Health Services Safety Investigations Body

Investigation report

Mental health inpatient settings: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services

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Mental health

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Before reading this report

This report considers the care of people experiencing mental health problems and includes discussion about suicide, death and sexual safety. Some readers may find the contents of this report distressing. Information about how to access mental health support can be found on the NHS website.

Acknowledgements

Over a period of almost a year the HSSIB team visited at least 40 care areas across 30 mental health care providers and met with numerous patients, families, carers and staff along the way. We would like to thank the many people who contributed to this investigation. Thank you to the patients, families and carers who described their personal experiences to us which included the sharing of very intimate and traumatic situations. Thank you to the staff and providers who supported our visits and welcomed us with openness.

About this report

In June 2023 the Secretary of State for Health and Social Care announced that HSSIB would undertake a series of investigations focused on mental health inpatient settings. This report describes the findings of the third of those investigations.

In September 2024 HSSIB published an interim report titled ‘Learning from inpatient mental health deaths and near misses: assessment of suicide risk and safety planning’.

In October 2024 HSSIB published an investigation report titled ‘Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings’.

In November 2024 HSSIB published an investigation report titled ‘Mental health inpatient settings: out of area placements’.

In December 2024 HSSIB published an investigation report titled 'Supporting safe care during transition from inpatient children and young people’s mental health services to adult mental health services'.

This report is intended for the Secretary of State for Health and Social Care, healthcare policy makers and organisational leaders to help influence improvements in patient safety. This report has been published at a time when the government is considering long-term plans to radically reform the NHS and is responding to the findings of the ‘Independent investigation of the NHS in England’ (Darzi, 2024). It is expected that the findings of this report will be able to contribute to the government’s long-term plans in relation to mental health inpatient settings. This report is also intended for those who work in and engage with those settings, such as integrated care boards.

This investigation explored the patient safety risks associated with the transition of patients from inpatient children and young people’s mental health services (CYPMHS) to adult mental health services (AMHS). Transitions that are developmentally appropriate and based on need rather than age have been shown to support positive patient outcomes.

Glossary

The terminology in this report has been chosen while acknowledging that there are differing views across organisations and groups. For example, this report refers to ‘patients’ in line with NHS documents (NHS England, 2024a) and refers to people who experience a ‘mental health problem’ in line with Mind (2024).

Term	Definition
Aftercare (Section 117)	The help a person gets when they leave hospital if they have been detained under certain sections of the Mental Health Act. This help is provided until they no longer need it to stay well.
Developmentally appropriate	Recognising young people as a distinct group, with a holistic approach to care and support for their changing biological, psychological and social needs.
Inpatient adult mental health services	General acute (immediate) mental health inpatient services in hospital for adults aged 18 to 64 years.

Inpatient children and young people’s mental health services	General acute (immediate) mental health inpatient services in hospital for children and young people, often up to 18 years of age.
Residential children and young people’s mental health services	Mental health services for young people, often up to 25 years of age, provided in residential homes or supported living. These can also be referred to as a community settings.
Mental Health Act (1983)	Main legislation covering assessment, treatment and rights of people experiencing a mental health problem. Amended in 2007.
Mental health problem	Disturbance of a person’s mental wellbeing, impairing their ability to function as they would do normally (Mind, 2024).
Observation	A restrictive intervention where a member of staff watches and engages with a patient continually or intermittently.
Outcomes	Results from care and treatments.
Restrictive practice/ intervention	Techniques to reduce a patient’s movement, control risk actions, isolate and/or reduce sensory stimulation.
Safe care	The avoidance of physical and psychological harm to patients during the provision of care, and creation of an environment that makes them feel safe.
Self-harm	Any behaviour where someone causes harm to themselves; this may be to help cope with difficult thoughts and feelings (Mental Health Foundation, 2022).
Sexual safety	Protecting patients from feeling uncomfortable, frightened or intimidated in a sexual way, and protecting them from sexual incidents.
System	The interactions between providers, stakeholders and people that use services at local, regional and national levels spanning health, social care and education.
Therapeutic care – engagement and relationships	Partnership between staff and patient with shared decision making and recovery-focused goals (Care Quality Commission, 2023). Relationships embody core values such as respect, compassion, trust and kindness.
Therapeutic care – environment	Creates the conditions for therapeutic care by providing psychological safety and privacy, supporting activity and interaction, and preventing re-traumatising of patients.
Transition	

	A purposeful and planned process that supports young people to move from children's to adults' services.
Transition age	An age that determines when a transition between children and young people’s mental health services to adult mental health services takes place.
Transitional recovery services	Services that bridge the gap between acute hospital care and home. They include residential services that promote recovery from illness, support independent living, and avoid readmission to an acute hospital.
Workforce	The multidisciplinary team providing care and support to patients. Includes nursing, medical, allied health professions (such as speech and language therapy and occupational therapy) and psychological professions.

Executive summary

Background

This is one of a series of HSSIB investigations on the theme of patient safety in mental health inpatient settings. This investigation focuses specifically on the conditions that contribute to the outcomes for young people who transition from inpatient children and young people’s mental health services (CYPMHS) to adult mental health services (AMHS).

The aim of the investigation was to examine the impacts of transition from inpatient CYPMHS to AMHS on people who have experienced it, their families and carers, and on staff involved. The investigation also considered wider system implications regarding the integration of childhood to adulthood transitional services across health, social care and education.

The investigation was bound by its terms of reference and resources which meant it was not able to consider some elements in depth. The investigation acknowledges that the delivery of mental health inpatient care is complex and influenced by multiple interacting factors.

The investigation’s findings offer opportunities to facilitate improvements in systems, practices and future plans to support patient safety in mental health inpatient settings. Findings may also be applicable to other healthcare services in England.

Findings

- Young people may be discharged from inpatient CYPMHS because they have reached 'transition age' and not because their mental health care needs have changed.
- AMHS criteria for ongoing care as an 'adult' inpatient may mean young people are discharged from inpatient CYPMHS to an alternative setting which is not suitable to meet their ongoing needs, for example bed and breakfast hostels, with community services providing more limited mental health care and support.
- Young people, families and carers are not reliably informed of, or prepared for, the differences in care approach between inpatient CYPMHS and inpatient AMHS.
- Health, social care, local authorities and education do not always work together in a consistent and integrated way to support positive outcomes for young people who are transitioning from inpatient CYPMHS to AMHS.
- There is currently no alignment, equity of access, or clear responsibility and accountability for children and young people's health, education and social support that spans their transition from childhood to adulthood.
- In many CYPMHS, 'blanket' safeguarding measures are implemented overnight for people reaching 18. These measures are not based on a change in individual behaviours or risks. Perceived safeguarding challenges are a driver for rigid aged-based transitions.
- Young people, their families, and carers described that communication and information sharing changed when the young person reached 18. This meant safety risks were not always discussed and families and carers were not involved in safety planning or risk mitigation.
- NHS England service specifications and commissioning guidance for inpatient CYPMHS do not support needs-based flexible transitions. More flexible, developmentally appropriate needs-led transitions were seen to have more positive patient outcomes.
- Definitions of 'children', 'young people' and 'adults' vary across legal and professional guidance. This contributes to challenges in defining these groups across services.
- In comparison with young people in mainstream education, the education needs of young people transitioning from inpatient CYPMHS due to reaching 18 are not always being met.

- A robust training needs analysis and competency assessment of the inpatient mental health workforce is required if changes to the specifications and delivery of inpatient mental health services are made.

HSSIB makes the following safety recommendations

Safety recommendation R/2024/047:

HSSIB recommends that NHS England reviews and updates its inpatient children and young people's mental health services specifications and commissioning guidance to ensure they support developmentally appropriate, needs-based transitions. Any changes to service delivery will require a review of funding lines to enable successful implementation.

Safety recommendation R/2024/048:

HSSIB recommends that NHS England reviews and revises its guidance and policies to ensure consistency regarding the language used for age ranges (for example children, young people, young adults and adults). This is to support a consistent approach to healthcare delivery that aligns services and mitigates gaps.

Safety recommendation R/2024/049:

HSSIB recommends that the Care Quality Commission work with the Department of Health and Social Care to understand prioritisation for assessing transitions in mental health care within Integrated Care System assessments. Any subsequent work should include the development of a methodology to identify the challenges described in the investigation report relating to transition from inpatient children and young people's mental health services, to adult mental health services. This is to improve the safety, quality and consistency of transitions across England.

Safety recommendation R/2024/050:

HSSIB recommends that the Department of Health and Social Care works across government to identify opportunities to support closer cooperation between local government, education and health systems for the safe and effective transition of young people into adulthood. This is to ensure alignment, equity of access, and clear responsibility and accountability for their health, education and social support that spans the ages of 16 to 25. Cross governmental work would be supported by the adoption of consistent language for age ranges of children, young people, and adults.

Safety recommendation R/2024/051:

HSSIB recommends that NHS England provides guidance regarding communication of essential safety and risk mitigation information when patients transition from inpatient children and young people's mental health services due to reaching transition age. This is to safeguard vulnerable people and may include how to share information with families and carers, health and social care providers, and third sector organisations.

HSSIB makes the following safety observations

Safety observation O/2024/053:

Providers of inpatient children and young people's mental health services can improve patient safety by ensuring there is not a blanket approach to safeguarding mitigation measures based on a person's age, and that mitigation measures are individualised and based on behaviours and risks.

Safety observation O/2024/054:

Children and young people's mental health services and adult mental health services can improve patient safety by having more aligned thresholds and criteria to access care, and improved data sources to inform decision making. This is to support closer alignment of services and mitigation of gaps, and to enable more seamless care pathways from childhood to adulthood.

Safety observation O/2024/055:

Mental health providers can improve patient safety by adopting a consistent approach to involving and informing young people, and their families and carers, about how care decisions and the sharing of care information change when young people reach 18. This is to support a consistent and proactive approach to seeking young people's wishes, and enabling a shared understanding between staff, young people and their families and carers.

Safety observation O/2024/056:

Inpatient children and young people's mental health services can improve patient safety by ensuring that young people, families, and carers are involved, informed and prepared as possible for the young person's next place of care. This may require increased levels of engagement with partner inpatient adult mental health services to support a full understanding of the differences that will be encountered.

1. Background and context

This investigation report is one of a series of HSSIB investigations focused on mental health inpatient settings. This section provides background to the investigation, which focused on the transition of patients from inpatient children and young people's mental health services (CYPMHS) (also known as child and adolescent mental health services (CAMHS)) to adult mental health services (AMHS).

Many additional mental health care challenges were encountered during the course of the investigation; however not all were related specifically to the transition from inpatient CYPMHS and were therefore outside the scope of this report.

The definitions for people in specific age ranges is inconsistent across organisations and legislation, this is described in appendix 2. Throughout this investigation report HSSIB will refer to children as under 18 years of age, and adults over 18 years of age. Young people span the age boundaries of children and adults and are defined as between 16 and 25 years of age, and where most transitions between CYPMHS and AMHS occur. Other organisations can have different definitions of age ranges.

Young people require specific definition as some mental health services, guidelines and policies are targeted to this group. Through stakeholder, patient, and family and carer consensus, 16-25 years of age was regarded as the most applicable age range for defining young people.

1.1 Mental health care

1.1.1 A person's mental wellbeing/health influences how they feel, what they think and how they behave (World Health Organization, 2022). Around a quarter of the population of England will experience a 'mental health problem' each year (Mind, 2024). A mental health problem is a change to a person's mental wellbeing that impairs their ability to function as they would do normally (Mind, 2024). Mental health is determined by a combination of biological (for example genetics and physical health), psychological (for example beliefs, perceptions and previous traumas) and social (for example relationships, culture and life circumstances) factors (Mental Health Foundation, n.d.).

1.1.2 Most people experiencing a mental health problem will be cared for outside of hospital in the community. For some people admission to hospital on a voluntary or compulsory basis is needed. The Mental Health Act (1983) is the main legislation that covers the assessment, treatment and rights of people experiencing a mental health problem in the community and in hospital. Where a person is admitted to hospital on a compulsory basis they may be described as 'detained' under the Mental Health Act. The Act is split into different sections which contain information about being detained, treatment while detained and the allowance of 'leave' from hospital for an agreed purpose and period (this may be referred to as 'section 17 leave'). The Mental Health Act was amended in 2007 and at the time of writing further reforms were being considered.

Mental health inpatient care

1.1.3 In England, there are various mental health inpatient services. The demand on mental health inpatient services in England is high and has been increasing. Between 2016 and 2023 there was a 24% increase in the number of patients in hospital (The King's Fund, 2024). Bed occupancy has consistently been above the recommended maximum of 85% (except during the COVID-19 pandemic) since 2010/11 (Mental Health Watch, 2024).

Children and young people's mental health inpatient wards

1.1.4 Inpatient CYPMHS in England can be provided by the NHS or the independent sector. Hospital services are offered at different levels to support:

‘… the effective management of differing nature of risk presented by children and young people who are under 18 years:

- Medium secure services accommodate young people with mental and neurodevelopmental disorders [problems] (including learning disability and autism) who present with the highest levels of risk of harm to others including those who have committed grave crimes.
- Low secure services accommodate young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Young people may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with behaviour that challenges, self-harm and vulnerability.
- Psychiatric Intensive Care Units (PICU) manage short-term behavioural disturbance which cannot be contained within a Tier 4 CAMHS general adolescent service. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security.
- General adolescent services provide inpatient care without the need for enhanced physical or procedural security measures.’ (NHS England, 2018)

1.1.5 Mental health care is also provided in alternative settings to an acute hospital for children and young people up to 25 years. These placements can be jointly funded by the NHS and local authorities and could be a residential home for young people with mental ill-health or emotional wellbeing needs such as transitional recovery services, or in supported living accommodation that also provides mental health support.

1.2 Acknowledging the challenge

1.2.1 In 2023 approximately 23% of people aged 17 to 19 had a probable mental disorder (NHS England, 2023). Young people who have a mental disorder can receive various approaches to provide them with the most appropriate care and support. Where this care and support requires transition from inpatient CYPMHS to

AMHS, or discharge from inpatient CYPMHS and a move to a residential setting that provides mental health support in the community, they routinely take place when patients are aged between 17 and 19.

1.2.2 Challenges associated with the transition from CYPMHS to AMHS have been considered by many organisations and reports, over many years. Examples include the ‘Five year forward view for mental health’ (NHS England, 2016), ‘Delivering better outcomes for children and young adults’ (Royal College of Psychiatrists, 2022), ‘Meeting the needs of young adults within models of mental health care’ (National Collaborating Centre for Mental Health, 2022), the NHS Long Term Plan (NHS, 2019a). In 2018 the Healthcare Safety Investigation Branch also published an investigation report, ‘Transition from child and adolescent services to adult mental health services’ (Healthcare Safety Investigation Branch, 2018).

1.2.3 Each of these previous reports describe how the systems in place for transitions do not support positive outcomes for young people, and suggest potential opportunities to develop and improve. Although they consider transitions from CYPMHS to AMHS, they are largely focused on community care, with lesser focus on inpatient transitions and the associated specific challenges. This investigation acknowledges the findings of the previous reports and will highlight that many challenges and impacts of transitions for young people remain. Where required the investigation has explored links with community mental health services; however, this report focuses on transitions from inpatient CYPMHS to AMHS.

1.2.4 Transition challenges are not specific to mental health services alone, but also affect children and young people with other conditions, as described in ‘Facing the Future: Standards for children with ongoing health needs’ (Royal College of Paediatrics and Child Health, 2018) and ‘Forgotten generation - Shaping better services for children and young people’ (NHS Providers, 2024).

1.3 Transition

1.3.1 Transition is described as ‘a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child centred to adult-oriented health care systems’ (Blum et al, 1993).

