Treat as One

Bridging the gap between mental and physical healthcare in general hospitals

NCEPOD

Improving the quality of healthcare

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Bridging the gap between mental and physical healthcare in general hospitals

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Foreword

There is no doubt in my mind that this is an important report. It is the first time anyone has critically examined the way physicians and surgeons respond to the mental health disorders of patients admitted to acute general hospitals for management of their co-existing physical ill health. It is also a timely publication, when viewed in the light of our increasing recognition of the importance of Parity of Esteem between mental and physical wellbeing.

It has been acknowledged for many years that mental health services are a Cinderella of our NHS, but after reading this report you may rightly conclude that those mental health patients being treated for physical disorders are seriously disadvantaged. By definition, all the patients in this report had dual pathology: the physical problem that triggered the admission to a general hospital, together with the underlying mental health disorder which added to the complexity of management.

I suspect that many clinicians reading this report will be surprised by the magnitude of the problem. The recruitment period was confined to one month in 2014 and yet 11,980 patients met the study criteria of dual pathology.

Furthermore, the population we have studied could well be the tip of the iceberg because many mental health problems are often missed and hence these patients would not have received a mental health code at the time of hospital discharge. So poor coding is another significant obstacle inhibiting our understanding of the extent of the problem, which in turn prevents appropriate solutions being found. Added to which, we deliberately excluded the 20% of all pregnant and post partum women who suffer from perinatal mental health problems, which account for 1 in 4 maternal deaths in this country and are documented by our colleagues at MBRRACE-UK in their annual reports.

In more than a third of the patients whose care was reviewed by liaison psychiatry but delayed, we are told that the liaison psychiatry team did not attend until the patient was declared 'medically fit'. However, this report exposes the fact that in many cases the physical illness cannot be treated effectively until the mental illness is recognised and appropriately managed. Which is why highlighting that many staff reported a lack of knowledge, and confidence, in dealing with mental health conditions is so important if we want to improve the situation.

When general hospital clinicians recognise the need for referral, all too often it is assumed that better liaison psychiatry could fix all the problems. But this intervention alone cannot resolve the situation in the long term. Effecting a sustainable improvement requires significant organisational change, with many more clinicians contributing to improve the patient journey at each step of the way. It is only when all clinicians involved in the care of these patients learn from their experiences and become more confident in identifying symptoms and referring swiftly and appropriately that real improvements in outcome can be expected.

So the first lesson is that this is a massive problem, far larger than we had supposed and that we must change our attitude and find ways of bridging the gap between physical and mental health services if we are going to deliver optimal care in the future. We need a workforce that has been educated to understand this gap and are trained and supported to have the competence and the confidence to recognise and bridge the gaps at every level of the service in order to make a sustainable difference.

In the view of our reviewers, mental health risk assessments were performed in only about half the cases where they were clearly indicated and in a similar proportion there was no adequate mental healthcare management plan. It is even more alarming that a formal assessment of mental capacity was even less likely to be carried out – in more than half of the patients where no assessment was carried out, our

reviewers tell us it should have been. Remember that these reviewers are clinicians undertaking similar work routinely in our hospitals and have been asked to decide whether the patient got the sort of care that they would accept from themselves or their team, and if not, whether the shortfall was due to organisational or clinical shortcomings.

The second lesson from this report is that opportunities to identify patients with dual pathology are regularly missed despite there being clear evidence of the mental health disorder staring us in the face. For example, only half of those patients who would have benefited from a referral to liaison psychiatry received one from the emergency department. That almost half of those who were referred presented following acts of self-harm suggests that there are many occasions when these patients are not being cared for appropriately or perhaps receiving the community support they need.

Hence, one reason why good care does not happen is because we do not look for the problem and when we do there can be resistance from both the referring and the receiving team to making and receiving the referral whilst the patient is acutely ill. But the shortfalls do not end there. Once the liaison psychiatrists saw the patient, usually only once, most aspects of the review were judged to have room for improvement.

This report should be a clarion call that we have a major problem that will in practice be difficult to disentangle. We are failing a significant proportion of our patients and the divide between mental and physical health needs to be bridged since in many cases we reviewed, the mental health disorder was integral to the physical problem and neither could be treated optimally in isolation. Attention must also be paid to the complexities of fragmented commissioning services, which currently presents another major obstacle to providing good care for patients with dual pathology.

Whilst this report has concentrated mainly on what can be improved in this area, we must not finish without noting all the good practice that was witnessed through the case reviews. And to acknowledge that many areas around the UK are already providing integrated care, demonstrating that it can be done.

So the first of my thanks are due to the proposers of the study. Then the Study Advisory Group who took the raw proposal and hammered out the details of the design, together with the Local Reporters and NCEPOD Ambassadors who made it happen by identifying the cases and securing copies of the clinical notes. The local clinicians who found time to fill in our questionnaires. The Reviewers who also give their time unpaid to ensure that the report you are holding really does reflect the mainstream views of the members of our profession who treat these patients. The Authors who have written the report and the Clinical Researcher who, along with the NCEPOD staff have run the study. Lastly the rest of our team of Clinical Co-ordinators, the Trustees and the Steering Group nominated by all the Royal Colleges who have considered the data and debated the recommendations.

