; 18.7%).

On an organisational level, a policy for the initial assessment, referral and management of common mental health conditions was in place in 180/230 (78.3%) hospitals in which 11-25 year olds were cared for. For 11-17 year olds this was 102/131 (77.8%) hospitals and for 18-25 year olds this was 78/99 (78.9%) hospitals (Table 3.18).

Table 3.18 Guidance or a care pathway/bundle available for the management of young people with the included condition/behaviour

	Severe depression				Self-harm				Eating disorders			
	11-17 years		18-25 years		11-17 years		18-25 years		11-17 years		18-25 years	
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	59	45.7	43	46.2	105	81.4	64	66.7	93	73.8	53	57.0
No	70	54.3	50	53.8	24	18.6	32	33.3	33	26.2	40	43.0
Subtotal	**129**		**93**		**129**		**96**		**126**		**93**	
Not answered	11		18		11		15		14		18	
Total	**140**		**111**		**140**		**111**		**140**		**111**	

Source: Organisational questionnaire

Emergency management algorithms for mental health were only available in 124/218 (56.9%) hospitals in which 11-25 year olds were cared for. For 11-17 year olds this was 65/126 (51.6%) hospitals and for 18-25 year olds this was 59/92 (64.7%) hospitals (Table 3.19).

Table 3.19 Emergency management algorithms for mental health were available specifically for 11-25 year olds (e.g. acute psychosis)

	11-17 years		18-25 years	
	n	%	n	%
Yes	65	51.6	59	64.1
No	61	48.4	33	35.9
Subtotal	**126**		**92**	
Not answered	14		19	
Total	**140**		**111**	

Source: Organisational questionnaire

Table 3.20 Delays to mental health service assessment

	n	%
Yes	68	27.6
No	178	72.4
Subtotal	**246**	
Unable to answer	14	
Total	**260**	

Source: Peer review assessment form

Peer reviewers found that the mental health assessment in the ED was delayed in 38/135 (28.1%) cases reviewed and that this had an impact on the quality of care of 16 patients.

A delay in responding to a referral to mental health was identified in 68/246 (27.6%) cases reviewed (Table 3.20), and peer reviewers expressed a view that this delay had an impact on both the quality of the physical and mental healthcare in 36/60 (60.0%) patients.

Initial assessment by a mental health professional in the general hospital

Of those patients referred to mental health services during their admission to a general hospital, 303/323 (93.8%) patients were recorded in the general hospital notes as having been seen and assessed by a mental health professional. Of the 20 patients referred but not seen, 2 were reported to have refused the consultation and in a further 8 the consultation was deemed to be inappropriate as the patient was already under the care of another mental health team. In others, no reason was recorded.

The profession and grade of staff undertaking the mental health assessment, and the service from which they originated is shown in Table 3.21.

Table 3.21 Origin and professional background of staff making the initial mental health assessment in general hospital

Grade	Adult mental health practitioner	Child and adolescent mental health practitioner	Liaison psychiatry practitioner	Other
	n	n	n	n
Consultant	4	15	3	0
Staff grade/associate specialist	0	0	0	0
Senior specialist trainee	2	5	0	0
Junior specialist trainee	5	2	3	3
Basic grade	1	0	2	1
Specialist nurse	2	12	12	0
Senior staff nurse	1	3	0	0
1st level nurse	1	0	0	0

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Mental health assessment in a general hospityal (liaison psychiatry) questionnaire

Table 3.21 Origin and professional background of staff making the initial mental health assessment in general hospital (continued)

Grade	Adult mental health practitioner	Child and adolescent mental health practitioner	Liaison psychiatry practitioner	Other
	n	n	n	n
Registered mental health nurse	5	10	8	3
Clinical psychologist	0	5	1	0
Psychotherapist	0	0	1	1
Mental health practitioner (other)	0	11	2	0
Subtotal	**21**	**63**	**32**	**8**
Unknown	18	52	46	16
Total	**39**	**115**	**78**	**24**

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Mental health assessment in a general hospityal (liaison psychiatry) questionnaire

Peer reviewers identified from the general hospital notes that first patient contact with mental health services took place within 24 hours of admission in 128/212 (60.4%) patients and within 48 hours in 166/212 (78.3%) (Table 3.22). Nevertheless, in the opinion of the peer reviewers the first assessment was delayed in 55/209 (26.3%) (Table 3.23).

Table 3.22 First patient contact with mental health services

	n	%
< 14h	57	26.9
< 24h	71	33.5
< 48h	38	17.9
< 72h	23	10.8
>72h	23	10.8
Subtotal	**212**	
Unable to answer	3	
Total	**215**	

Source: Peer review assessment form

Location of mental health review

On an organisational level, private and secure areas were available for assessment in the ED or assessment units in 86/103 (83.5%) of hospitals in which mental healthcare was provided on-site. For 11-17 year olds it was 49/60 (81.7%) hospitals and for 18-25 year olds it was 37/43 (86.0%) hospitals (Table 3.24).

Table 3.23 Delay in the first ward based mental health assessment or triage

	n	%
Yes	55	26.3
No	154	73.7
Subtotal	**209**	
Unable to answer	6	
Total	**215**	

Source: Peer review assessment form

There was variation in whether the facilities met the Royal College of Psychiatrists Quality Standards (Table 3.25).[28] However, where no mental health services were provided on-site 31/73 (42.5%) providers reported the absence of private and secure interview facilities for 11-17 year olds.

Data from the mental health assessment questionnaire showed that the most frequent location for patient assessment by a mental health professional within the general hospital was on an inpatient ward 58/112 (51.8%) followed by the ED in 33/112 (29.5%) and then an outpatient department in 14/112 (12.5%) patients. There were 7/112 (6.3%) 'other' areas. In 7/104 (6.7%) cases reviewed the assessment location was deemed by the responding mental health professional to be not appropriate for the task. It was reported that assessments in the general

Table 3.24 Availability of a private/secure area in the emergency departments/assessment units or equivalent, for confidential mental health assessment

	Mental health services provided on-site				NO mental health services provided on-site			
	11-17 years		18-25 years		11-17 years		18-25 years	
	n	%	n	%	n	%	n	%
Yes	49	81.7	37	86.0	42	57.5	46	79.3
No	11	18.3	6	14.0	31	42.5	12	20.7
Subtotal	**60**		**43**		**73**		**58**	
Not answered	5		5		2		5	
Total	**65**		**48**		**75**		**63**	

Source: Organisational questionnaire

Table 3.25 Facilities for confidential mental health assessment were fully compliant with the Royal College of Psychiatrists Quality Standards for Liaison Psychiatry Services in hospitals that provided mental health services on-site

	11-17 years		18-25 years	
	n	%	n	%
Yes	17	77.3	14	63.6
No	5	22.7	8	36.4
Subtotal	**22**		**22**	
Unknown	27		15	
Total	**49**		**37**	

Source: Organisational questionnaire

hospital lasted between 20 minutes and 3 hours and that a clear management plan was documented in the general hospital notes for 93/112 (83.0%) patients.

Reason for referral to mental health services

The main reason for referral was to undertake a psychosocial assessment in 79/112 (70.5%) patients admitted for deliberate self-harm. Other reasons for referral included the assessment of an eating disorder, the mental health component of chronic pain and the management of risk on the hospital ward.

In all 79 patients who were referred for a psychosocial assessment, a clear action plan was developed and agreed with the patient at initial assessment and 67/79 (84.8%) patients were referred on for further help from mental health services after discharge. The management plan was recorded in the general hospital notes in 64/67 (95.5%) of these patients, and in mental health notes for 65/67 (97.0%) patients.

Recording and communication of the initial mental health assessment

General hospital clinicians reported an entry in the medical notes made by the mental health professional following an assessment, in 259/283 (91.5%) cases. These notes were reported to be sufficiently detailed for the purposes of the general hospital clinical team in 215/247 (87.0%) and that a clear action plan was outlined and agreed following initial assessment in 255/272 (93.8%) patients where a response was given. However, general hospital staff were clear that the plan had been communicated to the patient in only 148/255 (58.0%) cases (this was unknown in 110 as not recorded in the case notes), and clear that the plan had been communicated to the patient's family or carers in 120/125 (96.0%) instances (unknown in 133 cases, again as not recorded in the case notes).

General hospital staff reported that the initial mental health assessment resulted in the formation of a collaborative risk management plan in fewer patients. For the 153 general health questionnaires where the question was answered, staff knew of such a risk plan in 102/153 (66.7%) instances. Where it did exist, the plan was reported to have led to changes in the care of the patient in general hospital either through the level of monitoring, or through a change in location in 45/89 (50.6%) patients.

Peer reviewers reported that there were sufficient case notes relating to the contact with mental health services (from another team not undertaking the inpatient care) during the patient's admission during the study period to assess the care provided in 157/251 (62.5%) patients.

Table 3.26 Content of mental health entries into general health and mental health notes

	General Hospital note contents		Mental health note clinical note	
	n	%	n	%
Name and contact detail of professional(s) seeing the patient	224	81.6	116	75.3
The outcome of the assessment	214	84.2	0	0
Mental health history	166	59.9	108	73.5
Follow-up arrangements after discharge	158	65.1	76	51.7
Mental state	142	55.3	103	70.1
Changes to treatment or management plan initiated	140	49.3	22	15.0
Whether the patient was seen alone or accompanied	123	48	79	55.6
Advice about discharge when physically fit	122	49.3	52	35.4
Where the patient was seen	120	44.7	87	58.4
Risk assessment	119	50.7	100	68.0
Mental health diagnosis or formulation	117	47.4	80	54.4
Advice regarding ward management	117	44.1	44	29.9
Follow-up arrangements whilst in general hospital	88	34.9	40	27.2
Safeguarding issues and vulnerability	75	29.6	47	32.0
Advice about treatment of mental health condition	73	27.6	89	60.5
Collateral information obtained	61	26.3	37	25.2
The impact of the assessment on the patient	39	17.1	0	0
Bed finding arrangements if needed	39	15.8	32	21.8
Views and wishes of patient	0	0	73	49.7
Views and wishes of family	0	0	44	29.9
Other	18	5.9	0	0
Subtotal	**284**		**147**	
Not answered	51		10	
Total	**335**		**157**	

Source: Peer review assessment form

Peer reviewers examined the content of the mental health clinical note and the general hospital clinical note entries made by mental health professionals about their contact with patients. The frequency of the clinical issues addressed in the notes showed considerable variation and is shown in Table 3.26.

DURATION OF ADMISSION AND DISCHARGE PLANNING FROM AN ACUTE GENERAL HOSPITAL

▶ *LINK TO LENGTH OF STAY IN REPORT II*

Duration of admission was calculated when date and time were available for admission and discharge. As reported earlier, the study population was stratified in order to ensure that it included a population of patients with each of the chosen conditions and a group who remained in the general hospital in excess of three days duration. Nevertheless, 386/469 (82.3%) patients were admitted for six days or less.

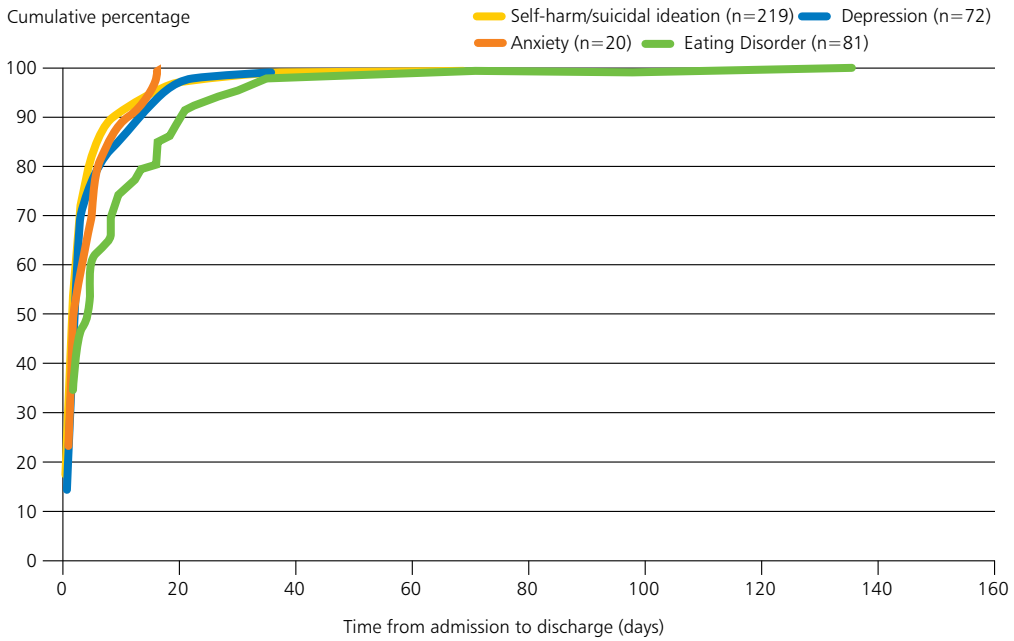


Figure 3.3 Length of stay **Answers may be multiple*
Source: General health clinician questionnaire

As can be seen from Figure 3.3, excluding outliers, there was a trend for patients with an eating disorders to have longer general hospital admissions than others, perhaps reflecting their need for physical stabilisation. This was also reflected in the routine national data presented in REPORT II.

Discharge plans

Mental health services were involved overall in discharge planning in 326/430 (75.8%) patients: crisis or general hospital mental health liaison services in 162/430 (37.7%), community mental health teams in 102/430 (23.7%) and inpatient services in 62/430 (14.4%) (Table 3.27).

Table 3.27 Healthcare staff involved in discharge planning

	11-17 years		18-25 years				
	n	%	n	%	Subtotal	Not answered	Total
Treating medical/surgical team	105	47.7	129	63.5	**234**	4	**238**
Liaison mental health team	78	35.5	83	40.9	**161**	1	**162**
Community mental health team	86	39.1	15	7.4	**101**	1	**102**
Other	47	21.4	27	13.3	**74**	1	**75**
Inpatient mental health team	35	15.9	26	12.8	**61**	1	**62**
Primary care team	5	2.3	4	2.0	**9**	0	**9**
Subtotal	**220**		**203**		**243**	**187**	**430**
Not applicable	16		28		**44**	1	**45**
Not answered	23		20		**43**	0	**43**
Total	**259**		**251**		**810**	**188**	**518**

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Peer review assessment form

CASE STUDY 8

A 20 year old university student with longstanding depression and previous history of active mental healthcare near her family home was admitted acutely unwell with pneumonia. She was on fluoxetine, and her mood was noted to be very low by nursing and junior medical staff. Despite this there was no obvious care leadership or co-ordination during her admission, which was exclusively under general health. There was also no documentation about possible contact with a GP or the community mental health team for ongoing help. She was discharged home to a student flat.

Peer reviewers commented on the poor level of risk assessment and consultant supervision apparent for this patient. Treatment focused almost exclusively on her physical health and without an awareness of the possibility of her mental health issues further impacting her recovery.