1.3.2 Figures 1 and 2 represent transitions that can occur for a young person from inpatient CYPMHS to AMHS as they go through development from childhood to adulthood. This representation is not exhaustive, and there will be additional

factors, policies and legislation that influence a ‘holistic’ transition, including those that fall outside the scope of this investigation. The changes in colour between figure 1 and figure 2 represent stakeholders that often change in the systems that support young people. Where there is no change in colour the stakeholders remain the same. The stakeholders at each level of the system are not directly linked with stakeholders at other levels, and are not intended to indicate responsibility or accountability between them.

Figure 1 Example system for young people under 18 in CYPMHS

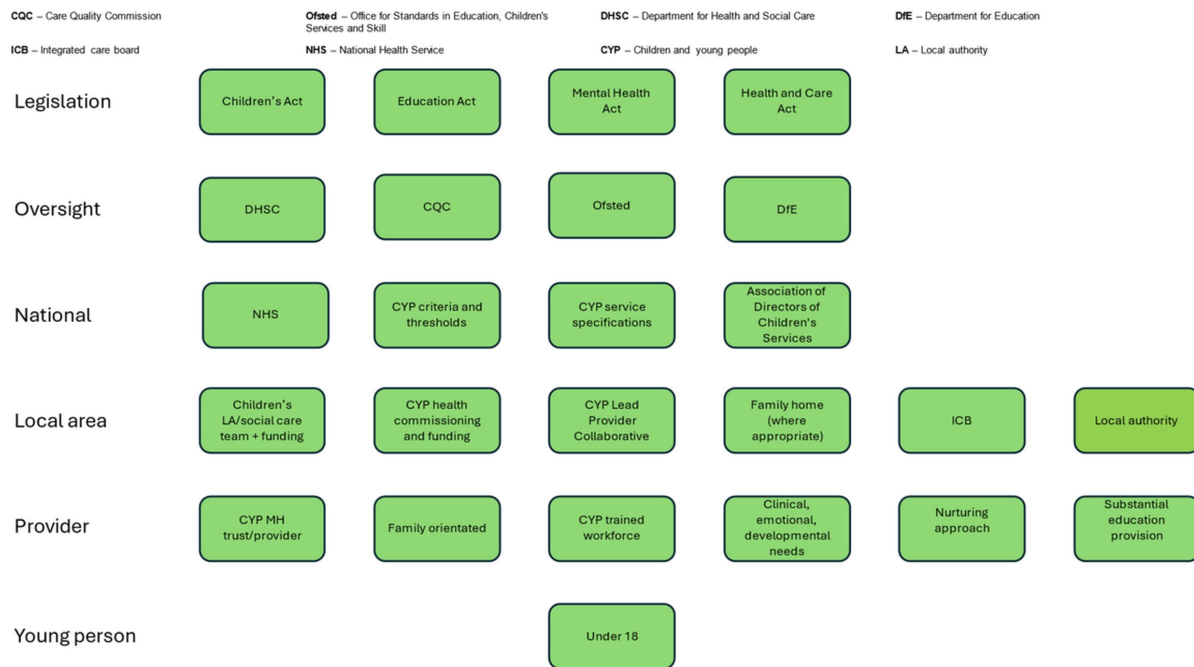
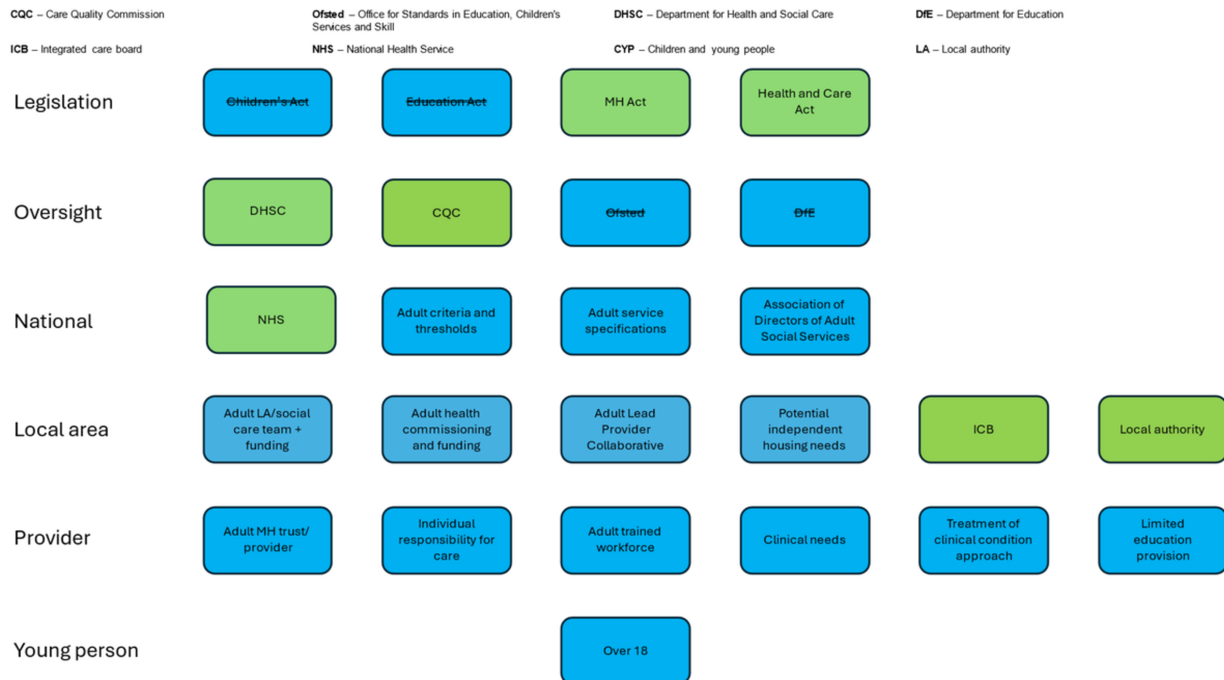


Figure 2 Example system for young people over 18 in AMHS



1.3.3 The stakeholders shown in the two systems in figures 1 and 2 will have varying degrees of influence on the outcomes for young people.

1.4 Timing of transition

1.4.1 The timing of transition and the impacts this can have on young people is well documented in research and reports. Transitions to 'adult' services in physical health often occur at 16 years of age, however for mental health the age at which transitions occur is more nuanced. It is widely acknowledged that people in their late teens (aged 16 to 20) are going through major changes physically, emotionally and psychologically. These developmental changes are happening at the same time as most transitions between CYPMHS and AMHS take place (Royal College of Psychiatrists, 2022).

1.4.2 It is recognised that transitions from CYPMHS to AMHS are a time of vulnerability and challenge for many young people, with significant complexities in navigating healthcare alongside social care, education and various legal frameworks. This is further exacerbated when each of these parts of young people's lives change as they move from childhood to adulthood.

1.5 Guidance and ambition

1.5.1 Positive health outcomes for young people who transition from inpatient CYPMHS to AMHS are delivered by transitions which are developmentally appropriate and driven by need rather than age. National guidance is to ensure that

‘transition planning is developmentally appropriate’ and ‘the point of transfer should … not be based on a rigid age threshold’ and ‘take place at a time of relative stability for the young person’ (National Institute for Health and Care Excellence, 2016a).

1.5.2 The Five year forward view for mental health (NHS England, 2016) made a recommendation that ‘NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25…’. The NHS Long Term Plan (NHS, 2019a) states that ‘We will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults.’ This approach was supported by the Royal College of Psychiatrists (2022), which states that ‘the delivery of the 0-25 commitment will hinge on the expansion and improvement of services for age groups who currently often fall through the cracks of specialist provision’.

1.6 Commissioning of mental health services in England

1.6.1 Commissioning is ‘the process by which health and care services are planned, purchased and monitored’ (The King’s Fund, 2023). ‘Most NHS mental health services in England are commissioned by Integrated Care Boards (ICBs). ICBs are responsible for planning and funding most local NHS services’ (NHS England, n.d.a). Within ICBs there may be several ‘Places’ that align with historic Clinical Commissioning Group (CCG) boundaries, these are linked to individual local authorities. Approaches to commissioning, and the services that are commissioned, differ between ‘Places’. Some specialist services, such as CYPMHS, low and medium secure mental health services and adult eating disorder services, are commissioned by NHS England, which delegates commissioning to lead provider collaboratives.

1.6.2 Provider collaboratives are groups of ‘providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. They will do this by taking responsibility for the budget and pathway for their given population’ (NHS England, n.d.). The lead provider in a collaborative is accountable to NHS England for the commissioning of specialist services. From July 2022 all NHS trusts providing acute and mental health services needed to join a provider collaborative (The King’s Fund, 2022).

2. Individual and organisational challenges impacting on transition from inpatient children and young people's mental health services

This section of the report explores the process of transition from inpatient children and young people's mental health services (CYPMHS) to adult mental health services (AMHS). It reflects the thoughts, experiences and views of young people, their families and carers, and staff involved in providing care and commissioning services. A summary of the evidence sources that inform this section can be found in appendix 1.

A foundation of this investigation was to understand the impacts on young people of the transition from inpatient CYPMHS to AMHS. This section is grouped into the themes below, which draw from what the investigation heard, observed and understood from the people it engaged with. Quotes are also included which provide insight into how patients, families, and carers feel.

This section explores:

- Planning for transition
- Transition
- Workforce considerations
- Safeguarding
- Continuation of care
- Preparation for adulthood and family involvement
- Patient involvement in service design
- Regulatory considerations
- Legislated additional support.

2.1 Planning for transition

2.1.1 The way transition is planned and managed is critical for patient outcomes, and the wider impact on their families and carers. During site visits the investigation heard from patients, families and carers, and staff, examples of several factors that affected the planning and timing of transition from inpatient CYPMHS. These factors impacted the mental health and recovery of patients who were in the transition stage of their care pathway.

2.1.2 The investigation heard consistently from patients, families, and carers that the transition was initiated because the patient was approaching or reaching a specific age, which was usually 18 years of age.

> “I was having to be moved on my 18th birthday. 18 is a big birthday, but what I was doing was moving away from my friends to a new hospital and people I didn’t know. It was horrible. I couldn't stop crying.”
>
> Patient insight

2.1.3 The investigation heard numerous accounts where the transition had been driven by age, but the young person’s mental health care needs had not changed. This caused anxiety for young people, their families, and carers, especially where they were receiving appropriate care to help them towards their recovery in inpatient CYPMHS, but were now presented with an imminent move to a new provider and the unknowns that would entail.

> “I started to hide how unwell I was. Because I decided that I'd rather get out than go to an adult ward.”
>
> Patient insight

2.1.4 The investigation met with several bereaved families and carers. The transition from inpatient CYPMHS to AMHS described in all of these meetings was initiated because the young person had reached a ‘transition age’. The transition was often described as a stressful process, and one which contributed to the poor outcomes for their loved ones.

2.1.5 The investigation also explored the views of staff about age-based transitions at 18 years old. Some staff reflected that a child being discharged on their 18th birthday felt inappropriate. Other staff described how they were worried about a patient’s impending 18th birthday and whether appropriate care of the young person would continue in adult services.

2.1.6 Several providers described inpatient CYPMHS as “stretched”, which meant patients needed to transition to AMHS to “prevent bed blocking” and “maintain flow”. The age of 18 was regarded as “the one concrete way to move people on and

keep flow through the system”. Staff said that national pressure on bed places made it difficult to identify an inpatient AMHS bed early and, if they did, it was difficult to hold once identified if a patient could not move immediately.

2.1.7 A more flexible and individualised approach to transitions was described “as very much the right thing to do, but idealistic as the current systems did not support it”. However, other comments from providers suggested a more flexible approach could cause backlog issues should young people “never move on” from their current provider. Resource and funding were described as a challenge to keeping people for longer in inpatient CYPMHS, even though their needs may not have changed.

2.1.8 The investigation heard that an age threshold, such as 18, may help to drive transitions and crystallise an approach across teams. However, this relied upon AMHS engaging early, for example 6 months before a patient turned 18. Inpatient CYPMHS staff described frustration with AMHS regarding this: “They often won’t allocate anyone to consider a referral until 2 weeks before a patient turns 18.”

2.1.9 The investigation reviewed the transition guidelines of a CYPMHS trust, which stated that ‘The age of formal transition will be when the young person is 18 years of age’. Standards included ‘a meeting between transitioning services from six months before transition occurs, evidence the young person feels prepared for transition, evidence the young person has agreed to the transition plan’. However, the investigation heard that this approach was not always followed in practice. Challenges included bringing together required stakeholders to plan early and effectively and, should a young person not have felt prepared for or agree to their transition plan, it was routine practice they would still have to transition at 18 years of age due to how the service was delivered.

2.1.10 The investigation saw a variety of care planning support tools which facilitated discussions regarding the complex needs and circumstances of some patients who were approaching 18, and assisted in determining which health and social care professionals were required at multidisciplinary planning meetings in order to break down cross-boundary silos. Many tools were generally healthcare related. They included little consideration of education and social care, which were described as key considerations for a holistic approach to transition for young people whose lives cannot be separated into silos.

2.1.11 The investigation visited a provider that used a planning support tool, which was drawn out from their digital patient management system to support effective and holistic transitions. The tool was based on assessing young people’s needs

rather than their level of risk, and formed part of an escalation framework to enable people and partners to come together to meet people's needs. If young people were identified as 'Red' for the transition element on the planning tool there was a likelihood they would need to access adult services. The recommendations that were drawn from the tool were described as being made into a "usable action plan" and the provider commented that "transition is about teamwork".

2.1.12 The investigation heard about several meetings that support bringing services and agencies together, such as 'gateway meetings' supported by the use of planning tools. These were attended by providers, collaboratives, integrated care boards (ICBs) and local authorities, and were described as being able to "go outside the box a little bit".

2.1.13 In summary, the investigation learned that the planning and timing of transition from inpatient CYPMHS to AMHS varied across England. There were examples of flexibility, and the use of extensive and effective planning tools to support cross-boundary working. However, there was an inconsistent approach across providers and lead provider collaboratives (LPCs).

2.2 Transition

2.2.1 The investigation observed providers that had implemented flexibility in their approach to transitions from inpatient CYPMHS. Evidence was presented to the investigation which showed that this resulted in better outcomes and experiences for patients and their families and carers. An example was where a young person and their family were treated as "partners" in their ongoing needs and were involved in decisions about their future care provision.

2.2.2 The investigation spoke with staff members who felt that an ideal approach to the transition from inpatient CYPMHS to AMHS would be an interim service provision for patients aged 16 to 25. However, it was described that providing this would involve overcoming a number of hurdles, for example additional wards and infrastructure, specific staff training and competencies, and a more flexible approach to funding that spans current CYPMHS and AMHS. An interim service approach was also supported by some young people and their families and carers.

> "I would like to see a 17 to 21 transition to enable them to understand the difference between being a child and an adult. I don't understand in mental health why there is not an extended window."

Family insight

2.2.3 It was described to the investigation that “there can be quibbling between services”, for example, “CYPMHS will say that someone who is 18 is now not their problem”.

“A more flexible approach to transitions requires a more flexible approach to funding that spans current CYPMHS to AMHS.”

Staff insight

2.2.4 The investigation heard that when trusts provide both inpatient CYPMHS and inpatient AMHS, transitions are usually easier and result in better patient outcomes. The investigation heard an example where a young person moved from inpatient CYPMHS to inpatient AMHS within the same provider, with the AMHS having significant contact with the young person prior to their 18th birthday. This ensured they were well prepared for the transition, which was supported with a good pathway which was effectively managed. It was discussed that this was much harder to achieve when working across providers, which may be in different parts of the country.