It has been a significant group effort and if it results in a wake up call to everyone who is involved in the care of patients who present to our hospitals suffering from dual mental and physical pathology, then it will have been truly worthwhile.

Professor Lesley Regan
NCEPOD Chair

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)*

Please see page 87 for the full list of recommendations

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.

The report is laid out in eight chapters and focuses on the presentation of 552 cases of patients who presented to general hospitals with an array of physical health issues and who also had a significant mental health problem. The study did not aim to look at the care given for a specific mental health condition, but sought to identify the common themes that emerged in the general hospital setting.

After this introduction, chapter one describes the methodology of the study from case identification through to analysis of the various pieces of data gathered from general hospital clinician and psychiatrist questionnaire, through to case note reviews and organisational data.

Chapter two identifies the study population and demographics of the sample and lays out both the physical and mental health conditions the individuals presented with, along with the array of co-morbidities of each.

Chapter three focuses on the presentation to hospital. The majority of patients arrived on the acute care pathway via the emergency department, however, a variety of other routes into the hospital are described for this sample of patients including transfers from mental health hospitals.

Chapter four focuses on the admission to a ward in the hospital and data are presented on general hospital and liaison psychiatry care during the admission.

Chapter five reviews the ongoing care during the admission including incidents and challenges and complications.

Chapter six focuses on discharge planning to ensure that patients have effective transition from hospital at the end of their stay. For those who sadly died during the admission this chapter also comments on the end of life care that was provided.

Chapter seven describes the organisational data received and focuses a lot, but not exclusively on the recent expansion of liaison psychiatry services and what these services have to offer as a solution to some components of bridging the gap. This chapter also presents data on a separate education and training survey that was conducted as improving this is one of the key recommendations of the report.

Finally, chapter eight describes the overall quality of care that was received by the patients in this sample and draws together the findings of the report.

Throughout the report a series of key findings are described in each chapter based on the analysis which inform key recommendations.

1

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 this 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.

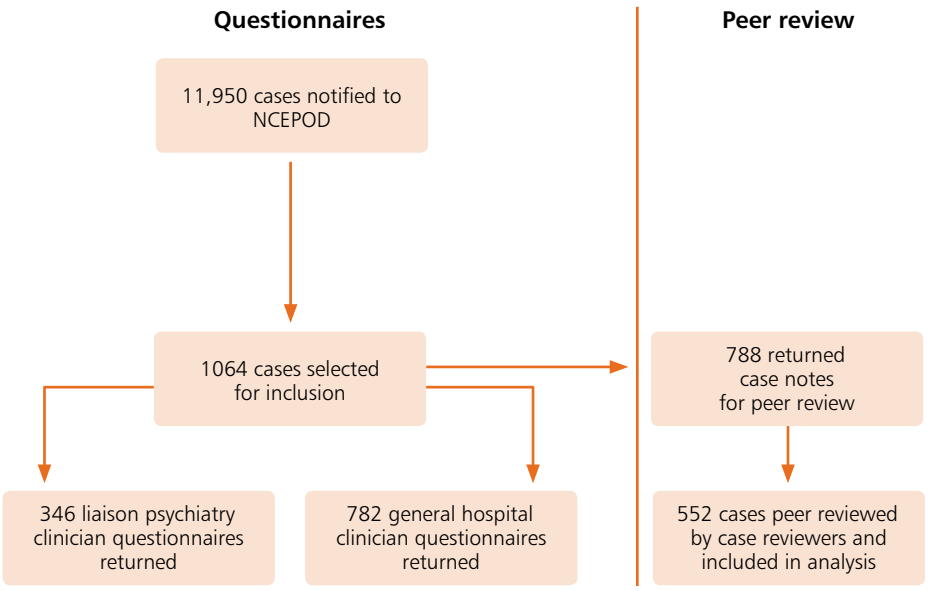

Figure 1.1 Data returns

2

Sample population

Patient demographics

Age and gender

Figure 2.1 illustrates the age and gender distribution of the 552 patients included in this study. It shows that 47.5% (262/552) of the sample was male, with a majority in the age range of 51-80 years.

Ethnicity

The composition of the sample population by ethnicity is shown in Table 2.1. Data were not provided in 15.0% (83/552) of cases. White British accounted for 90.8% (426/469) of the group, which is a little over the 2011 UK National Census figures at 86.0%.[23] Asian/Asian British were 3.6% (17/469) of the sample, which was approximately half the 2011 census rate of 7.5% and those of multiple Black ethnicities accounted for 3.0% (14/469) of the sample which was in line with the national data at 3.3%.

