Treat as One

Bridging the gap between mental and physical healthcare in general hospitals

summary
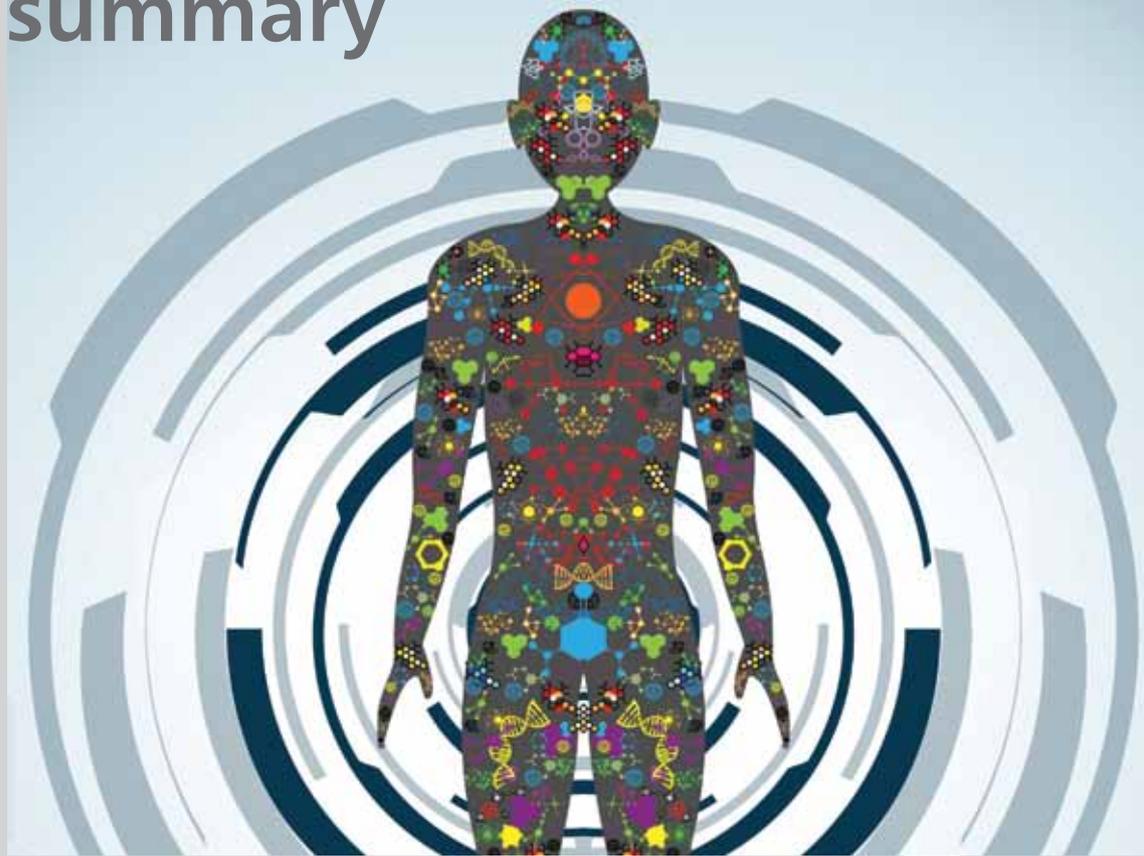
NCEPOD

Improving the quality of healthcare

Treat as One

Bridging the gap between mental and physical healthcare in general hospitals

A report published by the National Confidential Enquiry into Patient Outcome and Death (2017)

Contents

Principal recommendations

Patients who present with known co-existing mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital. These should be documented:

a. In referral letters to hospital

b. In any emergency department assessment

c. In the documentation on admission to the hospital

Existing guidance in these areas for specific groups should be followed which includes but is not limited to NICE CG16 and CG113 *(General Practitioners, Community Care Teams, Community and Hospital Mental Health Teams, Paramedics, Allied Health Professionals (e.g. Occupational Therapy) Emergency Medicine Consultants, Medical Directors of Mental Health Hospitals, Medical Directors of General Hospitals, Directors of Nursing and all Hospital Doctors and Nurses)*

National guidelines should be developed outlining the expectations of general hospital staff in the management of mental health conditions. These should include:

a. The point at which a referral to liaison psychiatry should be made

b. What should trigger a referral to liaison psychiatry and

c. What relevant information a referral should contain

(All relevant Royal Colleges, Specialist Colleges and Specialist Associations, and led by the Academy of Medical Royal Colleges)

Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes at the time of assessment. As a minimum the review should cover:

a. What the problem is (diagnosis or formulation)

b. The legal status of the patient and their mental capacity for any decision needing to be made if relevant

c. A clear documentation of the mental health risk assessment – immediate and medium term

d. Whether the patient requires any further risk management e.g. observation level

e. A management plan including medication or therapeutic intervention

f. Advice regarding contingencies e.g. if the patient wishes to self-discharge please do this '…'

g. A clear discharge plan in terms of mental health follow-up *(Faculty of Liaison Psychiatry, Royal College of Psychiatrists)*

All hospital staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway from undergraduate to workplace based continued professional development. *(Medical Directors and Clinical Directors of General Hospitals and Directors of Nursing)*

In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team. *(Medical Directors of General Hospitals, Medical Directors of Mental Health Hospitals, Directors of Nursing and Clinical Commissioners)*

Record sharing (paper or electronic) between mental health hospitals and general hospitals needs to be improved. As a minimum patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient. *(Medical Directors and Clinical Directors)*

Introduction

High quality mental healthcare offered to patients in general hospitals should be our aim. Yet, as has been noted in the foreword, there are many barriers to this occurring well.

