



**RCEM**

Royal College  
*of* Emergency  
Medicine

# Adolescent Mental Health

National Quality Improvement Project (QIP)

**Information Pack**

Published: November 2025



<b>Welcome .....</b>	<b>3</b>
<b>Introduction .....</b>	<b>3</b>
Meet the Team .....	3
.....	4
.....	4
.....	4
The evidence.....	5
Rationale .....	5
<b>Quality improvement information .....</b>	<b>6</b>
Objectives for all RCEM QIPs .....	7
<b>Standards.....</b>	<b>8</b>
<b>Measures.....</b>	<b>9</b>
<b>Methodology.....</b>	<b>10</b>
Forming your QIP team.....	10
Data entry portal.....	10
Inclusion criteria .....	10
Exclusion criteria.....	10
Sample size .....	10
Data entry frequency.....	11
Data collection period.....	11
<b>Data to be collected .....</b>	<b>12</b>
Organisational data.....	12
Clinical data.....	13
Introduction .....	13
Standard 1 .....	15
Standard 2 .....	16
<b>Data Sources .....</b>	<b>18</b>
<b>References.....</b>	<b>19</b>
<b>Appendices.....</b>	<b>20</b>
Appendix 1: ECDS/SNOMED Codes to support case identification. ....	20
Appendix 2: Definitions .....	21
Appendix 3: Clinical standards – Analysis plan (Dashboard charts) .....	22
Standards direct measure SPC Charts.....	22
Additional charts to support improvement.....	25

## WELCOME

This document tells you everything you need to know if your Emergency Department (ED) wishes to participate in the 2026 RCEM National Quality Improvement Programme (QIP) on Adolescent Mental Health (AMH).

## INTRODUCTION

### Meet the Team



#### **Dr Jessica Green (QIP Deputy Chair)**

I am an ST4 EM trainee working in the East Midlands. I have a keen interest in children's and young people's emergency care and plan to sub-specialise in Paediatric EM. I have also previously had a post as an ED QI fellow.



#### **Dr Katie Manning**

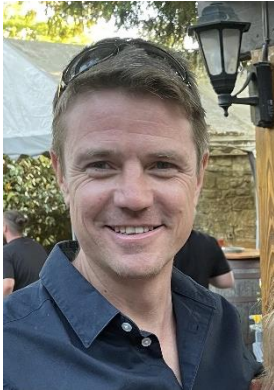
I am a consultant in Emergency Medicine with subspecialty accreditation in paediatric emergency medicine. I work at St Richards Hospital (a district general hospital in Chichester, & part of University Hospitals Sussex NHS Foundation Trust).

I am the Lead Consultant for Paediatric Emergency Medicine at my hospital site. I'm interested in improving the care and patient experience for adolescents in our Emergency Departments.



#### **Dr Daniel Darbyshire**

I'm an EM trainee in the Northwest of England. Though I'm originally from Stockton-on-Tees in the Northeast. I'm a NIHR Clinical Lecturer and a PEM sub-specialty trainee. I've also had various leadership roles with EMTA and RCEM and some other organisations. I did some previous QI work doing a little bit on a very large project and enjoyed it much more than small scale projects. I also have a passion for improving care for groups which are not always prioritised so when I saw the advert for this QIP I was intrigued. Out of work I'm a dad to a very energetic toddler and a loud and needy dachshund called Lady Darbyshire.



**Dr Deon Louw (QIP Co-Chair)**

I am an ED consultant in Oxford, where I have been working as mental health lead for almost 9 years. I currently sit on the RCEM Mental Health Subcommittee and have the opportunity to represent RCEM on the RCPsych Faculty of Liaison Psychiatry Executive Committee, as well as the Psychiatric Liaison Accreditation Network (PLAN). Like all my ED colleagues, I am acutely aware of the challenges we face in caring for our younger patients with mental health needs. I am delighted that the College has recognised it as a priority. It's been a pleasure to work with RCEM and the rest of the QI Topic Team, and hope that like me clinicians across the country can use this QIP to bring about positive changes in their Trusts.



**Dr Lalarukh Asim (QIP Co-Chair)**

I am an Emergency Medicine and Major Trauma consultant at King's College Hospital, Associate Medical Director for Patient and Staff Experience, and the EM lead for Children's Safeguarding. With roles as CAMHS liaison and a clinical supervisor for our youth work team, I am passionate about adolescent medicine and mental health, alongside safeguarding our most vulnerable, so when this QIP was advertised by RCEM it immediately attracted my attention. I am hopeful that this work will help raise the standards nationally for all young people presenting in crisis, as well as focusing attention on a wider scale by the challenges faced by those involved in delivering this care. By participating in this QIP we can all make a difference so please join us on this journey of improvement.

**The context**

Adolescence is a period of significant physical, emotional, and social changes. The World Health Organization states that "protecting adolescents from adversity, promoting socio-emotional learning and psychological well-being, and ensuring access to mental health care are critical for their health and well-being during adolescence".[1]

Adolescents attending the Emergency Department are often seen in an inadequate physical environment by staff with insufficient time and understanding of the specific needs of this group. Opportunities to identify and intervene early in problems related to home life, education and employment, drugs and alcohol, sexual health, mental health, and social safety are often missed due to a lack of holistic assessment. Adolescents with a mental health crisis are disproportionately affected by challenges in both emergency care and mental health services.