2.2.5 The investigation heard that some inpatient mental health services, both for young people and adults, were “pulling back and sticking very much to a rigid responsibility because they are stretched” and that “this is a commissioning issue” where “very few commissioners were being brave to commission inpatient CYPMHS services above the usual age cut-off of 18”.

2.2.6 A service commissioner described that the “system is using criteria in a very restrictive way that only suits the service needs and not the people. We are not as person centred as we could or should be”.

2.2.7 During visits to organisations that had a more flexible approach to transitions, the investigation heard that this was enabled by providers and commissioners “pushing the boundaries” of how inpatient services have been delivered in the past. Where this flexibility occurred, the investigation was shown evidence that it supported safer and more therapeutic transitions.

2.2.8 When a move for a young person had been initiated, the investigation heard that this could result in a need for joint funding between healthcare (NHS) via ICBs, and local authorities. For example, a young person with an eating disorder may be discharged from a fully healthcare funded inpatient CYPMHS and be admitted to a joint healthcare and local authority funded residential home that provides adult eating disorder services, to meet their ongoing needs.

2.2.9 The investigation visited a residential home that provided mental health care for young people over and under 18. The beds in the home were jointly funded by healthcare (via ICBs) and local authorities. Most of the young people in the home were from out of area, so the home had to engage with many different ICBs and many different local authorities. It was described that the approach of each was “personality driven”, and there was “huge inconsistency”. The manager of the home gave an example of a young person reaching 18 and having their funding removed by their local authority, whereas other patients continued to be funded.

2.2.10 The investigation heard an example of a local authority that was engaged and supported flexible transitions. This included funding to allow patients to remain in their current care beyond their 18th birthday, in order to support finding the “most appropriate” adult placement. It was described that this was “much better than transitioning in a rush and to an inappropriate placement”.

2.2.11 Staff described a “postcode lottery” and “pot luck” for individual patients in the approach and oversight taken by their individual local authority. It was discussed that there was a lack of clear policy, guidance or framework, resulting in significant inconsistency for different patients being cared for within the same provider. Staff described that differing resource and capacity challenges across different local authorities likely contributed to this.

2.2.12 The investigation heard from staff that if someone “is an inpatient for over 90 days then this has to be reported to their local authority, for their social care and support needs”. Some staff said that if they did let a local authority know, some would say “get back in touch when they are a week away from discharge”. Therefore effective planning to meet social care needs could not take place.

> “We can only influence system partners, including local authorities and social care. We can’t control what they do, and there is limited clear accountability and responsibility across partners.”
>
> Staff insight

2.2.13 The investigation heard challenges where staff working across healthcare and social care may have disagreements regarding the need, and the funding, for future provision of services for young people. Although different areas had different processes, there would generally be an escalation route to ‘senior professionals’ if needed, through meetings such as ‘dispute meetings’, ‘resolution meetings’ and ‘escalation meetings’. The final step in this process was usually a meeting between the ICB/Place director and a senior local authority representative, to provide a resolution.

2.2.14 In one ICB the investigation heard that there were lead directors for each Place, which are aligned to the different local authorities, and that each Place director would have different relationships with their local authorities. It was described that where Place directors worked in close proximity, such as in the same building, to their local authority counterparts “They might not always agree, but their relationships are better”. It was described that resolutions to transition challenges were however driven by relationships, rather than clear lines of responsibility and accountability for the young person. It was described as “who blinks first pays”.

2.2.15 The investigation heard staff across providers, LPCs and ICBs describe what good transitions would be. Terms such as “all age”, “joined up”, “holistic” and “needs based” were used. Staff considered that these approaches would support the best outcomes for people who were transitioning from inpatient CYPMHS to AMHS.

2.2.16 Systems, transitions, and service delivery were commonly described as being very much driven by funding lines. It was described that funding could be used as “an excuse” to be able to retreat into boundaries, and “pass the buck” of responsibility for patients.

2.2.17 In summary, a safe and effective transition from inpatient CYPMHS to AMHS relies on a system of providers and partners working together, supported by appropriate commissioning and funding. The investigation found an inconsistent approach to transitions across England which was contributed to by variation in the integration of services, and the relationships between providers, collaboratives, ICBs and local authorities.

2.3 Workforce considerations

2.3.1 The investigation spoke with providers and staff about what the mental health workforce would need to deliver more flexible care, or care for different age ranges. It was described to the investigation that currently many staff were aligned to providing care for children and young people up to the age of 18, or to providing adult care for those over 18.

2.3.2 For psychiatry, the investigation heard that “you do your core psychiatry training across broad psychiatric care, and then specialise in CYPMHS, AMHS, Old Age or Learning Disabilities”.

2.3.3 The investigation visited a provider that delivered both inpatient CYPMHS and AMHS across two separate wards. Historically staff were aligned, and trained, to provide care on one of the wards: “We would have CYP ward staff, and we would have adult ward staff.” The provider went through a major transformation in how care was delivered, and therefore how staff competencies were aligned. Mental health nursing staff and allied mental health professionals were trained and upskilled to provide care across both inpatient CYPMHS and AMHS. Each ward continued to have a dedicated specialised psychiatrist.

2.3.4 The investigation heard that the transformation was a challenging time, with several staff leaving as they felt they could not specialise in the care that they were passionate about. However, the long-term benefits of having staff that could provide care for children and young people and for adults was described as extremely positive and yielded significant advantages.

2.3.5 The investigation heard examples of staff from adult wards visiting a young person in their inpatient ‘child’ ward to “get to know them” if they were going to transition between wards. The staff member would continue to support the young person when they moved to the ‘adult’ ward. Staff approaches to care were also more aligned across the young people’s and adult wards. In addition, young people were in the same location, and although moving wards, everything else remained familiar for them. Young people also had the opportunity to engage with their friends during supervised joint ward activities. The investigation heard that the benefits of this approach were “huge”.

> “We need to build up confidence and skills through professional training to approach delivery of an all-age service.”

Staff insight

2.3.6 The investigation spoke with a psychiatrist who said that professional confidence and competence requires organisational support. Their view was that a professional's capacity to be more flexible increases with organisational support.

2.3.7 In summary, the investigation learned that a flexible approach to transitions, or delivering different models of care across inpatient CYPMHS and inpatient AMHS, requires the workforce to enable it. The current inpatient mental health workforce is typically aligned to the provision of children and young people or adult care across most providers in England.

2.4 Safeguarding

2.4.1 The investigation commonly heard that safeguarding was a significant factor in the need for transition from CYPMHS. Providers described overnight changes in their approach to the mitigation of safeguarding risks for young people who reach 18. These changes were heard more often in acute inpatient CYPMHS hospitals compared to residential homes that provided mental health care.

> "If someone turned 18 on a children's ward, they would then immediately be put on one-to-one observations, for the mitigation of safeguarding risks to the other patients that are under 18."
>
> Staff insight

2.4.2 Staff and patients described a variety of safeguarding processes that were introduced overnight, from a patient going to bed aged 17 and waking up aged 18. These included:

- Being placed on one-to-one observations – associated with being more ill, or with increased risks.
- The patient could not be in the room of a patient who was under 18 without staff supervision.
- Limitations on social interaction with other patients under 18.

2.4.3 The investigation heard examples of the impact on patients when the approach to them, their care, their wellbeing and their social interaction changed on reaching the age of 18.

> “It's frustrating the way that overnight you have apparently completely changed and they are expecting you to be a completely different person and a risk to other young people.”
>
> Patient insight

> “Because she was technically an adult in the eyes of the law. She wasn't allowed to be left unaccompanied with her friends; she wasn’t even allowed to play scrabble with them.”
>
> Family insight

2.4.4 The investigation had a number of discussions regarding sexual safety and safeguarding implications relating to ‘children’ (under 18s) and ‘adults’ (over 18s) being accommodated on the same ward. The investigation heard that it was feasible that an 18 year old could be just as sexually vulnerable with a 17 year old, as a 17 year old is with an 18 year old. Staff did express, however, that challenges would become more evident where ‘older’ young people in their late teens and early 20s were accommodated with younger children.

2.4.5 The investigation heard about a patient with complex challenges and specific risks relating to their sexual disinhibition around female patients and staff. They were over 18 on an inpatient CYPMHS ward. The safeguarding of female patients on the ward who were under 18 was described as always being effectively managed, as risk mitigation measures were appropriate for the person based on their individual behaviours and risks. Staff and patients described feeling safe and supported at all times.

2.4.6 There are areas across healthcare where patients under and over 18 may receive care in the same environment, such as adult emergency departments which are often for over 16s. At one inpatient CYPMHS visited by the investigation, a patient aged 17 with an urgent physical health problem would need to go to the

adult (over 16s) emergency department where they would be treated alongside adult patients of any age. It was described that no additional safeguarding mitigation measures would be put in place for this.

2.4.7 The investigation heard that some staff in an inpatient CYPMHS felt that, if allowed, patients could be facilitated to stay there into their early 20s. However, this “would be completely dependent upon the patient as an individual, and in consideration of their specific behaviours and risks to other patients”.

2.4.8 In summary, the investigation learned that the approach to safeguarding across providers was inconsistent for young people who turned 18 in inpatient CYPMHS. Some applied blanket approaches when young people reached 18, while others based mitigation measures on individual behaviours and risks with no overnight change in approach. Where blanket mitigation measures were implemented, safeguarding was often considered a key driver for age-based transitions.

2.5 Continuation of care

2.5.1 Challenges relating to differences of criteria and thresholds between CYPMHS and AMHS were heard extensively throughout the investigation. The investigation heard that “the numbers [of patients] that transition from inpatient children settings to inpatient adult settings is low”. However, when young people did not transition from inpatient CYPMHS to inpatient AMHS on reaching 18, this was often described as being due to “a difference in thresholds and criteria between children’s and adult care”.

2.5.2 It was described that many young people’s needs do not change, but the thresholds to access the same level of inpatient care change when they reach 18. The investigation heard that this often means young people no longer meet the eligibility criteria for continued inpatient care.

> “The [gateway] meeting is almost used as a pitch to try and sell their patients to the adult mental health services. Only 1 in 10 patients are picked up due to different thresholds and risks.”
>
> Staff insight

2.5.3 The investigation identified variation and inconsistency in criteria and thresholds, both from an inpatient CYPMHS perspective and an inpatient AMHS perspective. The description of thresholds across different providers and staff was inconsistent and appeared subjective, and was not defined in local guidance for patients, families and carers, or staff to support a clear and shared understanding of the gaps and differences.

2.5.4 Once a decision is reached about the AMHS criteria and thresholds that a young person’s ongoing mental health problem and needs meet, then an appropriate AMHS can be identified. This could be an inpatient AMHS in the NHS or independent sector, a residential home, supported living with appropriate mental health support, or community AMHS. The suitability of the care received at a young person’s next setting is vital in supporting positive outcomes. The investigation heard that for some young people, the transition to AMHS could be very positive, however there were many examples of where it was not.

2.5.5 The investigation heard that inpatient CYPMHS and inpatient AMHS had “different philosophies”. It was described that inpatient CYPMHS were about family, and the young person getting the therapy they needed for the treatment of developmental and emotional disorders. However, in inpatient AMHS there was less nurturing and family engagement and the approach was more clinical. It was described that the AMHS approach was driven by specific medical diagnoses, unlike the approach at CYPMHS. The difference in approach was also considered a key factor in the “gaps” in criteria and thresholds between children and adult inpatient services.

> “CAMHS feels warm and fluffy. Adult feels service centred and not individualised or accommodating. I didn’t think that about CAMHS like that until now being an adult.”
>
> Patient insight

2.5.6 The investigation heard about a young person who had reached 18 years of age, but whose developmental age was much younger. They were transitioned from their inpatient CYPMHS to an acute inpatient AMHS with “high risk adults”. It was described that the young person would sit separately on the ward and play with their toys, among extremely ill adults in a “chaotic and scary environment”. Staff at the CYPMHS the young person had transitioned from described feeling extremely

anxious for the young person’s safety. The investigation also heard that the inpatient AMHS ward staff did not feel comfortable, nor competent, to provide care for this young person’s complex needs as they “presented as a child”.

2.5.7 The investigation was told that when people are transitioned from inpatient CYPMHS but their needs have not changed, continuing care is crucial for their ongoing recovery. If they move to inpatient AMHS or a residential home that provides support for mental health needs then, although the care approach may be different from inpatient CYPMHS, the new setting will provide specific, accountable and evidenced-based mental health interventions with clear oversight and regulation. The investigation heard that where transitions have placed young people in supported living, the oversight of their care has been less effective. Where new placements do not meet the ongoing and unchanged needs of young people who have transitioned because of their age, it was expressed that these placements were more likely to fail.

2.5.8 The investigation heard about a young person who moved from an eating disorder residential home because they had turned 18. Their local authority found a supported living placement in a different area, funded jointly by the local authority and the young person’s ICB. The patient and the staff caring for them were told that the placement could provide appropriate support for their mental health needs. The patient told the investigation: “Things were promised and it seemed really good, my social team were very happy with it but the transition ended up being 3 months, mostly because they were trying to sort out mental health services, because they had nothing.”

2.5.9 The patient also told the investigation that when they arrived at the supported living placement: “Staff clearly weren’t trained in mental health, they didn't even know what a MAR (medicines administration record) was. I'm not supposed to be trusted with my medication.” The patient went on to say: “When I turned up one day the door to the office was unlocked and there was access to the meds keys, it was very easy to open. They did have a lock box but it wasn't very secure. So I got in and took my bag of meds.”

2.5.10 This resulted in the “manager of the commissioning team withdrawing the supported living placement as it wasn't appropriate. This was because they couldn't give [the patient] the mental health care that they needed, or mitigate their risks”. It was deemed a “failed placement”, and the patient was transferred back to the CYP residential home they were at previously. Staff described that the patient “needed other people to demonstrate care and take away risks” but that the adult supported living placement did not provide this.

2.5.11 During interviews with bereaved families and carers the investigation heard examples of young people being discharged from inpatient CYPMHS to bed and breakfast hostels, and to caravans on holiday sites. Community mental health support was put in place, but families and carers described it as falling far below what was suitable to meet young people’s ongoing mental health care needs. They were “receiving 24/7 inpatient care one day, and then left to fend for themselves with almost no mental health support the next”. Families and carers described that these placements had often contributed to the poor outcomes for their loved ones.

2.5.12 The investigation spoke with a Place director at an ICB to discuss this issue. They said: “Many of our costs are in breakdowns of care [failed placements] and their resolution … if you do it really well in the first place you mitigate the risk of it failing.”

2.5.13 Although uncommon, the investigation also heard from both patients and staff about young people being discharged from care on reaching 18 with ongoing needs, without any clear support from healthcare or their local authority. Reasons for this included not meeting “adult’ thresholds” for their mental health needs, and where they fell through cracks for social care or social housing support, exacerbated when multiple agencies spread across different areas of the country were involved.

> “Not discharging me homeless, that would have been great.”
>
> Patient insight

2.5.14 In summary, when transitions had taken place from inpatient CYPMHS due to young people reaching transition age, there were examples of the care in their next environment not meeting their needs, and poor outcomes. This included placements that ‘failed’ and therefore required further time, funding and resources to rectify with a new placement that more safely met people’s ongoing mental health needs.

2.6 Preparation for adulthood and family involvement

2.6.1 Patients, families, and carers described challenges with how inpatient CYPMHS prepared young people for reaching ‘adulthood’ and discharge from inpatient care, including continuity of education. The impacts on young people when health and social care transitions were not holistic – that is, they did not account for all aspects of a person’s life – were significant.