The benefits of integrating care across boundaries (e.g. health, social care, employment and housing) are understood, however, good integrated care for people with mental health conditions often appears to remain the exception rather than the rule, with physical healthcare and mental healthcare largely disconnected.

There has been, and still are, many drivers to try and change the situation, to improve the care for this patient group,[1-20] This study looked at one particular aspect of care – mental healthcare in the general hospital setting of patients on an acute inpatient pathway. This fact is important, as the report is a snapshot of this one pathway of care available in general hospitals. A large part of the analysis of the healthcare offered to the patients in the study sample therefore focused on that delivered by physicians and nursing staff from the general hospital and from psychiatrists and nursing staff in any liaison psychiatry service.

Liaison services by their very name expose the gap in the way the services are commissioned and provided, as they describe a service reaching from one place to another. These services are currently undergoing significant expansion and indeed their names are also evolving, with 'liaison services', 'mental health liaison' and as this report chooses, 'liaison psychiatry', all used to describe them. However, they are only part of the solution.

Those patients who stay longer as inpatients, or who attend out-patient and community focused services may be seen by a range of other professionals from counsellors to psychologists and other professionals who may or may not be hospital based but who are a crucial part of the solution to bridging the gap in the healthcare system.

Focusing on the pathway covered in this study, there is the requirement for healthcare professionals in general secondary care to feel knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for the patients they see.

The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients.

Method and Data Returns

Method

Study Advisory Group
A multidisciplinary group contributed to the design of the study and review of the findings. This group comprised a patient representative and clinical representation from acute medicine, anaesthesia and acute pain, clinical psychology, critical care nursing, emergency medicine, general liaison psychiatry, healthcare for the elderly, mental health nursing, pharmacology, plastic surgery, psychiatry, and occupational therapy.

Study aim
To identify and explore remediable factors in the overall quality of mental health and physical healthcare provided to patients with significant mental health conditions who were admitted to a general hospital.

Objectives
The Study Advisory Group identified a number of areas of care to review that would address the primary aim of the study.

At an organisational level
Data were collected on the provision of services and organisational structures and policies in place to facilitate the delivery of care (for both mental and physical health) to this group of patients, particularly focusing on the following areas:
- Systems in place to provide safe and effective treatment including structured access to mental healthcare, where appropriate
- Systems in place to provide appropriate support to patients with mental health conditions and to the healthcare professionals who were treating them
- The access to mental healthcare in the hospital: where present, the composition and role of the liaison psychiatry team; the extent to which mental health professionals were involved in hospital policy and leadership

- Systems to allow communication and sharing of relevant information, including history and medication records:
  - Between different healthcare providers: general medical hospitals, GPs, community mental health providers and inpatient mental health providers
  - Between the liaison psychiatry teams and medical care teams working within the hospital
- Services and facilities available to facilitate the delivery of safe and effective medical care to patients with mental health conditions
- Training, competences and confidence of healthcare professionals who may be providing care to patients with mental health conditions.

At an individual case level
Data were collected to explore remediable factors in the overall quality of care provided to this group of patients, particularly focusing on the following areas:
- Access to mental healthcare within the general hospital, timely referral to and review by specialist mental healthcare where appropriate, and appropriate management by healthcare professionals
- Communication and record sharing between mental health and general hospitals and between general hospitals and liaison psychiatry teams within the hospital, including evidence of joint working of these teams
- Effective communication of relevant information to patients and relatives including expectations and risk
- The assessment of mental capacity and consent for treatment
- The management of medications, reconciliation and possible drug interactions
- Planning within the general hospital for safe/ timely discharge
- The standard of care and treatment provided
- Evidence of missed opportunities for intervention and escalation of care (for example to another specialty or critical care).

Hospital participation

National Health Service hospitals in England, Wales, and Northern Ireland were expected to participate as well as hospitals in the independent sector and public hospitals in the Isle of Man, Guernsey and Jersey. Hospitals in Scotland became part of NCEPOD's remit mid-way through the study and participated by completing the organisational questionnaire. A named contact within each hospital, the NCEPOD Local Reporter, acted as a link between NCEPOD and the hospital staff, facilitating case identification, dissemination of questionnaires and data collation.

Study population and case identification

Patients aged 18 or older who were admitted to a general hospital for a physical health condition, who also had a significant, known mental health condition and/or who were detained under mental health legislation either at the time of admission or during their hospital stay, were included. These criteria were selected to focus on mental health conditions that would have the greatest impact on the patient's physical healthcare. The Study Advisory Group identified the mental health conditions and the relevant ICD-10 codes for inclusion, these are listed in Appendix 1. Patients who met the inclusion criteria were identified retrospectively from hospital central records relating to admissions to hospital during the study period: 13th October - 13th November 2014.

Case selection

From all cases identified, a sample of up to 5 patients per hospital was selected for inclusion in the study:
• 1 case of a patient who had self-harmed
• 1 case of a patient who died in hospital or who was admitted to critical care during their hospital stay
• 1 case of a patient who was admitted from and/or discharged to a mental health hospital
• 2 cases of patients who had a hospital stay of more than 72 hours.

If there were an insufficient number of cases identified with the codes to meet the above criteria, then a case was selected from the returned sample at random. The selection was done this way to ensure a sample would reflect a variety of cases.

Exclusions

Two groups were excluded as decided by the Study Advisory Group:
• Pregnant women and women up to 1 year post-partum. This group was felt to be a separate population for which data had been collected by other organisations[21]
• Elective day cases - due to the short time in hospital, insufficient data would have been available to collect for this group.

Questionnaires and case notes

Two clinical questionnaires were disseminated to collect data on each case in the study: a general hospital clinician questionnaire and a liaison psychiatry clinician questionnaire. An organisational questionnaire was sent to each participating hospital.