CASE STUDY 9

A 24 year old mother of two small children, including one under the age of a year was admitted after an impulsive but significant overdose following an argument with her partner. There was a history of previous overdoses at age 16 years, and of sexual abuse. Emergency department staff used an excellent proforma to aid assessment and recording of her mental health. A risk assessment was also performed as part of an on-site liaison psychiatry review and as a result she was discharged to 'self-directed care' involving her GP. However, there was no documentation of the possible safeguarding risk in relation to the patient's two small children.

Peer reviewers commented that whilst it was very good to see a jointly held document in use which indicated local systems in place for adult liaison in mental health, there should also have been clearer involvement of postnatal mental health services which would offer specific advice in this case in relation to safeguarding concerns.

Table 3.28 Items included in the discharge plan

	Yes	No	**Subtotal**	Unknown	Not answered	**Total**
Clear medication plan	268	95	**363**	19	30	**412**
Follow-up arrangement - Mental health therapists	234	119	**353**	34	25	**412**
Follow-up arrangement - Physical/general health	230	133	**363**	20	29	**412**
Meal diet plan	55	265	**320**	48	44	**412**

Source: General health clinician questionnaire

The relative lack of involvement of community teams at discharge contrasts with the fact that 196/291 (67%) were involved prior to admission.

Admitting clinicians stated that there was a clear written discharge plan for 412/460 (89.6%) patients. Many discharge plans contained information about the patient's medication (268/363; 73.8%) but there was less detail about diet and follow-up with either physical health or mental health professionals. In particular, admitting clinicians stated that mental health follow-up was only part of the discharge plan for 234/353 (66.3%) patients (Table 3.28).

There was evidence of multidisciplinary discharge planning in only 156/301 (51.8%) sets of notes reviewed (Table 3.29). Where there was evidence, documentation of

Table 3.29 Evidence in the notes of multidisciplinary discharge planning

	n	**%**
Yes	156	51.8
No	145	48.2
Subtotal	**301**	
Unable to answer	34	
Total	**335**	

Source: Peer review assessment form

communication with the family, the GP and the community mental health team (if they were involved in care) occurred in only 116/156 (74.4%) of these cases.

On an organisational level it was reported that 39/42 (92.8%) hospitals had a process of support, rapid liaison, shared decision-making with colleagues in Tier 4 services and discharge planning for patients with a severe mental health condition placed in an acute general hospital.

The destination on discharge for the study population as reported by general hospital clinicians is shown in Table 3.30; 355/499 (71.1%) patients were discharged to their home and 95/449 (21%) patients were transferred to mental health inpatient care at a different location. Of these, 42 patients were transferred to an adult mental health ward and 53 to child and adolescent mental health facilities.

▶ *LINK TO DISCHARGE DESTINATION IN REPORT II*

These data were reflected in the review of routine national data in REPORT II and there was little difference across the included sample.

▶ *LINK TO READMISSIONS IN REPORT II*

Table 3.30 Discharge destination

	n	%
Discharged home	355	71.1
Transferred to a mental health unit outside this hospital (11-17 years)	47	9.4
Transferred to a mental health unit outside this hospital (18-25 years)	37	7.4
Discharged to a residential/care home	9	1.8
Transferred to a mental health unit within this hospital (11-17 years)	6	1.2
Transferred to a mental health unit within this hospital (18-25 years)	5	1.0
Died	1	0.2
Other	39	7.8
Subtotal	**499**	
Not answered	19	
Total	**518**	

Source: General health clinician questionnaire

Figure 3.4 shows the time spent in hospital by patients transferred to mental health facilities.

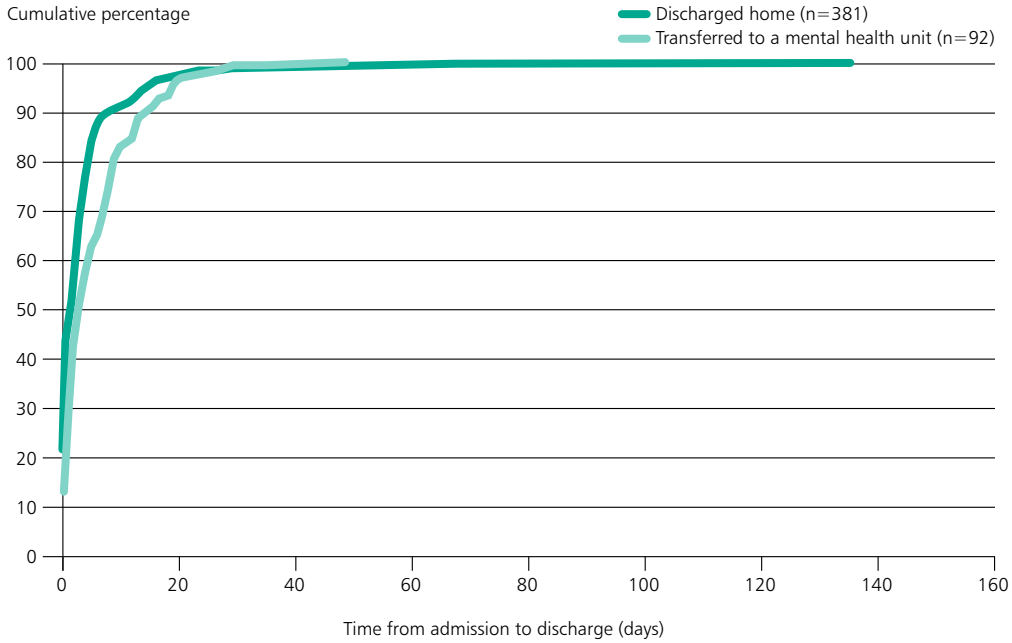


Figure 3.4 Time from admission to discharge by discharge destination (transferred to a mental health facililty or discharged home)

Source: General health clinician questionnaire

Table 3.31 Distance of the mental health facility from the patient's home

	11-17 years		18-25 years		Total
	n	%	n	%	n
Less than 10 miles	6	15.0	17	36.7	**23**
Between 10-25 miles	11	27.5	9	30.0	**20**
Between 26-50 miles	14	35.0	4	13.3	**18**
Between 51-100 miles	5	12.5	0		**5**
More than 100 miles	4	10.0	0		**4**
Subtotal	**40**		**30**		**70**
Unknown	12		13		25
Total	**52**		**43**		**95**

Source: General health clinician questionnaire

Transfer and distance from home

Where patients were admitted to a mental health facility the distance from the patient's home is shown in Table 3.31. Patients who transferred to mental health facilities from general hospitals tended to travel further afield for their treatment than those admitted from community settings. For 11-17 year olds who transferred to a mental health facility and where the distance travelled was reported, 9/40 (22.5%) patients travelled more than 50 miles for treatment and 4/40 (10.0%) more than 100 miles.

On an organisational level, 23/102 (22.5%) hospitals in which care was provided to 11-25 year olds reported distances of greater than 80 miles to travel to a mental health facility when mental health services were not on-site (Table 3.32).

CASE STUDY 10

A 17 year old was in treatment with a local outpatient specialist Eating Disorders service. She appeared to be well engaged in all psychological therapies, but despite dietary plans and support, continued to lose weight. She became physically unwell with a slow heart rate, marked muscle weakness and showed signs of confusion. She was referred to the general hospital, stabilised in the emergency department and admitted for monitoring on an adult medical ward. The following day she was transferred to a specialist private sector Eating Disorder Unit 150 miles from her home.

Peer reviewers were concerned about the distance away from home that this young person experienced in order to access inpatient care. There was concern that an earlier, and planned referral had not been pursued given the physical deterioration with outpatient treatment.

Table 3.32 Average distances travelled by patients admitted for tier 4 services

	Mental health services provided on-site				NO mental health services provided on-site			
	11-17 years		18-25 years		11-17 years		18-25 years	
	n	%	n	%	n	%	n	%
<10 miles	5	10.4	8	25.0	10	18.5	18	48.6
10-20 miles	6	12.5	3	9.4	10	18.5	10	27.0
21-40 miles	10	20.8	10	31.3	11	20.4	2	3.4
41-80 miles	19	39.6	7	21.9	8	14.8	3	8.1
>80 miles	8	16.7	4	12.5	15	27.8	4	10.8
Subtotal	**48**		**32**		**54**		**37**	
Not applicable	2		2		2		0	
Not answered	15		14		19		26	
Total	**65**		**48**		**75**		**63**	

Source: Organisational questionnaire

OVERALL QUALITY OF GENERAL HOSPITAL CARE

General hospital clinicians were of the opinion that in 81/465 (17.4%) patients the standard of care delivered for 11-25 year olds with a mental health condition was not the same as that delivered to patients admitted with a more complex acute medical condition (and requiring input from an additional specialist team). The most common areas for improvement were delivery of mental healthcare (48), organisation of care (36) and general clinical care (7), with some answers being multiple.

Peer reviewers were asked to rate the overall quality of general health and mental healthcare care during the inpatient acute hospital episode (Figure 3.5). They reported overall more good practice however they also highlighted more room for improvement in the clinical care of this patient group and more with and overall rating of less than satisfactory.

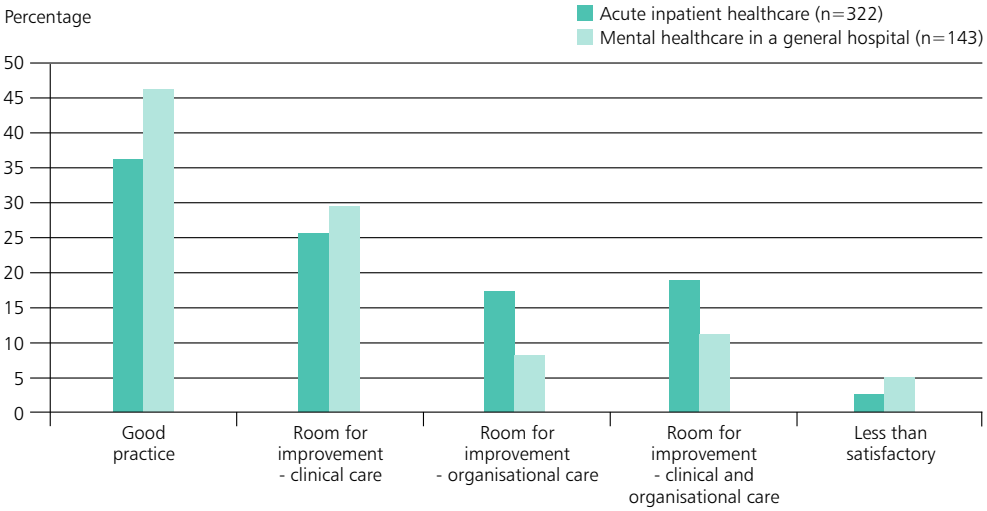


Figure 3.5 Overall quality of care of general health and mental healthcare in a general hospital

Source: Peer review assessment form

Key Findings CHAPTER 3

▶ *LINK TO CHAPTER 4 IN REPORT II*

Arrival at the general hospital

(General hospital data – questionnaire or case notes)

1. 196/292 (67.1%) patients were under the care of a community mental health team at the time of admission
2. 223/325 (68.6%) patients had been under the care of a mental health team at some point in the two years prior to admission
3. 157/491 (32%) patients had a physical as well as a mental health condition recorded at the initial assessment
4. 79/176 (44.9%) patients had physical health conditions which required urgent medical attention

(Organisational data)

5. 78/132 (59.1%) hospitals in which care was provided to 11-17 year olds, and 53/93 (57.0%) hospitals in which care was provided to 18-25 year olds, reported there to be a lead clinician with special responsibility for liaison with the child protection team(s) or adult safeguarding teams with regard to mental health conditions

Previous mental healthcare admissions to a general hospital

(General hospital data – questionnaire or case notes)

6. 173/435 (39.8%) patient's attendance at the general hospital was the first presentation with their mental health condition
7. 238/438 (54.3%) patients had been admitted to a general hospital within the previous two years and in 121/226 (53.5%) patients a mental health condition had been the reason

Recording of medical and mental health history

(General hospital data – questionnaire or case notes)

8. 106/491 (21.6%) patients did not have their existing mental health history recorded in the general hospital case notes at the initial assessment
9. 297/332 (89.5%) cases peer reviewed at the point of admission to a general hospital ward had a medical history included in the general hospital notes, which was adequate in only 181/297 (60.1%) cases reviewed
10. 196/292 (67.1%) patients were known to be undergoing active treatment with mental health services at the time of admission, however:

a. In only 76 patients had a current mental health formulation and management plan available to staff
b. At the time of arrival and/or admission to the general hospital, the admitting general health team were only able to access community mental health notes and summaries for 47/226 (20.1%) patients
c. A referral letter was present in the case notes of 89/113 (78.8%) patients referred from community mental healthcare or via primary care

11. 140/322 (43.5%) cases reviewed had the patient's mental state recorded in the general hospital notes and in just 233/313 (74.4%) cases peer reviewers found a formulation of differential diagnoses

Mental capacity

(General hospital data – questionnaire or case notes)

12. 103/309 (33.3%) patients had their mental capacity documented in the general hospital notes
13. Mental health professionals were involved in an assessment of competence or capacity in 39/93 (41.9%) patients in a general hospital

(Organisational data)

14. Fewer hospitals in which 11-17 year olds were cared for had a specific policy for, and used proforma templates to facilitate, mental capacity assessment compared with 18-25 year olds (79/122; 64.8% vs. 88/94; 93.6%)

Clinical leadership and care co-ordination

(General hospital data – questionnaire or case notes)

15. General health clinicians reported a lack of clarity as to who was leading the mental healthcare in 50/403 (12.4%) patients

(Organisational data)

16. In 114/231 (49.4%) hospitals there was variability in whether there was a lead clinician of any specialty, or team for the care of 11-25 year olds admitted as the result of a mental health condition. A lead was more likely to be in place where mental health services were provided on-site

17. Mental health nurses were available to routinely support the care of 11-25 year old patients with mental health conditions when they were admitted to a general hospital in 74/116 (63.8%) hospitals

Delivery of routine ward care and risk assessments

(General hospital data – questionnaire or case notes)

18. 310/318 (97.5%) patients had adequate physical health monitoring plans made on the general hospital ward compared with 148/285 (51.9%) patients who had adequate mental health monitoring plans made
19. 47/56 (83.9%) patients had issues with physical health monitoring on the general hospital ward due to their mental health condition
20. General health clinicians stated that the patient's mental health condition impacted on the management of an acute medical condition for 64/449 (14.3%) patients
21. The peer reviewers were of the opinion that the problems in monitoring would have been avoidable through better training (21/43; 48.8%) and patient care (52/67; 77.6%)

Referral to general hospital mental health liaison services/crisis teams

(Organisational data)

