Summary Report

Investigation into the transition from child and adolescent mental health services to adult mental health services

Independent report by the Healthcare Safety Investigation Branch

I2017/008
Summary Report

About HSIB

The Healthcare Safety Investigation Branch (HSIB) began operating on 1 April 2017. HSIB offers an independent service for England, guiding and supporting NHS organisations on investigations and also conducting safety investigations.

HSIB aims to improve patient safety through effective and independent investigations that do not apportion blame or liability. This is delivered through:

- Learning for improvement – by using findings to deliver practical solutions, address causes and contributory factors and provide support to increase the capability within local NHS systems
- Diffusing learning – through effective communications and engagement with the wider health and social care system

HSIB’s investigations are conducted by a team of professional investigators from a range of safety critical backgrounds. This includes the NHS, aviation, transport and the military. HSIB also draws on additional expertise when required, including human factors advisers.

HSIB investigates up to 30 safety incidents each year to provide meaningful safety recommendations and share learning across the whole of the healthcare system for the benefit of everyone who is cared for by it and works in it.

HSIB Investigators

HSIB investigators have:

- Access to any organisation we’re investigating as per standard contract
- Immediate access to the proceedings of any local investigation related to our work - for example, internal complaints investigations or Care Quality Commission investigations
- Free access to any other relevant information as required for the investigation
- Freedom to interview those considered relevant to our investigation
- The ability to preserve evidence, within appropriate Data Protection guidelines, including records and equipment (faulty equipment may be needed for analysis by the Medicine and Healthcare Products Regulatory Agency)

HSIB investigations do not replace local investigations and are focused on looking at the wider opportunities to learn from exploring where harm may or has happened.

HSIB works with patients and their families and carers, healthcare staff, trusts, hospitals and other healthcare providers across England.
How HSIB decides what to investigate

HSIB welcomes information about patient safety issues for potential investigation from individuals, groups or organisations. The decision to investigate could relate to a single event, a series of events or a problem uncovered during investigation.

HSIB investigations will not replace local investigation of patient safety incidents. HSIB’s purpose is to identify national learning from such events and consider the wider systems and processes. It considers the following criteria when deciding whether to start an investigation:

Outcome impact

Assessing the impact or potential impact on people is a crucial part of the process. HSIB considers the physical and/or emotional harm suffered by anyone involved. The impact on services and whether the safety issues have reduced their ability to deliver safe and reliable care is also assessed. HSIB considers whether an incident has caused a loss of confidence in the healthcare system.

Systemic risk

HSIB reviews the system-wide risk associated with the safety issues. How common or widespread is the problem? Does it span different areas of healthcare and/or multiple locations?

Learning potential

HSIB exists to support improvements in patient safety. Its purpose is to show how investigations can produce new information about safety and to identify meaningful, influential and effective recommendations designed to benefit everyone working in or being cared for by the healthcare system.

HSIB investigators use a range of approaches to focus on identifying risk and the cause[s] of incidents.
Investigation approach

HSIB never attributes blame or liability. Its focus is solely to identify opportunities to learn and to improve patient safety. HSIB does not investigate on behalf of families, staff, organisations or regulators. It may investigate similar incidents in different locations, or incidents that have occurred across different organisations.

HSIB is funded by the Department of Health and hosted by NHS Improvement. HSIB is independent from regulatory bodies, including the Care Quality Commission. Its aim is to bring a new perspective.

HSIB will identify safety actions taken and make safety recommendations and safety observations to organisations or bodies that can influence and support change.

**Safety Actions** are actions taken during the course of the investigation as a response to the issue under investigation.

**Safety Recommendations** are directed to an individual or organisation for action. The recommendation(s) are based on information from the investigation and/or other eligible sources, including safety studies. Recommendations are made with the intention of preventing similar events.