Clinician questionnaire: general hospital

This questionnaire was sent to the consultant who was responsible for the care of the patient at the time of their discharge from hospital or death. If this clinician had not been correctly identified by the hospital, then they were asked to identify the correct consultant. Senior trainees could also complete the questionnaires providing the completed questionnaire was reviewed and signed off by a consultant. Information was collected on the patient's care throughout their hospital stay, including: their previous medical history and mental health condition/s, mode of admission into hospital and initial management, mental capacity assessment, consent, and communication, interventions, escalation in care, and end of life care/discharge planning.

Clinician questionnaire: liaison psychiatry

If the patient was referred to the liaison psychiatry service during the hospital stay, a questionnaire was sent to the named liaison psychiatrist or, if not named then a nominated liaison psychiatry contact to either complete or disseminate to colleagues in liaison psychiatry. Similar areas were covered to those in the general hospital questionnaire including details of any mental health legislation deployed, with a focus on assessment and review by the liaison psychiatry team, and mental healthcare input throughout the hospital stay.

Organisational questionnaire

An organisational questionnaire was sent to general/ acute hospitals and tertiary specialist centres where patients with a mental health condition may be treated for a physical health condition. For independent hospitals a separate questionnaire was sent to reflect the case mix of patients they see.

Completion of the organisational questionnaire was the responsibility of the Medical Director of the Trust/Health Board or a person nominated by them. Input from the leads for liaison psychiatry (where applicable), the emergency department, and general medical care was recommended. The data requested in the organisational questionnaire included information on facilities and services of the general hospital as well as those specifically for patients with mental health conditions, the referral process to liaison psychiatry, protocols and policies, staff training, and quality improvement initiatives.

Case notes

Photocopied case note extracts for each case for peer review were requested for the entire index admission. Additionally, copies of the emergency department documentation and discharge summaries were requested for any admissions to the hospital during the 12 months prior to the index admission date. The following extracts were requested:
- All inpatient annotations/medical notes
- Ambulance notes/Ambulance Service Patient Report Form

- GP (or other) referral letter (if applicable) and GP notes (if available in the case notes)
- Other correspondence relating to the admission
- Emergency department clerking proformas (if applicable)
- Nursing notes
- Observation charts
- Care pathway proformas
- Operation/procedure notes/anaesthetic charts
- Consent forms
- Fluid balance charts/ blood transfusion records
- Drug charts
- Nutrition/dietitian notes
- Discharge letter/summary
- Autopsy report (if applicable)
- Datix or other incident reporting (if applicable/possible)
- Physiotherapy, occupational therapy, speech and language therapy notes
- Psychiatry notes (if available in main clinical case notes) and
- Any mental health legislation record (if applicable).

Peer review of the case notes and data

A multidisciplinary group of case note reviewers was recruited for the peer review process. This group comprised consultants and senior trainees from the following specialties: acute medicine, anaesthesia, cardiology, critical care outreach, emergency medicine, gastroenterology, liaison psychiatry, intensive care medicine, neurology, old age psychiatry, oral and maxillofacial surgery, general psychiatry, and senior nurses specialising in emergency medicine and critical care, and mental health nurses.

The non-clinical staff at NCEPOD anonymised the questionnaires and case note extracts. All patient identifiers were removed so neither the Clinical Co-ordinators at NCEPOD, nor the reviewers, had access to patient identifiable information.

Once each case was anonymised it was reviewed by one reviewer as part of a multidisciplinary group. At regular intervals throughout the meeting, the Clinical Co-ordinator chairing the meeting allowed a period of discussion for each reviewer to summarise their cases and ask for opinions from other specialties or raise aspects of the case for discussion. Using a semi-structured assessment form, case reviewers provided both quantitative and qualitative responses on the care that had been provided to each patient.

The grading system below was used by the reviewers to grade the overall care each patient received:

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

Survey of training

A link to an online survey was disseminated to doctors and nurses via the NCEPOD Local Reporters at each hospital as well as several Royal Colleges/Associations. The survey was open for 3 months and 1340 responses were received. The aim was to ascertain what mental health training they had received and how much confidence they had in treating patients with a mental health condition in a general hospital setting. Advice was sought on the development of the survey and similar questions were obtained as those from the King's Health Partners 'Mind and Body Education and Training' report.[22] This included, training on self-harm, mental capacity assessment, and psychotropic medication,

where training had been delivered (e.g. as part of their undergraduate/postgraduate training or in the workplace), how it was delivered (e.g. simulation training), and whether or not it was delivered by liaison psychiatry.

Information governance

All data received and handled by NCEPOD complies with relevant national requirements, including the Data Protection Act (DPA) 1998 (Z5442652), the NHS Act 2006 (PIAG 4-08(b)/2003, App No 007) and the NHS Code of Practice.

Data quality

On receipt of the case data each case was given a unique NCEPOD number. The data from all questionnaires received were electronically scanned into a preset database. Prior to any analysis taking place, the data were cleaned to ensure that there were no duplicate records and that erroneous data had not been entered during scanning. Any fields that contained data that could not be validated were removed.

Data analysis

Following cleaning of the quantitative data, descriptive data summaries were produced. The qualitative data collected from the case reviewers' opinions and free text answers in the clinician questionnaires were coded, where applicable, according to content to allow quantitative analysis. The data were reviewed by NCEPOD Clinical Co-ordinators, a Clinical Researcher and 2 Researchers to identify the nature and frequency of recurring themes.

All data were analysed using Microsoft Access™ and Excel™ by the research staff at NCEPOD.

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

Case studies have been used throughout the full report to illustrate particular themes.