22. In 87/102 (85.3%) hospitals there was an emergency mental health pathway specifically for 11-25 year olds in crisis
23. In the general hospital setting, crisis services tended to be provided by general hospital mental health liaison teams for 11-17 year olds (32/59 (54.2%) hospitals) in normal working hours and crisis resolution teams (23/42; 54.8%) for 11-17 year olds out of hours. For 18-25 year olds hospital based mental health liaison team provided services in 33/39 (84.6%) hospitals in normal working hours and out of hours in 35/42 (83.3%) hospitals
24. The most common route of emergency referral to mental health services from the general hospital was via:
    a. A dedicated on-call mental health liaison service in 88/134 (65.7%)
    b. The psychiatry team in 50/134 (37.3%)
    c. A specified emergency care pathway for all acute mental health referrals in 47/134 (35.1%)
    d. A specified emergency care pathway for certain conditions in 35/134 (26.1%)
25. Referrals to mental health services were made primarily by medical and nursing staff, with varying levels of seniority. They originated in the main from emergency medicine (59/211; 28.0%), paediatrics (100/225; 44.4%), and general medicine (42/225; 18.7%)
26. On an organisational level a policy for the initial assessment, referral and management of common mental health conditions was in place in 180/230 (78.3%) hospitals in which 11-25 year olds were cared for
27. Emergency management algorithms for mental health were only available in 124/218 (56.9%) hospitals in which 11-25 year olds were cared for
28. 39/42 (92.8%) hospitals had a process for support, rapid liaison, shared decision-making with colleagues in Tier 4 services and discharge planning for patients with a severe mental health condition placed in an acute general hospital

Initial assessment by a mental health professional in the general hospital

(General hospital data – questionnaire or case notes)

29. 303/323 (93.8%) patients were recorded in the general hospital notes as having been seen and assessed by a mental health professional
30. 68/246 (27.6%) general hospital case notes reviewed highlighted a delay in response by mental healthcare to a referral, and the delay had an impact on the quality of both the physical and mental healthcare in 36/60 (60.0%) patients
31. 55/209 (26.3%) patients experienced a delay in the first assessment by a mental health professional in a general hospital

Location of mental health review

(Organisational data)

32. 86/103 (83.5%) of hospitals in which mental healthcare was provided on-site had private and secure areas for assessment in the emergency department or assessment units

Recording of the initial mental health assessment

(General hospital data – questionnaire or case notes)

33. The main reason for referral was to undertake a psychosocial assessment in 79/112 (70.5%) patients admitted for deliberate self-harm
34. The risk management plan was recorded in the general hospital notes in 64/67 (95.5%) cases, and in mental health notes in 65/67 (97.0%) cases
35. The initial mental health assessment resulted in the formation of a collaborative risk management plan in 102/153 (66.7%) patients

Discharge plans

(General hospital data – questionnaire or case notes)

36. Crisis or general hospital mental health liaison services were involved in 162/430 (37.7%) discharge plans where relevant
37. Community mental health teams were involved in 102/430 (23.7%) discharge plans where relevant
38. Inpatient mental health services were involved in 62/430 (14.4%) discharge plans where relevant
39. 234/353 (66.3%) patients had mental health follow-up as part of their discharge plan

4

Mental healthcare in mental health facilities

▶ *LINK TO CHAPTER 5 IN REPORT II*

This chapter considers the presentation and admission of 11-25 year olds with a mental health condition to a mental health inpatient facility and their pathway of care.

ADMISSION TO A MENTAL HEALTH FACILITY

As with the overall study sample there was a higher proportion of females admitted to mental health facilities, only 7/48 (14.6%) patients aged 11-17 years of age were male, increasing to 58/166 (34.9%) of patients in the 18-25 age group (Table 4.1). This reflects the gender balance of the conditions chosen for this study over this age range. Based on the routine national data it was estimated that this sample included approximately one quarter of all admissions to mental health facilities for this age group in the study period.

Of this sample 104/195 (53.3%) patients, where it could be determined, were reported to have one or more high-risk factors associated with mental health difficulty (Table 4.2).

Table 4.1 Gender and age group of the study population on arrival at the mental health facility

	11-17 years		18-25 years		Total
	n	%	n	%	
Male	7	14.6	58	34.9	**65**
Female	41	85.4	108	65.1	**149**
Total	**48**		**166**		**214**

Treatment prior to the admission

Among the sample, 140/200 (70%) patients had received community mental health interventions for the problems leading to their admission. Pharmacotherapy and individual psychological work were the most common element of the care provided (Table 4.3 overleaf). It is of note that general hospital clinicians who expressed a view in this area reported that additional community resources could have prevented the admission in 20/104 (19.2%) patients.

Table 4.2 The percentage of patients falling within a high-risk group admitted to a mental health facility

	n	%
None	91	46.7
Substance misuse	47	24.1
Social care involvement for safe guarding risk e.g. Child at Risk, child in need vulnerable adult	25	12.8
Offending history leading to the involvement of youth offending team, probation service or criminal justice service	15	7.7
Autistic spectrum disorder	14	7.2
Looked after child or care leaver	12	6.2
Learning disability	7	3.6
Other	24	12.3
Subtotal	**195**	
Not answered	19	
Total	**214**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Mental health inpatient clinician questionnaire

Table 4.3 Elements of the intervention

	n	%
Individual talking treatment	80	59.7
Pharmacotherapy	75	56.0
Nutritional Intervention e.g. weight restoration	32	23.9
Family Intervention group intervention	24	17.9
Other	59	44.0
Subtotal	**134**	
Not answered	6	
Total	**140**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*
Source: Community mental health clinician questionnaire

Clinically appropriate environment

Figure 4.1 shows the different study sample groups and the type of mental health facility to which the patient was admitted following discharge. A number of admissions to children's units were identified and were primarily for complex presentations of anxiety. The admissions to specialist mental health facilities, whether for adults or children, in the sample were primarily for complex eating disorders with associated comorbidities.

CASE STUDY 11

A 16 year old young woman in the care of her local authority as a result of child sexual abuse within her family had a history of emotional instability and self-harming behaviour. She moved from a children's home in her local area to a foster placement in another area and was referred to the local child and adolescent mental health services. She settled initially, but during outpatient appointments began to explore past abuse. Her mental state deteriorated, with acute self-harm risk. When this escalated to crisis, she was detained under Section 2 of the Mental Health Act to an adult mental health ward in the area of her community placement. On admission she was verbally aggressive and assaulted staff. She was nursed in a side room in seclusion with 2:1 nursing observations for 5 days until a bed was identified in a specialist mental health intensive care unit for adolescents nearer to her local authority area when she was transferred.

Peer reviewers were concerned about the admission of a young person to an adult mental health ward whilst in crisis, and also about the limitations of the multi-agency support available to her and her to her foster carers at the time of her transfer from her local area.

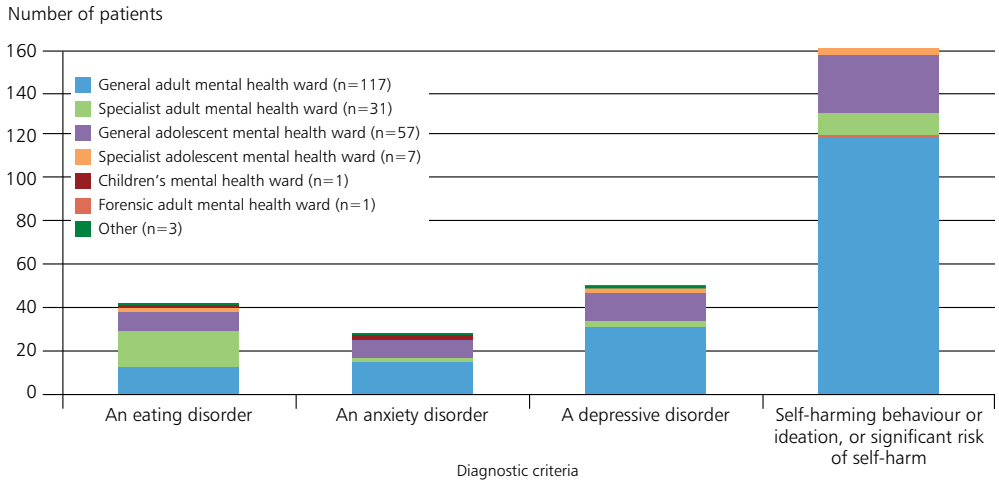


Figure 4.1 Diagnostic category and type of facility **Answers may be multiple*
Source: Mental health inpatient clinician questionnaire

Although 7 patients were identified as having a learning disability, no admissions to specialist learning disability units were identified in this sample.

The majority of patients in the study admitted to a mental health facility were admitted to adult and adolescent wards. Self-harming behaviour, ideation and/or risk was present in 118/130 (91%) patients admitted to an adult mental health ward and in 27/34 (79.4%) patients admitted to adolescent units.

Mental health inpatient clinicians reported the safe containment of risks of self-harm as the main reason for admission in most settings (Figure 4.2).

The NCEPOD peer reviewers felt that patients were admitted to the correct location for their age and development in 96/103 (93%) cases reviewed where notes were available.

Type of admission

▶ *LINK TO SOURCE OF REFERRAL IN REPORT II*

Within this study sample, emergency admissions to inpatient mental health facilities were four times more common (167/208; 80%) than planned elective admissions (41/208; 20%) (Table 4.4). However, there was considerable variation with the referral source. Emergency referrals were more common amongst patients originating from general hospital settings and on-call mental health teams, than amongst patients originating from community mental health teams.

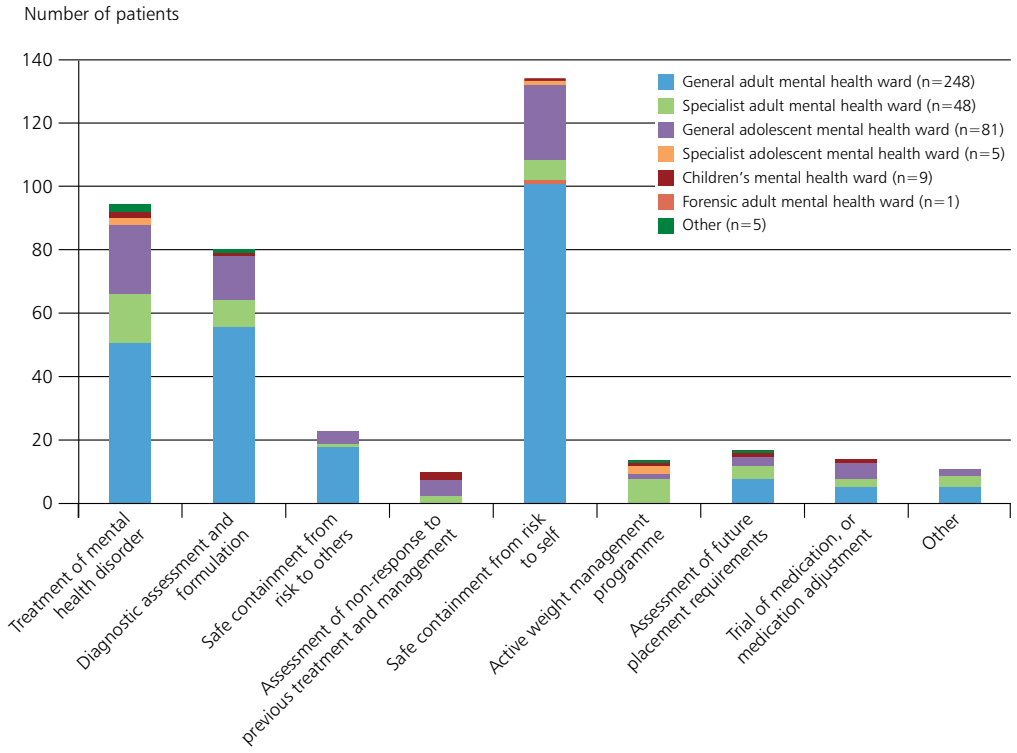


Figure 4.2 Reason for admission by type of facility

**Answers may be multiple*
Source: Mental health inpatient clinician questionnaire

A designated place of safety is a locally agreed facility to which a person who is at risk to themselves or others in a public place can be removed to by the police or other authority within the terms of national Mental Health Act, Capacity Act or Children's Act legislation for the purpose of further assessment. As would be expected, in this study sample, such facilities were always associated with mental health emergencies (Table 4.4).

▶ *LINK TO URGENCY OF REFERRAL IN REPORT II*

Table 4.4 Urgency of admission by referral source

	Emergency	Elective	Subtotal	Not answered	Total
Via a general hospital	44	2	**46**	2	**48**
An adult community mental health team	36	16	**52**	2	**54**
A mental health out of hours emergency duty team	31	2	**33**	0	**33**
A CAMHS team	22	12	**34**	0	**34**
An officially designated place of safety	21	0	**21**	0	**21**
A primary care practitioner	7	2	**9**	0	**9**
Via an inpatient mental health facility	6	7	**13**	1	**14**
Subtotal	**167**	**41**	**208**	**5**	**213**
Not answered	0	0	**0**	1	**1**
Total	**167**	**41**	**208**	**6**	**214**

Source: Mental health inpatient clinician questionnaire

There was substantial variation between source of referral and age. As can be seen from Table 4.5 patients aged 11-17 years within the sample were proportionately more likely to be admitted via officially designated places of safety.

Table 4.5 Referral source for mental health admission by age group

	11-17 years	18-25 years	Total
An adult community mental health team	1	53	**54**
Via a general hospital	3	45	**48**
A CAMHS team	33	1	**34**
A mental health out of hours emergency duty team	7	26	**33**
An officially designated place of safety	2	19	**21**
Via an inpatient mental health facility	2	12	**14**
A primary care practitioner	0	9	**9**
Subtotal	**48**	**165**	**213**
Not answered	0	1	**1**
Total	**48**	**166**	**214**

Source: Mental health inpatient clinician questionnaire

CASE STUDY 12

A 23 year old woman was referred to local adult mental health services by outpatient obstetric ante-natal services. She had a history of intra-familial child sexual abuse and had been admitted to an inpatient adolescent unit in her local area on two occasions when 15 following paracetamol overdoses and emotional instability. Subsequently she was treated on an outpatient basis for panic attacks. She made positive progress and was not transferred to adult mental health services. Symptoms of anxiety and low mood recurred in pregnancy. She was treated initially with SSRI anti- depressants on an outpatient basis, but when at 35 weeks gestation, deteriorating depressive symptoms and risk of self-harm led to a voluntary admission to a local adult mental health ward for a period of seven days. She was discharged to the care of the community mental health service home treatment team

Peer reviewers questioned whether an early referral specialist perinatal mental health services was indicated both for inpatient care and subsequent follow-up. They noted problems in the continuity of care in such a situation.