2.6.2 Young people described how, after transition from inpatient CYPMHS to AMHS, they had missed planned exams because of a difference in the education offer. The investigation heard that these impacts could be lifelong, affecting young people’s ongoing mental health, their preparation for adulthood and discharge, and contributing to poor outcomes.

> “I was sent to an adult ward 3 days after my 18th birthday without notice. I was about to do my GCSEs but I then missed them. This affected my life from then on, playing catch-up.”
>
> Patient insight

2.6.3 During visits to providers where transition planning was being discussed, education was not routinely factored into decisions about when the transition would happen, or where the patient would be moved to. The investigation spoke with education staff in inpatient CYPMHS who described a need to allow transitions to align with the academic year as a minimum, for education purposes.

2.6.4 In a location where more flexible transitions were facilitated the investigation heard that “inpatient mental care absolutely needs to be aligned to education, and education needs should be fed into any multidisciplinary team meeting, especially regarding discharges and transitions”. Because of the flexible approach to transition at this CYPMHS, young people could remain there until they were 19, by which time they would have usually have taken key exams they may have been studying for.

2.6.5 Across the many inpatient AMHS visited, the education offer varied; however, it rarely met the education offer delivered at inpatient CYPMHS. It was described that AMHS did not have the same remit to provide education because patients were over school age, and it therefore happened on a “more ad-hoc basis”. In addition, many inpatient AMHS environments were quite transient, with stays in the most acute settings being as short as possible in line with targeted and time-based interventions.

2.6.6 The investigation also heard examples from young people, families and carers where the life experiences of young people who had had long stays in inpatient CYPMHS did not reflect those of young people in the general population. It was described that this could affect their preparation for adulthood, and could be a significant factor for a successful transition from inpatient CYPMHS.

> "You never learn actual life skills being in a hospital for so long. Most of us have been in hospitals for years. You don't actually gain your life skills because you've been in hospital and they don't teach you how to do stuff, and then they discharge you."
>
> Patient insight

2.6.7 People's experiences of learning life skills while receiving inpatient CYPMHS were inconsistent. While some young people did feel prepared, there were many who did not. A key aspect affecting their preparedness related to the impact on their education, and the ability to learn key life skills.

2.6.8 The investigation heard how the approach to family involvement in the care of young people changes when they reach 18. Where someone was under 18 families and carers usually felt informed and were encouraged to be involved in, and were able to contribute to, their child's support. However, once a young person reached 18, the investigation heard that this approach often changed. On reaching 18, a young person has responsibility for their own care, and the level that families and carers remain involved depends on the wishes of the young person.

> "I had no knowledge of what [the patient] was doing, I had no involvement in care as her mother because [the patient] was 18. On the CAMHS unit they would tell me. When she went to adult services, I did not know."
>
> Family insight

2.6.9 Staff described that it was difficult to keep families and carers involved when patients reached 18 without breaking confidentiality: "There can be a mismatch between what parents and carers want, and what the patients want." Once people reach 18, families and carers can feel disempowered. The investigation heard that

this can pose challenges to relationships and family dynamics. A previous investigation report, ‘Care delivery within community mental health teams’ (Healthcare Safety Investigation Branch, 2023) has highlighted these issues.

2.6.10 The investigation heard that staff try to prepare families and carers for a distinct change in approach to their involvement when young people are likely to need mental health care beyond their 18th birthday. They described that it can be very hard for families and carers and a “shock to the system”.

2.6.11 In addition to the safeguarding issues discussed in section 2.4, families and carers described some specific considerations relating to their continued involvement in safety planning for young people, and their ability to mitigate risks.

2.6.12 Families and carers described how young people had been discharged from inpatient CYPMHS on reaching transition age as they did not meet the thresholds for inpatient AMHS. These young people were discharged into the community, often to live in the family home. However, many families and carers described not being made fully aware of their loved ones needs and risks, both at discharge from inpatient CYPMHS and by community AMHS services during their ongoing care. Families and carers therefore felt “in the dark” and unable to support their children fully, or keep them suitably safe from harm.

> “Had I have known the risks I could have made changes to the house, but I was not informed. Luckily she didn’t do it in this house.”
>
> Family insight of patient who died by suicide

2.6.13 In summary, the investigation learned that the approach to family involvement in young people’s care can change overnight when they reach 18. Families and carers felt disempowered and unable to contribute to the degree that many felt was appropriate. Staff acknowledged that these changes were difficult for families and carers; however, for young people turning 18, the level of family involvement was their decision in line with their new rights as an adult.

2.7 Patient involvement in service design

2.7.1 During visits to providers the investigation explored how services are evaluated, and how this then drives improvements. Providers, and provider collaboratives, described a number of different ways this was carried out by using the experiences and feedback from patients, their families, and carers – referred to in this section as experts by experience (EBEs).

2.7.2 One provider told the investigation that EBEs can meet with a trust chief executive officer and chair to speak about their experiences. This would then enable the trust's senior management to have ownership and oversight for driving improvements in the care for young people.

2.7.3 The investigation heard that not all feedback was specific to individual providers' services, with many experiences relating to system partners or to the integration of services, for example local authorities and the sourcing of appropriate placements.

2.7.4 Providers' approaches varied, with some proactively seeking feedback from EBEs at different stages. For example, one provider described how their service user feedback went to the LPC governance meetings, and this also went to ICB meetings, which could be escalated to a regional and national level if required. In other providers, EBE feedback was described as being used much more at the local level, and reliant on the approach of individual staff rather than being integrated into governance. It was described that the "family and patient voice regarding experiences needs to become embedded" in consistent day-to-day improvement practices.

2.7.5 Staff said that "co-production of services is paramount" and that "providers and patients share many values, but speak different languages". Arranging mechanisms to bridge the language gap, to enable a shared understanding of challenges which can then drive improvements, was considered key.

2.7.6 The investigation visited an inpatient CYPMHS provider where several EBEs who had previously received care as inpatients were now working on the wards as staff. Patients and the EBEs described benefits in being able to bridge the gap between patients receiving care and clinical staff providing care. Patients described the EBEs as allies who they could look to for advice and aspects of advocacy.

2.7.7 EBEs also described how they could provide a "patient's perspective", from someone who could provide a more considered view and was in a "better place mentally and physically" than someone currently receiving inpatient care. This

could be for clinical care, environmental risks, ward and room design, and improvement programmes. Staff described immense value from having EBEs working alongside them to support the delivery of patient-centred safe and effective inpatient mental health care.

2.7.8 In summary, the investigation learned that there were examples of provider-level mechanisms that enabled EBEs to support improvements in care and influence positive outcomes. However, on exploration, the investigation found fewer examples of transition-specific feedback being captured and used. Where it was, it was mainly captured when transitions happened from inpatient CYPMHS to AMHS within the same provider, as it fed into the provider's internal governance practices.

2.8 Regulatory considerations

2.8.1 During observational visits, and through engagement with stakeholders, the investigation learned that regulatory activities influence the timing of inpatient CYPMHS transitions.

2.8.2 During a visit to an inpatient CYPMHS for eating disorders the investigation heard about a young patient who "had to go as they reached 18" as their place of care was only regulated by the Care Quality Commission (CQC) to provide services for people up to the age of 18. The investigation also regularly heard that "if someone over 18 is on a children's ward, or if someone under 18 is on an adults' ward" this must be notified to the CQC. These were examples of regulatory pressure described by providers, which were factors that contributed to age-based transitions.

2.8.3 The investigation visited a residential home that provided care for people aged 17 to 24 with eating disorders. The home was registered with the CQC as 'caring for adults under 65 years' and 'caring for children 0-18 years'. The home therefore spanned both 'children' and 'adult' services and could be flexible in its approach to the transition point. It was described that there was no requirement to report over and under 18s being in the same care environment because its registration status with the CQC "allowed for flexibility".

2.8.4 Some facilities were regulated by both the CQC and Ofsted (the Office for Standards in Education, Children's Services and Skills). A residential home visited by the investigation provided transitional recovery services for young people with mental health problems. Staff described that the home "did not quite fit nicely" into the category of either health facility or children's home, and was also responsible for ensuring young people received education.

2.8.5 The investigation was told that in the past the residential home had a usual age range up to 21 years old, but that "this became problematic with Ofsted regulation" due to safeguarding considerations for the home's younger patients. Ofsted was considered by the provider to be a key driver for the need to transition people at 18, to safeguard other young people who were still receiving care at the home.

2.8.6 Staff described that an Ofsted inspection identified challenges with patients not receiving education to an appropriate level. It was described that the residential home "would approach the mental health care as the priority, and then support suitable education". Staff described that "without addressing trauma and its impacts as the priority, there is a likelihood that effective education would be impacted". This was described as an example of where health and education regulations and requirements could "pull in different directions".

2.8.7 In summary, the investigation learned that there were perceptions and aspects of regulations and regulatory activities that influenced how and when providers initiated and carried out inpatient transitions for young people. These related to the registration status of services, notification requirements due to the age ranges of young people being cared for, and the challenges in providing mental health care alongside education and the associated 'dual regulation' considerations.

2.9 Legislated additional support

2.9.1 The investigation heard about variation in the support young people in inpatient CYPMHS receive when they transition to adult services. Examples were given of young people who were entitled to receive additional support through Section 117 aftercare, which may be provided for those who have been in hospital under certain sections of the Mental Health Act.

2.9.2 The investigation heard it was difficult when there were not clear boundaries and responsibilities between services and providers, such as with Section 117 aftercare, because then "no-one wants to pick up ongoing care". A number of staff told the investigation that they would like to see Section 117 aftercare applied to all young people who have received inpatient mental health care, not just to those detained under the Mental Health Act. It was described to the investigation that this would drive "joint working as a duty, not just a nicety" and would make it easier to get the organisations and providers that needed to be involved to work together to support positive transitions.

2.9.3 The investigation also heard about young people in inpatient CYPMHS who are ‘children in care’, where to meet their needs and mitigate risks the young person is placed in the care of their local authority. Although a young person will stop being ‘looked after’ when they reach 18, local authorities are required to support them until they are 25. Examples of local authority approaches to planning and support for young people being discharged from inpatient care on reaching transition age varied significantly, many being dependent upon whether they were ‘children in care’ or not. For example, as described in section 2.5, some young people reaching 18 had been discharged homeless; those who have been ‘children in care’ are protected from this.

2.9.4 The scope of this investigation was inpatient mental health care; however it is widely recognised that within inpatient mental health environments there are many patients who have additional complex needs and circumstances. The investigation heard about the use of care, education and treatment reviews (C(E)TR) to support people with learning disabilities or autism to receive appropriate care and support, including during discharge planning, to ensure community care can meet their needs. The investigation also heard that young people who have Special Education Needs and Disability (SEND) may be assessed for an education, health and care plan (EHCP). The EHCP outlines the support required to meet a young person’s education, health and social care needs until they reach the age of 25.

2.9.5 The investigation heard about the experience of a young person with mental health problems and learning disabilities who would soon be turning 18. The person had very complex needs and required enhanced support. Challenges in finding a suitable placement were anticipated and, as the young person did not fit into a “standard box”, a “new box” needed to be created – that is, a bespoke package. Initial attempts to source a suitable placement were described as “a struggle”, and one provider would not take the young person because of specific swallowing risks. Determining who was ultimately responsible for finding a suitable placement was described as the responsibility of the trust-based social worker, but doing so required support across many system partners, and crossed different legislation.

2.9.6 In summary, in the context of inpatient CPYMHS transitions, understanding which type of support, for which patients, under which aspects of legislation, was a complex process. It depended on factors such as whether the person had been detained under sections of the Mental Health Act, was a 'child in care', or had a learning disability, is autistic, or had special educational needs. Young people reaching transition age in inpatient CYPMHS who did not meet the requirements of legislation for continued care and support could be, and were, discharged without appropriate support for their ongoing needs.

3. National challenges impacting on transition from inpatient children and young people's mental health services

This section of the report explores national considerations that relate to the local evidence gathered about transitions from inpatient children and young people's mental health services (CYPMHS) to adult mental health services (AMHS).

The national considerations are discussed in the following sections:

- Key drivers of age-based inpatient CYPMHS transitions
- Supporting the transition process
- Inpatient mental health service opportunities and workforce implications
- Previous investigations
- Closing comments.

3.1 Key drivers of age-based inpatient CYPMHS transitions

3.1.1 The investigation identified a range of key drivers that contribute to age-based transitions from inpatient CYPMHS. These are considered in the following sections:

- Safeguarding in inpatient CYPMHS settings
- Service specifications, commissioning and funding
- Criteria, thresholds and data
- Defining children, young people and adults
- Oversight and regulation.

Safeguarding in inpatient CYPMHS settings

3.1.2 As described in section 2.4, staff and providers considered safeguarding to be a key driver for the need to transition young people from inpatient CYPMHS.

3.1.3 The investigation reviewed national safeguarding guidance (HM Government, 2023; NHS England, 2024b, Department of Health and Social Care, 2014), none of which included content or directions which would preclude young people over and under 18 receiving care in the same inpatient environment or having blanket

safeguarding approaches placed upon them on turning 18. However, moving patients to adult services or adopting blanket safeguarding approaches had become custom and practice across many inpatient CYPMHS.

3.1.4 When engaging with NHS safeguarding specialists and discussing guidance, the investigation heard that safeguarding is not about limiting interaction between over 18s and under 18s, and therefore should not be a key driver for age-based mental health service transitions for young people. Safeguarding is about protecting people from abuse, exploitation and discrimination, which could be carried out by people either over or under 18, on people over or under 18.

3.1.5 The investigation discussed safeguarding considerations for young people in inpatient CYPMHS with national stakeholders across health, social care and education. Stakeholders described that there were areas in healthcare, and other sectors, that were able to manage the safeguarding complexities associated with having over 18s and under 18s in the same environment.

3.1.6 The investigation heard that there are facilities that provide accommodation for young people with special educational needs and disabilities that have an age range of 16 to 25. The investigation also visited residential homes for young people with eating disorders that had age ranges of 16 to 25.

3.1.7 Outside of healthcare settings there are examples of over 18s and under 18s being accommodated in boarding schools, where students are not made to leave when they have reached 18. The investigation heard from a member of the Royal College of Psychiatrists that “safeguarding experiences we have heard refer to custom and practice, and have no stipulation in law. There is nothing to stop professionals acting flexibly and professionally”.

3.1.8 There was, however, a consistent and strong voice across many staff in inpatient CYPMHS that having over 18s and under 18s on the same ward was a concern. As described in Section 2.4, a specific safeguarding concern heard across providers was that of sexual safety, this was echoed by several national stakeholders. Sexual safety on mental health wards has been acknowledged and recognised as a specific challenge, with ‘sexual safety standards’ for inpatient services being produced (National Collaborating Centre for Mental Health, 2020). The standards found that ‘addressing sexual safety and effectively managing sexual behaviours on mental health wards is complex’ and that training ‘needs to be tailored to the setting and the needs of the people being supported, for staff to effectively support their sexual safety. For instance, a children and young people’s inpatient service should provide training relevant to adolescence and sexual

development, including gender identity and exploration of sexuality.' Any change in age boundaries of inpatient CYPMHS or AMHS, would require appropriate consideration in sexual safety training requirements for staff.

3.1.9 In providers that did support more flexible transitions, there was evidence of successful and safe individualised approaches to the mitigation of safeguarding risks for young people who reach 18. These included not applying restrictive blanket approaches, and continuing to assess people based on individual behaviours and risks, for example.

3.1.10 The perception of safeguarding challenges regarding over 18s and under 18s receiving mental health care in the same setting is a key driver for age-related transitions, which do not support positive outcomes. These perceptions were based on custom and practice, not legislation or policy. This investigation found that this manifested in a culture of 'we can't because', rather than 'we can if'. However, it is recognised that staff are required to balance changing and variable patient risks with the need for flexible, patient centred care.