Data returns

In total 11,950 patients from 200 hospitals were identified as meeting the study inclusion criteria (Figure 1.1). When the sampling criterion (5 cases per hospital) was applied 1064 cases were selected for inclusion. A total of 782/1064 (73.5%) completed general hospital clinician questionnaires and 788 (74%) sets of case notes were returned to NCEPOD, 346 completed liaison psychiatry clinician questionnaires were also returned. The case reviewers were able to assess 552 cases. The remainder of the returned case note extracts were either too incomplete to allow assessment or were returned after the final deadline and final case reviewer meeting.

Within this report the denominator may change for each chapter and occasionally within each chapter. This is because data have been taken from different sources depending on the analysis required. For example, in some cases the data presented will be taken from the clinician questionnaire only, whereas some analysis may have combined the clinician questionnaire and the case reviewer's view taken from the case notes. The term "clinician" is used to refer to data obtained from the clinician responsible for that patient's discharge and/or mental health care and the term "reviewer" used to refer to data obtained from the multidisciplinary group who undertook the peer review of case notes.

Questionnaires

Peer review

11,950 cases notified to NCEPOD

1064 cases selected for inclusion

788 returned case notes for peer review

346 liaison psychiatry clinician questionnaires returned

782 general hospital clinician questionnaires returned

552 cases peer reviewed by case reviewers and included in analysis
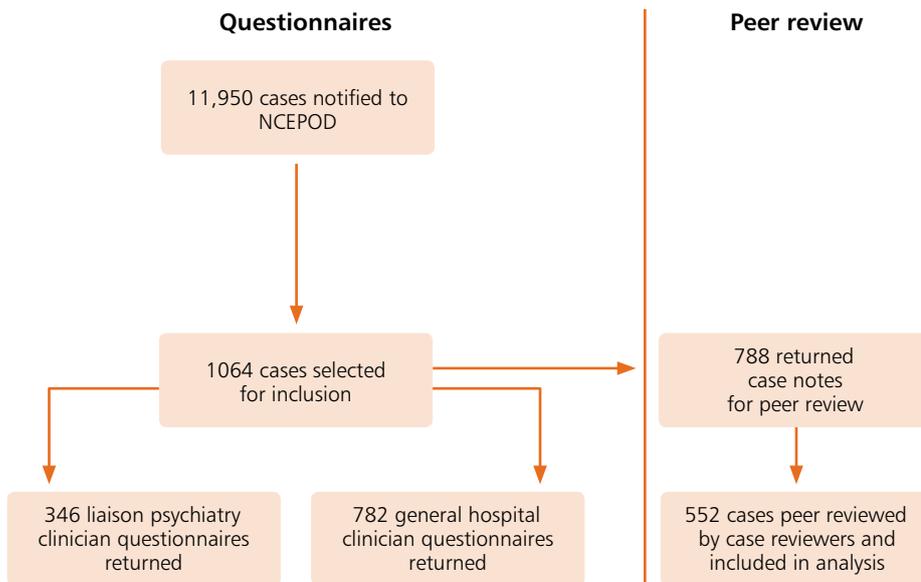
Figure 1.1 Data returns

Key Findings

Presentation to hospital

- 351/552 (63.6%) patients were admitted to hospital via the ED

- 80 patients were admitted via their GP and 57/552 were transferred from either a mental health or other general health hospital

- The patient's mental health condition should have been noted in the ED, but was not, in 47/96 patients at triage and in 24/47 patients at senior review in the opinion of the reviewers

- 55/327 (16.8%) patients were referred to the liaison psychiatry team in the ED

- 55/236 (23.3%) patients were not referred to the liaison psychiatry team in the ED but should have been in the opinion of the reviewers

- The lack of liaison psychiatry input/referral in the ED affected the overall quality of care in 20/38 patients

- The most common reason given for not referring to liaison psychiatry in the ED was that the clinician did not consider it to be necessary (23/55) the reason given was that the patient was not 'medically fit' for review in 5/55 patients

- In this study the most common mental health conditions seen in patients referred to the liaison psychiatry team while in the ED, were depression (31/55) and self-harm (24/55)

- In this study the most common mental health conditions seen in patients who were not referred to the liaison psychiatry team but should have been while in the ED, were depression (19/55) and schizophrenia (19/55)

- The liaison psychiatry team arrived in a timely fashion to the ED in 32/43 patients.

Admission and initial management

- 347/538 (64.5%) of patients were admitted to hospital out of hours or on the weekend

- Medicines reconciliation was found to have occurred at the initial assessment in 206/291 (70.8%) and in 144/211 (68.2%) in the consultant review

- Inadequate mental health history was taken in 101/471 (21.4%) patients at initial assessment and 208/424 (49.1%) during consultant review

- During the initial assessment mental health medications were prescribed in 311/431 (72.2%)

- Smoking cessation was offered in only 15/164 (9.1%) patients (who were smokers)

- Mental health risk issues were recorded in 161/476 (33.8%); of those not recorded 140/261 (53.6%) should have been

- An adequate risk management plan was made in 106/224 (47.3%) of patients

- Mental capacity issues were noted in 66/479 (13.8%) patients during the initial assessment. In those patients without mental capacity issues noted, they should have been in 184/344 (53.5%)

- 103/458 (22.5%) patients were referred to the liaison psychiatry team during the initial assessment. Of those patients who were not referred, in 30/301 (10%) should have been at this time and their care suffered as a result

- The consultant review initiated the referral to liaison psychiatry in 50/452 (11.1%) and the mental health diagnosis in 36/452 (8.0%) patients

- The mental health condition of the patient was recorded in the nursing notes in 355/493 (72.0%) of cases and the mental health history in 252/459 (54.9%)

- An assessment of complex needs was carried out in 171/380 (45.0%) patients, and was adequate in 135 of these (135/169; 79.9%)