**Safety Observations** are directed to a specific individual or organisation for consideration. Observations are made when there is a lack of information on which to make a definitive safety recommendation but HSIB believes its findings warrant attention.
The reference incident

Ben\(^7\), a 17½-year-old boy, visited his GP with a history of low mood and recent thoughts of harming himself. He had been diagnosed with Autism Spectrum Disorder (ASD) aged 10, and had tried twice to hang himself in previous years. He found managing change difficult.

Ben was prescribed an antidepressant medication and his GP made an urgent referral to Child and Adolescent Mental Health Services (CAMHS). His CAMHS worker noted his suicidal thoughts, his ASD diagnosis and his dislike of change. Ben’s risk was assessed as medium to high and a care plan, which included a crisis plan, was completed.

Ben remained under the care of CAMHS over the next eight months. He was managed by three successive care coordinators, due in part to staff sickness.

He was seen by a consultant psychiatrist and his medication was adjusted but his low mood, morbid and intrusive thoughts persisted. He was prescribed, and undertook, a course of Cognitive Behavioural Therapy (CBT) with a trainee clinical psychologist.

Seven weeks before his 18\(^{th}\) birthday, a ‘transition request’ was completed by the trainee clinical psychologist which noted that Ben had expressed his intention to end his life when he turned 18 years old. The request went to the Early Intervention Service (EIS) because he was experiencing auditory and visual hallucinations. The EIS assessed Ben but decided not to accept him because they did not consider he was showing signs of psychosis.

Ben’s mood continued to deteriorate and at one point he self-harmed. He expressed anxiety about the prospect of transition to AMHS and the loss of his relationship with his original CAMHS care coordinator, who had returned to work. However, she told Ben that he would need to transition to AMHS once he turned 18 years of age. Ben had his first meeting with his new AMHS care coordinator three weeks after his 18\(^{th}\) birthday. Two days later he met his CAMHS care coordinator, who reassured him regarding the transition process.

On the night of this last appointment with CAMHS, Ben died by suicide.

\(^7\) The young man’s name has been changed
The national investigation

A combined Community and Mental Health Trust contacted the HSIB about Ben’s case. Following initial information gathering and evaluation of the safety issues against the HSIB criteria for investigation, the Chief Investigator authorised an HSIB safety investigation.

This investigation identified a number of factors that contributed to this event, which this report describes both in relation to Ben’s case and in the context of the wider healthcare system.

Findings

Ben’s management

1. The transition planning between CAMHS and AMHS was hampered, in part, by a lack of shared care. This was impacted by high workloads, other work commitments and difficulties in staff coordinating diaries to meet collectively with Ben and his mother.

2. Frontline CAMHS staff and managers had differing perceptions about flexibility with transition age. Frontline staff felt a pressure to move young people to AMHS on turning 18, and Trust managers believed that staff were given the flexibility to continue to work with young people beyond 18 if necessary.

3. Ben expressed difficulty managing changes in his life but; CAMHS staff considered that they could work with him to mitigate the need for a referral to adult services. However, as he approached his 18th birthday CAMHS staff considered that he would require ongoing mental health services. When Ben turned 18, it was not apparent to CAMHS staff which service would accept him, would best suit his needs, and would be available under the current commissioning arrangements.

4. Ben was not managed in line with the Care Programme Approach (CPA) guidance, which might have been helpful, particularly during the absence of his original care coordinator, and might have provided other staff with the opportunity to review his care and treatment and to consider whether wider links or support would have helped.

5. The inability to recognise the escalating risk in Ben’s case was due in part to this deterioration occurring at the time of transition.

6. There were two positive aspects in how services engaged with Ben. In some areas, CAMHS would not have accepted the GP’s referral at age 17½ because of the limited time to undertake meaningful intervention before the age of 18. The local AMHS also accepted Ben into their service although the severity of his condition – even if not fully appreciated - might not have met the relevant criteria, which might have been more strictly applied in other areas.
National Findings

1. It is estimated that more than 25,000 young people transition from CAMHS each year, and although there is national policy, guidance and legislation in place to support the process, the TRACK study reported that only 4 per cent of young people received an ‘ideal’ transition.