3.1.11 Implementing blanket safeguarding approaches overnight for young people turning 18 affects their wellbeing and ongoing mental health. To enable a flexible, developmentally appropriate and needs-based approach to transitions providers and staff would need to be informed, trained, confident and competent to move from blanket to individualised safeguarding approaches.

HSSIB makes the following safety observation

Safety observation O/2024/053:

Providers of inpatient children and young people's mental health services can improve patient safety by ensuring there is not a blanket approach to safeguarding mitigation measures based on a person's age, and that mitigation measures are individualised and based on behaviours and risks.

Service specifications, commissioning and funding

Service specifications and commissioning

3.1.12 Since the 'NHS mental health implementation plan' (NHS, 2019b), which supports the NHS Long Term Plan (NHS, 2019a), the service specifications for 'child and adolescent mental health services (CAMHS T4) [CYPMHS]' published by NHS

England in 2018 have not been updated. Much of the content of the service specifications conflicts with the aim of supporting a developmentally appropriate needs-based transition, rather than an age-based transition, only allowing for very limited flexibility. For example, the specifications document states: ‘A young person who turns 18 during an admission to inpatient care and who still requires admission should be transferred to an adult service’ (NHS England, 2018).

3.1.13 The CAMHS service specification has a section relating specifically to ‘Exclusion criteria’, of which one is the person being ‘Over 18 years of age (unless this is for a short time period to complete an episode of care…)’ (NHS England, 2018). In addition, regarding the ‘Post-18 care pathway’ it states: ‘There must be a transition policy in each provider to transfer young people when they reach 18th birthday.’

3.1.14 NHS England published the ‘Commissioning framework for mental health inpatient services’ (NHS England, 2024c). Much of the content aligns with the ambitions of the NHS Long Term Plan in how services can support positive outcomes for patients by being ‘personalised’ and that ‘barriers to delivering the right care and support at the right time need to be removed’. This commissioning framework is specific to inpatient AMHS provision but shows an approach to adult mental health care being more needs led, rather than diagnosis-led. This is echoed in the culture of care standards regarding ‘inpatient settings everyone wants to experience’ (NHS England, 2024a), and aligns with supporting safer transitions from inpatient CYPMHS to inpatient AMHS.

3.1.15 The investigation did not identify any comparable commissioning guidance for inpatient CYPMHS published since the NHS Long Term Plan. Guidance from 2015 (NHS England, 2015) that supports ‘commissioners responsible for funding transitional services for adolescents with mental health problems’, states: ‘In some areas, transition takes place at 16, in others 18, in still others during the 19th year, and in some areas services are commissioned for 0-25 year olds.’ The transition from CAMHS [CYPMHS] to AMHS is ‘subject to extreme local variation, with regard to age, and effectiveness.’ and has been described as a ‘postcode lottery’ (NHS England, 2017).

3.1.16 Although the NHS service specifications and commissioning guidance have not been updated for inpatient CYPMHS, there was evidence of several providers being innovative and “pushing the boundaries” for more flexible care which is more closely aligned with the ambition of the NHS Long Term Plan and national guidance. These providers showed the investigation evidence that they were enabling more positive outcomes for young people. However, rather than placing the onus on

providers and commissioners to "push boundaries", service specifications and commissioning guidance that drive the changes needed to support evidence-based positive outcomes for young people would enable a more consistent approach across England. Guidance states that services should have 'a clear procedure to prepare young people for the transition from health and care services designed for children and young people to adult health services, consistent with current NICE guidance' (Office for Health Improvement and Disparities, 2023).

3.1.17 In summary, NHS mental health commissioning guidance and mental health service specifications for CYPMHS do not support developmentally appropriate, needs-based transitions for young people, aligned to positive outcomes. Some providers have developed more flexible arrangements, where others have not. This manifests in variation and an inconsistent approach across providers in England. NHS England launched an inpatient quality transformation programme in 2022, with inpatient CYPMHS in scope. As well as reviewing models of care (Sect 3.3) the investigation was informed that new CYPMHS service specifications are in development, which aim to take a person-centred, needs based approach to transitions, supporting completion of episodes of care in hospital, regardless of age.

Funding

3.1.18 As explored in section 2.2, funding was widely considered to be a driver for age-based transitions when it was aligned to services that had rigid age thresholds. Consequently, funding rigidity becomes a key determinant in the outcomes for young people whose needs have not changed, but are transitioned on reaching a "cliff edge age".

3.1.19 The investigation heard across several national stakeholders that to enable a more flexible approach to commissioning, a more flexible approach to mental health funding would be needed that spans traditional CYPMHS and AMHS age boundaries. Without more flexible funding, any changes to service specifications and commissioning guidance to support more flexible transitions would be difficult to deliver.

3.1.20 To enable a developmentally appropriate and needs-based approach to transitions from inpatient CYPMHS to AMHS, service specifications, commissioning guidance and funding flexibility are needed. A holistic approach to transitions should be supported; healthcare guidance regarding transitions should appropriately consider education and social care (see section 3.2). There should

also be consideration of any challenges associated with delivering mental health care in dual regulated settings, and closer alignment of criteria and thresholds across CYPMHS and AMHS, as discussed later in this section.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/047:

HSSIB recommends that NHS England reviews and updates its inpatient children and young people’s mental health services specifications and commissioning guidance to ensure they support developmentally appropriate, needs-based transitions. Any changes to service delivery will require a review of funding lines to enable successful implementation.

Criteria, thresholds and data

3.1.21 As discussed in section 2.5, the investigation heard the significant impacts that different criteria and thresholds across inpatient CYPMHS and inpatient AMHS contributed to in relation to driving age-based transitions, and the effect these had on outcomes. The description of thresholds was often subjective, and not clearly defined in local guidance to support patients, families and carers, and staff with a clear understanding of differences across inpatient CYPMHS and inpatient AMHS.

3.1.22 The Royal College of Psychiatrists states:

‘Within adult mental health services, unless the young adult [18 to 25] meets the threshold for use of the Mental Health Acts, there is no remit to provide assessment, diagnosis or treatment if they do not request it and attend appointments offered.’ (Royal College of Psychiatrists, 2022).

However, the investigation heard that even if treatment was requested by a patient, such as for ongoing inpatient care when they had reached a specific transition age, the difference in thresholds for adult care often meant this was not possible.

3.1.23 In a qualitative study, Appleton et al (2020) stated: ‘The most commonly identified barrier to the continuity of care was young people being judged as not severely ill enough to access ongoing care.’ For many young people reaching transition age this does not mean the severity of their illness has changed, only that the criteria that it is assessed against has stricter thresholds.

3.1.24 Statutory guidance on discharge from all mental health inpatient settings states that health and local authority social care partners should ‘support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital’ and that this applies to ‘people being discharged into the community, whether to their home or other accommodation in the community including temporary step-down services, supported accommodation or a care home’ (Department of Health and Social Care, 2024). The guidance continues: ‘A person is considered Clinically Ready for Discharge (CRFD) when the multi-disciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.’ The NHS culture of care standards states that the purpose of inpatient care is ‘for people to be consistently able to access a choice of therapeutic support, and to be and feel safe’ (NHS England, 2024a).

3.1.25 If a young person in inpatient CYPMHS reaches a stage in their recovery where their needs can be met in the community, the CYPMHS multidisciplinary team will conclude that they are clinically ready for discharge and they will be discharged from inpatient care. For a young person reaching transition age who is not clinically ready for discharge, the inpatient CYPMHS will refer them to AMHS for assessment of their future care needs.

3.1.26 If AMHS assess that the young person’s needs meet the threshold for inpatient care, the young person will transition to inpatient AMHS. If AMHS assess that the young person does not meet the threshold for inpatient care they will conclude that the young person is clinically ready for discharge and instruct CYPMHS to discharge the young person to the community.

3.1.27 Discharge from inpatient care for young people who have not been deemed clinically ready for discharge by inpatient CYPMHS, but have reached ‘transition age’, often happens because of differences in thresholds between inpatient CYPMHS and inpatient AMHS. The investigation heard from staff that these young people’s mental health problems may not have changed – if they had, the CYPMHS would already have considered them clinically ready for discharge and they would have been discharged. A young person’s mental health care needs may not have changed, but the goalposts for inpatient care for their mental health problem have moved.

3.1.28 The investigation approached NHS England to understand further how criteria and thresholds for mental health care are derived, considered and implemented. NHS England stated that outside of the Mental Health Act, there is no guidance or national policy that specifies criteria and/or thresholds. Comparison

between the differing service specifications for CYPMHS and AMHS can provide some indication of where there are differences and gaps. Individual services that are commissioned determine the services they offer, and the thresholds required to access them.

3.1.29 Closer alignment of criteria and thresholds across CYPMHS and AMHS would help to close the gaps that young people can currently fall through. This would mitigate an identified barrier to continuity of care and support a more all-age approach to mental health care delivery, aligning with NHS England's ambitions and new models of care. A more seamless and safe transition from childhood to adulthood would be supported if criteria and thresholds, including those relating to severity of illness, were more closely aligned across CYPMHS and AMHS. (See safety recommendation **R/2024/047** regarding the development of new service specifications for inpatient CYPMHS.)

3.1.30 During visits to providers and engagement with national stakeholders, the investigation heard "that the numbers of young people that transition from inpatient CYPMHS to inpatient AMHS is low". However, the investigation was unable to identify a national data source that would enable further understanding of how many young people are discharged because they have been deemed clinically ready by their CYPMHS, or how many are discharged from inpatient care because they reach transition age and do not meet the different thresholds for inpatient AMHS.

3.1.31 Such data could enable key oversight of lead provider collaborative commissioned services by NHS England, and provide insights into the outcomes for young people who have received inpatient CYPMHS. It could enable further understanding of how many young people have not received inpatient AMHS for their ongoing needs because of a difference in criteria and thresholds – that is, an age-based rather than needs-based discharge, which is associated with poor outcomes. This data could be used to inform improvements to support patient safety.

HSSIB makes the following safety observation

Safety observation O/2024/054:

Children and young people's mental health services and adult mental health services can improve patient safety by having more aligned thresholds and criteria to access care, and improved data sources to inform decision making. This is to support closer alignment of services and mitigation of gaps, and to enable more seamless care pathways from childhood to adulthood.

Defining children, young people and adults

3.1.32 To determine definitions of the terms 'children', 'young people' and 'adults', the investigation initially reviewed UK legislation, across several Acts of Parliament, as well as international and professional definitions contained within guidance (see appendix 2). It found that health, education, social care and the criminal justice system may use the terms 'children' and 'young people', but they are not used consistently to refer to the same age ranges or for the same purposes, with young people being defined as anywhere between 12 and 25 years of age across different legislation and guidance.

3.1.33 There is significant inconsistency between, and conflicting understanding of, the age ranges signified by the use of the terms 'children' and 'young people'. This inconsistency is found across aspects of legislation, guidance, and NHS policy.

3.1.34 For example, many inpatient CYPMHS are for patients up to 18 years of age. They are therefore for children and do not encompass the full age range of 'young people' as defined by the NHS (up to 25 years). Using the term 'young people' in the definition of a service that does not encompass the age range for young people can cause confusion. It can also cause frustration when young people (aged 16 to 25) are transitioned from a service that is notionally for young people when they have reached 18.

3.1.35 In addition, a person who is 17 can be defined as a child or young person while in inpatient CYPMHS, but as an adult if they go to their local adult emergency department, which is for over 16s.

3.1.36 Inconsistency between definitions of 'children', 'young people' and 'adults' creates the potential for confusion, misalignment and gaps in the delivery of healthcare services. This inconsistency applies to mental health care, as detailed within this investigation report, but would also apply to physical health. Alignment between mental and physical health for age definitions and age appropriate services would mitigate disparity across settings.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/048:

HSSIB recommends that NHS England reviews and revises its guidance and policies to ensure consistency regarding the language used for age ranges (for example children, young people, young adults and adults). This is to support a consistent approach to healthcare delivery that aligns services and mitigates gaps.

3.1.37 A consistent approach across government in defining children, young people and adults would support cross-sector alignment of services for young people during transition from childhood to adulthood – see appendix 2, section 3.2 and safety recommendation **R/2024/050**.

Oversight and regulation

3.1.38 The investigation considered how regulatory activities, determined by the UK government, support developmentally appropriate and flexible needs-based transitions. This included health and social care regulation by the Care Quality Commission (CQC), and the inspection of education and regulation of children's social care, including children's residential accommodation, by Ofsted (the Office for Standards in Education, Children's Services and Skills).

Care Quality Commission

Notification requirements

3.1.39 As explored in section 2.8, CQC notification requirements in relation to young people were a key consideration for staff and providers, and contributed to decisions about the timing and delivery of transitions. CQC regulations have a notification requirement for 'any placement of a service-user under the age of eighteen in a psychiatric unit whose services are intended for persons over that age where that placement has lasted for longer than a continuous period of 48 hours' (Care Quality Commission, 2009).

3.1.40 There was a strong perception across inpatient CYPMHS that the CQC must be notified if a patient over the age of 18 is in inpatient CYPMHS. This perception was held across inpatient wards for all mental health conditions, and not only for psychiatric wards as set out in the legislation. However, there is no legislated CQC notification requirement for an over 18 being in inpatient CYPMHS, such as when a

young person reaches 18. In effect, there is legislation to notify the CQC if a ‘child’ (under 18) is on an adult ward, but not if an ‘adult’ (over 18) is on a children and young people’s (under 18s) ward.

3.1.41 The investigation met with the CQC to understand this further. It was discussed that there are no formal notification requirements that are legislated in the Mental Health Act to report someone reaching 18 remaining in inpatient CYPMHS; however, there were occasions where informal notifications took place. Relationships between providers and the CQC could be very efficient, and providers did not want to “surprise” the CQC with anything that may be considered contrary to good care delivery. They may therefore let the CQC know if someone in an inpatient CYPMHS was about to, or had, turned 18. This was however an informal notification, rather than formal, and could be the source of some perceptions. The CQC confirmed that there is no legislation or regulation that prevents someone who has turned 18 from remaining on a ward with under 18s.

3.1.42 The CQC told the investigation that they have to ‘distinguish between children and adult services and regulate them separately’. However it was unclear to the investigation how this approach would apply to the services that CQC regulate which span children and adult ages, for example residential homes that provide mental health care for young people from 16 to 25 years of age, or inpatient CYPMHS hospitals that allow flexibility for patients to remain after their 18th birthday.

Inspection activity

3.1.43 During observational visits to providers, and meetings with senior leaders who provide oversight of ‘systems’, the investigation heard that CQC inspections focus on providers, rather than pathways and transitions of care. The ‘Five year forward view for mental health’ (NHS England, 2016) recommended that the CQC ‘should develop regulation and inspection of NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups, beyond the inspection of providers’.

3.1.44 Reflecting stakeholders’ views, a Healthcare Safety Investigation Branch (HSIB) report on community mental health care and transitions noted that the CQC ‘primarily assessed and regulated individual providers rather than considering the care provided across a whole pathway’. This meant that provider ratings ‘may not reflect the quality of transition between services in different providers’. The report described a CQC study that considered how well providers worked together in a system, and stated that this inspection activity approach for CAMHS [CYPMHS] to

AMHS ‘would almost certainly identify gaps in provision and risks to young people who may become lost in the system or disengage’ (Healthcare Safety Investigation Branch, 2018).