Facing the Future: Standards for children and young people in emergency care was published by RCPCH in October 2025 and has influenced the final stages of this national QIP's development.[2]

## The evidence

20% of adolescents experience a mental health problem in any given year.[3]

70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age[4]

54% of respondents to a 2022 RCEM survey reported that mental health services for children and adolescents were generally poor or awful. This has not improved since the 2018 survey.[5]

Half of the respondents said children and young people experiencing mental health crises arriving between 3 and 7 pm faced waits of 12-24 hours after presenting to the ED to see a specialist mental health professional.[5]

An emergency department attendance is an opportunity for a focused psychosocial assessment. NICE, RCPsych and RCPCH recommend timely and parallel assessment for those attending emergency departments with mental health presentations.[2,6]

## Rationale

Delivering high-quality care to adolescent patients in the Emergency Department presents significant challenges.

This quality improvement project (QIP) seeks to improve nationwide assessment, care and treatment of this vulnerable and underserved group by addressing three main domains:

- to become more patient-centred and caring
- to be safe and effective in our management
- to deliver more timely and efficient care

There is no one-size-fits-all approach to this, and we recognise that the path to providing high-quality care for adolescent patients will differ for each hospital. However, we believe that this QIP allows individual hospitals to pinpoint their own areas for improvement and develop strategies for lasting change. Supported by the RCEM QI topic team, by joining this project you will be part of a national effort to enhance the care of our valued adolescent patients.

While we acknowledge that not all adolescents presenting with a mental health problem will need a referral to the local mental health services (CAMHS or adult/liaison psychiatry), all adolescents should have an ED-initiated psychosocial assessment. **This means that not all patients meeting the initial inclusion criteria will be entered into standard 2. However, please ensure that the remaining metrics are still completed so we can evaluate their journey through the ED.**

The QIP team also recognises that the care of these vulnerable patients in the ED cannot be managed by EM alone, so we need to promote better engagement as a specialty with our mental health team partners, and proactively seek their commitment and support to help us raise these standards collectively. The QIP will require both teams to make changes as recommended by RCEM, RCPCH, and RCPsych.

We also understand that not all patients referred to MH services will be accepted for assessment, but we are optimistic that including this particular metric will help us better map service demands during the acute phase of the patient journey.

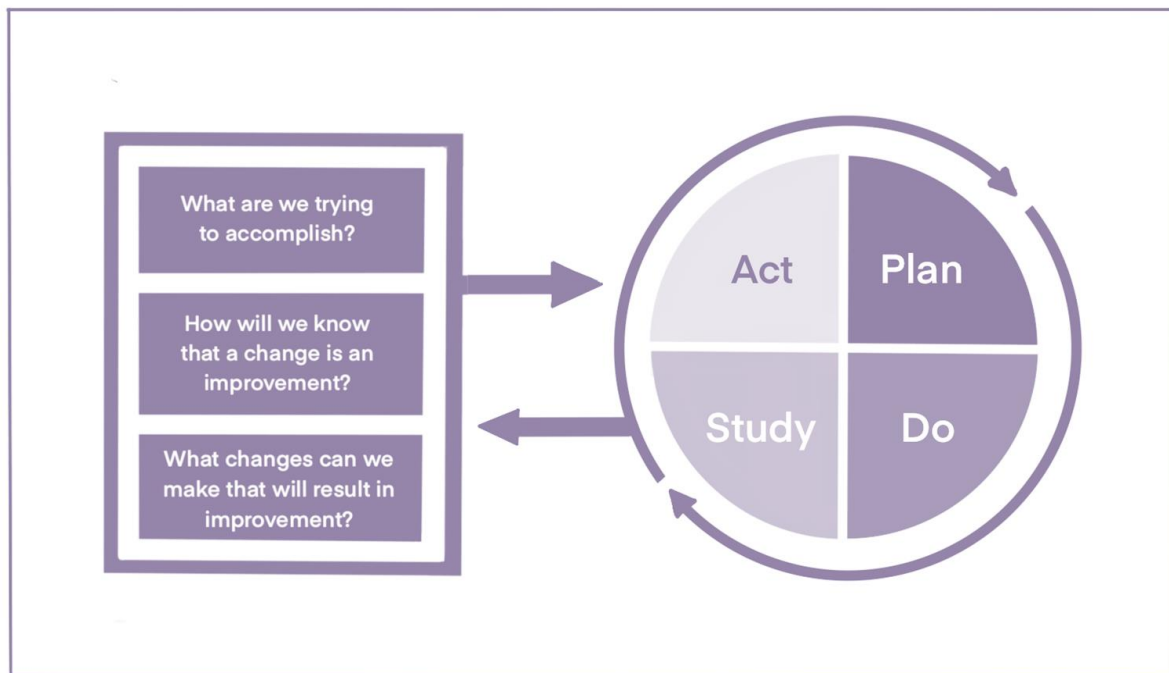
## QUALITY IMPROVEMENT INFORMATION

The purpose of this QIP is to continually quality assure and improve your service whereby the patient benefits as an outcome of the project. The RCEM system allows your team to record details of QIPs and see on your dashboard how each initiative affects your data on key outcomes and process measures.