- The provision for 1:1 mental health observations (specialling) was inadequate in 151/222 (68.0%) of cases

Admission and initial management (cont)

- The discussion of the case at a multidisciplinary case review was inadequate in 131/169 (77.5%) cases

- 256/552 (46.4%) of patients in the study had a review by the liaison psychiatry team during their hospital stay

- Assessments made by the liaison psychiatry team most commonly included risk management (121/256; 47.3%) and assessment (125/256; 48.8%); liaison with other mental health teams (97/256; 37.9%) and discharge planning (110/256; 43.0%)

- There was room for improvement in mental health risk assessment (22/125; 17.6%), mental capacity assessments (11/53), prescription of medications (11/48) and advice to nursing staff (20/86)

- The first assessment by liaison psychiatry was delayed according to the reviewers in 74/199 (37.2%) cases. This impacted the quality of care in 22/51 patients

- The most commonly given reason for the delay in the liaison psychiatry assessment was that "the liaison psychiatry team would not attend until the patient was medically fit" (26/74)

- Most patients seen by the liaison psychiatry team were seen only once (135/225; 60.0%)

- Of those patients seen by the liaison psychiatry team (256), there was deemed by the reviewers to be adequate input in 149/217 (68.7%) cases

- Of those patients not seen by the liaison psychiatry team, this was felt to be appropriate in 86/182 (47.3%)

- 65/541 (12%) of patients were detained using mental health legislation. In 15/65 of these patients there were issues in the documentation of the process

- There was room for improvement in the mental capacity assessment in 42/105 (40.0%) of patients in the reviewers opinion

- Liaison psychiatry were involved in MDT meetings in 20/95 cases. The management plan for the patient changed following the MDT meeting in 45 cases.

Ongoing care

- 13/552 patients were restrained during their admission

- Self-harm occurred during the hospital stay in 8 patients

- Security staff were called to help manage the patient in 23 cases in 5/23 there was room for improvement in this process

- Surgery or an intervention occurred in 135 patients. There was room for improvement in the consent process in 24/109 (22%)

- Measures were taken to facilitate the critical care management of patients with mental health conditions in 9/50 patients.

Discharge and death

- 209/423 (49.4%) patients discharged alive at the end of the study period received multidisciplinary discharge planning. The discharge was delayed in 65/443 (14.7%) of cases

- There was an inappropriate risk assessment in 193/404 (47.8%) cases and for review/ follow-up appointment in 52/356 (14.6%)

- The discharge summary lacked the mental health diagnosis in 95/340 (27.9%) and details of the mental health medications in 90/308 (29.2%)

- 37/424 (8.7%) patients in the sample were readmitted. 23/37 of these had received inappropriate discharge planning. 15/23 had no multidisciplinary discharge planning, 13/23 had inappropriate risk assessment

- There was no evidence that discharge summaries were copied to the relevant mental health consultant covering care.

Organisational data and survey of training

- 118/175 (67.4%) hospitals with an ED had a specific assessment room for mental health patients

- 28/175 (16.0%) hospitals had no specific facilities in the ED for assessing patients with mental health needs

- Of those hospitals with a dedicated room for the assessment of patients with a mental health condition, 108/117 (92.3%) had a panic button or alarm; 95/118 (80.5%) were free of ligature points; 83/118 (70.3%) were not used for any other purpose. None fulfilled all the requirements of the RCPsych guidelines

- 185/230 (80.4%) hospitals had a liaison psychiatry service; 145/185 (78.4%) on-site

- 157/185 (84.9%) liaison psychiatry teams covered the whole hospital

- The liaison psychiatry team was available 24/7 in 94/84 (51.1%) hospitals. Of those who were not available 24/7, 31 were available during extended working hours

- 102/178 (57.3%) hospitals had a policy/ protocol specifying which patients should be referred to liaison psychiatry. This protocol was specified by the liaison psychiatry team in 34 and jointly in 35 hospitals

- Self-harm patients were automatically referred to the liaison psychiatry team in 122/178 (68.5%) hospitals

- The liaison psychiatry team was involved in writing / reviewing the mental health hospital policy in 143/180 (79.4%) hospitals; teaching/ training in 157/180 (87.2%) hospitals and committees in 128/178 (71.9%) hospitals

- The liaison psychiatry service was PLAN accredited in 54/175 (30.9%) hospitals and under review in 19/175 (10.9%). In hospitals with a team that was not PLAN accredited there was work to try and achieve this in 53/91

- There was a protocol for the treatment of patients with mental health conditions in 123/211 (58.3%) hospitals. This included details of mental capacity assessment in 106/121 (87.6%), self-harm management in 91/117 (77.8%) and 1:1 mental health observations in 88/116 (75.9%)

- The clerking proforma had space or a specific section to record the mental health condition of the patient in 105/176 (59.7%) hospitals and space to document mental capacity issues/ assessment in 95/168 (56.5%)

- 117/181 (64.6%) hospitals had a policy for the management of addictive substances

- 80/231 (34.6%) hospitals had a policy for nicotine replacement

- 21/190 (11%) hospitals shared complete access to mental health community records

- The discharge summary was routinely copied to the patient's mental health team (for patients with mental health conditions) in 33/203 (16.3%) hospitals and to the patient's named psychiatrist in 20/198 (10.1%) hospitals

- There was ongoing work to improve data sharing in 57.9% (113/195) of hospitals

- 20/40 independent hospitals would admit patients with pre-existing mental health conditions

- 10/40 independent hospitals had a policy for the management of patients with a pre-existing mental health condition

- 95/208 (45.7%) hospitals had mandatory training in the management of patients with mental health conditions. There were no hospitals that offered training covering all aspects of management of patients with mental health conditions

- Healthcare professionals responding to the on-line survey stated that 11.4% (151/1323) had no training in basic mental health awareness, 38.9% (497/1276) had no training in management of self-harm, 21.2% (274/1295) had no training in assessing mental health capacity; 41.4% (523/1263) had no training on risk assessment, 58.9% (727/1234) had no training in psychotropic medications and 19.1% (248/1298) had no training in dealing with violence/ aggression.