3.1.45 The HSIB report made a safety recommendation to the CQC:

‘It is recommended that the Care Quality Commission extend 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.’ (Healthcare Safety Investigation Branch, 2018)

3.1.46 The CQC’s response was that its ‘current approach to inspection is determined by the Health and Social Care Act 2008. We inspect registered providers or locations and do not normally inspect local systems’ and to do so would require a ‘change in legislation’ (Healthcare Safety Investigation Branch, 2018).

3.1.47 The Health and Care Act 2022 gave the CQC ‘new responsibilities to assess whether integrated care systems (ICSs) are meeting the needs of their local populations’ (Care Quality Commission, 2024a). The CQC is now the legislated and dedicated body to provide oversight of integration across health, social care and local authorities.

3.1.48 As part of this the CQC has proposed a number of underpinning quality statements regarding ‘Integration’:

- Safe systems, pathways and transitions
- Care provision, integration and continuity
- How staff, teams and services work together.

3.1.49 The CQC’s proposed assessments for ICSs will cover ‘the functioning of the integrated care system, especially how well system partners are working together to deliver good care and meet the needs of their populations’ (Care Quality Commission, 2024b).

3.1.50 The CQC and National Institute for Health and Care Excellence (NICE) have a memorandum of understanding ‘to ensure, where appropriate, there is alignment between NICE guidelines, interventional procedures, guidance and quality standards, with the CQC's assessment frameworks’ (Care Quality Commission, 2022).

3.1.51 The evidence and findings within this investigation report provide insight into where 'integration' of inpatient CYPMHS and AMHS do not currently align with NICE guidance (National Institute for Health and Care Excellence, 2016a), and where system partners do not always work well together. These insights may support the CQC in developing its practical level assessment activities for ICSs. This would support the identification of poor transitions at regulator level, with the outputs driving change for more consistent and positive patient outcomes.

3.1.52 The CQC told the investigation that there are two routes by which they could commit to assessing the transition of CYPMHS to AMHS, by the Secretary of State for Health and Social Care setting it as a priority for ICS assessments, or if it were specified within an ICS's own strategy and the CQC assess how they were then delivering on it. Should the assessment of the transition from CYPMHS to AMHS rely on specific prioritisation by the Secretary of State for Health and Social Care, or on featuring in an ICS's strategy, then it is feasible that it may not meet either requirement, in which case the challenges highlighted in this investigation report may not be identified, assessed or addressed at regulator level.

3.1.53 The CQC told the investigation that outside of these two routes, CYPMHS to AMHS transitions would need to be considered amongst other assessment priorities, where it 'would not be possible to commit to consistently measure it in every inspection'. It is therefore unclear to the investigation what regulatory levers could be used to consistently and systematically improve the safety of transitions from CYPMHS to AMHS which span systems, that is across health, local authorities, and service providers.

3.1.54 The CQC, while developing new systems and processes for the assessment of ICSs, has an opportunity to work with the Department of Health and Social Care to consider the extent to which transitions from CYPMHS to AMHS should be prioritised during ICS assessments. Subsequently the CQC can develop and embed assessment methodology to support developmentally appropriate needs-based transitions for patients moving from inpatient CYPMHS to AMHS. Although this investigation focuses on the transition from inpatient CYPMHS to AMHS, it is envisaged this would also support community mental health care transitions.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/049:

HSSIB recommends that the Care Quality Commission work with the Department of Health and Social Care to understand prioritisation for assessing transitions in mental health care within Integrated Care System assessments. Any subsequent work should include the development of a methodology to identify the challenges described in the investigation report relating to transition from inpatient children and young people's mental health services, to adult mental health services. This is to improve the safety, quality and consistency of transitions across England.

3.1.55 The CQC told the investigation that if they identified challenges in an ICS that they can make recommendations to them as a result of their assessments but, as ICSs are not 'statutory bodies', recommendations to them cannot be enforced. Therefore, if an ICS is assessed by the CQC as not functioning effectively there is no mechanism for regulatory enforcement action to drive required change and improvement. Although CQC provide an oversight function from their ICS assessment activities, there is no mechanism or framework for holding a specific body to account with associated responsibility or accountability for the performance of an ICS. A House of Commons Committee of Public Accounts reflected a similar concern 'The 'Integrated' element of ICSs as well as their accountability arrangements appear under-developed… It is not clear who will intervene if joint working between the NHS, local government and other partners breaks down' (House of Commons, 2023).

3.1.56 Accountability and responsibility for the integration of systems that span health, social care, local authorities and providers will be considered further in an overarching mental health themed report. This report will consider challenges encountered that span across the Secretary of State for Health and Social Care directed HSSIB inpatient MH investigations.

CQC provider registration

3.1.57 As described in section 2.8, the investigation heard examples where providers considered they were only able to provide care that was within the terms of their registration with the CQC. However, where providers engaged with the CQC, it was often described there was flexibility where appropriate. For example, there was flexibility to reduce an unwarranted transition by admitting someone who is almost 18 directly to inpatient AMHS.

3.1.58 Should future CYPMHS specifications, commissioning guidance and funding support more flexible transitions, then providers will need to react accordingly in the services that they provide. The CQC stated that providers can state who they are providing services for, and they can register this with the CQC; however, they must then demonstrate that they can deliver those services safely. Commissioners and providers therefore have a known route to enabling more flexible transitions, but would need to ensure that their services develop any additional measures for providing safe care, such as ensuring the workforce is trained and competent to provide the services specified. The CQC said that “changes of function” for providers can have quality and safety impacts that take time to overcome; this needs to be acknowledged in any approach to changes in service delivery.

Ofsted

3.1.59 Most inpatient CYPMHS providers that the investigation visited were regulated solely by the CQC. However, as described in 2.8.4 some providers were registered and regulated by both the CQC and Ofsted. These providers were transitional recovery services that accommodated young people in a ‘children’s’ residential home while treating them for mental ill-health or emotional wellbeing needs, such as emotionally unstable personality disorder or risk of self-harm. There are approximately 30 dual regulated providers in England which provide different services, not all of which are related to mental health care provision.

3.1.60 Dual regulated providers could also be responsible for ensuring the delivery of education, unlike most inpatient CYPMHS hospitals where education was outsourced and was the responsibility of a partner provider. The investigation heard challenges associated with being dual regulated; Ofsted was described by providers as being a driver for age-based transitions.

3.1.61 The investigation met with Ofsted to understand its regulatory activities in relation to residential homes that provide mental health care and may also be responsible for ensuring education. Ofsted stated that it does not inspect ‘inpatient care’, but does inspect a ‘home’ that provides care and accommodation which is ‘wholly or mainly’ for children (Ofsted, 2024). It was described that Ofsted regulates the children’s home and the CQC regulates the service.

3.1.62 When exploring how regulatory activity may be a driver for age-based transitions, Ofsted expressed its flexibility regarding age thresholds. Ofsted said that it would not require a young person to transition to adult services when they were 18 as long as the provision remained wholly or mainly for children. Ofsted’s inspection framework for children’s homes states that ‘it is not always right for

them [young people] to leave the children's home by their 18th birthday. It may be in their best interests to stay at the children's home'. Reasons for this may include 'the child is in education and wishes to finish their course' (see section 3.2) and 'there is agreement, including the child's, that they are not yet ready to leave and a focused plan is in place to achieve this' (Ofsted, 2024).

3.1.63 Ofsted said that it recognised that young people may need to stay in 'children's' homes into early adulthood. If this was needed, then the provider would need to demonstrate that there was no adverse impact on other young people at the home. If any young person, regardless of their age, posed particular risks to other young people then the provider would need to demonstrate how this was being managed and mitigated. If it could not be managed safely, Ofsted could restrict the accommodation so that no more young people could live there.

3.1.64 In rare cases where some risks may mean the environment is not safe, Ofsted could talk to the local authorities that have responsibility for the young people in a residential children's home, to understand if there was any additional support available to strengthen provision and support safer care.

3.1.65 Contrary to perceptions heard by the investigation that Ofsted's regulatory activities could drive age-based transitions (see 2.8.5), the investigation determined that age is not a condition that requires a transition by Ofsted. Ofsted indicated that it is supportive of flexible transitions, where service provision remains wholly of fully for children (young people), and the environment remains safe for all residents.

3.1.66 When the NHS develops guidance and policy relating to the provision of inpatient CYPMHS, consideration should be given to NHS-funded mental health care in settings that may be dual regulated by the CQC and Ofsted. Future reviews of inpatient CYPMHS service specifications and/or guidance for commissioners should determine and reflect particular considerations for dual regulated provision (see safety recommendation **R/2024/047**).

3.2 Supporting the transition process

3.2.1 The investigation identified a range of factors that influenced outcomes for inpatient CYPMHS transitions. These are considered in the following sections:

- Flexible approach to transitions
- Integration – health, local authorities, social care and education
- Preparation for adulthood, family engagement, keeping people safe

- Continuation of care.

Flexible approach to transitions

3.2.2 There were inconsistencies across England in how transitions from acute inpatient CYPMHS hospitals were planned and managed. Some providers had a degree of flexibility, allowing young people to remain potentially up to the age of 19 if they were showing recovery, while other providers showed no flexibility and had a rigid cut-off point at 18.

3.2.3 Using 18 as a rigid cut-off age for transitions was considered to have some benefits; however those benefits were for the system, and not for young people. Even where there were rigid age cut-offs for transition, staff recognised that a needs-based, flexible transition would support better outcomes for young people. However, current systems, and the underpinning guidance and commissioning, were unable to support this consistently and effectively.

3.2.4 In the providers and collaboratives where more flexibility had been achieved, there was a clear drive to involve patients and their families and carers (experts by experience, referred to here as EBEs) in the design and transformation of services – far greater than at providers that had a rigid age cut-off. It was considered critical that service design was supported by service users, and young people and their families and carers were central to this. Guidance states that ‘Young people are experts in their own health’ and it is essential that ‘there are processes in place to ensure that young people’s views are included in care planning, governance, service design and development’ (Office for Health Improvement and Disparities, 2023).

3.2.5 There were exemplar sites which could be recognised and used to demonstrate tools and techniques for EBE feedback that have become embedded in governance structures. This could be useful for sites that may be earlier in that journey and whose EBE involvement mechanisms are less well developed.

3.2.6 However, the investigation observed that the EBE feedback used to support system design and transformation mostly came from EBEs who had remained engaged with the system, and had relatively positive outcomes. Taking this further would mean developing tools to gather the feedback of EBEs whose outcomes were less positive and re-engage with those who had disengaged during or after the transition process. This would be a challenge; however, many young people and their families and carers that the investigation spoke with who had poor experiences and outcomes felt that their voices had not been heard.

3.2.7 More flexible, developmentally appropriate and needs-led transitions had more positive patient outcomes. This was evidenced by providers and aligns with national research, data and guidance. By enabling a more consistent approach to flexible transitions across England, with EBE involvement at every level, benefits and positive outcomes for young people, rather than systems, would be prioritised. System benefits could also be realised, such as in mitigating failed placements (3.2.19).

3.2.8 The investigation was also told that there were challenges for transitions in community mental health settings, that were outside the scope of the investigation. These included:

- **Age-based transitions that can overlook individual needs:** Transitions in community settings should also be person-centred and needs-based (and can occur between the ages of 16 and 25), it was reported that these principles do not apply consistently across England.
- **Differences in eligibility criteria and service thresholds:** It was reported that young people can face different thresholds/eligibility requirements between community CYPMHS and AMHS, leading to waits and gaps in care.
- **Changes in communication and care approaches:** Community CYPMHS clinicians actively engage with families and carers and schools to support the needs of young people. Families and carers often feel central to care planning. However, it was reported that young people transitioning to AMHS in the community can find challenges in adjusting to a service where they are expected to take more responsibility for their care, and other stakeholders are less involved.

Integration – health, local authorities, social care and education

3.2.9 The investigation heard overwhelmingly across the mental health landscape about the challenges associated with delivering an integrated approach to transitions from inpatient CYPMHS across healthcare, local authorities, social care and education. Integration across these key influencing stakeholders in young people's lives, and a holistic approach to transition from childhood to adulthood, are essential in supporting positive outcomes and mitigating safety risks.

3.2.10 The investigation report '[Mental health inpatient settings: out of area placements]' (Health Services Safety Investigations Body, 2024) discussed the need for seamless integration between healthcare, social care and local authority social housing services to support inpatient flow and facilitate efficient discharge. It identified that healthcare, social care and local authorities operate to different laws,

regulations and business processes, making integration very challenging, including where a single healthcare provider has to navigate a complicated system that may involve several ICBs and local authorities. The investigation identified the lack of integration across healthcare and local authorities as a significant factor that impacts people receiving inpatient mental health care. The investigation made a safety recommendation to the Department of Health and Social Care to create a proposal that reviews the integration challenges. This investigation report does not aim to repeat the findings of the out of area placements report, but this section will discuss similar aspects that are specifically relevant to transitions from CYPMHS.

3.2.11 This investigation identified that when young people in inpatient CYPMHS, or in residential homes that provide mental health care, were approaching transition age there were challenges in bringing services together in an integrated way. CYPMHS might want to start planning for a young person reaching 18 and this could require support from social care or a local authority. Enabling effective planning to take place could require early engagement from local authorities and adult social services, and potentially social housing, alongside community AMHS, plus any third sector organisations such as drug and alcohol services. Local authorities 'should be involved in transition planning led by another organisation, for example a child and adolescent mental health service [CYPMHS], where there are also likely to be needs for adult care and support' (Department of Health and Social Care, 2014).

3.2.12 Early engagement from adult social services and local authorities was inconsistent. It was often described as being dependent on the approach of individual staff and influenced heavily by capacity and resource challenges, creating inconsistency across England. Some adult social services considered it outside their remit to engage with children (under 18s) and were not resourced for it, even though this would support effective and safe transitions.

3.2.13 Appropriate engagement was often described as taking place just before, or even as, a young person was turning 18, which did not allow sufficient time for effective planning. This was shown to impact the ability to find appropriate placements for young people at the point of discharge and had resulted in inappropriate placements. This did not support good transitions or positive outcomes.

3.2.14 Planning for transitions should begin early, with many providers' guidance stating that it should begin a minimum of 6 months before a young person reaches their 18th birthday. However, effective planning cannot take place in silos and requires a joint and integrated approach, as young people's lives are influenced by their health, social care, and education needs.

3.2.15 When young people are discharged from inpatient CYPMHS because they have reached a transition age, this investigation has shown that often their needs will not have changed, and therefore they may be vulnerable and require support. The responsibility for ownership of the holistic transition was however difficult to determine. This issue has been raised in a Local Government Association paper, which says that ‘The needs of young people are not met when, in order to be provided with a service, they have to strictly meet the requirements of either the health or the social care categories’. It goes on to say that vulnerable people ‘require simultaneous – and ideally collaborative – support from both sectors (health and social care services) and unless there is a clear provision for that, they risk falling through the cracks of the system’ (Local Government Association, 2021).

3.2.16 The investigation heard about the impact on young people who were transitioned from inpatient CYPMHS to inappropriate placements that did not meet their continuing mental health needs or mitigate their continuing risks. Reasons for this included lack of sufficient planning, contributed to by mental health providers and wider system partners, including social care. An investigation report into the death of a young person, where a rigid age-based transition was a contributory factor, stated that the place they were transitioned to for inpatient AMHS was ‘an available environment, not an appropriate environment’.

3.2.17 National stakeholders described that inappropriate placements can occur where young people are placed in “unregulated” accommodation, for example some supported living arrangements. Supported living ‘on the whole is not regulated’ (Social Care Institute for Excellence, n.d.). However, if personal care is provided, such as mental health support, supported living settings are regulated by the CQC.