We encourage you to use this feature in your department. If you are new to QIPs, we recommend you follow the Plan Do Study Act (PDSA) methodology. The [Institute for Healthcare Improvement](#) (IHI) provides a useful worksheet which will help you to think about the changes you want to make and how to implement them.

Further information on ED quality improvement can be found on the [RCEM website](#).

### The model for improvement (Institute of Healthcare Improvement)



## Objectives for all RCEM QIPs

---

### **Ensuring effective care, which is evidence based leading to measurable improvement**

How RCEM supports you

Expert teams of clinicians and QIP specialists have reviewed current national standards and evidence to set the top priority standards for this national QIP

RCEM have built a bespoke platform to collect and analyse performance data against the standards for each ED

### **Show EDs their performance in comparison with other participating departments both nationally and in their respective country in order to stimulate quality improvement**

How RCEM supports you

The QIP will be run over a 3-year period. The longer duration should allow better planning and effective iteration. This should lead to improved patient care. Participating EDs can see how they perform as compared to the national mean. This should enable EDs to revisit changes implemented and plan further PDSA cycles.

### **To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected, and track the impact of the QI initiative on their weekly performance data**

How RCEM supports you

The RCEM platform includes a dashboard with graphs showing your EDs performance. The dashboard graphs are SPC charts (where applicable) with built in automatic trend recognition, so you are able to easily spot statistically significant patterns in your data.

Once you have completed a PDSA template with your team, this is overlaid onto your dashboard charts so you can easily see the impact of your PDSA.

RCEM have also published a QI guide to introducing a range of excellent QI methodologies to enhance QI knowledge and skills.

## STANDARDS

Standard	Reference
<p><b>Standard 1 -</b></p> <p>All adolescent patients attending the emergency department with mental health problems should have an emergency clinician initiated psychosocial assessment documented.</p>	<p>RCEM Standards for Mental Health – Section 1.9. Available at: <a href="https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf">https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf</a></p> <p>RCPCH. Facing the Future: Standards for children and young people in Emergency Care. 5<sup>th</sup> Edition. Oct 2025. <a href="http://www.rcpch.ac.uk/sites/default/files/2025-10/FtF-emergency-care-standards-5th-ed-full.pdf">http://www.rcpch.ac.uk/sites/default/files/2025-10/FtF-emergency-care-standards-5th-ed-full.pdf</a></p>
<p><b>Standard 2a -</b></p> <p>They should be responded to by mental health liaison services within one hour of referral.</p>	<p>RCEM Standards for Mental Health – Section 1.8. Available at: <a href="https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf">https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf</a></p> <p>Psychiatric Liaison Accreditation Network (PLAN) standard 10, type 1. Available at: <a href="plan---7th-edition-standards.pdf">plan---7th-edition-standards.pdf</a></p> <p>[RCPCH. Facing the Future: Standards for children and young people in Emergency Care. 5<sup>th</sup> Edition. Oct 2025. <a href="http://www.rcpch.ac.uk/sites/default/files/2025-10/FtF-emergency-care-standards-5th-ed-full.pdf">http://www.rcpch.ac.uk/sites/default/files/2025-10/FtF-emergency-care-standards-5th-ed-full.pdf</a></p>
<p><b>Standard 2b -</b></p> <p>They should have a parallel assessment by the emergency and mental health teams for onwards care plan or discharge within 4 hours of arrival to the ED.</p>	<p>Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance Available at: <a href="https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf">https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf</a></p> <p>RCEM Management of Adolescent/Young Adults in the Emergency Department. Page 5 <a href="Management_of_Adolescent_Young_Adult_Patients_in_EDs_Final.pdf(rcem.ac.uk)">Management_of_Adolescent_Young_Adult_Patients_in_EDs_Final.pdf (rcem.ac.uk)</a></p> <p>Psychiatric Liaison Accreditation Network (PLAN) standard 13, type 1 <a href="plan---7th-edition-standards.pdf(rcpsych.ac.uk)">plan---7th-edition-standards.pdf (rcpsych.ac.uk)</a></p> <p><a href="Handbook_to_the_NHS_Constitution_for_England-GOV.UK(www.gov.uk)">Handbook to the NHS Constitution for England - GOV.UK (www.gov.uk)</a></p>

## MEASURES

Standard	Clinical metric
<p><b>Standard 1</b> All adolescent patients presenting to the Emergency Department should have an emergency clinician led psychosocial assessment completed and documented within the Emergency Department.</p>	<p>Documented elements of the psychosocial tool</p> <ul style="list-style-type: none"> <li>⇒ 1. Home life</li> <li>⇒ 2. Education/Employment or Training</li> <li>⇒ 3. Eating/Exercise</li> <li>⇒ 4. Activities/Hobbies</li> <li>⇒ 5. Drugs and Alcohol</li> <li>⇒ 6. Sexual activity, sexual identity and gender identity</li> <li>⇒ 7. Suicide and Self-Harm, Mental Health</li> <li>⇒ 8. Safety</li> </ul>
<p><b>Standard 2a</b> Should be responded to by mental health liaison services within one hour of referral.</p>	<ul style="list-style-type: none"> <li>⇒ Time to triage</li> <li>⇒ Early referral</li> <li>⇒ Parallel assessment</li> </ul>
<p><b>Standard 2b</b> Should have a parallel assessment and care planning by the emergency and mental health teams for onwards care or discharge within 4 hours of arrival to the ED.</p>	<ul style="list-style-type: none"> <li>⇒ Time to documented mental health plan</li> <li>⇒ Time in department (LOS)</li> </ul>

## METHODOLOGY



### Forming your QIP team

RCEM recommends forming a multidisciplinary QI team; to include consultants, residents, advanced care practitioners (ACPs), specialty and associate specialist (SAS) doctors, nursing and, patient representatives and others to suit your local set up.