Overall quality of care

- Good practice was recorded in 46% (252/548) of cases reviewed

- Examples of good clinical practice were noted in 17.9% (93/521) of patients in this study

- 23.7% (130/548) of the sample notes included room for improvement in clinical care

- 16.1% (88/548) of the sample notes included room for improvement in the organisation of care

- 11.7% (64/548) of the sample notes included room for improvement in both the clinical care and the organisation of care

- The effect of having a liaison psychiatry team, and one which was PLAN accredited was noted. Good practice in the quality of mental healthcare was demonstrated in 40.8% (20/49) of cases from hospitals with no liaison psychiatry team; in 46.1% (97/210) of cases with non-PLAN accredited liaison psychiatry team and in 59.8% (58/97) of hospitals with a PLAN accredited liaison psychiatry team.

Recommendations

The overarching theme of this report is that the divide between mental and physical healthcare needs to be reduced. This will require long-term changes in both organisational structures and individual clinical practice to produce a working environment where the mind and body are not approached separately. The following are a series of recommendations that should be undertaken now to help that process.

The text in italics after each recommendation is a suggestion as to who should be aware of / lead on the recommendation, but this will vary locally so please include all groups who need to be involved.

Presentation to hospital

1. Patients who present with known co-existing mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital. These should be documented:
   a. In referral letters to hospital
   b. In any emergency department assessment
   c. In the documentation on admission to the hospital
   Existing guidance in these areas for specific groups should be followed which includes but is not limited to NICE CG16 and CG113 *(General Practitioners, Community Care Teams, Community and Hospital Mental Health Teams, Paramedics, Allied Health Professionals (e.g. Occupational Therapy) Emergency Medicine Consultants, Medical Directors of Mental Health Hospitals, Medical Directors of General Hospitals, Directors of Nursing and all Hospital Doctors and Nurses)*

2. The recognition of potential mental health conditions in all patients presenting to a general hospital would require routine screening at presentation and during the hospital stay. This would be an enormous change in practice and the benefits and challenges of this need to be investigated. *(All relevant Royal Colleges, Specialist Colleges and Specialist Associations and led by the Academy of Medical Royal Colleges)*

3. National guidelines should be developed outlining the expectations of general hospital staff in the management of mental health conditions. These should include:
   a. The point at which a referral to liaison psychiatry should be made
   b. What should trigger a referral to liaison psychiatry and
   c. What relevant information a referral should contain
   (All relevant Royal Colleges, Specialist Colleges and Specialist Associations, and led by the Academy of Medical Royal Colleges)

Liaison psychiatry review

4. As recommended by the Psychiatric Liaison Accreditation Network, mental health liaison assessments should be made in an appropriate timeframe, and by a mental health professional of appropriate seniority to meet the needs of the patient. *(Medical Directors of General Hospitals, Directors of Nursing, Faculty of Liaison Psychiatry, Royal College of Psychiatrists)*

5. Patients who have been admitted to hospital and have been referred to liaison psychiatry should have a named liaison psychiatry consultant documented in the general hospital case notes and recorded centrally wherever possible. *(Medical Directors and Clinical Directors of General Hospitals, Faculty of Liaison Psychiatry, Royal College of Psychiatrists)*

6. Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes at the time of assessment. As a minimum the review should cover:
   a. What the problem is (diagnosis or formulation)
   b. The legal status of the patient and their mental capacity for any decision needing to be made if relevant
   c. A clear documentation of the mental health risk assessment – immediate and medium term

d. Whether the patient requires any further risk management e.g. observation level

e. A management plan including medication or therapeutic intervention

f. Advice regarding contingencies e.g. if the patient wishes to self-discharge please do this '…'

g. A clear discharge plan in terms of mental health follow-up *(Faculty of Liaison Psychiatry, Royal College of Psychiatrists)*

Supporting care issues

7. All healthcare professionals must work together to eradicate terms such as 'medically fit' or 'medical clearance'. The terms 'fit for assessment', 'fit for review' or 'fit for discharge' should be used instead to ensure parallel working. *(All Healthcare Professionals)*

8. Patients with mental health conditions should be supported in overcoming/managing alcohol and/or substance abuse. Smoking cessation services and brief interventions must be offered to all patients who would benefit. *(All Healthcare Professionals)*

9. All general hospital pharmacy departments should be able to undertake medicines reconciliation of medications for mental health conditions within the first 24 hours of admission. Communication between general hospital and mental health hospital pharmacists should be encouraged. *(Medical Directors of Mental Health Hospitals, Medical Directors of General Hospitals, Pharmacy Leads)*

10. The use of mental health one-to-one observation support needs to be available for patients in a general hospital setting. Organisations should determine whether this occurs via training of their own general hospital staff or by arrangement with the local mental health service. The sole use of security staff or other staff members who are not trained for this purpose must not occur. *(Medical Directors of Mental Health Hospitals, Medical Directors of General Hospitals, Directors of Nursing)*

Mental health legislation

11. Mental capacity assessments should be documented in the case notes using the language of the relevant Act, and regular audits of the quality of the documentation undertaken. *(Medical Directors and Clinical Directors of General Hospitals and Directors of Nursing)*

12. If the primary clinical team has concerns about mental capacity in patients who have a mental health condition, they should involve liaison psychiatry to assist in decision making. *(All Consultants, Liaison Psychiatry)*