Quality of referral by referral source: mental health inpatient clinicians reported on 121 patients

Referrals from community mental health teams including Community Mental Health Trusts (CMHT), Child and Adolescent Mental Health Services (CAMHS) and specialist community mental health teams were considered together:

- 90/121 (74.4%) patients were in active ongoing treatment at the time of referral for admission
  - 76/90 (84.4%) patients had community mental health teams convey details of the treatment offered, and the patient's response to it
  - 76/90 (84.4%) patients had a risk assessment or risk management plan reportedly conveyed at the time of admission, and in 69 (90.1%) this was reported to have been communicated at the time of the mental health admission
- There had been active consideration and discussion of alternatives to admission in 88/104 (84.6%) patients where an answer was given
- There were additional community resources which could have been deployed to prevent admission in 24/111 (21.6%) patients where an answer was given
- 15/117 (12.8%) patients were reported to have incurred delays or barriers to referral. The lack of availability of a suitable hospital bed was the most commonly identified reason in 9 instances

Mental health inpatient clinician respondents reported on 48 referrals from acute general hospitals:

- 41/48 (85.4%) patients were referred with a full assessment of their mental health having been undertaken in the general hospital
  - In 39/41 (95.1%) of these the assessment was reported to include an adequate risk assessment, and in 35/41 (85.4%) this was reported to have been communicated at the time of the mental health admission
- 22/48 (45.8%) patients had clinical notes from the general hospital setting available to the admitting mental health inpatient team
- 36/48 (75.0%) patients had been cared for in an age appropriate environment while in the general hospital in the view of the mental health inpatient clinician responding
- 33/48 (68.8%) patients had evidence of alternatives to admission being actively considered by the referring team. However, they reported that in only 7 patients would the deployment of additional community resources not have prevented admission

Referrals from an officially designated place of safety were reported for 21 patients:

- 9 patients had an assessment and were cared for in this setting by a mental health facility team, in 7 by an urgent care mental health team, and in 2 by a general hospital mental health liaison service and in another 2 by an 'ad hoc' arrangement pending transfer
- 19 patients had an adequate risk assessment undertaken during the place of safety admission
- 12 patients had an alternative to admission actively considered, but in only one patient was it the view of the inpatient clinician that additional community resources could have been deployed to prevent admission
- 3 patients had a delay or barrier to the referral and transfer to a mental health facility reported

A further 9 patients were admitted following a direct referral from primary care sources, and 14 by transfer from another inpatient facility.

Delays to admission

Peer reviewers identified delays in admission in 19/86 (22.1%) cases reviewed from the mental health inpatient sample. In 12 this was due to lack of bed availability, in 2 there was a delay in staffing the transfer, and in another 2 the patient was unwilling to access the facility offered. In 1 case, a peer reviewer identified a delay in recognising or escalating the urgency of the condition and the need for admission. In 2 further cases the cause of delay was unidentified.

In the peer review sample arising from a general hospital admission and requiring transfer to a mental health facility for ongoing treatment or assessment, difficulties and delays in the process were identified in 37/83 (44.6%) cases reviewed (Table 4.6). For 23 patients this was related to delays in bed identification and in 3 cases patients absconding or refusing to transfer voluntarily. In a further 11 cases the cause of delay was unidentified.

Table 4.6 Difficulties in the transfer process for those patients transferred from another hospital

	n	%
Yes	37	44.6
No	46	55.4
Subtotal	**83**	
Not answered patient not transferred	144	
Unable to answer	108	
Total	**335**	

Source: Peer review assessment form

TRANSPORT AND DISTANCE TO HOSPITAL

Once an inpatient bed was identified 62/162 (38.2%) patients were reported to have made their own way to the mental health facility, or arranged family transport. Ambulance or secure forms of transport were required for 100/162 (61.7%) patients. Guidance about the transport of patients can be found in the *'Mental Health Act 1983: Code of Practice'* Chapter 17.[29]

The youngest unaccompanied patient was 19 years of age. Of the 48 patients aged 11-17 years of age, 26 were accompanied by a parent, guardian or other relative with additional professional support for 5 of these patients.

Distance from home

The distance from home to the inpatient mental health facility in which patients in this sample were treated is shown in Table 4.7.

Table 4.7 Age by the distance of the inpatient mental health hospital from patients home

	11-17 years	18-25 years	Total
Less than 10 miles	11	88	**99**
Between 10 and 25 miles	14	37	**51**
Between 25 and 50 miles	14	16	**30**
Between 50 and 100 miles	5	10	**15**
More than 100 miles	2	2	**4**
Subtotal	**46**	**153**	**199**
Unable to answer	2	13	**15**
Total	**48**	**166**	**214**

Source: Peer review assessment form

Whilst the great majority of 11-25 year olds in this sample were treated less than 50 miles away from home, those aged 11-17 years were more likely to have to travel further for inpatient care due to the generally lower number of beds and admissions for this age group. There were 125/153 (81.7%) patients aged 18-25 years who were treated less than 25 miles from home, this was the case for only 25/46 (54.3%) of those aged 11-17 years.

It was found that any factor which added a time pressure to the need for early admission contributed to greater distances travelled for treatment. Therefore, patients requiring an emergency admission and those admitted from a general hospital or designated place of safety were further from home than for patients located in the community.

Detained patients were more likely to be located further from home for treatment: 6/50 (12.0%) of detained patients were placed more than 50 miles from home compared to 11/147 (7.5%) of voluntary patients.

Mental health inpatient clinician respondents reported that distance from home had an impact on treatment for 21/176 (11.9%) patients. This included a positive impact due to separation from adverse social and family factors, and a reduction in the risk of absconding. Negative impacts mainly related to the ease of family and professional contacts.

DETENTION, MENTAL CAPACITY AND CONSENT

The legal status of the sample of patients admitted to a mental health facility is shown in Table 4.8. Overall, 51/212 (24.1%) patients were detained under the relevant Mental Health Act. Forty-one patients were admitted under an assessment order or under a holding power until a further mental health assessment could be arranged. Twelve patients, of whom 2 were under 18 years old, were detained under a Treatment Order.

Mental Health Act assessment prior to admission occurred in 59 patients of whom 39 were detained involuntarily. The locations of the Mental Health Act assessment were in a general hospital setting in 41/55 (74.5%) cases where it was known. No delay was identified in organising the assessment for any patient.

Table 4.8 Patient's legal status

	11-17 years	18-25 years	Total
Voluntary patient (fully competent/capacitous consent)	30	119	146
Voluntary patient treated with parental consent	10	0	10
Detained under relevant mental health act (admitted under a treatment order)	2	9	12
Detained under relevant mental health act (admitted under an assessment order)	6	34	39
Detained under a provision of Capacity Act	0	0	0
Admitted under a provision of Children Act	0	0	0
Voluntary at time of admission but was later detained	1	2	3
Short term Mental Health Act assessment orders not converted	1	1	2
Order of High Court	1	0	1
Subtotal	**48**	**164**	**212**
Not answered	0	2	2
Total	**48**	**166**	**214**

Source: Mental health inpatient clinician questionnaire

Independent of legal status an assessment of the child or young person's competence and mental capacity to agree to hospital admission was documented in the notes in 76/106 (71.7%) cases. Mental capacity to consent to treatment was recorded in 46/73 (63.0%) voluntary patients.

The notes of 19 patients involuntary detained were reviewed. Complete Mental Health Act documentation was found in 17 sets of notes examined. In 12 of the documented cases the young person was detained prior to admission. In two cases errors were found in documentation which made the detention technically invalid: in one case a Section 2 assessment order was unsigned and in the second case a short-term hospital detention order (S5 (2)) applied in general hospital was used to facilitate transfer. This error was identified by the receiving hospital and the patient informed and subsequently legally detained for assessment. In 5 cases the patient was admitted informally and then subsequently detained within the first five days of assessment. In this group of 17 patients, documentation that their right to appeal against detention had been explained to them in an age appropriate manner was identified in only 13 case notes examined.

INPATIENT CARE

Inpatient care plan

Peer reviewers found recorded evidence of a care plan for the admission in 70/103 (68.0%) sets of case notes examined. In the same number the patients' views and involvement in goal setting was adequately recorded. The use of standardised assessment tools to inform inpatient intervention was identified in 48/81 (59.3%) cases reviewed.

Inpatient clinician respondents reported that patients were in agreement with their treatment plans in 150/203 (73.9%) cases reviewed and of these, written consent was obtained in 83/120 (69.2%). There was no difference across the 11-25 year age group. Whilst peer reviewers found sufficient evidence that the patient was in agreement with their treatment plan in 85/104 (81.7%) cases, written consent to the treatment plan was only identified in 22/85 (25.9%) cases.

In 76/100 (76%) sets of case notes reviewed it was recorded that the patient had been given a copy or information of their treatment, management or recovery plan. In 64/94 (68.1%) cases there was a record that the patient had been given a copy or information of their risk management plan. In 51/87 (58.6%) cases was there a record of the patient being given details or information about their individualised case team.

Peer reviewers identified an active process of care planning and review in 86/96 (89.6%) sets of case notes. In 76 cases, family, carers and other agencies were involved. Peer reviewers also found evidence in 78/103 (75.7%) cases where there was recorded evidence of the patients being fully involved in all discussions and decision-making about them. In 88/93 (94.6%) cases the process was at least adequately documented. The most common failure of documentation was the presence of an aftercare risk plan. Peer reviewers' rating of the overall quality of communication during admission is shown in Table 4.9.

Table 4.9 Overall quality of communication regarding the patients' healthcare during the admission

	n	%
Good	50	45.5
Adequate	49	44.5
Poor	10	9.1
Unsatisfactory	1	<1
Subtotal	**110**	
Not answered	6	
Total	**116**	

Source: Peer review assessment form

Table 4.10 Elements of the inpatient treatment by age

	Therapeutic milieu		Pharmacotherapy		Individual talking treatment (including CBT)		Group therapy intervention		Family therapy		Nutritional intervention	
	11-17 years	**18-25 years**	**11-17 years**	**18-25 years**	**11-17 years**	**18-25 years**	**11-17 years**	**18-25 years**	**11-17 years**	**18-25 years**	**11-17 years**	**18-25 years**
Yes	37	92	42	128	34	52	30	42	24	13	19	42
No	8	50	5	28	12	91	14	100	20	125	21	99
Subtotal	**45**	**142**	**47**	**156**	**46**	**143**	**44**	**142**	**44**	**138**	**40**	**141**
Not answered	3	24	1	10	2	23	4	24	4	28	8	25
Total	**48**	**166**	**48**	**166**	**48**	**166**	**48**	**166**	**48**	**166**	**48**	**166**

Source: Mental health inpatient clinician questionnaire

Inpatient treatment

Table 4.10 overleaf highlights the elements of the inpatient treatment plans.

- 37/45 (82.2%) patients aged 11-17 years were reported to have benefitted from the therapeutic qualities of the ward environment, this was reported in only 92/142 (64.8%) of those aged 18-25 years
- The use of psychotropic medication was reported in 42/147 (28.6%) of patients aged 11-17 years in inpatient facilities, compared to 128/156 (82.1%) of those aged 18-25 years

The use of psychological treatments was reported to be much more prevalent in the 11-17 years age group rather than the 18-25 years age group:

- Patients aged 11-17 years were reported to have accessed individual talking treatment in 34/56 (60.7%) cases, group therapy in 30/34 (88.2%) and family interventions in 24/44 (54.5%) during the admission.
- Patients aged 18-25 years were reported to have accessed individual talking treatment in 52/143 (36%), group interventions in 52/156 (33%), and family interventions in 13/138 (9%) only

This variation reflects the differences in the patient group admitted at differing ages, the degree of urgency involved, the increased level of detention, and the primary purpose of admission. Nevertheless, there may also be an issue that children and young people find it difficult to access and engage with any form of psychological therapy to address their problems during the inpatient process. Peer reviewers found similar evidence recorded in the case notes of patients accessing any form of psychological therapy during inpatient admission in only 83/107 (77.6%) cases.

It proved more difficult than expected for peer reviewers to identify whether the treatment and care provided was in line with national clinical guidelines for the inpatient treatment of specific conditions. In 59/74 (79.7%) cases there was evidence of treatment in line with NICE guidance and other national guidelines for the specific condition treated. In 15 cases however, national guidelines were clearly not met. This related to NICE guidance for self-harm[30] where 7 patients aged 18-25 years received no psychological assessment or treatment for their condition. In 6 patients national standards for Eating Disorders, 'NICE Guidance 69',[31] and/or 'Management of Really Sick People with Anorexia Nervosa (MARSIPAN)' intercollegiate guidance[32] were not followed.

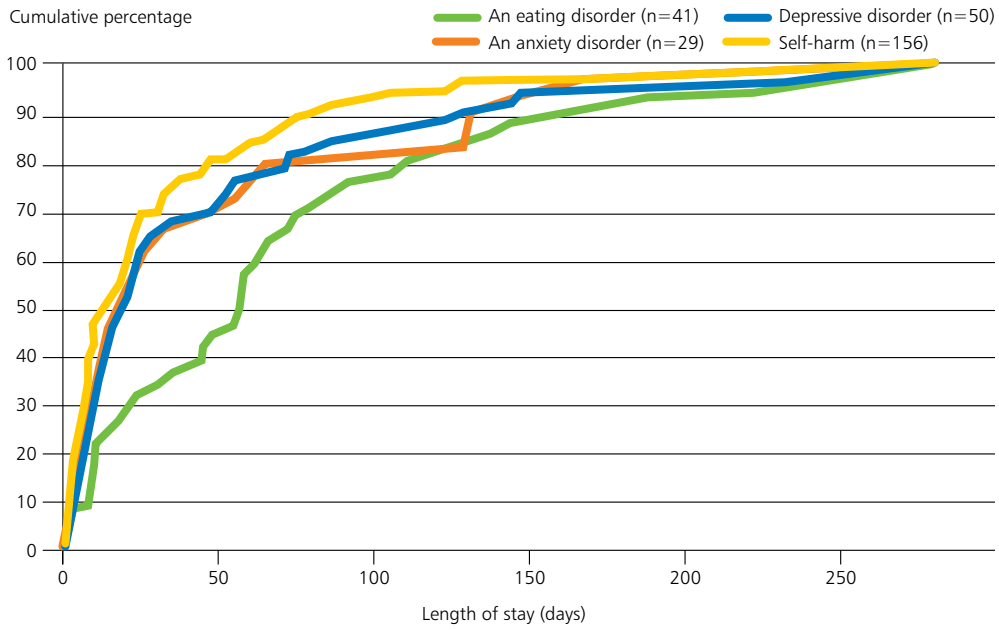


Figure 4.3 Duration of admission by diagnostic group

Source: Peer review assessment form

DURATION OF ADMISSION AND DISCHARGE PLANNING

Duration of admission

▶ *LINK TO DURATION OF ADMISSION IN REPORT II*

The duration of admission by diagnosis is shown in Figure 4.3.

These data were replicated in the national routine data collections in REPORT 2.

Discharge planning

A formalised process of discharge planning was used in 129/174 (74%) patients. Difficulty in identifying the correct community team to involve in the process was reported in 9 patients, and difficulty in identifying a community care co-ordinator or responsible clinician in 11. Social care teams took part in the discharge process for 34/163 (21%) patients, most commonly from children and family local authority teams. Difficulty in identifying and involving social work support in the discharge process was reported in 3 patients.