### Data entry portal

You can find the link to log into the data entry site at <https://rcemqip.rcem.ac.uk/> (registered users only).



### Inclusion criteria

All 10–17-year-olds presenting to the Emergency Department with any of these criteria:

- ⊕ Mental health problems
- ⊕ Substance abuse
- ⊕ Social/safeguarding concerns
- ⊕ Psychological distress/crises
- ⊕ Intentional overdose
- ⊕ Self-harm (either self-injury or self-poisoning)



### Exclusion criteria

- ⊗ Age (years): Less than 10, more than 17
- ⊗ Accidental Self-Harm
- ⊗ Any patient who was unable to undergo a mental health examination or risk assessment in the ED due to their physical condition:
  - Unable to provide a clinical history
  - No source of collateral history
  - No clinical history on electronic patient records
  - Requiring resuscitation care
  - Brought in dead



### Sample size

Please collect a minimum of 5 randomised cases per week.



## Data entry frequency

**Recommended:** To maximise the benefit of the run charts RCEM recommends entering a minimum of 5 cases each week. This will allow you to see your ED's performance on key measures changing week by week. PDSA cycles should be regularly conducted to assess the impact of changes on the week-to-week performance.

**Alternative:** If your ED will find weekly data entry too difficult to manage, you may enter data fortnightly instead. The system will ask you for each patient's arrival date and automatically split your data into weekly arrivals, so you can get the benefit of seeing weekly variation if you spread the cases across the fortnightly. If you decide to enter data fortnightly, we recommend that you enter at least 10 cases fortnightly (5 cases from week 1 and 5 from week 2). You can then consider fortnightly cycles of PDSA with specific interventions and evaluate their impact by reviewing the trend over that time period.



## Data collection period

Data should be collected on patients between **1<sup>st</sup> Jan 2026 – 31<sup>st</sup> Dec 2028**

### Specific QIP Year reporting period-

Year 1 Interim report period: Jan 2026 – Dec 2026

Year 1 report available: June 2027

Year 2 Interim report period: Jan 2027 – Dec 2027

Year 2 report available: June 2028

Year 3 Final report period: Jan 2028 – Dec 2028

Final report available: June 2029

The project length has been increased to allow time to understand your local service offering and establish areas of need. These can then be targeted with PDSA interventions and change monitored over enough time to embed real change. Nationally we are aiming to improve sharing of best practice to facilitate idea development.



It is recommended to enter data as close to the date of patient attendance as possible, and to review progress regularly. This will help you QI team spot the impact of intervention more promptly for refinement or disposal depending on the changes observed.

## DATA TO BE COLLECTED

### Organisational data

Please complete this section for your ED

No.	Question	Answer Option(s)
1	Does your ED have an appropriate space where adolescent patients with mental health problems can be cared for?	• Yes / No
2	Does your ED have a specific psychosocial screening tool (e.g. form/template/QR code) for use of emergency clinicians?	• Yes / No
3	Does your ED have a policy for reporting and acting on safeguarding concerns?	• Yes / No
4	Does your department have a relevant policy on violence and aggression in adolescent patients?	• Yes / No
5	Does your department have a relevant policy around absconding adolescents?	• Yes / No
6	Does your department have a relevant search policy for adolescents?	• Yes / No
7	Does your department have a relevant physical restraint policy for adolescents?	• Yes / No
8	Does your ED have a relevant policy for the use of sedation/rapid tranquilisation for adolescents?	• Yes / No
9	Can your ED team access mental health documentation in real time?	• Yes / No
10	In your trust do 16/17 year olds usually see CAMHS in ED?	• Yes / No