2. Young people using mental health services would benefit from a flexible, managed transition from CAMHS that has been carefully planned with the young person, incorporates a period of shared care and provides continuity of care and follow up after transition.

3. Flexible services are especially important for young people with emotional problems, complex needs, mild learning disability, ADHD and ASDs, for whom services in adult mental health care are limited.

4. The investigation visited a number of Mental Health Trusts and found no standardised methods or tools used to manage transition. In contrast, Acute Trusts were more likely to plan transitions in acute care over a longer period and to use tools to help standardise the process.

5. The use of tools for structured conversations in transition planning from CAMHS to AMHS would allow for structured conversations and empower young people and their families to ask questions and take ownership of their diagnosis, needs and treatment.

6. The way mental health services are configured does not always support optimal working through transition for young people. There is evidence that moving to a flexible model that can provide mental health services up to the age of 25 can minimise some barriers and reduce the risks associated with transition.

7. The NHS and partners are making significant efforts to improve early intervention provision in mental health for young people. Research indicates that early intervention reduces the impact both on the young person and on the NHS through improved outcomes and a reduction in longer-term resources.
HSIB makes the following Safety Recommendations:

1. Recommendation 2018/006: That NHS England within the ‘Long-Term Plan’\(^2\), works with partners to identify and meet the needs of young adults who have mental health problems that require support but do not meet the current criteria for access to adult mental health services.

2. Recommendation 2018/007: That NHS England requires Clinical Commissioning Groups to demonstrate that the budget identified for current children and young people’s services – those delivering care up until the age of 18 – is spent only on this group.

3. Recommendation 2018/008: That NHS England and NHS Improvement ensure that transition guidance, pathways or performance measures require structured conversations to take place with the young person transitioning to assess their readiness, develop their understanding of their condition and empower them to ask questions. NHS England and NHS Improvement must then ensure that the effectiveness of this is robustly evaluated.

4. Recommendation 2018/009: That NHS England within the ‘Long-Term Plan’, requires services to move from aged-based transition criteria towards more flexible criteria based on an individual’s needs.

5. Recommendation 2018/010: That NHS England and NHS Improvement work with commissioners and providers of mental health services to ensure that the care of a young person before, during and after transition is shared in line with best practice, including joint agency working.

6. Recommendation 2018/011: That the Care Quality Commission extends the remit of its inspections to ensure that the whole care pathway, from child and adolescent mental health services to adult mental health services, is examined.

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\(^2\) Jeremy Hunt, Secretary of State for Health and Social Care, made a statement on Monday 18 June 2018, on a new long-term funding plan for the NHS. He announced that the NHS will receive an increase of £20.5 billion a year in real terms by 2023-24—an average of 3.4% per year growth over the next five years. We propose that the plan includes provision to address this recommendation [https://www.parliament.uk/business/news/2018/june/statement-long-term-plan-for-the-nhs/]
The investigation makes two Safety Observations:

1. It would be beneficial for both CAMHS and AMHS clinicians to be trained in safe and effective transitions from CAMHS to AMHS.

2. It would be beneficial for NHS England to consider developing a method to identify where Clinical Commissioning Groups spend on CAMHS per capita is lower than reasonably expected.

HSiB has directed safety recommendations to NHS Improvement, NHS England and the Care Quality Commission. These organisations are expected to respond within 90 days of the publication of this report. We will publish their responses on our website: [www.hsiib.org.uk](http://www.hsiib.org.uk)
More information about HSIB – including its team, investigations and history – is available at [www.hsib.org.uk](http://www.hsib.org.uk).

If you would like to request an investigation then please read our [guidance](http://www.hsib.org.uk) before submitting a safety awareness form.

**Contact Us**

[@hsib_org](https://twitter.com/hsib_org) is our Twitter handle. We use our feed to direct followers to publications, news and events. Unfortunately we won’t be able to answer queries via Twitter but please do contact us via email using [enquiries@hsib.org.uk](mailto:enquiries@hsib.org.uk).

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