Key messages

KEY MESSAGES – REPORT I

	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 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'

KEY MESSAGES – REPORT 2

	Key message	Key findings
1	Routine, national data collection, including coding and ease of access, required improvement	• The processes around obtaining access to the routinely collected datasets, data cleaning and preparation for analysis proved to be complex and time consuming • UK countries differed in the quality, extent and type of routine national data collected. Whilst standard ICD-10 and READ codes were used, the variables collected differed. Different definitions and reporting systems were used (e.g. for admission or discharge) and outcome data was poorly recorded
2	For the conditions of interest there was variability in the presentation to primary and secondary care and admissions to hospital when the demographics of age, sex, country and index of deprivation were compared	a. Self-harm • There was little change in the overall presentation to or the recording of self-harm in primary care. It was more common in females, in people from deprived areas and increased significantly for 11-15 year olds over time • Rates of hospital admission for self-harm were the highest of all the conditions analysed, particularly in older females (16-24 years) • Trends in hospital inpatient admission rates for self-harm varied between countries, increasing in Wales and Northern Ireland, decreasing in Scotland and remaining relatively constant in England b. Depression • There was an overall decrease in recording of depression diagnosis in primary care, thought to be due to recording behaviours of GPs to code for symptoms (in order to avoid labelling or acting strategically in relation to the Quality Outcomes Framework) • Diagnosis of depression in primary care was more common in females and increased with deprivation index • There was a steep increase in hospital admissions associated with depression in females and in those aged 16-24 years • General hospital inpatient admission rates associated with depression increased significantly across all countries between 2004 and 2014, apart from Scotland where rates decreased marginally. This maybe an impact of policy changes in Scotland with the implementation of its mental health strategy 2012-2015, which aimed to strategically shift the mental healthcare of people from inpatient treatment to care in the community

	Key message	Key findings
2	Continued	c. Anxiety • There was an increase in recording of anxiety in 11-24 year olds presenting to primary care, as well as, an increase in hospital admissions across all countries associated with anxiety d. Eating disorders • Rates of eating disorder presentation to primary care remained relatively stable while hospital admissions for eating disorders increased over time, although numbers remain relatively small • Eating disorders were more common in females and demonstrated the reverse pattern for deprivation to other conditions – being most evident in least deprived areas for both primary care and hospital admissions
3	The proportion of referrals from primary care to secondary care for children and young people was highest for people from the least deprived areas despite levels of mental health conditions being higher in the most deprived areas but 'did not attend' rates were higher for those from the most deprived areas and for older males	• Proportionally more males than females were referred from primary to secondary care for 'all mental health' conditions. This may reflect severity on presentation to primary care given known sex differences in help-seeking behaviour • The proportion of referrals from primary care to secondary care for children and young people was highest for people from the least deprived areas despite levels of conditions being higher in the most deprived areas (except for in eating disorders where a pattern was unclear) • Mental health specialty outpatient attendances for individuals with new appointments increased over the study period • The rate of 'new to follow-up' appointments were higher for mental health conditions than for all specialties together i.e. people with mental health conditions were provided with more follow-up appointments implying a greater need for specialist support • In contrast to the number of appointments made, 'did not attend' (DNA) rates for mental health specialties were significantly higher than those for all specialties but had shown some improvements • Children and young people from the most deprived areas attended fewer follow-up appointments for every new appointment than people from the least deprived areas • 21-24 year old males consistently had the highest DNA rates for outpatient appointments

	Key message	Key findings
4	Emergency department attendance showed an increased presentation rate due to mental health conditions when compared with other health conditions, this was also associated with the demographics of sex and index of deprivation	• While there were fewer males overall with a record of self-harm or a mental health condition compared to females, a higher percentage of males presented to emergency departments for all conditions except eating disorders • There was a steep deprivation gradient for individuals attending emergency departments for self-harm or psychiatric conditions, with 50% of attendances from the two most deprived quintiles • Re-attendance rates to emergency departments were much higher for self-harm and mental health conditions than all attendances, particularly for people from the most deprived areas
5	All hospital admissions showed variation in length of stay when the demographics of sex and index of deprivation for patients with mental health conditions was compared	• For all the conditions of interest approximately a third to a half of individuals (range 31.9% (anxiety) - 55.7% (self-harm)) with a new diagnosis in primary care were admitted to a hospital (general or mental health) within the subsequent year • People from the most deprived areas were the most likely to be admitted with any of the conditions of interest recorded, except for eating disorders • Virtually all admissions for self-harm were unplanned emergency admissions • The mean length of stay for people with an associated 'all mental health' diagnosis was considerably longer than for 'any' admission in this age group (21 days vs. 8 days) • Males were more likely to be admitted to an ICU for self-harm than females, despite females having higher recorded rates of self-harm in primary and secondary care. This could reflect the severity of self-harm methods used by males • More males than females aged 11-24 years were admitted to inpatient mental health facilities. The excess of male admissions is in contrast to community prevalence where females out-number males • In England, transition from child to adult services in children and young people over 11 years with associated depression, anxiety, eating disorders or self-harm occurred later than all children and young people regardless of treatment specialty. Admissions for eating disorders transitioned later still than the other conditions