## Clinical data

### Introduction

<p><b>1</b></p>	<p>What is the age of the patient in years?</p>	<p><u>Select one:</u></p> <ul style="list-style-type: none"> <li>• 10</li> <li>• 11</li> <li>• 12</li> <li>• 13</li> <li>• 14</li> <li>• 15</li> <li>• 16</li> <li>• 17</li> </ul>
<p><b>2</b></p>	<p>Date and time of arrival</p>	<p><u>dd/mm/yyyy hh:mm</u></p>
<p><b>3</b></p>	<p>At triage, what was the chief complaint identified?</p> <p><i>Select the primary presenting complaint - if there are multiple use your judgement to decide on the primary problem at time of triage and not eventual diagnosis</i></p>	<p><u>Select the primary complaint:</u></p> <ul style="list-style-type: none"> <li>• None</li> <li>• Anxiety disorder</li> <li>• Behaviour: Agitated/Violent</li> <li>• Behaviour: Unusual</li> <li>• Depressive disorder</li> <li>• Hallucinations/Delusions</li> <li>• Self-Harm (Includes overdose)</li> <li>• Suicidal thoughts</li> <li>• Substance-related attendance</li> <li>• Safeguarding/Social concern</li> </ul>
<p><b>4</b></p>	<p>Reference</p> <p><i>For local use – do not include patient identifiable information, including Hospital number or NHS Number.</i></p>	<p>Free text</p>
<p><b>5</b></p>	<p>Patient ethnicity</p>	<p>Select one:</p> <ul style="list-style-type: none"> <li>• Not known</li> <li>• Not stated</li> <li>• Any other ethnic group</li> <li>• White British</li> <li>• Chinese</li> <li>• African</li> <li>• Caribbean</li> </ul>

		<ul style="list-style-type: none"> <li>• Any other Asian background</li> <li>• Bangladeshi</li> <li>• Pakistani</li> <li>• Indian</li> <li>• Any other mixed background</li> <li>• White and Asian</li> <li>• White and Black African</li> <li>• White and Black Caribbean</li> <li>• Any other white background</li> </ul>
<b>6</b>	Patient gender	<p>Select one:</p> <ul style="list-style-type: none"> <li>• Female</li> <li>• Male</li> <li>• Not known (person stated gender code not recorded)</li> <li>• Indeterminate (unable to be classified as either male or female)</li> </ul>

## Standard 1

*All adolescent patients presenting to the Emergency Department should have an Emergency Medicine clinician (not Mental Health Team) led psychosocial assessment (e.g., HEADSSS, HEADSED) completed within the ED.*

<b>1</b>	In the clinical context was there a reasonable psychosocial assessment led by EM clinician recorded?	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<b>- Q1 sub-questions 1.1 to 1.9 only visible if Q1 = Yes -</b>		
Were the following elements of a psychosocial assessment explored and documented in the ED notes?		
<b>1.1</b>	Home life	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.2</b>	The patient's education, employment or training	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.3</b>	The patient's eating and exercise routine	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.4</b>	The patient's activities/hobbies	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.5</b>	The patient's relationship with drugs, alcohol, and smoking	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.6</b>	Sexual health, experiences and relationships	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.7</b>	The patient's experience of self-harm, depression and suicidality	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.8</b>	If the patient feels safe (safety/risk of exploitation)	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>
<b>1.9</b>	The patient's use of social media	<ul style="list-style-type: none"> <li>• Not explored</li> <li>• Explored</li> </ul>

## Standard 2

All adolescents referred for mental health assessment by the Emergency Department:

**Standard 2a** - Should be responded face to face to by mental health liaison services within one hour of referral.

**Standard 2b** - Should have a parallel assessment by the emergency medicine and mental health teams for onwards care or discharge within 4 hours of arrival to the ED.

1	Date and time of ED Triage	<ul style="list-style-type: none"> <li>dd/mm/yyyy hh:mm</li> <li>Not recorded</li> </ul>
2	Date and time of ED clinician review	dd/mm/yyyy hh:mm <ul style="list-style-type: none"> <li>Not reviewed</li> <li>Not recorded</li> <li>Patient did not wait/self-discharge</li> <li>Not seen by ED clinician, referral directly to mental health services</li> </ul>
3	Date and time of referral to mental health services (not exclusively CAMHS)  <i>If the mental health team in your department participates in the triage, please use the same time as ED triage</i>	dd/mm/yyyy hh:mm <ul style="list-style-type: none"> <li>No referral</li> <li>Not recorded</li> </ul>
4	Date and time of first response from mental health team <b>--Not available if Q3 = No referral</b>  <i>If the mental health team in your department participates in the triage, please use the same time as ED triage.</i>	dd/mm/yyyy hh:mm <ul style="list-style-type: none"> <li>No mental health input</li> <li>Referral not accepted</li> <li>Not recorded</li> </ul>
4.1	Was a face-to-face assessment of the patient by the mental health team completed in ED (either triage or full assessment)?	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> <li>Not recorded</li> <li>Telephone triage only</li> </ul>
4.1.1	<b>If Q4.1 = Yes</b> Date and time of face-to-face assessment by the mental health team:	dd/mm/yyyy hh:mm

4.2	<p>Date and time of documented mental health team management plan</p> <p><i>This is referring to the management plan following assessment of the patient.</i></p>	<p>dd/mm/yyyy hh:mm</p> <ul style="list-style-type: none"> <li>• Not recorded</li> <li>• No documented plan provided</li> <li>• Full assessment deferred to community services</li> </ul>
5	<p>If there was a delay in discharging the patient, after being clinically ready to proceed*, what was the main contributing factor for the delay?</p>	<p>Select any that applies:</p> <ul style="list-style-type: none"> <li>• No delay</li> <li>• Awaiting in-patient acute hospital admission</li> <li>• Awaiting transfer to mental health unit/hospital</li> <li>• Awaiting mental health team assessment</li> <li>• Awaiting Mental Health Act assessment</li> <li>• Awaiting mental health team care plan</li> <li>• Social services plan being made</li> <li>• Other: Free text</li> </ul>
6	<p>Date and time of departure from the ED</p> <p><i>Record the date/time the patient <b>has left the ED premises</b>, not when discharge paperwork is completed.</i></p>	<p>dd/mm/yyyy hh:mm</p>

## DATA SOURCES

ED patient records including nursing notes (paper, electronic or both).