3.2.18 The investigation heard that many transitions from inpatient CYPMHS happened very quickly, and the placements young people went to may have only just been established and commissioned. In this scenario it was described that even if the care setting had been recently registered with the CQC, it may not have had an inspection that assesses its ability to provide the care claimed. The CQC told the investigation that there are ‘checks and balances in place’ to assess a service upon registration.

3.2.19 Where placements do not meet young people’s ongoing needs, they can fail. Resolving a failed placement was described as highly expensive in terms of money, time and resources. In the most severe cases failed or inappropriate placements have resulted in poor outcomes, including contributing to deaths. Failed or

inappropriate placements therefore add an additional, unnecessary and unwarranted mental health care burden to a health and social care system “where capacity and resources are stretched”.

3.2.20 Many national stakeholders recognise challenges associated with integration among system partners. Even where there is a statutory requirement for aftercare, such integration can be a challenge. Guidance by the Department of Health and Social Care (2024) following an independent review of the Mental Health Act noted that the review ‘highlighted a lack of clarity over who is responsible for arranging the provision of care for people subject to section 117 aftercare under the Mental Health Act’. Patients with ongoing and complex mental health needs who lack community or family support may face higher risks if aftercare planning is insufficient, plans should be established to prevent relapse or crisis following discharge.

3.2.21 Within the Mental Health Act review (Department of Health and Social Care, 2018) there was a recommendation that any child or young person admitted to a mental health facility is regarded as a ‘child in need’, and therefore able to access additional support on discharge. This was echoed by several national stakeholders across health, social care and education. The recommendation was not accepted by the government because ‘the Children's Act already covers children or young people [under 18] who are in need due to mental health needs or related issues’ and ‘health services should refer cases to children’s services where they believe there is a risk to that child's health or development’ (Department of Health and Social Care, 2021a).

3.2.22 However, it is unclear how young people who were not detained under the Mental Health Act and have been discharged because they have reached 18 would be supported as a duty. They fall through the cracks of legislation and systems; they are not covered by the Children Act 1989 as they are no longer under 18, and they are not entitled to Section 117 aftercare as they were not detained under the Mental Health Act. Overnight they become an ‘adult’ and although they gain ‘rights’ they also lose ‘protections’.

3.2.23 Young people discharged from inpatient CYPMHS have to navigate many services across a complex system that have separate legislation, funding lines, responsibilities and agendas. NHS Providers published a report (2020) that identified that the split in the commissioning of health and social services can lead to disjointed and fragmented care for people. There is no single organisation, or role, that has been given, or takes, responsibility and accountability across health,

social care, local authorities, or education for young people transitioning from inpatient CYPMHS due to reaching transition age, and more generally from their childhood to adulthood.

> "Who's in charge? Identifying who is in charge and who has responsibility for transitions is absolutely key. Both from a physical location and continuity of care perspective."
>
> National stakeholder insight

3.2.24 Transitions from inpatient CYPMHS are not aligned with the academic year, with many examples heard where on reaching inpatient AMHS there was no support for young people to continue their education, and they missed key exams. Some were supported to remain in inpatient CYPMHS until they were 19 where they could complete their academic year; however, others were not. The impacts of this were significant, lifelong and considered to impact their future potential.

3.2.25 Statutory guidance states:

'The law requires all young people in England to continue in education or training until at least their 18th birthday, although in practice the vast majority of young people continue until the end of the academic year in which they turn 18.' (Department for Education, 2024)

The Mental Health Act and NICE transitions guidance (National Institute for Health and Care Excellence, 2016b) also supports this for mental health inpatients, but only for people under 18. However, this does not account for young people in inpatient CYPMHS who have reached 18, have not completed their final academic year, and are transitioned due to reaching 18.

3.2.26 The investigation did see many children and young people receiving excellent educational provision while in inpatient CYPMHS, but this did not continue on transition to AMHS. The Local Government Association has stated:

'Transitions from childhood to adulthood is a difficult time for everyone, but it is also a crucial period that can define personal development and life opportunities as an adult. The challenges related to this transition are even more pronounced for young people with mental health difficulties, who are likely to need additional support.' (Local Government Association, 2021)

3.2.27 Statutory guidance (Department for Education, 2024) states that local authorities have a duty to ‘secure enough suitable education and training provision to meet the reasonable needs of all young people in their area who are over compulsory school age [16] but under 19’ and ‘identify and resolve gaps in provision’ and ‘agree ways of working with partners such as ‘health services (including mental health services)’. Guidance regarding alternative provision (Department for Education, 2013) states that local authorities are ‘responsible for arranging suitable education for … pupils who – because of illness or other reasons would not receive suitable education without such arrangements being made’; this is however only for up to 16 years of age.

3.2.28 The investigation spoke with a representative of the Department for Education who described how it issues education guidance and funds education via local authorities. It is the duty of local authorities to ensure that education provision takes place; however, the Department for Education has no jurisdiction on how local authorities carry out that duty.

3.2.29 The investigation spoke with the Association of Directors of Children’s Services to understand how local authorities carried out their duties regarding education for young people in mental health inpatient services. Scenarios were described where the first time a local authority would know that someone from their area was in inpatient CYPMHS was when they receive a bill for the person’s education, especially if they have been placed out of area.

3.2.30 It was described that local authorities would pay for the education provision for young people in inpatient CYPMHS because there is a statutory requirement to do so, but if a person turned 18 while in inpatient CYPMHS there was a likelihood that the local authority would not be made aware. Local authorities could also be unaware that the person had been moved to inpatient AMHS where they do not get continuity of education, even though it is the local authority’s duty to ensure education provision. The system was described as “quite fractured” in those circumstances.

3.2.31 It was expressed that enabling young people to stay in a mental health provider that is meeting their educational needs alongside their mental health needs for longer, or at least until the end of the academic year, might be an option, but that local authorities did not have the power to do this.

3.2.32 The investigation spoke with the National Association for Hospital Education. It was described that almost all NHS inpatient CYPMHS are registered as exam centres, due to their obligation to provide education for children of school age, but

this is not the case for inpatient AMHS. A “black hole” was described on a young person’s 18th birthday, where they can be moved to inpatient AMHS and do not have adequate education to meet their needs.

3.2.33 It was expressed that education should feed into a young person’s inpatient CYPMHS needs assessments. For example, such assessments could ask: “What is the risk to a young person losing out on education for their long-term prospects and opportunities, due to transitioning them to a place where they can't access education?” It was described that this was linked to hope for the future: “We should tell young people we are expecting them to get better and recover, and do their exams, that's a really powerful message, but we then need to enable that.”

3.2.34 Young people’s education needs, which are crucial to their ongoing mental health and preparation for adulthood and discharge, are not being met in a consistent way. A contributory factor is inflexible transitions from inpatient CYPMHS where young people were receiving education and aiming towards taking exams, to AMHS where there is no provision for continuity of their education.

3.2.35 Compared to young people in mainstream education, young people in inpatient CYPMHS are disadvantaged in relation to continuity of their education when they reach 18 and are transitioned to inpatient AMHS.

3.2.36 Integrated and effective working across health, social care, local authorities and education is essential for enabling safe transitions for young people from inpatient CYPMHS to AMHS. For people using either CYPMHS or AMHS, the systems they were in are complex but relatively constant. Transitioning across these two complex systems is where challenges are evident. Health, social care, local authority and education organisations do not always work together in a consistent and integrated way to support positive outcomes for young people transitioning from inpatient CYPMHS to AMHS.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/050:

HSSIB recommends that the Department of Health and Social Care works across government to identify opportunities to support closer cooperation between local government, education and health systems for the safe and effective transition of young people into adulthood. This is to ensure alignment, equity of access, and clear responsibility and accountability for

their health, education and social support that spans the ages of 16 to 25. Cross governmental work would be supported by the adoption of consistent language for age ranges of children, young people, and adults.

Preparation for adulthood, family engagement, keeping people safe

Preparation for adulthood

3.2.37 Many families and carers, and young people who were in inpatient CYPMHS, described how preparation for adulthood whilst receiving care could be limited. This could be for transition to inpatient AMHS, or when discharged from inpatient care into the community either at home, in a residential home, or in supported living.

3.2.38 Key aspects of this were education, and being unable to learn key life skills, which was compounded for young people who were in inpatient CYPMHS for extended periods.

3.2.39 The development of children and young people and their mental health 'are affected by factors such as the environments they're raised in, the relationships they build and the experiences they have' (National Society for the Prevention of Cruelty to Children, n.d.). The inpatient CYPMHS environment, and the relationships that young people form and experiences they have in this setting, are significantly different to those of young people in the general population. Addressing this is challenging while young people are receiving inpatient mental health care. The investigation did see examples where this worked well; however, this was inconsistent across providers and services.

3.2.40 Where inpatient CYPMHS were less restrictive, often aligned with patients who were less unwell, the investigation saw opportunities for increased leave, and for offsite activities to gain experiences and encounter situations and environments that young people simply could not get in the inpatient environment. These were considered key for young people's development into adulthood, and a key aspect of providing therapeutic care. Therapeutic care is explored in the HSSIB (2024b) investigation report 'Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings' and will be explored further in a future HSSIB report on learning from deaths and near misses in inpatient and community mental health settings.

3.2.41 The investigation heard from young people that more positive outcomes for people who are transitioned to inpatient AMHS, or discharged from inpatient care, would be achieved by ensuring they are supported to learn key life skills for the next stage of their mental health care, and to prepare for their future life.

3.2.42 The investigation heard many examples from patients and their families and carers where they were not fully prepared for transition from inpatient CYPMHS, and the resulting challenges and impacts. Young people reaching a stage in their recovery where their mental health can be managed outside of inpatient care is positive. However, the transition from inpatient care may put them in circumstances that do not match their emotional and cognitive development, and therefore affect their ability to flourish during the next stage of their life. This will be explored further in the future HSSIB report on learning from deaths and near misses in inpatient and community mental health settings.

3.2.43 Where young people have been discharged from inpatient CYPMHS because they have reached transition age, but where their needs have not changed, or they are not fully prepared for adulthood emotionally and cognitively and with the required life skills, they will need ongoing appropriate support.

3.2.44 In these circumstances families and carers can be a key pillar in providing that support. However, as the evidence has shown, many families and carers felt unable to effectively contribute to their child's care once they had reached 18. Family involvement in the care for mental health inpatients will be considered in more detail in the future HSSIB report on learning from deaths and near misses in inpatient and community mental health settings. However, this investigation identified a number of key challenges specific to the transition from inpatient CYPMHS.

Family involvement

3.2.45 When young people reached 18, there was a change in providers' approach to communication with families and carers. Families and carers felt cut out and disempowered, both when their children had gone to inpatient AMHS, and when they had been discharged from inpatient CYPMHS to community AMHS.

3.2.46 When a young person turns 18, responsibility for their care, and decisions regarding it, moves from parents to the young person, who is now legally an 'adult'. There are also associated additional rights relating to disclosure of care and treatment information for young people who are 18. As set out in law, at 18 the young person makes decisions about how much they wish to involve their family.

3.2.47 This change in legal status means the approach to family involvement and the information the family receives about their child can change overnight, which can create tension between families and carers and staff providing care. A change in family involvement can of course be the wish of the young person and therefore appropriate. However, the investigation heard many accounts where it was not due to a young person's wishes but because a 'blanket approach' to the involvement of a young person's family has been taken. Young people, to the same extent as families and carers, described not knowing there would be changes to the approach.

3.2.48 Many young people and their families and carers said that they had not been told or given sufficient information about how family involvement would change, and that it often came as a shock. Had young people and their families and carers been made aware, there could have been discussion between them, and staff, before applying blanket approaches overnight. This could support more positive outcomes for young people who want their families and carers to continue to be involved; however, they are not consulted sufficiently by staff to understand their wishes.

HSSIB makes the following safety observation

Safety observation O/2024/055:

Mental health providers can improve patient safety by adopting a consistent approach to involving and informing young people, and their families and carers, about how care decisions and the sharing of care information change when young people reach 18. This is to support a consistent and proactive approach to seeking young people's wishes, and enabling a shared understanding between staff, young people and their families and carers.

Keeping people safe

3.2.49 One of the most significant aspects the investigation heard regarding the change in approach to communicating with families and carers was how they could keep young people safe once they had turned 18 and been discharged from inpatient CYPMHS. Families and carers described not being made appropriately aware of the needs and risks of young people being discharged, which meant they were not able to mitigate risks and keep them safe. Safety assessment and management for people discharged from inpatient care was considered in the

HSSIB interim (2024d) report ‘Creating conditions for learning from deaths and near misses in inpatient and community mental health services: assessment of suicide risk and safety planning’ and will be further considered in the future HSSIB investigation report on learning from deaths and near misses in inpatient and community mental health settings.

3.2.50 Therefore, not only are young people discharged from inpatient CYPMHS when their needs have not changed, the effective management of associated and known risks and behaviours to ensure their safety is compromised because families and carers are not given key information. This contradicts a key principle of safeguarding: protecting people from harm. Although this investigation focused on the flow of information to families and carers about keeping young people safe on discharge from inpatient CYPMHS, this also applies to ensuring appropriate agencies have the information they need to keep young people safe. Guidance regarding the sharing of information, including with families and carers, has been published by the Department of Health and Social Care (2021b).

HSSIB makes the following safety recommendation

Safety recommendation R/2024/051:

HSSIB recommends that NHS England provides guidance regarding communication of essential safety and risk mitigation information when patients transition from inpatient children and young people’s mental health services due to reaching transition age. This is to safeguard vulnerable people and may include how to share information with families and carers, health and social care providers, and third sector organisations.

Continuation of care

3.2.51 The approach to the delivery of care changed when young people transitioned from inpatient CYPMHS to inpatient AMHS. The care approach, the environments, and the family ethos were all described as being significantly different.

3.2.52 Inpatient CYPMHS was generally described as being family orientated and nurturing, which many young people, families, and carers cherished. It was described that inpatient AMHS wards did not have the same nurturing approach, and were significantly more intense and pressurised environments, with more risks.

3.2.53 The HSSIB (2024b) report ‘Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings’ considered how therapeutic care is supported and delivered in inpatient AMHS. The future HSSIB report on learning from deaths and near misses in inpatient and community mental health settings will also discuss therapeutic care and environments. The care approach and therapeutic delivery in inpatient CYPMHS and inpatient AMHS was outside the scope of this investigation; however, the impacts of the differences in approach were consistently heard.

3.2.54 There was often insufficient planning for the transition from CYPMHS, which meant young people did not know in advance where they were going to be transitioned to, and even if they did, neither they nor their family would be reliably informed or prepared for the different care approach and/or environment.

HSSIB makes the following safety observation

Safety observation O/2024/056:

Inpatient children and young people’s mental health services can improve patient safety by ensuring that young people, families, and carers are involved, informed and prepared as possible for the young person’s next place of care. This may require increased levels of engagement with partner inpatient adult mental health services to support a full understanding of the differences that will be encountered.

3.3 Inpatient mental health service opportunities and workforce implications

3.3.1 There has been previous consideration of potential models of care for children and young people. The Royal College of Psychiatrists (2022) considered ‘CAMHS extending to 25 years, AMHS continue treating young adults (16/18-25s), a new service for 18-25s and a flexible boundary between services at around age 18’. Each of these potential models discussed would provide a shift in the transition process, but there are a number of specific considerations for inpatient care, as discussed below.

3.3.2 Mental health beds for children and young people are at a premium; the investigation heard repeatedly that inpatient CYPMHS are operating at capacity with waiting lists for admission. NHS England told the investigation that whilst bed

occupancy for children and young people is a challenge in some areas, this varies across the country. Realigning people over 18, such as those in the 18 to 25 age range, to CYPMHS would require a shift in bed numbers and capacity from adult inpatient services to CYPMHS inpatient services, and the flexibility of associated funding lines and service commissioning to achieve this. While it would still require young people to transition at 25, this would be at a period in their lives where they would have usually gone through the significant developmental ages of younger adulthood. The Royal College of Psychiatrists (2022) report also stated that ‘it is untenable to consider that specialist CAMHS could just “see up to 25-year-olds” without a huge increase in funding and expansion of the workforce’.