	Key message	Key findings
6	Deprivation was associated with a lack of access to psychological therapies and antidepressants were used frequently but varied when associated with the demographics of age, deprivation and sex	• A larger proportion of females than males were referred to Improving Access to Psychological Therapies (IAPT) (adult service in England) but once referred similar proportions of males and females received treatment • A larger proportion of children and young people aged 11-24 years from deprived areas were referred to IAPT (adult service) but they were less likely to attend at least one appointment and receive treatment • Of the annual incident cases of recorded depression between 2004 and 2014 in 11 to 24 year olds 80% received an associated prescription (12 months either side of the recorded diagnosis) for an antidepressant. In comparison for self-harm, anxiety and eating disorders, 43%, 41% and 34% were prescribed associated antidepressants respectively. The rates of antidepressants prescribed associated with the conditions of interest: • Decreased significantly for depression diagnosis between 2004 and 2014 • Increased significantly for anxiety between 2004 and 2014
7	Education data demonstrated variation in attainment in those under 18 years of age when compared with the conditions of interest and the demographic of sex	• The presence of any of the conditions of interest diagnosed in primary care between the ages of 11 and 18 years was associated with lower attainment at Key Stage 4, GCSE (except for in females with anxiety and/or eating disorders where there was no significant difference) and lower attendance • Males with self-harm recorded in primary care before they were 18 years old were more likely to be excluded from school than those with no record

Recommendations

RECOMMENDATIONS – REPORT 1

	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*

	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*
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

	Recommendations	Who should action
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

RECOMMENDATIONS – REPORT 2

	Recommendations	Who should action
DESIGN OF SERVICES for EQUITY of CARE		
11	Implement evidence-based interventions in all healthcare and educational settings and organisations	• *Executive Boards for Mental Health and for Physical Health* • *Commissioners* • *Public Health England/ Wales* • *Primary Care* • *Community Mental Health Leads* • *Schools, further and higher educational establishments*
12	Raise awareness, improve emotional literacy, tackle stigma and particularly engage with males in improving their help-seeking behaviour	• *Executive Boards for Mental Health and for Physical Health* • *Commissioners* • *Public Health England/ Wales* • *Primary Care* • *Community Mental Health Leads* • *Schools, further and higher educational establishments*
DESIGN OF SERVICES for EQUITY of CARE		
13	Design mental health services to: a. Promote access for children and young people from the most deprived communities b. Provide access to developmentally appropriate healthcare c. Provide training initiatives to promote staff awareness of the impact of inequalities, such as deprivation d. Monitor the impact of any change in service provision on such inequalities	• *Commissioners* *Supported by* • *Executive Boards for Mental Health and for Physical Health* • *Community Mental Health Leads* • *Public Health England* • *Health Education England*

	Recommendations	**Who should action**
14	Undertake local clinical audit of people with mental health conditions who 'do not attend' clinics to understand why and facilitate improvements thereafter through action plans and local quality improvement projects	• Executive Boards for Mental Health and for Physical Health • QI leads
DATA COLLECTION and CODING		
15	Harmonise the governance and application process to obtain faster and easier access to routinely collected national datasets in England, Wales, Scotland and Northern Ireland	• *NHS Digital* • *NHS Improvement* • *NHS Scotland* • *NHS Wales Informatics Service* • *Northern Ireland Statistics and Research Agency*
16	Ensure coding of mental health conditions in all healthcare records and routinely collected datasets is accurate and consistent. Service providers need to: a. Review and agree data metrics to determine what is relevant for families, clinicians and commissioners b. Train primary and secondary care staff and clinical coders c. Ensure hospitals have the appropriate IT and data collection/entry processes d. Ensure review of the data by local stakeholders e. Record and use outcome data to guide future care delivery	• *NHS Wales Informatics Service* • *NHS* • *England* • *NHS Improvement* • *Department of Health* • *NHS Scotland* • *NHS Wales* • *Northern Ireland Statistics and Research Agency* • *Commissioners*