Flow of data searches to identify QIP cases

For information about using the Emergency Care Data Set (ECDS) or your ED's electronic patient record to identify relevant cases, and to extract data from your system, please see [Appendix 1](#).

Using the codes list in [Appendix 1](#), first identify all patients attending your ED between the relevant dates, then by age at time of attendance, then through the other relevant criteria.

If your ED is reliably using the Emergency Care Data Set (ECDS), then your IT department or information team should be able to a) pull off a list of eligible cases for you, and b) extract some or all of the data you need to enter. Please see [Appendix 1](#) for the list of codes they will need to identify eligible cases or extract the data.

Collaborating with local teams:

Approach your mental health service to request assistance with sourcing eligible patients.

## REFERENCES

- 1 World Health Organization. Mental health of adolescents. WHO Website. 2025. <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health> (accessed 17 October 2025)
- 2 RCPCH. Facing the Future - standards for children and young people in emergency care settings. RCPCH: London, UK 2025.
- 3 NHS England. Mental health of children and young people in England, 2023 - wave 4 follow up to the 2017 survey. NHS England Digital. 2023. <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up> (accessed 17 October 2025)
- 4 The Children's Society. Children's mental health statistics. 2023. <https://www.childrenssociety.org.uk/what-we-do/our-work/well-being/mental-health-statistics> (accessed 17 October 2025)
- 5 Buchanan M, Blackburn R, Hayhurst C. A survey of children and adolescent mental health (CAMH) services in the emergency department. London, UK: RCEM 2022.
- 6 RCEM Paediatric Emergency Medicine Professional Advisory Group, Stafford R, Jacobs M, *et al.* Management of adolescent/young adult (AYA) patients in the emergency department. London, UK: RCEM 2023.

## APPENDICES

### Appendix 1: ECDS/SNOMED Codes to support case identification.

The codes below can be used to help initially identify potential cases. This is not an exhaustive list; other search terms can be used but all potential patients should then be reviewed to check they meet the definitions & selection criteria before inclusion in the QIP.

The ECDS codes below relate to Emergency Care Data Set (ECDS) Enhanced Technical Output Specification v4.0.

<b>Chief Complaint</b>	<b>SNOMED Codes</b>
Self-Harm	248062005
Suicidal thoughts	267073005
Depressive disorder	35489007
Anxiety disorder	48694002
Behaviour: unusual	248020004
Behaviour: agitated / violent	248004009
Hallucinations / Delusions	7011001
Social problem (medically well)	271437004
<b>Mental Health Diagnosis</b>	<b>SNOMED Codes</b>
Personality disorder	33449004
Eating disorder	72366004
Anxiety disorder	197480006
Depressive disorder	35489007
Bipolar affective disorder	13746004
Schizophrenia	58214004
Psychotic disorder	69322001
Somatisation disorder	397923000
Somatoform pain disorder	30077003
Dissociative disorder	44376007
Factitious disorder	50705009
Adjustment disorder	17226007
Illicit drug use	308742005
Alcohol dependence	66590003
Dementia	52448006
<b>Injury Intent</b>	<b>SNOMED Code</b>
Self-inflicted injury	276853009

## Appendix 2: Definitions

Section	Term	Definition
Standard 1	Emergency clinician initiated psychosocial assessment	An assessment that captures psychosocial themes can be in the form of verbal history, paper templates, digital tools, etc. HEEADSSS and HEADSED are two examples but individual departments may decide to use their own/different screening tools.
Whole document	Mental health team	Child and Adolescent Mental Health, Adult or Liaison Psychiatry
	Adolescence	10–17-years-old
	Clinically ready to proceed	No further investigation or intervention by the ED team required

### Appendix 3: Clinical standards – Analysis plan (Dashboard charts)

This section explains how the RCEM team will analyse your data. You may wish to conduct analysis locally. 'Analysis sample' shows which records will be included or excluded. 'Analysis plan' defines how the RCEM team will present the data graphically, and which records will meet or fail the standards.





#### Standards direct measure SPC Charts

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
1	<u>Standard 1 [Q1]</u>	All patients	<p><b>Standard MET</b></p> <p><u>Standard 1 [Q1]</u> = Yes</p> <p><b>Standard FAIL</b></p> <p><u>Standard 1 [Q1]</u> = No</p>