13. General hospitals must have a robust centralised hospital system for the management of mental health legislation processes whether by themselves or with their local mental healthcare providers. This should be audited regularly to ensure that the law is complied with. *(Medical Directors of General Hospitals, Directors of Nursing and Chief Operating Officers)*

Ongoing patient care

14. Mental healthcare should be routinely included in step-up and step-down documentation to critical care, with appropriate involvement from liaison psychiatry. *(Medical Directors and Clinical Directors of General Hospitals, Directors of Nursing and Faculty of Liaison Psychiatry, Royal College of Psychiatrists)*

15. Discharge planning for patients with mental health conditions should involve multidisciplinary input, including liaison psychiatry where appropriate and in all cases where the patient has been under the care of liaison psychiatry. The discharge letter should be copied to all specialties providing ongoing mental and physical healthcare outside of the general hospital. Sharing of clinical information between care providers using a Summary Care Record or equivalent should be utilised. *(Medical Directors and Clinical Directors of General Hospitals and Liaison Psychiatry)*

Training

16. All hospital staff who have interaction with patients, including clerical and security staff, should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway from undergraduate to workplace based continued professional development. *(Medical Directors and Clinical Directors of General Hospitals and Directors of Nursing)*

Organisation of services

17. In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team. *(Medical Directors of General Hospitals, Medical Directors of Mental Health Hospitals, Directors of Nursing and Clinical Commissioners)*

18. Liaison psychiatry consultants and associated mental health staff should be actively integrated into all relevant general hospital governance structures and committees. This should include issues around audit, risk management, education and training, serious/ adverse incident investigations and senior director level meetings. *(Medical Directors of General Hospitals)*

19. Record sharing (paper or electronic) between mental health hospitals and general hospitals needs to be improved. As a minimum patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient. *(Medical Directors and Clinical Directors)*

20. NCEPOD supports the continued successful implementation the Psychiatric Accreditation Liaison Network nationally. *(Medical Directors and Clinical Directors)*

Coding

21. Diagnostic coding of mental health conditions must be improved. Liaison psychiatrists should enter the diagnosis in the general hospital notes so that they can be coded appropriately and included in discharge summaries made by general hospital doctors. This will help with local and national audit. *(Faculty of Liaison Psychiatry, Royal College of Psychiatrists, General Hospital Doctors)*

Overall quality of care

Overall, 46.0% (252/548) of the case notes reviewed were thought to have demonstrated good practice. There were cases showing a need for improvement in clinical and organisational factors in 51.5% (282/548); and 14/548 (2.6%) were scored as less than satisfactory. Comparing the quality of the physical and mental healthcare, a similar proportion was seen as good practice at 44.6% (232/520) with 55.4% (288/520) deemed as having room for improvement again split between clinical and organisational. Since both aspects of a patient's care are closely interlinked it is no surprise that the figures are similar, suggesting that teams that work closely with the liaison psychiatry team end up providing good physical and mental healthcare (Table 8.2 and Figure 8.1).

Table 8.2 Overall quality of physical care and overall quality of mental healthcare – reviewers' opinion

|	Overall quality of care		Overall quality of mental healthcare	
	Number of patients	**%**	**Number of patients**	**%**
Good practice	252	46.0	232	44.6
Room for improvement - clinical care	130	23.7	123	23.7
Room for improvement - organisational care	88	16.1	85	16.3
Room for improvement - clinical and organisational	64	11.7	68	13.1
Less than satisfactory	14	2.6	12	2.3
Subtotal	**548**		**520**	
Insufficient data	4		32	
Total	**552**		**552**	
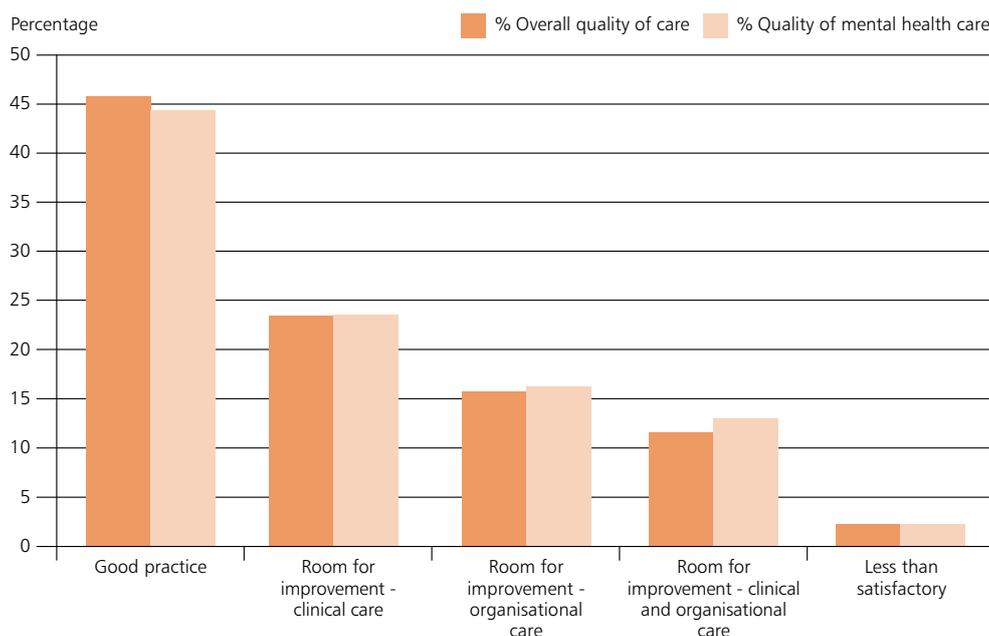
Figure 8.1 Overall quality of care and overall quality of mental healthcare – reviewers' opinion

Summary

It is well established that patients with severe mental illness develop co-moribid physical health conditions, like heart disease, about a decade earlier in their life. They are also more likely to die more than a decade earlier than those without mental health conditions. Previous studies have shown that there is inconsistency in how physical health care is delivered to patients with co-existing mental health conditions.