CASE STUDY 13

A 21 year old young woman with a diagnosis of emotionally unstable personality disorder was admitted to a general hospital with and overdose of Codeine. She was under the care of her local community adult mental health service and was allocated to a case co-ordinator, but not receiving either specific psychological treatment or psychotropic medication. She told the assessing general hospital mental health liaison services that she had taken the overdose as she was worried about a forthcoming Court appearance when she would giving evidence against a defendant accused of childhood sexual abuse. Her self-harm risk was assessed as high and she was transferred to her local adult mental health ward. After 7 days she requested her own discharge. Her care co-ordinator was notified. No care or support plan was in place on discharge, and she had received no specific psychological assessment or intervention while in hospital.

Peer reviewers expressed some concern about whether the young lady's treatment and safety needs had been met by this episode, and whether the discharge planning was sufficiently safe and containing.

Carers, nearest relatives or those with parental responsibility were invited to participate in discharge planning for 116/146 (79.5%) patients, and participated in a discharge planning meeting in 84. In most instances (80/84; 95.2%), this was in person rather than by telephone or video link. Patient advocates were invited to attend the discharge planning process for 25/131 (19.1%) patients, where it could be ascertained, and attended in 12 instances.

A written discharge plan was produced for 154/167 (92.2%) patients, when a response was given. Evidence that it was shared with the patient, and when appropriate their family or carer, was reported in only 112/138 (81.2%) patients.

OVERALL QUALITY CARE IN AN INPATIENT MENTAL HEALTH FACILITY

Peer reviewers were asked to rate the overall quality of care in relation to the inpatient episode described in the case notes available to them. The results are shown in Figure 4.4.

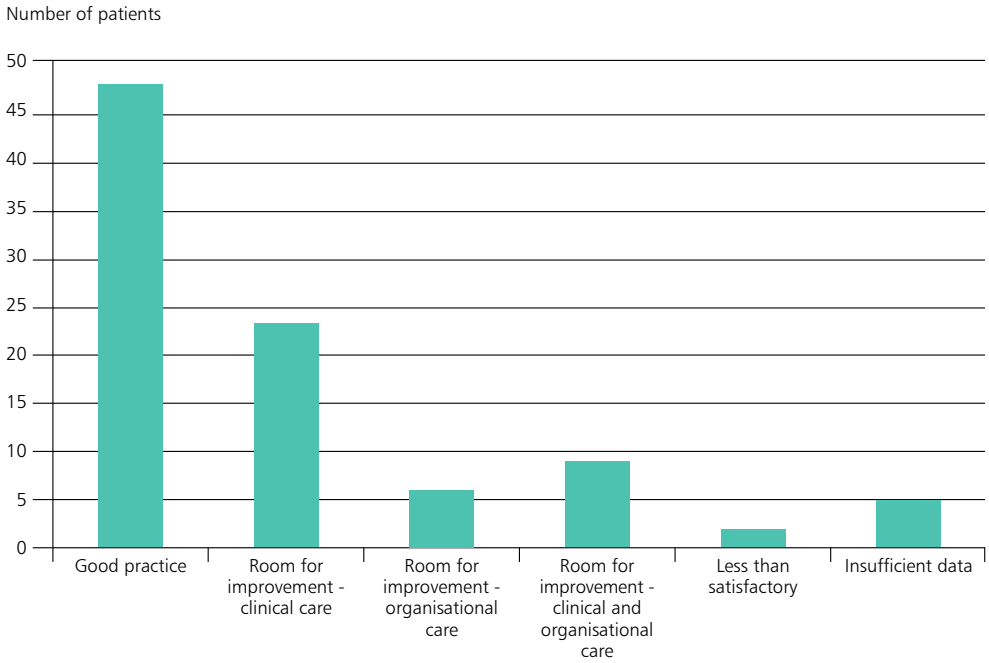


Figure 4.4 Overall quality of care – inpatient mental health facility

Source: Peer review assessment form

Key Findings CHAPTER 4

▶ *LINK TO KEY FINDINGS IN CHAPTER 5 IN REPORT II*

Type of admission

(Mental health facility inpatient data – questionnaire or case notes)

40. Emergency admissions to inpatient mental health facilities were four times more common (167/208; 80%) than planned elective admissions (41/208; 20%)

Quality of referral

(Mental health facility inpatient data – questionnaire or case notes)

Referrals from community mental health teams:

41. 90/121 (74.4%) patients were in active treatment at the time of referral for admission
    a. 76/90 (84.4%) patients had community mental health teams convey details of the treatment offered, and the patient's response to it
    b. 76/90 (84.4%) patients had a risk assessment or risk management plan reportedly conveyed at the time of admission, and in 69 (90.1%) this was reported to have been communicated at the time of the mental health admission
    c. There were additional community resources which could have been deployed to prevent admission in 24/111 (21.6%) patients
42. 41/48 (85.4%) patients were referred with a full assessment of their mental health having been undertaken in the general hospital; in 39/41 (95.1%) of these the assessment was reported to include an adequate risk assessment, and in 35/41 (85.4%) were communicated at the time of the mental health admission
43. The clinical notes from the general hospital setting were available to the admitting mental health inpatient team for 22/48 (45.8%) patients

Delays to admission

(Mental health facility inpatient data – questionnaire or case notes)

44. 19/86 (22.1%) patients experienced a delay in their admission to a mental health inpatient facility
45. 37/83 (44.6%) patients experienced difficulties or delays in the process of transfer from an acute general hospital to a mental health facility
46. 21/176 (11.9%) patients were impacted by the distance of their admission facility to their home. This included a positive impact due to separation from adverse social and family factors, and a reduction in the risk of absconding
47. 15/117 (12.8%) patients were reported to have incurred delays or barriers to referral to a mental health facility. The lack of availability of a suitable hospital bed was the most commonly identified reason in 9 cases

Inpatient care plan

(Mental health facility inpatient data – questionnaire or case notes)

48. Whilst peer reviewers found sufficient evidence that the patient was in agreement with their treatment and management plan in 85/104 (81.7%) cases, written consent to the treatment plan in an inpatient mental health facility was only identified in 22/85 (25.9%) cases
49. 76/100 (76%) sets of case notes from mental health facilities had a record that the patient had been given a copy or information of their treatment, management or recovery plan

Inpatient treatment

(Mental health facility inpatient data – questionnaire or case notes)

50. Independent of legal status, an assessment of the child or young person's competence and mental capacity to agree to a mental health inpatient admission was documented in the notes in 76/106 (71.1%) cases
51. 37/45 (82.2%) patients aged 11-17 years were reported to have benefitted from the therapeutic qualities of the mental health ward environment, this was reported in only 92/142 (64.8%) of those aged 18-25 years
52. 42/147 (28.6%) of patients aged 11-17 years in inpatient mental health facilities, compared to 128/156 (82.1%) of those aged 18-25 years received psychotropic medication

53. 34/56 (60.7%) patients aged 11-17 years were reported to have accessed individual talking treatment, group therapy in 30/34 (88.2%) and family interventions in 24/44 (54.5%) during the inpatient mental health facility admission
54. 52/143 (36%) patients aged 18-25 years were reported to have accessed individual talking treatment, group interventions in 52/156 (33%), and family interventions in 13/138 (9%) during the inpatient mental health facility admission
55. 83/107 (77.6%) cases reviewed showed evidence of patients accessing any form of psychological therapy during the inpatient mental health facility admission
56. 59/74 (79.7%) patients received treatment in line with NICE guidance and other national guidelines for the specific condition treated. In 15 patients national guidelines were clearly not met

5

Transition from child to adult mental healthcare and communication at the interface with joint agencies, specialties and patients

▶ *LINK TO CHAPTER 6 IN REPORT II*

TRANSITION

Transition describes the process of moving from child to adult healthcare, whether that is physical or mental health, and encompasses the initial planning, the actual transfer between services, and any support provided throughout.[33,34] When not well managed the changes and challenges that children and young people encounter at transition may be associated with a deterioration in their overall mental/psychological health and function, sometimes with permanent effect. Effective planning to bridge the gap between child and adult based patterns of care can help reduce this loss of wellbeing.[34-39]

On an organisational level there was no framework to facilitate continuity of patient care at the point of transition from child to adult mental health services in 22/101 (21.8%) organisations:

- 13/61 (21.3%) organisations in which patients aged 11-17 years were treated
- 9/40 (22.5%) organisations in which patients aged 18-25 years were treated.

Furthermore, it was reported that monitoring of how well the policies were working was undertaken in only 46/74 (62.2%) organisations which had this in place:

- 29/44 (65.9%) organisations in which 11-17 year olds were treated
- 17/30 (56.7%) organisations in which 18-25 year olds were treated

In 69/96 (71.9%) organisations with mental health services on-site, a policy for transition planning was in place:

- 40/58 (69.0%) organisations in which 11-17 year olds were treated
- 29/38 (76.3%) organisations in which 18-25 year olds were treated

Where a policy existed it addressed the issue of what would occur if the patient did not meet the criteria for adult community mental health services in only 25/39 (64.1%) organisations. In organisations where this issue was addressed, referral to voluntary sector services, psychological services and GP/ primary care were the main alternatives (Table 5.1).

Table 5.1 Sources of support/information in place for when the patient is not accepted by the adult community mental health teams

	11-17 years		18-25 years	
	n	%	n	%
General practitioner	52	94.5	33	94.0
Voluntary sector services	43	78.2	27	77.1
Referral to a Psychological Therapies service (IAPT)	37	67.3	24	68.6
Signposting to independent providers	29	52.7	20	57.1
Primary care services (not IAPT/GP)	22	40.0	18	51.4
None	0	0	1	<1
Subtotal	**55**		**35**	
Not answered	10		13	
Total	**65**		**48**	

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*

Source: Organisational questionnaire

Children and young people with chronic physical health issues are 2-3 times more likely to have long-term mental health needs.[40] Therefore when hospitals have no on-site mental health services, and there are both physical and mental health needs at transition to adult care, it is particularly important that both are met with a clear plan for continuity of care. In only 11/27 (40.7%) hospitals where 11-17 year olds were cared for and 10/20 (50.0%) where 18-25 year olds were cared for was there a framework for handover between child and adult services for patients with both physical and mental health needs.

Age criteria for transitioning between child and adult services

In most hospitals with mental health services on-site, decisions about when transition to adult services should occur was based primarily on age (51/58; 87.9% and 35/36; 97.2% hospitals in which 11-17 year olds and 18-25 year olds were cared for, respectively - Table 5.2).

Table 5.2 Transition to 'adult' mental health services based primarily on age

	11-17 years		18-25 years	
	n	%	n	%
Yes	51	87.9	35	97.2
No	7	12.1	1	<1
Subtotal	**58**		**36**	
Not answered	7		12	
Total	**65**		**48**	

Source: Organisational questionnaire

organisational level, the age for leaving children's services, and entering adult services varied, with 36/129 (27.9%) hospitals reporting 16 years as the cut-off point, and 69/129 (53.5%) reporting 18 as the cut-off point.

Where it was answered 40/51 (78.4%) hospitals in which 11-17 year olds were treated, and 26/35 (74.3%) in which 18-25 year olds were treated reported flexibility in the age that transition generally occurred. It was reported from only one hospital that transition might be modified if a patient had cognitive impairments, and from one other hospital that a decision was based on whether the young person was still in full time education. This lack of flexibility is contrary to generic guidance on transition in healthcare published by NICE in 2016.[41]

▶ *LINK TO AGE OF TRANSITION IN REPORT II*

Designated leadership in transition planning

Designated leadership in planning and implementation of transition to adult care has been identified as an important factor in the success of the process. Of the hospitals with on-site mental health services 46/96 (47.9%) reported designated professional leads for transition in place:

- 26/58 (44.8%) in hospitals where 11-17 year olds were treated
- 20/38 (52.6%) in hospitals where 18-25 year olds were treated

The additional service needs of children and young people with autism, ADHD and emerging personality disorders were particularly poorly recognised in clear and funded structures (Table 5.3).

Table 5.3 Clear and funded organisation or network structures which recognise the additional needs of the following at risk groups at transition from child to adult services

	Yes	No	Subtotal	Not answered	Total
Looked after young people	40	16	**56**	9	**65**
Young people with autism	20	36	**56**	9	**65**
Young people with ADHD	24	30	**54**	11	**65**
Young people with learning disability	39	18	**57**	8	**65**
Young people with emerging personality disorders	15	38	**53**	12	**65**
Young people with early psychosis	37	16	**53**	12	**65**
Young people with eating disorders	34	22	**56**	9	**65**
Young people in the justice system	28	27	**55**	10	**65**

Source: Organisational questionnaire

CASE STUDY 14

A 19 year old young man was released from prison but was then arrested after unusual behaviour in a shopping centre and taken by police to an inpatient mental health facility where he was held informally initially and then under section as he was assessed as being psychotic. There were clear and detailed notes that stated that he had been under CAMHS directly before imprisonment when he was still under 18 years old and had an emerging personality disorder. However there was no evidence of ongoing care or follow-up.

Peer reviewers recognised that this young man had 'transitioned' whilst in detention but there had been no continuity or handover of his mental health needs. Whilst it was not difficult to understand how this had occurred in a complex patient it was felt there should have been better recognition of his likely long-term mental health needs.

Of the patients whose care was peer reviewed in this study 230/500 (46%) were aged 15-19 years. These were the ages that were considered by peer reviewers to be the most likely for transition to adult mental health services to be apparent in the case notes.

Peer reviewers identified only 23 patients where there was evidence that transition was occurring or had occurred in mental healthcare within the previous two years. Of these patients 16 were 18 years or older, and in just 7 patients there was evidence of a transition plan in their case notes. In 6 people who were in transition or had recently moved to adult mental healthcare there was difficulty or delay implementing a safe and effective plan.

NICE guidance emphasises the need for transition to adult services to have been actively considered by the age 14.[41] Whilst it is understandable that if a condition is not recognised as 'chronic' at this age it may be difficult to make plans for a future health need which may or may not exist in adult life, this should not be the case when there is a likely requirement for services to be provided into adulthood. This should be recognised early and transition arrangements actively considered. Even if a young person has been relatively well for some time, there are particular stressors which may contribute to recurrence or deterioration of mental health problems in early adult life e.g. leaving home or higher education. For these reasons there is a need to actively plan forward and consider the possible need for transition.[42,43]

NICE also states that health transition to adult services should be managed as a process wherein there is some in-built flexibility, so that overall care and important relationships are not disrupted at a particular and previously defined age e.g. 16 or 18 years. Recognising that children and young people vary considerably as to their individual needs and that these may change over time. Different and flexible levels of social support should also be part of good transition planning in the organisation of mental health services.

A further single recommendation made by the 2016 NICE transition guidance is that children and young people have a lead general practitioner (GP), emphasising that a good relationship with a GP for patients with complex health conditions will be even more important in adult life. However, when patients have been cared for largely in child based mental health services this link with primary healthcare may or may not have been developed.

In the 23 patients identified as undergoing current or recent transition to adult care a lead GP was identified in the case notes in just 11 cases. Questionnaires returned by community mental health teams in this study also revealed very small numbers of patients undergoing transition. There were 13 patients for whom data were available - 5 patients in the 11-15 age group and 7 aged 16-20 years, all of whom were 18 years or younger. There were a further 13 patients who had transitioned in the previous two years for which information was available (Table 5.4).