3.3.3 A new inpatient service for young people aged 18 to 25 would also require a significant restructure in how services are delivered. New wards would need to be set up, and where there is not the current infrastructure for new wards, investment or a reorganisation across providers would be required to enable delivery. As discussed in the Royal College of Psychiatrists report, it would also mean that there would still be a transition at 18, and then a new additional one at 25.

3.3.4 A flexible boundary was described in the Royal College of Psychiatrists (2022) report as ‘working well for the boundary between general adult and older adults services’ and could support a more person-centred approach. This is where the investigation has seen some providers and commissioners already delivering local initiatives, with evidence of more positive outcomes for young people.

3.3.5 The Healthcare Safety Investigation Branch (2018) report on transition from children and young people’s to adult mental health services found that ‘Flexible services are especially important for young people with emotional problems, complex needs, mild learning disability, ADHD and ASDs [attention deficit hyperactivity disorder and autism spectrum disorder], for whom services in adult mental health care are limited’.

3.3.6 Another option that the investigation heard was for under 18s already receiving inpatient CYPMHS to continue to do so in their current provider until completion of their episode of care, potentially up to the age of 25, or until they were fully ready and prepared for transition to adult services prior to 25. However, any young people over (or close to) 18 who require admission for the first time would receive adult inpatient care. The advantages of this approach would be a reduction in the need for transitions as more young people would have completed their episode of care and sufficiently recovered for discharge before reaching 25. This approach could also provide greater flexibility to plan and manage the transition at a developmentally appropriate point during a 7-year window (18 to

25), rather than on a person’s 18th birthday or very shortly after. This would require a flexible funding and commissioning approach across children and young people’s and adult inpatient services.

3.3.7 During engagement with national stakeholders, this approach gained general consensus. It was described that enabling young people to complete their current episode of care without the need for transition would support a more seamless approach to continuity of care that is not afforded by transitions based on rigid age thresholds.

3.3.8 The ‘Five year forward view for mental health’ (NHS England, 2016) recommended trialling new care models for acute inpatient care for young adults aged 16 to 25, stating: ‘The safeguarding and legal implications of inpatient care for young people up to the age of 25 must also be considered.’ The investigation engaged with NHS England to understand what trials were undertaken in response to the recommendation, and what the outcomes from these trials were. The investigation also asked how the safeguarding and legal implications were considered.

3.3.9 NHS England’s response was that it had ‘not been able to test and develop different approaches to inpatient care for 16-25 year olds – the safeguarding and regulatory considerations are significant to overcome’. More detail regarding what considerations were significant to overcome was not provided. NHS England told the investigation that reviewing models of care is a priority that the quality transformation programme aims to take forward, and that they have undergone extensive co-production to redesign the inpatient CYPMHS model engaging with young people and their families and carers, also employing EBEs within the transformation team.

3.3.10 Many approaches to safeguarding have become custom and practice, are based on historical perceptions, and are not supported by legislation or policy that would prevent a trial of inpatient care for young people aged 16 to 25 years. There are examples across healthcare and other sectors of services that manage safeguarding challenges across this age range for people receiving care, education, or for work.

3.3.11 Under the Mental Health Act, the presence of under 18s on an adult ward has to be notified to the CQC. However, a 16 to 25 inpatient setting is specifically in the NHS’s age range for ‘young people’, rather than a more generic ward for adults.

There are NHS-commissioned services in the independent sector that are for the 16 to 25 age range. In addition, there are no regulations that prevent someone over 18 remaining in inpatient CYPMHS.

3.3.12 The current delivery of age-based transitions from inpatient CYPMHS does not support positive outcomes for young people. Potential models of care have been described and recommended in previous reports, and although these were not specifically inpatient-focused, the impacts on young people remain the same. Recommendations made to NHS England for trials were not implemented; the reasons provided by NHS England for this, which included safeguarding and regulatory challenges, are not supported by the findings of this investigation.

> "We can tinker around the edges of transitions, but it feels like it should be something more bold."
>
> Staff insight

3.3.13 Implementation of safety recommendation **R/2024/047** would support a more flexible needs-based approach to transitions from inpatient CYPMHS, with the range of flexibility and implementation decided and developed by NHS England. There could be circumstances where it may be appropriate for young people to transition to adult services prior to reaching 18 years of age, dependent upon their maturity and independence. However, as described in Section 3.1 there would be additional regulatory considerations for this on 'psychiatric units'.

3.3.14 Any shift to inpatient CYPMHS or AMHS services delivering care for different or more flexible age ranges would come with a number of implementation considerations. A significant consideration would be having an adequate number of appropriately qualified, trained and competent workforce to enable and deliver such a shift.

3.3.15 In section 2.3.3 the investigation described how one provider had taken a different approach to delivery, and how it had overcome some challenges in delivering both inpatient CYPMHS and inpatient AMHS. However, psychiatry training and competency was described by the provider, and across many other locations and by national stakeholders, as being a specific challenge.

3.3.16 This was considered by the Royal College of Psychiatrists, which has stated that:

‘Regardless of the model, development would need to ensure that the workforce can have the training time and resources to adapt and provide effective and safe services. This would have implications for employers (providers of services). Similarly, there would need to be an explicit acknowledgment and investment in resources to ensure trainees can access training pathways and appropriately trained clinical supervisors so that they may be employed in such services.’ (Royal College of Psychiatrists, 2022)

3.3.17 The Royal College of Psychiatrists (2022) described a potential solution – the development of a ‘youth services credential’ which would enable CYPMHS specialists to ‘work up to 25’ and AMHS specialists to ‘work down to 14/16’.

3.3.18 Any changes to the specifications and delivery for inpatient mental health services will need to be supported by appropriate changes to the training and competence of the inpatient mental health workforce, with sufficient funding and resources, to enable successful implementation.

3.4 Previous investigations

3.4.1 In July 2018 the Healthcare Safety Investigation Branch (HSIB) published an investigation report on how young people are supported in the transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) when they turn 18. While this investigation primarily focused on community care, it had implications for inpatient mental health services.

3.4.2 One of the report’s safety recommendations was:

‘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.’ (Healthcare Safety Investigation Branch, 2018)

3.4.3 The NHS England response included commissioning the National Collaborating Centre for Mental Health (NCCMH) to:

‘… consider and review approaches to improve mental health support for young adults; this includes consideration of existing needs-based approaches to transition.’ (Healthcare Safety Investigation Branch, 2018)

3.4.4 The outcome was a report published in 2022, ‘Meeting the needs of young adults within models of mental health care’ (National Collaborating Centre for Mental Health, 2022). The report explores many aspects considered by this HSSIB

investigation and states: ‘As with community services, there has been a call for acute care to deliver developmentally and age appropriate services for young people.’

3.4.5 The investigation engaged with NHS England to understand what actions were taken in response to the report that it had commissioned NCCMH to produce. NHS England’s detailed response discussed many aspects of improvements to community mental health services, such as removing rigid age thresholds for people turning 18, supporting joint agency working, adapting existing pathways to offer developmentally appropriate support and supporting staff to have the right skills and competencies for these changes. The response stated that the majority of ICBs have fully or partially implemented these changes.

3.4.6 However, these changes related to community services. NHS England was unable to provide information on similar improvements for inpatient mental health services and transitions. Young people in inpatient CYPMHS will continue to feel the impacts of rigid age-based transitions as reflected throughout this report, until inpatient mental health services receive similar and equitable transformation as that afforded to community mental health transitions.

3.4.7 There have been other investigations related to individual incidents of poor patient outcomes in mental health services, with aspects relating specifically to inpatient transitions. One such investigation was carried out by an independent investigation organisation (Niche, 2022), commissioned by NHS England. One of two system issues identified in the Niche investigation was: ‘The transition from CAMHS to Adult Services, which was based entirely on age and did not take her [the young person’s] clinical needs into consideration.’ This transition was from inpatient CYPMHS to inpatient AMHS.

3.4.8 The recommendation directly relating to this patient transition was that NHS England, along with three other organisations:

‘… must provide assurance that all transitions between services for children and young people are completed in line with the NICE guidance on the Transition of Children and Young People.’ (Niche, 2022)

3.4.9 The investigation engaged with NHS England to understand what assurances have been provided for inpatient mental health transitions in response to the recommendation in the investigation report that it commissioned, specifically in relation to ensuring that transitions are in line with NICE guidance and are not based on a rigid age threshold. NHS England provided the investigation with evidence of actions it had taken to address challenges with transitions in

community mental health care. However, NHS England was unable to provide information on what steps had been taken to address this issue for transitions in inpatient mental health care.

3.5 Closing comments

3.5.1 Challenges associated with the transition from CYPMHS to AMHS have been considered by many organisations and reports, over many years. Although the findings, conclusions, safety observations and safety recommendations within this investigation report are targeted at making inpatient CYPMHS to AMHS transitions safer, many challenges are similar to those experienced in community mental health transitions.

3.5.2 The investigation saw that when young people were in CYPMHS, or in AMHS, the system and services were generally consistent and understood. However, the move between the two systems (see figures 1 and 2) is where both the challenges, and the impacts on people, were significant.

3.5.3 The investigation shows that national guidance, policy statements and investigation recommendations have called stakeholders to act to make changes to inpatient mental health transitions. However the system has not effectively responded to date. This aligns with findings in the HSSIB (2024a) report 'Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare'.

3.5.4 In 2022 the Royal College of Psychiatrists stated:

'We largely know what the issues are but we now need to move forward and implement the policy we have all been involved in forming over the years.' (Royal College of Psychiatrists, 2022)

This investigation indicates that we still need to move forward, specifically in relation to transitions from inpatient CYPMHS.

3.5.5 In summary, the experiences and feelings of many patients, families, and carers, in how they were supported by the systems they encountered, were as follows: the person did not change, their needs did not change, their risks did not change – the health, care and education system changed around them because they were a day older.

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5. Appendices

Appendix 1: Investigation approach

Stakeholder engagement

This is one of a series of four HSSIB investigations into patient safety in mental health inpatient settings. This meant it was able to draw on evidence from across the separate investigations in the series. Specific stakeholders engaged with primarily for this investigation are shown in table A and listed below.

Table A Patients, families and carers, providers and regional stakeholders engaged with primarily for this investigation

Patients, families and carers	**Inpatient providers/staff**	**Regional oversight**
Patient forums across mental health care providers	Inpatient children and young people's mental health service providers (NHS and independent sector)	Integrated care boards
Interviews with young people with experience	Inpatient adult mental health providers (NHS and independent sector)	NHS-led provider collaboratives
Patient, family and carer focus groups across England – arranged via Mind	Community adult mental health providers	NHS England regional teams
Targeted focus groups with specific independent charities	Interviews with individual staff across England	Social care teams
Interviews with bereaved families and carers and legal representatives		

The investigation directly engaged with the following national stakeholders and academics as part of the investigation:

- Department of Health and Social Care
- Department for Education
- Association of Directors of Children's Services
- National Association for Hospital Education
- Children's Commissioner Office

- NHS England
- service regulators – Care Quality Commission and Ofsted
- royal colleges and professional bodies
- charities
- independent sector – Independent Healthcare Provider Network and independent sector providers.

Further stakeholders were also engaged with during the consultation phase for this report.

Analysis of the evidence

The findings presented in this report were identified following triangulation of various evidence sources and following consultation with stakeholders involved in the investigation. The investigation approach was informed by the Systems Engineering Initiative for Patient Safety (SEIPS) to help explore the workplace conditions that influence patient outcomes (see Holden et al, 2013), and risk management frameworks to help understand risks across local, regional and national boundaries.

Appendix 2: Definitions of the terms ‘children’, ‘young people’ and ‘adults’

United Nations

Article 1 of the United Nations Convention on the Rights of the Child defines ‘children’ as persons up to the age of 18 (United Nations, n.d.).

UK government

The Education Act 1996 states that ‘“child” means a person who is not over compulsory school age’, therefore under 16. The Children Act 1989 states that a child is ‘a person under the age of eighteen’. Further UK statutory guidance states that children are ‘anyone who has not yet reached their 18th birthday, ‘‘Children’ therefore means ‘children and young people’’ (HM Government, 2023). The Health and Care Act 2022 states that a child ‘means a person aged under 18’. The terms ‘child’ or ‘juvenile’ refer formally to a person under the age of 18 as defined by section 105 of the Children Act 1989 (Parole Board, 2021).

UK government case management guidance states:

‘We define a child as anyone who has not yet reached their 18th birthday. This is in line with the United Nations Convention on the Rights of the Child and civil legislation in England and Wales. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.’ (Youth Justice Board for England and Wales, 2024).

The Children and Young Persons Act 1933 states that a young person is ‘a person who has attained the age of fourteen and is under the age of eighteen years’. The Education Act 1996 states that a young person is ‘a person over compulsory school age [16] but under the age of 18’. The Department for Education published a report regarding children and young people’s wellbeing. In this it refers to ‘children and young people aged 5- to 24-years old’ (Department for Education, 2023), inconsistent with the ‘young people’ age range in the Education Act. Further UK legislation (Children and Families Act 2014) states that ‘“young person” means a person over compulsory school age [16] but under 25’.

A UK parliament briefing paper, ‘Mental Health Act reform – children and young people’, refers to ‘children and young people (CYP) aged under 18’ (UK Parliament Post, 2022).

UK legislation is more consistent regarding what an adult is, with the Family Law Reform Act, Working Time Regulations and Criminal Law all stating that people become adults when they have reached the age of 18.

Mental Health Act

The Mental Health Act 1983 defines children as ‘any patient that has not attained the age of 18 years’. The ‘Mental Health Act 1983: code of practice’ (Department of Health, 2015) states: ‘When the Code refers to ‘children’ it means people under the age of 16. When it refers to ‘young people’ it means people aged 16 or 17.’

Mental Capacity Act

The Mental Capacity Act 2005 sets out how decisions can be made for people aged 16 or over who lack the mental capacity to do so. Unlike the Mental Health Act, the Mental Capacity Act applies to both physical and mental health interventions (UK Parliament Post, 2022).

Citizens Advice

A child means someone aged under 14 and young person means someone aged 14 or over but under 18 (Citizens Advice, n.d.).

Healthcare

The General Medical Council refers to children and young people from birth until their 18th birthday. ‘Children’ refers to ‘younger children who do not have the maturity and understanding to make important decisions for themselves’ and ‘Young people’ refers to ‘older or more experienced children who are more likely to be able to make these decisions for themselves’ (General Medical Council, n.d.).

A number of mental health providers, and the Care Quality Commission, refer to services as being for ‘Children and Young People’. Many of these then go on to describe the age range of care for people up to 18.

The NHS gives advice regarding ‘How to talk about different age groups and stages of life’ which states:

- ‘child: 4 to 12 years
- teenager: 13 to 19 years
- young people: 16 to 24 years
- adult: generally from age 18 but this may vary. Be specific, for example: "adults aged 19 to 64’ (NHS Digital Service Manual, 2024).

The NHS Long Term Plan discusses ‘a vision for the future of the NHS and new action in relation to children and young people aged 0-25’ (NHS England, n.d.c).

The National Collaborating Centre for Mental Health (2022) defines the age ranges as ‘Children: individuals aged 11 and under, Young people: individuals aged between 12 and 25, Young adults: individuals aged between 18 and 25 (a subset of ‘young people’)’.

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