This study aimed to identify and explore remediable factors in the quality of mental health and physical health care provided to patients with significant mental health conditions who were admitted to a general hospital with physical illness. This acute care pathway is one important part of the healthcare experienced by those with mental health conditions. Both the clinical aspects and the organisation of care were assessed.

A total of 552 case notes were peer reviewed along with data collected and analysed from completed questionnaires from the discharging consultant and liaison psychiatrist (where available).

164/413 (39.7%) of patients were current smokers, 104/552 (18.8%) had a history of alcohol misuse and 88/552 (15.9%) of substance misuse. Most of the admissions to hospital (351/552; 63.6%) occurred through the Emergency Department (ED), while 80 (14.5%) patients were referred by their GP and 57 (10.3%) were transferred from a mental health or another general hospital. Case reviewers were of the opinion that the ED notes should have but did not mention the mental health condition in 47/96 patients at triage and 24/47 patients at a subsequent senior review. Of the patients presenting to the ED, 55 were referred to liaison psychiatry, following which 32 patients were seen by liaison psychiatry in an appropriate time. The lack of liaison psychiatry input in the ED affected the overall quality of care of 20 patients. The medical clerking on admission to a hospital ward

lacked adequate mental health history in 101/471 (21.4%) patients. In addition, medicines reconciliation occurred at this stage in only 206/531 (38.9%) patients and mental health medications were prescribed in only 331/431 (72.2%). Drug interactions are an important aspect of care in this group of patients but were noted in 51/279 (18.3%) patients.

Mental health risk assessments were recorded in only a third of patients, 161/476 (33.8%). An adequate risk management plan should be available to the treating team, but was provided in only 106/224 (47.3%) of these patients. Assessment and management of mental capacity often requires careful attention in this group of patients. However, it was noted in only 66/479 (13.8%) patients during initial assessment. After their initial physical assessment 103/458 (22.5%) patients were referred to the liaison psychiatry team. Of those patients who were not referred, 30/301 (10.0%) should have been at this time and their care was believed to have been impacted as a result.

Complex needs assessments were carried out in 171/380 (45.0%) patients, and were deemed adequate in 135/169 (79.9%). During hospital care some patients may need 1 to 1 mental health observations (sometimes called specialling). In this study we found it was inadequate in 151/222 (68.8%) of cases reviewed.

A liaison psychiatry team reviewed 256/552 (46.4%) patients during their hospital stay. There was room for improvement in the following aspects: mental health risk assessment (22/125; 17.6%), mental capacity assessments (11/53; 20.8%), prescription of medications (11/48; 22.9%) and advice to nursing staff (20/86; 23.3%). However, the first assessment by liaison psychiatry was substantially delayed according to the reviewers in 74/199 (37.2%) patients. This impacted the quality of care in 22/51

patients. The most common reason for the delay in the liaison psychiatry assessment was that "the liaison psychiatry team would not attend until the patient was declared medically fit" (26/74).

Only a small proporation of patients admitted to a general hospital require detention under mental health legislation. However, appropriate procedures and documentation should be used on each occasion. In this study, 65/541 (12.0%) patients were detained using mental health legislation. In 15/65 of these patients there were issues in the documentation of the process.

The practicalities of ensuring safety saw security staff involved with patients in 23 cases, however in over fifth of those patients was there thought to be room for improvement in this process. A small minority of patients 13/552 required use of physical restraint.

Surgery, or an interventional procedure, was undertaken in 135/511 patients (26.4%). There was believed to be room for improvement in the consent process in 24/109 (22.0%), where seeking help from liaison psychiatry would have been useful.

Multidisciplinary discharge planning has an important role to play in patients with complex physical and mental health needs. It took place in 209/423 (49.4%) patients discharged from hospital. Management plans for the patient changed following MDT meetings in 45/107 patients for whom an MDT meeting was documented, demonstrating their value in discharge planning. However, liaison psychiatry were involved in the MDT meeting in only 20/107 (18.7%) of these. Delayed discharges occurred in 65/443 (14.7%) patients.

Each discharge summary should have all relevant medical information, but lacked the mental health diagnosis in 95/343 (27.9%) and details of the mental health medications in 90/308 (29.2%). We found that no discharge summaries were copied to the relevant out of hospital psychiatry consultant. Readmission rates were lower than expected at 37/502 (7.4%). However, analysis of discharge documents revealed inadequate discharge planning in 23/37 of these patients.

The overall quality of care was rated by the reviewers as good in 46.0% (252/548) of cases reviewed. Examples of good clinical practice were noted for 17.9% (93/521) of patients in this study. However, 23.7% (130/548) of the case notes reviewed had room for improvement in clinical care and 16.1% (88/548) had room for improvement in the organisation of care. Room for improvement in both clinical and organisational aspects of care was noted in a further 11.7% (64/548) of the cases reviewed. Similar figures were seen when the quality of mental healthcare data was analysed separately.

Good practice in the quality of mental healthcare was demonstrated in 40.8% (20/49) of cases from hospitals with no liaison psychiatry team; in 46.2% (97/210) of cases with non-PLAN accredited liaison psychiatry team and in 59.8% (58/97) of hospitals with a PLAN accredited liaison psychiatry team. The effect of having a liaison psychiatry team, especially one which was PLAN accredited was positively associated with better quality of care.

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