Of the 26 patients who were transitioning, or who had transitioned, 12 were leaving or had left a general Child and Adolescent Mental Health Service (CAMHS). However, 7 patients had been receiving inpatient care and in 4 patients there had been specialist care from CAMHS. This indicated that where data were available on transition it likely represented patients with more severe and/or longstanding mental health issues.

Table 5.4 The patient was in the process of transitioning between child and adult mental healthcare services, by age

	11-15 years	16-20 years					21-25 years	Subtotal	Not answered	Total
		16	17	18	19	20				
Yes	5	5	1	1	0	0	0	**12**	1	**13**
No	38	13	5	5	1	9	18	**89**	4	**93**
Subtotal	**43**	**18**	**6**	**6**	**1**	**9**	**18**	**101**	**5**	**106**
Not answered	1	1	0	0	0	0	0	**2**	1	**3**
Total	**44**	**19**	**6**	**6**	**1**	**9**	**18**	**103**	**6**	**109**

Source: Community mental health clinician questionnaire

CASE STUDY 15

An 18 year old young woman was referred by her GP to secondary care due to marked weight loss, and low heart rate (38-45 bpm). She was in a second term of her first year at university. There was no record in the inpatient notes of her social circumstances, and she self-discharged without an accompanying person from an acute medical unit two days later and (according to nursing notes) back to student accommodation. There was a record of her being under CAMHS in her home town 100 miles away until about a year beforehand but there was no detail of a transition plan in place.

Peer reviewers commented that whilst this young person had a named GP linked to her university health centre she was extremely vulnerable by nature of her social isolation. Her GP may well not have records of her previous mental health management plan as this information is not always made readily or easily available when patients move location.

In 17/21 (81.0%) patients discharge to adult services, this decision was based on age criteria. In 20/22 (90.9%) patients there was planning and care co-ordination of transition and in 13/17 (76.5%) there was a lead/named worker that was involved in planning of transition care. Seventeen of the patients receiving community based mental health services and moving to adult services were involved in the planning of their move. There had been problems with transition planning or implementation in 6/20 (30.0%) patients (unknown in 3). The most common issues cited were delay in identifying a named clinician and/or acceptance into an adult service.

Systems of care

Only 34/127 (26.8%) of all general health hospitals and mental health facilities, with and without mental health services on-site and in which patients aged 11-17 years with mental health conditions were cared for had a specific adolescent mental health care pathway, and in only 30/128 (23.4%) there was a designated adolescent ward.

Specific care leadership for children and young people can provide better outcomes, especially if it is delivered alongside formal care pathways and age appropriate location of care.[44,45] However, only 42/126 (33.3%) organisations had a lead clinician for adolescent care (Table 5.5).

Table 5.5 A lead clinician or team for adolescent care

	n	%
Yes	42	33.3
No	84	66.7
Subtotal	**126**	
Not answered	3	
Total	**129**	

Source: Organisational questionnaire

Table 5.6 Healthcare professional making the initial mental health assessment by age band

	11-15 years	16-20 years					21-25 years	Subtotal	Not answered	Total
		16	17	18	19	20				
Adult mental health practitioner	5	1	6	5	4	2	15	**38**	1	**39**
Child and adolescent mental health practitioner	76	20	16	0	1	0	0	**113**	2	**115**
General hospital mental health liaison	9	5	8	11	9	5	30	**77**	1	**78**
Other	8	3	0	4	1	2	6	**24**	0	**24**
Subtotal	**97**	**29**	**26**	**19**	**14**	**9**	**51**	**245**	**4**	**249**
Not answered	16	13	3	4	2	4	12	**54**	0	**54**
Total	**113**	**42**	**29**	**23**	**16**	**13**	**63**	**299**	**4**	**303**

**Answers may be multiple* *Source: General health clinician questionnaire*

Children and young people need clarity on how they seek help for mental health conditions. There may be a natural preference to self-refer as this offers a more convenient, flexible option and the time and location is of the young person's choosing. Fewer hospitals with mental health services on-site offered local provision for self-referral for people aged 11-17 years (24/63; 38.1%), compared to those aged 18-25 years (29/44; 65.9%).

The majority of patients aged 11-17 years admitted to acute general health units were likely to have had an initial mental health assessment by a child/adolescent mental health professional (112/152; 73.7%) than by a professional from adult mental health (Table 5.6). However, there were 12 patients who were seen at least initially by an adult mental health professional and 22 by mental health liaison services. Fourteen of the patients who were assessed by adult or general hospital mental health liaison services were aged 15 years or under.

In community mental health whilst the majority of people aged 11-17 years were cared for by general or specialist adolescent mental health services (63/69; 91.3%), there were 3 (aged 16 and 17) patients cared for by adult teams.

These data reflect the lack of a standard care pathway and clear guidance about the expected competencies of general health and mental health professionals in locations where children and young people with mental health conditions present. Children and young people often find themselves caught between child and adult services. The organisational infrastructure may be artificially imposed by strict age cut-offs and competences for particular local services, historical referral patterns, service delivery pressures and geographical location. This presents a confusing organisational picture of the arrangements for mental healthcare for children and young people, which is more based on chronological age and what has been historically available than on quality and appropriateness of care.

Age appropriate physical facilities

Most hospitals in the peer reviewers' opinion, appeared to be able to offer private and secure areas within emergency departments and assessment units where patients could be seen (Table 5.7). Where it could be assessed, in 46/147 (31.3%) cases, peer reviewers stated that there was room for improvement in conducting confidential discussions without a parent present. This information was often not well documented.

Table 5.7 Confidential area for discussion by age band

	11-15 years	16-20 years					21-25 years	Total
		16	17	18	19	20		
Yes	26	6	4	3	1	1	5	**46**
No	36	12	9	10	6	6	22	**101**
Subtotal	**62**	**18**	**13**	**13**	**7**	**7**	**27**	**147**
Not applicable	11	2	2	2	3	6	**37**	**63**
Unable to answer	51	32	13	1	6	5	17	**150**
Total	**124**	**52**	**28**	**16**	**16**	**18**	**81**	**335**

Source: Peer review assessment form

Routinely providing space and time for private consultations with a young person is very important. These meetings need to be sensitively and carefully managed so that parents and carers are not excluded from all decision-making/information giving unless this is really necessary for the young person's wellbeing. However, recognising the emerging independence of the young person and their rights must be considered a primary responsibility for care givers in all settings.

In 27/28 (96.4%) inpatient mental health facilities it was reported in the organisational data that single room accommodation could be provided for 11-17 year olds, whereas just 8/12 (66.7%) organisations in which 18-25 year olds were cared for reported availability.

In the 31 responding inpatient mental health facilities to which 11-17 year olds were admitted, gender separation was mostly provided in sleeping and toilet areas (26/31; 83.9% and 28/31; 90.3% respectively) but this was not universal and living areas which were more often shared (19/31; 61.3%).

In acute general health 190/251 (75.7%) patients aged 11-17 years admitted to hospital were cared for in a paediatric ward. Only 6 patients aged under 18 years were admitted to an adolescent ward, with 24 going to an adult ward, and 20 cared for in an assessment unit or emergency department. Figure 5.1 demonstrates the diversity of admission location in acute general health wards across the whole 11-25 age range.

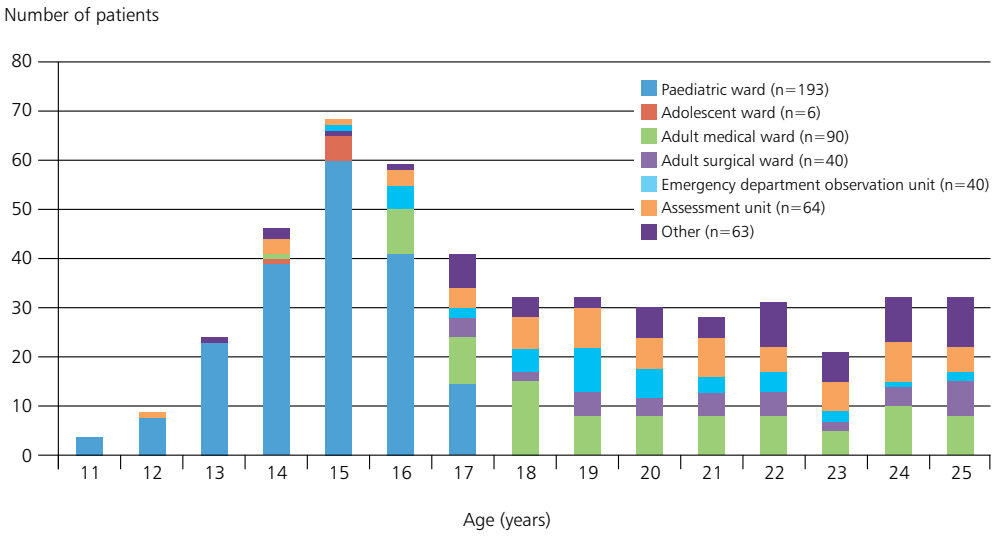


Figure 5.1 Specialty of the ward the patient was admitted to by age

In acute general hospitals children and young people may be cared for in ward areas primarily designed for children or for adults and in practice there was very little specific accommodation for 'adolescents'. Seventeen year olds in this study were admitted to virtually any ward area. By 18 years all were accommodated as adults.

In comparison there were relatively more patients admitted to an age appropriate location in inpatient mental health facilities, with 38/48 (79.2%) patients aged 11-17 years admitted to general or specialist 'adolescent' facilities. It was found that 6 patients under the age of 18 (one of whom was under 16 years of age) were admitted to adult mental health wards. Although a small number in absolute terms this still represented 6/48 (12.5%) of all admissions to mental health facilities for those aged 11-17 years.

The Mental Health Act (England and Wales) 2007 amendment aimed to ensure that patients aged under 18, who are admitted to hospital with a mental health condition are accommodated in an environment that is suitable for their age (subject to their needs). In England, admissions of patients under 16 years to an adult mental health ward must be reported as an adverse event. Figure 5.2 describes the mental health facility to which the patient was admitted, as stated by the admitting clinician.

CASE STUDY 16

A young person of 15 years with severe self-harm due to an overdose of paracetamol requiring intravenous therapy and close monitoring of plasma levels and liver function was cared for in a high dependency paediatric bay next to a small baby with pneumonia. The young person complained about being co-located with a baby as she could not sleep as a result. General hospital mental health liaison services also recorded the lack of private locations on the ward to conduct a confidential interview and returned two days later by which time the patient has taken their own discharge against medical advice but with a parent agreeing to this action.

Peer reviewers stated that this would not be an uncommon scenario and that the family of the severely ill baby may have also found this co-location inappropriate. Acute paediatric wards generally care for a range of patients aged 0-16 years and many of those requiring inpatient care under the age of 5 years.

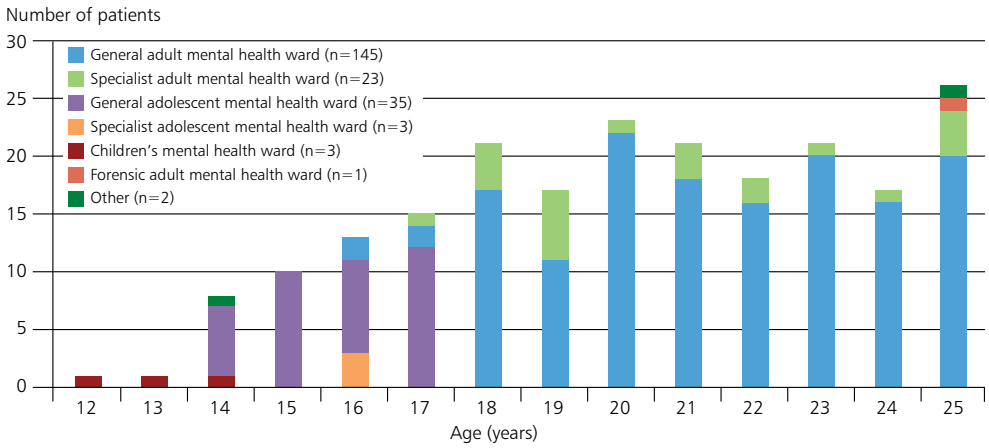


Figure 5.2 Location of mental health inpatient admitted by age

Source: Mental health inpatient clinician questionnaire

QUALITY OF CARE DURING THE TRANSITION BETWEEN CHILD AND ADULT SERVICES

Figures 5.3-5.7 examine the quality of care of various aspects of mental healthcare during the transition phase.