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
2a	<u>Standard 2 [Q3]</u> <u>Standard 2 [Q4]</u> <u>Standard 2 [Q2]</u> <u>Standard 2 [Q4.1]</u> <u>Standard 2 [Q4.1.1]</u>	<p><b>Exclusions:</b></p> <p><u>Standard 2 [Q3]</u> = <b>No referral</b></p> <p><u>Standard 2 [Q4]</u> = <b>Referral not accepted</b></p> <p><u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b></p> <p><b>Inclusion:</b></p> <p><u>Standard 2 [Q3]</u> IS NOT <b>'No referral'</b></p> <p><u>Standard 2 [Q4]</u> IS NOT <b>'Referral not accepted'</b></p>	<p>Standard <b>MET</b> (All conditions below must be true):</p> <ul style="list-style-type: none"> <li>✎ <u>Standard 2 [Q4.1]</u> = <b>Yes</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q4.1.1]</u> = <b>date and time recorded</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q4.1.1, Date and time]</u> - <u>Standard 2 [Q3, Date and time]</u> <b>&lt;= 1 hour</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q3]</u> = <b>date and time recorded</b></li> </ul> <p>Standard <b>FAIL</b> (Any condition below met):</p> <ul style="list-style-type: none"> <li>⊗ <u>Standard 2 [Q4.1]</u> = <b>'No' OR 'Not recorded' OR 'Telephone triage only'</b></li> <li>⊗ <u>Standard 2 [Q4.1.1]</u> = <b>'Not recorded'</b></li> <li>⊗ <u>Standard 2 [Q3]</u> = <b>'Not recorded'</b></li> <li>⊗ <u>Standard 2 [Q4.1.1, Date and time]</u> - <u>Standard 2 [Q3, Date and time]</u> <b>&gt; 1 hour</b></li> </ul>

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
2b	<u>Standard 2 [Q3]</u> <u>Standard 2 [Q4]</u> <u>Standard 2 [Q2]</u> <u>Standard 2 [Q4.2]</u> <u>Introduction [Q2]</u>	<p><b>Exclusions:</b></p> <p><u>Standard 2 [Q3]</u> = <b>No referral</b></p> <p><u>Standard 2 [Q4]</u> = <b>Referral not accepted</b></p> <p><u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b></p> <p><b>Inclusion:</b></p> <p><u>Standard 2 [Q3]</u> IS NOT <b>'No referral'</b></p> <p><u>Standard 2 [Q4]</u> IS NOT <b>'Referral not accepted'</b></p>	<p>Standard <b>MET</b> (All conditions below must be true):</p> <ul style="list-style-type: none"> <li>✎ <u>Standard 2 [Q4.1]</u> = <b>Yes</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q4.1.1]</u> = <b>date and time recorded</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q3]</u> = <b>date and time recorded</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q4.2]</u> = <b>date and time recorded</b></li> <li>AND</li> <li>✎ <u>Standard 2 [Q4.2, Date and time]</u> – <u>Introduction [Q2, Date and time]</u> &lt;= <b>4 hours</b></li> </ul> <p>Standard <b>FAIL</b> (Any condition below met):</p> <ul style="list-style-type: none"> <li>⊗ <u>Standard 2 [Q3]</u> = <b>Not recorded</b></li> <li>⊗ <u>Standard 2 [Q4.2]</u> = <b>Not recorded</b> OR <b>No documented plan provided</b> OR <b>Full assessment deferred to community services</b></li> <li>⊗ <u>Standard 2 [Q4.2, Date and time]</u> - <u>Introduction [Q2, Date and time]</u> &gt; <b>4 hours</b></li> </ul>

Additional charts to support improvement

Standard	Relevant questions	Analysis sample	Analysis plan
1	<p><u>Standard 1 [Q1]</u></p> <p><u>Standard 1 [Q1.1] to Standard 1 [Q1.9]</u></p>	<p><u>Standard 1 [Q1]</u> = <b>Yes</b></p>	<p>Bar chart containing count of assessments based on number of elements featured (<u>Standard 1 [Q1.1]</u> to <u>Standard 1 [Q1.9]</u>)</p> <p>Assessments are broken down into the following categories:</p> <ul style="list-style-type: none"> <li> 0 elements featured</li> <li> 1 to 2 elements featured</li> <li> 3 to 6 elements featured</li> <li> 7+ elements featured</li> </ul>

Standard	Relevant questions	Analysis sample	Analysis plan
2a	<p><u>Standard 2 [Q3]</u></p> <p><u>Standard 2 [Q4]</u></p> <p><u>Standard 2 [Q2]</u></p> <p><u>Standard 2 [Q4.1]</u></p> <p><u>Standard 2 [Q4.1.1]</u></p>	<p><b><u>Exclusion:</u></b></p> <p><u>Standard 2 [Q3]</u> = <b>No referral</b></p> <p><u>Standard 2 [Q4]</u> = <b>Referral not accepted</b></p> <p><u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b></p> <p><u>Standard 2 [Q4.1]</u> = <b>'No' OR 'Not recorded' OR 'Telephone triage only'</b></p> <p><u>Standard 2 [Q4.1.1]</u> = <b>'Not recorded'</b></p> <p><b><u>Inclusion:</u></b></p> <p><u>Standard 2 [Q3]</u> IS NOT <b>'No referral'</b></p> <p><u>Standard 2 [Q4]</u> IS NOT <b>'Referral not accepted'</b></p> <p><u>Standard 2 [Q3]</u> = <b>date and time recorded</b></p> <p><u>Standard 2 [Q4.1]</u> = <b>Yes</b></p> <p><u>Standard 2 [Q4.1.1]</u> = <b>date and time recorded</b></p>	<p>Run chart summarising weekly meantime to face-to-face assessment of the patient by the mental health team completed in ED from time of referral to mental health services and mean average time of the selected period for the analysis.</p> <p><u>Standard 2 [Q4.1.1, Date and time]</u> – <u>Standard 2 [Q3, Date and time]</u></p>

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
2a	<u>Standard 2 [Q4]</u>	<u>Standard 2 [Q4]</u> ( <i>response provided</i> )	Pie chart detailing breakdown of outcomes of the first response from the mental health team (Standard 2 [Q4] responses)

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
2b	<u>Standard 2 [Q3]</u> <u>Standard 2 [Q4]</u> <u>Standard 2 [Q2]</u> <u>Standard 2 [Q4.2]</u> <u>Standard 2 [Q4.1]</u> <u>Standard 2 [Q4]</u> <u>Standard 2 [Q4.2]</u>	<p><b>Exclusion:</b></p> <p><u>Standard 2 [Q3]</u> = <b>No referral</b> OR <b>Not recorded</b></p> <p><u>Standard 2 [Q4]</u> = <b>Referral not accepted</b> OR <b>No mental health input</b></p> <p><u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b></p> <p><u>Standard 2 [Q4.2]</u> = <b>Not recorded</b> OR <b>No documented plan provided</b> OR <b>Full assessment deferred to community services</b></p> <p><u>Standard 2 [Q4.1.1]</u> = <b>Not recorded</b></p> <p><u>Standard 2 [Q4.1]</u> = <b>'No'</b> OR <b>'Not recorded'</b> OR <b>'Telephone triage only'</b></p> <p><b>Inclusion:</b></p> <p><u>Standard 2 [Q3]</u> IS NOT <b>'No referral'</b></p> <p><u>Standard 2 [Q4]</u> IS NOT <b>'Referral not accepted'</b></p> <p><u>Standard 2 [Q4.2]</u> = <b>date and time recorded</b></p> <p><u>Standard 2 [Q3]</u> = <b>date and time recorded</b></p> <p><u>Standard 2 [Q4.1]</u> = <b>Yes</b></p> <p><u>Standard 2 [Q4.1.1]</u> = <b>date and time recorded</b></p>	<p>Run chart summarising weekly meantime to mental health management plan from arrival and mean average time of the selected period for the analysis.</p> <p>This Chart features a static line at the 4 hour mark as a reference point.</p> <p><u>Standard 2 [Q4.2, Date and time]</u> - <u>Introduction [Q2, Date and time]</u></p>

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
2b	<u>Standard 2 [Q4.2]</u>	<u>Standard 2 [Q4.2]</u> (response provided)	Pie chart detailing breakdown of outcomes of the mental health management plan ( <u>Standard 2 [Q4.2]</u> responses)
Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
All	<u>Standard 2 [Q5]</u>	<p><b>Exclusion:</b>  <u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b>  <u>Standard 2 [Q5]</u> = <b>No delay</b></p> <p><b>Inclusion:</b>  <u>Standard 2 [Q5]</u> (response provided)</p>	Pie chart detailing breakdown of main contributing factor for discharge ( <u>Standard 2 [Q5]</u> responses)
Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
All		<p>Exclusion:  <u>Standard 2 [Q1]</u> = <b>Not recorded</b></p> <p>Inclusion:  <u>Standard 2 [Q1]</u> is <b>date and time recorded</b></p>	Run chart summarising weekly meantime to triage from arrival and mean average time of the selected period for the analysis.  <u>Standard 2 [Q1, Date and time]</u> - <u>Introduction [Q2, Date and time]</u>

Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
All		<p><u>Exclusion:</u></p> <p><u>Standard 2 [Q3]</u> = <b>No referral</b></p> <p><u>Standard 2 [Q4]</u> = <b>Referral not accepted</b></p> <p><u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b></p> <p><u>Standard 2 [Q4]</u> = <b>'No mental health input'</b></p> <p><u>Standard 2 [Q3]</u> = <b>'Not recorded'</b></p> <p><u>Inclusion:</u></p> <p><u>Standard 2 [Q3]</u> IS NOT <b>'No referral'</b></p> <p><u>Standard 2 [Q4]</u> IS NOT <b>'Referral not accepted'</b></p> <p><u>Standard 2 [Q3]</u> = <b>date and time recorded</b></p>	<p>Run chart summarising weekly meantime to referral to MH Team from arrival and mean average time of the selected period for the analysis.</p> <p><u>Standard 2 [Q3, Date and time]</u> - <u>Introduction [Q2, Date and time]</u></p>
Standard	Relevant questions	Analysis sample	Analysis plan – Conditions for the standard to be met where applicable
All	<u>Standard 2 [Q6]</u>	<p><u>Exclusion:</u></p> <p><u>Standard 2 [Q2]</u> = <b>Patient did not wait/self-discharge</b></p>	<p>Run chart summarising weekly meantime to discharge from arrival and mean average time of the selected period for the analysis.</p> <p><u>Standard 2 [Q6, Date and time]</u> - <u>Introduction [Q2, Date and time]</u></p>

	<u>Standard 2</u> [Q2]  <u>Introduction</u> [Q2]	Inclusion:  All records where <u>Standard 2 [Q2] IS NOT</u> <b>Patient did not wait/self-discharge</b>	
--	--	---	--

- End -