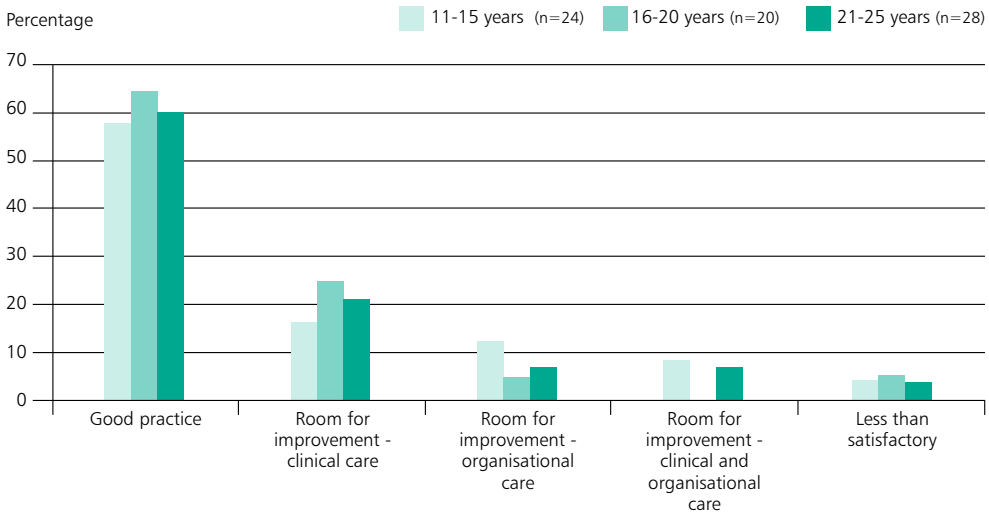


Figure 5.3 Quality of ongoing community mental health care by age

Source: Peer review assessment form

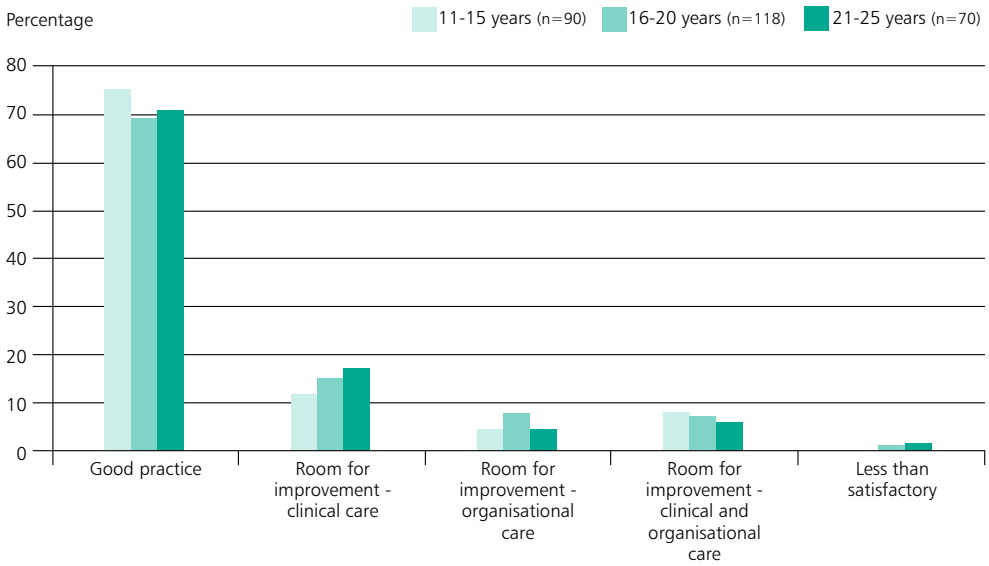


Figure 5.4 Quality of emergency department care by age

Source: Peer review assessment form

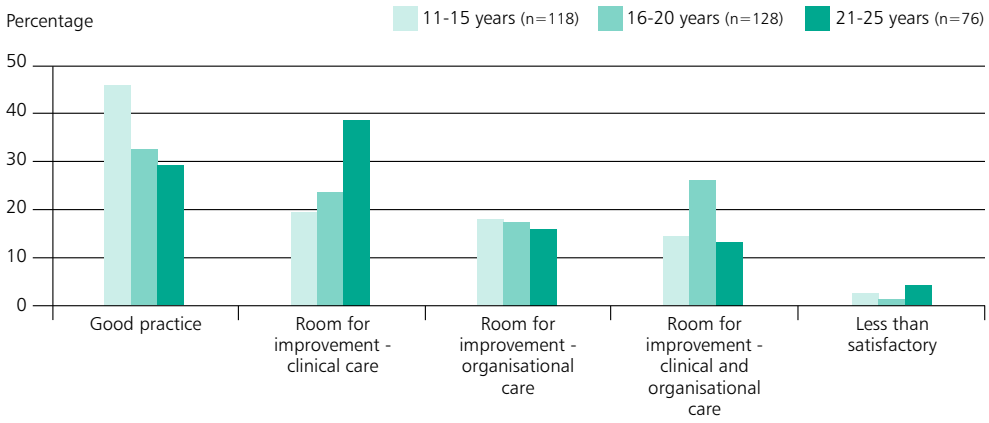


Figure 5.5 Quality of general hospital inpatient care by age

Source: Peer review assessment form

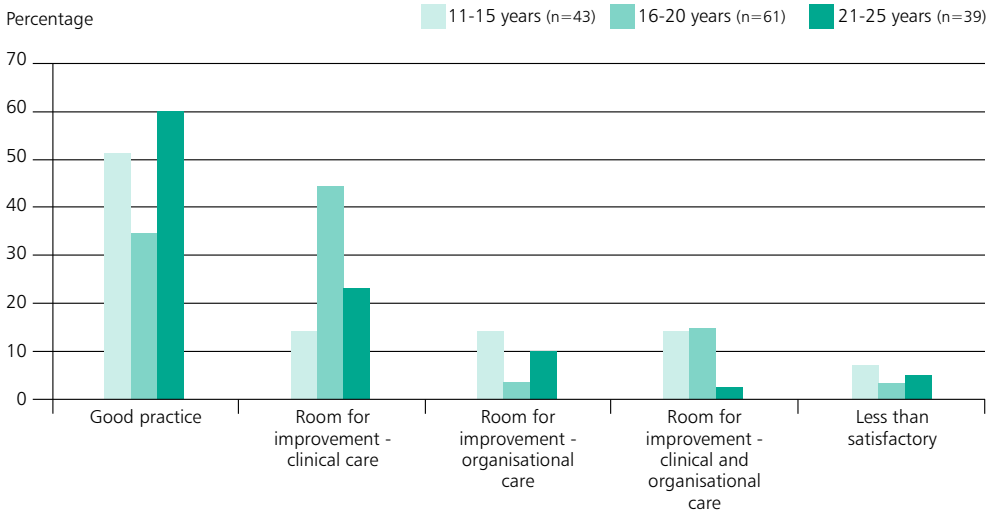


Figure 5.6 Quality of general hospital mental health liaison care by age

Source: Peer review assessment form

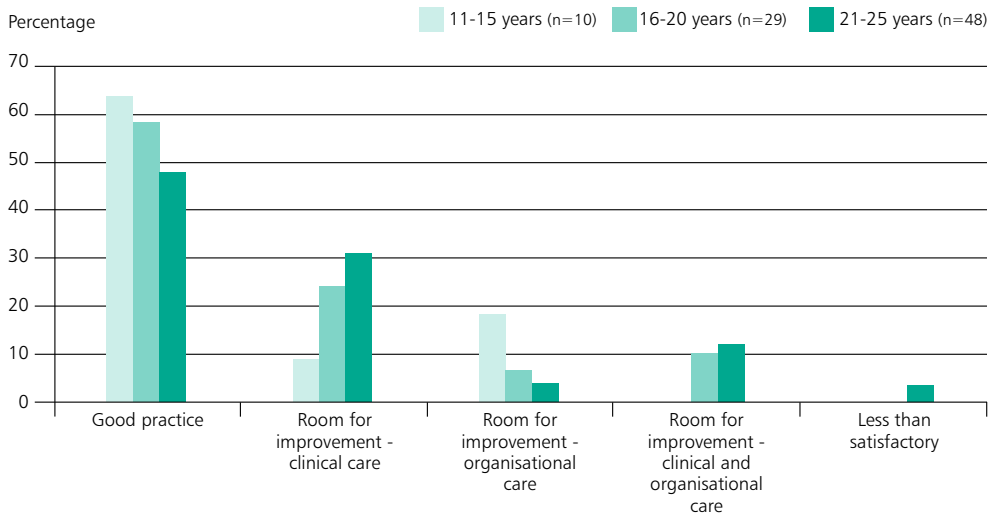


Figure 5.7 Quality of mental health inpatient care by age

Source: Peer review assessment form

COMMUNICATION AT THE INTERFACE WITH JOINT AGENCIES, SPECIALTIES AND PATIENTS

General hospital clinicians reported patient involvement in decision-making about their treatment plans and discharge plan in 397/403 (98.5%) patients for whom a response was given. In 292/405 (72.1%) reviewed patient involvement was clearly recorded in case notes. The involvement of relatives or carers in decision-making was reported for 270/277 (97.5%) patients and in 222/285 (77.9%) this was clearly recorded in the case notes.

Similarly high involvement was seen in the data collected from the community clinicians. An 'at least adequate' process of care co-ordination and review was recorded for 55/61 (90.2%) patients. The involvement and engagement of patients in the decision-making process was recorded in 50/57 (87.7%) cases, and the involvement of family members and/or carers in 46/53 (86.8%).

Following assessment in the community:

- A case co-ordinator or named lead clinician was allocated in 85/93 (91.4%) patients
- A formal process of care co-ordination was established in 68/100 (68.0%) patients
- The patient was reported to be involved in a care planning and review process in 87/96 (90.6%) cases and the patient's family involved in 84/97 (86.6%) cases
- The patient's care plan was reported to contain:
  - Their management and recovery plan in 76/81 (93.8%) cases
  - Their risk management plan in 77/83 (92.8%) cases
  - A crisis management plan in 75/83 (90.4%) cases
  - It was reported that 61/72 (84.7%) patients were provided with a copy of their care plan

Communication with other agencies about the admission and/or subsequent discharge plan was recorded in a minority of cases. Contact with social care teams was reported by general hospital staff in 92/263 (35%) patients where this was answered, but reported unknown in 169/263 (64%) Similarly community clinicians reported 40/92 (43.5%) of the patient group were in contact with social care agencies for issues other than the treatment and management of mental health issues. Contact with educational placements, where relevant, was reported in 37/217 (17.1%) patients but reported unknown in the remainder.

There were 27 patients identified in the community data who were not in education, employment or training (NEET). In only 5 was it reported that any form of specific help and support was offered to address this. Of these 27, 7 were aged 11-17 years, and of these 4 were offered help or support compared to only 1 of the 20 patients aged 18-25 years.

Table 5.8 Evidence that the patient, wherever possible, was fully included in all discussions and decision-making about them by age band

	11-15 years	16-20 years					21-25 years	Total
		16	17	18	19	20		
Yes	50	18	11	10	8	11	37	**145**
No	40	27	15	4	6	4	27	**123**
Subtotal	**90**	**45**	**26**	**14**	**14**	**15**	**64**	**268**
Not applicable	5	1	0	0	0	0	4	**10**
Unable to answer	29	6	2	2	2	3	13	**57**
Total	**124**	**52**	**28**	**16**	**16**	**18**	**81**	**335**

Source: Peer review assessment form

Table 5.9 Room for improvement in the documentation of inclusion of the patient in discussion and decision-making

	n	%
Yes	198	65.1
No	106	34.9
Subtotal	**304**	
Unable to answer	31	
Total	**335**	

Source: Peer review assessment form

Of the 40 patients identified through the community data who had joint mental health and social care involvement, problems with joint working were reported in 14/34 (41.1%) patients of whom 9 were aged 11-17 years.

Peer reviewers identified 8/69 (11.6%) instances of interagency delay or difficulty in joint working within the community case notes returned (unknown in 9).

Peer reviewers found evidence of the involvement of patients in decision-making in only 145/268 (54.1%) cases (Table 5.8) and reported room for improvement in documentation of this area in 198/304 (65.1%) of cases (Table 5.9).

Peer reviewers found evidence of adequate communication with the patient's wider multidisciplinary team in 161/280 (57.5%) cases, but reported less than adequate communication on discharge in a minority of cases (Table 5.10).

Table 5.10 Adequacy of communication on discharge with other people involved in the patient's care

	Yes		No		Subtotal	Unable to answer	Total
	n	%	n	%	n	n	n
Patient	198	86.5	31	13.5	**229**	106	**335**
The community mental health team(s) involved in care	164	76.3	51	23.7	**215**	120	**335**
General practitioner	158	76.7	48	23.3	**206**	129	**335**
Patient's family members	148	74.4	51	25.6	**199**	136	**335**
Social services	56	53.3	49	46.7	**105**	230	**335**
Other	22	51.2	21	48.8	**43**	292	**335**

Source: Peer review assessment form

Overall peer reviewers only rated communication with patients and other agencies as 'good' in 85/310 (27.4%) cases reviewed, and in 53/310 (17.1%) it was reported to be 'poor' or 'unsatisfactory'. This seemed to be a particular problem for patients aged 11-17 years where in 35/53 (66.0%) communication was rated 'poor' or 'unsatisfactory'.

Clinical networks of care

While the concept of a clinical network of care is frequently utilised in general hospital settings, the phrase is less well recognised in mental health settings. Defined examples of networks of care both formal and informal were provided to facilities providing mental health services. A clinical network of care was defined as *"linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services working together in a coordinated manner"*.[46] Less than half of all hospitals were reported as being a member of a clinical network of care for people with mental health conditions (106/251; 42.2%) (Table 5.11).

Generally, where mental health services were provided on-site, the network of care was regarded as a formal arrangement. A representative forum of some kind to facilitate communication and joint working between providers reported is shown in Table 5.12.

Table 5.11 Organisational membership of a network of care (informal or formal) for young people with mental health conditions

	Mental health services provided on-site				NO mental health services provided on-site			
	11-17 years		18-25 years		11-17 years		18-25 years	
	n	%	n	%	n	%	n	%
Yes	36	57.1	23	54.8	21	28.7	26	47.3
No	27	42.9	19	45.2	52	71.3	29	52.7
Subtotal	**63**		**42**		**73**		**55**	
Not answered	2		6		2		8	
Total	**65**		**48**		**75**		**63**	

Source: Organisational questionnaire

Table 5.12 A representative network forum was in place to facilitate communication and joint working between network providers

	11-17 years		18-25 years	
	n	%	n	%
Yes	24	70.6	19	82.6
No	10	29.4	4	17.4
Subtotal	**34**		**23**	
Not answered	2		0	
Total	**36**		**23**	

Source: Organisational questionnaire

Table 5.13 The network had regular communication for people aged 11-17 years in the following groups

	Forum representation	Formal communication	Informal communication	Subtotal	Not answered	Total
Commissioners	17	18	14	**27**	9	**36**
Acute health	11	13	15	**27**	9	**36**
Young people's mental health	20	15	16	**29**	7	**36**
Adult mental health	10	11	14	**24**	12	**36**
Social care	14	15	14	**26**	10	**36**
Education	10	16	11	**23**	13	**36**
3rd sector	10	14	13	**22**	14	**36**
Independent mental health providers	7	10	13	**20**	16	**36**
Learning disability services	12	15	11	**23**	13	**36**

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*

Source: Organisational questionnaire

Table 5.14 The network had regular communication for people aged 18-25 years in the following groups:

	Forum representation	Formal communication	Informal communication	Subtotal	Not answered	Total
Commissioners	8	7	10	**16**	7	**23**
Acute health	8	7	9	**16**	7	**23**
Young people's mental health	9	6	8	**16**	7	**23**
Adult mental health	12	8	7	**17**	6	**23**
Social care	8	6	10	**15**	8	**23**
Education	3	4	9	**10**	13	**23**
3rd sector	6	5	6	**12**	11	**23**
Independent mental health providers	2	5	7	**10**	13	**23**
Learning disability services	6	4	8	**14**	9	**23**

** Answers may be multiple therefore numbers under 'n' do not add up to the subtotal*

Source: Organisational questionnaire

Table 5.15 The care of young people with mental health conditions features in regular multidisciplinary audit and/or quality improvement initiatives in this organisation

	11-17 years		18-25 years	
	n	%	n	%
Yes	74	57.8	63	69.2
No	54	42.2	28	30.8
Subtotal	**128**		**91**	
Not answered	12		20	
Total	**140**		**111**	

Source: Organisational questionnaire

For both those aged 11-17 years (Table 5.13) and those aged 18-25 years (Table 5.14) there appeared to be inconsistent participation in regular communication as part of the clinical network of care with education, independent providers of care, third sector and learning disability services. The care of 11-25 year olds with mental health conditions featured regularly in multidisciplinary team or audit/quality improvement initiatives in only 137/219 (62.6%) hospitals (Table 5.15).

5

Key Findings CHAPTER 5

▶ *LINK TO KEY FINDINGS IN CHAPTER 6 IN REPORT II*

Transition process

(Organisational data)

57. 22/101 (21.8%) hospitals (general or mental health) had no framework to facilitate continuity of patient care at the point of transition from child to adult mental health services:
    a. 13/61 (21.3%) hospitals in which patients aged 11-17 years were treated
    b. 9/40 (22.5%) hospitals in which patients aged 18-25 years were treated
58. 46/74 (62.2%) hospitals had a process to monitor how well the hospital transition policies were working:
    a. 29/44 (65.9%) hospitals in which 11-17 year olds were treated
    b. 17/30 (56.7%) organisations in which 18-25 year olds were treated
59. 69/96 (71.9%) hospitals with mental health services on-site had a policy for transition planning in place:
    a. 40/58 (69.0%) hospitals in which 11-17 year olds were treated
    b. 29/38 (76.3%) organisations in which 18-25 year olds were treated
60. 11/27 (40.7%) hospitals where 11-17 year olds were cared for and 10/20 (50.0%) where 18-25 year olds were cared had a framework for handover between child and adult services for patients with both physical and mental health needs

Age criteria for transitioning between child and adult services

(Organisational data)

61. 36/129 (27.9%) organisational policies stated the age for leaving children's services and entering adult services was 16 years, and 69/129 (53.5%) stated 18 years

Designated leadership in transition planning

(Organisational data)

62. Of the hospitals with on-site mental health services it was reported in only 46/96 (47.9%) that designated professional leads for transition were in place:
    a. 26/58 (44.8%) hospitals where 11-17 year olds were treated
    b. 20/38 (52.6%) hospitals where 18-25 year olds were treated
63. 42/126 (33.3%) hospitals had a lead clinician for adolescent care
64. 34/127 (26.8%) general health hospitals, with and without mental health services on-site and mental health facilities in which patients aged 11-17 years with mental health conditions were cared for, had a specific adolescent mental health care pathway, and in only 30/128 (23.4%) there was a designated ward

Patients who transitioned

(General hospital and mental health facility inpatient data – case notes)

65. Only 23 patients had evidence that transition was occurring or had occurred in mental healthcare within the previous two years and there had been problems with transition planning or implementation in 6/20 (30.0%) patients (unknown in 3). The most common issues were delay in identifying a named clinician and/or acceptance into an adult service

Systems of 'adolescent' care

(General hospital and mental health facility inpatient data – case notes)

66. 112/152 (73.7%) patients aged 11-17 years admitted to acute general health units had an initial mental health assessment by a child/adolescent mental health professional

c. 12 patients were seen initially by an adult mental health professional and 22 by general hospital mental health liaison services

d. 14 patients who were assessed at any point by adult or general hospital mental health liaison services were aged 15 years or under

Age appropriate physical facilities

(Mental health facility inpatient data – questionnaire or case notes)

67. 46/147 (31.3%) cases reviewed showed room for improvement in how confidential discussions, without a parent present, were conducted

(General hospital data – case notes)

68. 190/251 (75.7%) patients aged 11-17 years admitted to hospital were cared for in a paediatric ward. Only 6 patients aged under 18 years were admitted to an adolescent ward, with 24 going to an adult ward, and 20 cared for in an assessment unit or emergency department

Communication at the interface with joint agencies, specialties and patients

(Community mental health data - case notes)

69. 50/57 (87.7%) cases reviewed documented involvement and engagement of patients in the decision-making process, and the involvement of family members and/or carers in 46/53 (86.8%)
70. Following assessment in the community:
    a. 85/93 (91.4%) patients had a case co-ordinator or named lead clinician allocated
    b. 68/100 (68.0%) patients had a formal process of care co-ordination established
    c. 87/96 (90.6%) patients were reported to be involved in a care planning
    d. The patient's care plan was reported to contain:
        i. Their management and recovery plan in 76/81 (93.8%) cases
        ii. Their risk management plan in 77/83 (92.8%) cases
        iii. A crisis management plan in 75/83 (90.4%) cases
    e. 61/72 (84.7%) patients were provided with a copy of their care plan
71. Community clinicians reported that in 40/92 (43.5%) of the patient group there was contact with social care agencies for issues other than the treatment and management of mental health issues
72. 40 patients were identified through the community data with joint mental health and social care involvement, and problems with joint working were reported in 14 patients of whom 9 were aged 11-17 years
73. 8/69 (11.6%) instances of interagency delay or difficulty in joint working within the community case notes were identified

(General hospital data – questionnaire or case notes)

74. Contact with social care teams was reported by general hospital staff for 92/263 (35%) patients
75. Contact with educational placements, where relevant, was reported for 37/217 (17.1%) patients
76. Peer reviewers found evidence of the involvement of patients in decision-making in only 145/268 (54.1%) cases reviewed and reported room for improvement in documentation of this area in 198/304 (65.1%) of cases
77. Peer reviewers found evidence of adequate communication with the patient's wider multidisciplinary team in 161/280 (57.5%) of general hospital case notes reviewed
78. Communication with patients and other agencies was described overall as 'good' in 85/310 (27.4%) general hospital case notes reviewed, and in 53/310 (17.1%) it was described as 'poor' or 'unsatisfactory'. This seemed to be a particular problem for patients aged 11-17 years where in 35/53 (66.0%) communication was rated 'poor' or 'unsatisfactory'

Networks of care

(Organisational data)

79. Less than half of all hospitals were reported as being a member of a network of care for people with mental health conditions (106/251; 42.2%)
80. For patients aged 11-17 years and those aged 18-25 years there appeared to be inconsistent participation in regular communication as part of the network of care with education, independent providers of care, third sector and learning disability services
81. The care of 11-25 year olds with mental health conditions featured regularly in multidisciplinary team or audit/quality improvement initiatives in only 137/219 (62.6%) hospitals

References

1. Royal College of Paediatrics and Child Health CHR-UK Programme of Work at the MRC Centre of Epidemiology for Child Health. University College London Institute of Child Health. Child Health Reviews-UK: Retrospective epidemiological review of all-cause mortality. 2013 https://www.rcpch.ac.uk/resources/child-health-reviews-uk-retrospective-epidemiological-review-all-cause-mortality
2. Department of Health. NHS England. Future in Mind. 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
3. NHS England. The five year forward view for mental Health, A report from the independent mental health taskforce to the NHS in England. 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
4. NHS England. Long Term Plan. 2019 https://www.england.nhs.uk/long-term-plan/
5. NHS England. Local Transformation Plans. https://www.england.nhs.uk/mental-health/cyp/transformation/
6. NHS Digital. Strategic Data Collection Service. Accessed 12th July 2018
7. NHS England Transformation Funding for Urgent and Emergency Liaison Mental Health Services. https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/transformation-funding/
8. Department of Health, Department of Education. Transforming Children's and Young People's Mental Health Provision a Green Paper, December 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf
9. NHS Digital. Mental Health of Children and Young People in England. 2018 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017
10. Welsh Government. 2018. Together for Mental Health -a Strategy for Mental Health and Wellbeing in Wales https://gweddill.gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/?lang=en
11. Welsh Government. 2018. Together for Mental Health – a Delivery Plan https://www.basw.co.uk/system/files/resources/basw_60019-4_0.pdf
12. Scottish Government. 2017.Mental Health Strategy 2017-2027 https://www.gov.scot/publications/mental-health-strategy-2017-2027/
13. Scottish Government. 2018. Rejected referrals to child and adolescent mental health service: audit https://www.gov.scot/publications/rejected-referrals-child-adolescent-mental-health-services-camhs-qualitative-quantitative/
14. Audit Scotland. 2018. Children and young people's mental health. http://www.audit-scotland.gov.uk/report/children-and-young-peoples-mental-health
15. Scottish Government. 2018. Programme for Government https://www.gov.scot/programme-for-government/
16. Scottish Government. Getting It Right For Every Child (GIRFEC) https://www.gov.scot/policies/girfec/
17. Department of Health. Northern Ireland. Child and adolescent mental health services - A service Model. 2012 https://www.health-ni.gov.uk/publications/child-and-adolescent-mental-health-services-service-model-july-2012
18. Health and Social Care Board. Working Together: A Pathway for Children and Young people through CAMHS'. 2013 http://www.hscboard.hscni.net/wpfb-file/21122018-hscb-camhs-pathway-document-pdf/

19. Royal College of Physicians. Acute care toolkit 13: Young and adolescent healthcare: resources. 2015 https://www.rcplondon.ac.uk/projects/outputs/young-adult-and-adolescent-healthcare-resources
20. Royal College of Paediatrics and Child Health. Facing the Future Standards: For acute general paediatric care. Revised 2015 https://www.rcpch.ac.uk/sites/default/files/2018-03/facing_the_future_standards_for_acute_general_paediatric_services.pdf
21. Royal College of Physicians. Acute care toolkit 4: Delivering a 12-hour, 7-day consultant presence on the acute medical unit https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
22. BMA. Toolkit 8. Children and young people's health information. 2016 https://www.bma.org.uk/advice/employment/ethics/children-and-young-people/children-and-young-peoples-ethics-tool-kit/8-children-and-young-peoples-health-information
23. CQC. Brief guide: Capacity and consent in under 18s https://www.cqc.org.uk/sites/default/files/20180228_briefguide-capacity_consent_under_18s_v2.pdf
24. HM Government Mental Capacity Act: Code of Practice 2005. Updated 2016 https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
25. Scottish Government. Adults with Incapacity Act (Scotland) Act 2000: Proposals for reform https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-proposals-reform/pages/2/
26. NHS Choices. Children and Young People - Consent to Treatment. 2016 https://www.nhs.uk/conditions/consent-to-treatment/children/
27. Royal College of Nursing. National Curriculum and Competency Framework for Emergency Nursing (Level 1). 2017 https://www.rcn.org.uk/professional-development/publications/pub-005883
28. Royal College of Psychiatrists. Standards for acute inpatient wards for working-age adults, 6th Edition, 2017 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/aims/aims_wa_6th_edition_final_version-updated_september_2017.pdf?sfvrsn=db5e4eb5_0
29. Department of Health. Mental Health Act 1983: Code of practice. 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
30. NICE. Quality Standard 34, Self-Harm. 2013 https://www.nice.org.uk/guidance/qs34
31. NICE. Nice Guidance 69. Eating Disorders: recognition and treatment. 2017 https://www.nice.org.uk/guidance/ng69
32. Royal College of Psychiatrists, Physicians and Psychologists. MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa. 2014 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr189.pdf?sfvrsn=6c2e7ada_2
33. NHS England. Model Specification for Transitions from Child and Adolescent Mental Health Services. 2015 https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf
34. CQC. From the Pond into the Sea: Children's Transition to Adult Health services. 2014 https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf
35. RCP Edinburgh. Think Transition – Developing the essential link between child and adult services. 2008 http://www.londoncancer.org/media/61885/rcpe-transition-steering-group-2008.pdf
36. Department of Health. You're welcome quality criteria. Making health services young people friendly. 2011 https://www.ouh.nhs.uk/paediatricorthopaedics/information/documents/youre-welcome.pdf
37. Association of Real Change Scotland. Principles of Good Transitions. 2017 https://scottishtransitions.org.uk/7-principles-of-good-transitions/

38. Royal College of Psychiatrists. Joint commissioning panel for mental health. Guidance for commissioners of child and adolescent mental health services. 2012 https://www.jcpmh.info/resource/guidance-commissioners-child-adolescent-mental-health-services/
39. Social Care Institute for Excellence. At a glance 51: Mental Health service transitions for young people. 2011 https://www.scie.org.uk/publications/ataglance/ataglance51.asp
40. The College of Emergency Medicine. Mental Health in Emergency Departments: A toolkit for improving care. 2017 https://www.rcem.ac.uk//docs/RCEM%20 Guidance/Mental%20Health%20Toolkit%202017.pdf
41. NICE. Nice Guidance 43. Transition from children's to adult services for young people using health and social care services. 2016 https://www.nice.org.uk/guidance/ng43
42. Improving young people's experiences in transition to and from inpatient mental health settings https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/improving-young-people-s-experiences-in-transition-to-and-from-inpatient-mental-health-settings
43. Royal College of Paediatrics and Child Health. Transition to Adult Services – https://www.rcpch.ac.uk/resources/transition-adult-services
44. Royal College of Paediatrics and Child Health. Standards for children and young people in emergency care settings 2012 https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings
45. CQC. Brief guide: Same sex provision in mental health hospitals. 2017 https://www.cqc.org.uk/sites/default/files/20180502_900760_briefguide-Same_Sex_Provision_Mental_Health_Hospitals_v2.pdf
46. Department of Health. A guide to promote a shared understanding of the benefits of managed local networks. 2005 https://dera.ioe.ac.uk/7650/7/dh_4114368_Redacted.pdf

Glossary

Anxiolytics	Medications used to reduce anxiety
CAMHS	Child and Adolescent Mental Health Services. CAMHS are the NHS services that assesses and treat young people with emotional, behavioural or mental health difficulties
Children	For the purpose of this study it refers to patients aged 11-17 years
CMHT	Community mental health teams
Comorbidities	The presence of one or more additional conditions (or diseases) occurring with a primary disease or condition.
CYP	Children and Young People
DNA	Did not attend
Hypnotics	Medications used to reduce anxiety and/or induce sleep
Improving Access to Psychological Therapies (IAPT)	Improving Access to Psychological Therapies – a large England-wide community-based expansion of psychotherapy services
Local Transformation Plans (LTPs)	NHS England asked Clinical Commissioning Groups (CCGs) to work with commissioners and providers across health, social care, education and youth justice and the voluntary sectors, to develop Local Transformation Plans for Children and Young People's Mental Health (LTPs). The LTPs were first published in 2015, with 123 plans covering the whole of England. They set out how local services will invest resources to improve children and young people's mental health across the "whole system". These plans are 'living documents' and CCGs are required to refresh and republish them on their websites every year.
Mental Health Act Assessment Order	The Assessment Order is made on the evidence of one medical practitioner. It allows a person to be detained in hospital for up to 28 days to enable assessment by an approved medical practitioner and treatment for mental disorder, if required.
Mental Health Act Treatment Order/ Compulsory Treatment Order	A compulsory treatment order (CTO) allows for a person to be treated for their mental illness.
Psychosocial	A combination of psychological and social factors
Self-harm	Self-harm is when somebody intentionally damages or injures their body, such as cutting or burning themselves, hitting or poisoning. It's usually a way of coping with or expressing overwhelming emotional distress.
Suicidal ideation	Suicidal thoughts

Third sector services	Mental health services for young people provided by voluntary not-for-profit organisations.
Tier 4 services	These are tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and inpatient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro- psychiatric teams, and other specialist teams (e-g. for children who have been sexually abused), usually serving more than one district or region.
***It is recognised organisations are moving away from the use of tiers, however tiers are referred to as a term commonly used and recognised across the four countries.**	For the purpose of this study it refers to patients aged 11-17 years
Transition	The process of moving from children's to adults' services. It refers to the full process including initial planning, the actual transfer between services, and support throughout. (Transition from children's to adult's services for young people using health or social care services. NG43 (2016))
Young people	For the purpose of this study it refers to patients aged 18-25 years

SEE APPENDICES 4 AND 5 FOR INFORMATION ON NCEPOD AND HOSPITAL PARTICIAPTION

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