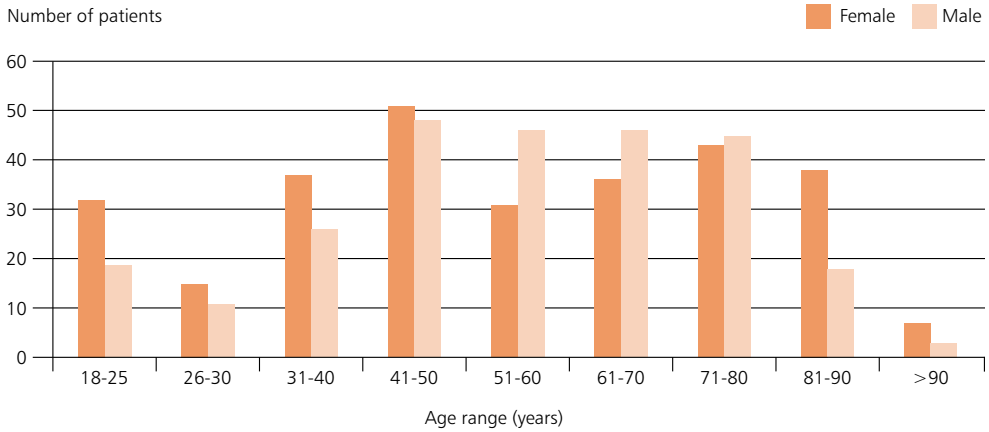

Figure 2.1 Age and gender

Table 2.1 Ethnicity

Ethnicity	Number of patients	%	% in population (2011 census data)
White British	426	90.8	87.1
Asian/ Asian British	17	3.6	6.9
Black / African / Caribbean / Black British	14	3.0	3.0
Mixed / Multiple Ethnic Groups	5	1.1	2.0
White Other	4	<1	<1
Other	3	<1	<1
Subtotal	**469**		
Unknown	83		
Total	**552**		

Primary medical reason for admission

To understand the spectrum of physical health conditions at admission and provide a clinical context to the study population, the primary presenting conditions of the patients in this study were reviewed. Many patients had more than one medical or surgical condition present at the time of admission; these are shown in Figure 2.2. Since one case of self-harm was included from each hospital, a fifth of the study population presented for this reason (110/552; 19.9%) with varying degrees of severity. Most of these cases of self-harm were related to drug overdoses, however a smaller but notable proportion of patients had self-inflicted injury or trauma that required surgical or orthopaedic intervention. The remaining surgical patients, who also had pre-existing mental health conditions, were admitted for planned elective procedures. Infections formed a large group (94/552; 17%) ranging from cellulitis to pneumonias. Non-infectious causes for admission included chronic obstructive pulmonary disease, heart failure, myocardial infarction, acute kidney injury and falls. A small group of patients had fluid and electrolyte disturbance (31/552; 5.6%), commonly seen in patients with eating disorders, or acute confusion, who are unable to, or refuse to, eat and drink. Another small group of patients presented with hypothermia or hyperthermia (3/552), which can occur as adverse effects of medications for mental illness.

Physical co-morbidities

Patients with long standing mental health conditions have an increased risk of medical co-morbidities.[24] In this study 81.3% (425/523) of patients gave a history of medical co-morbidities (Table 2.2). Disease affecting the lung was the most frequent co-morbidity, followed by heart disease, both of which would be associated with the high prevalence of smokers in the study population (Figure 2.3). Whilst it is possible that by selecting an older patient group in this study there was a larger representation of medical conditions common with advancing age, it is also well known that these conditions occur at an earlier age in patients with long standing mental health conditions.

Table 2.2 Physical co-morbidities present at admission

Co-morbidities present	Number of patients	%
Yes	425	81.3
No	98	18.7
Subtotal	**523**	
Not answered	29	
Total	**552**	

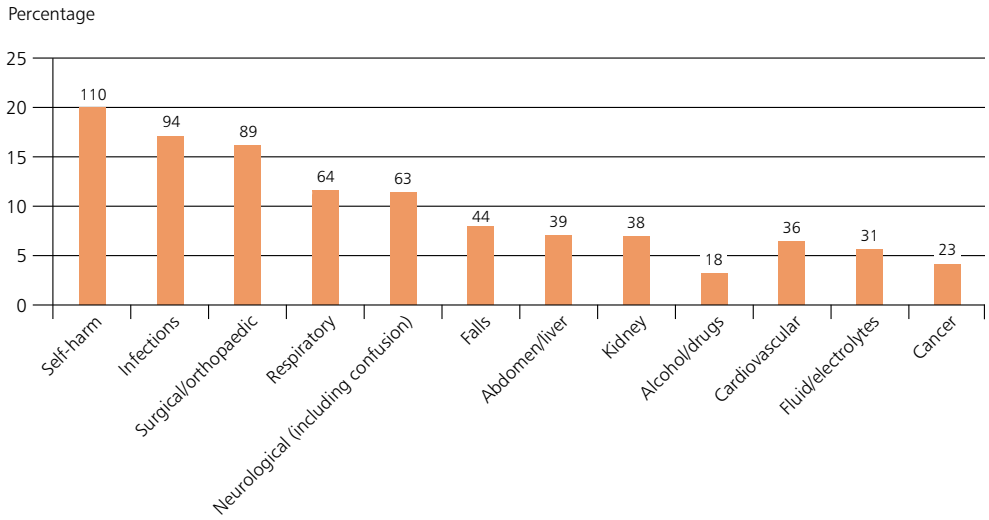

Figure 2.2 Primary medical reason for admission *(answers may be multiple; n=552)*

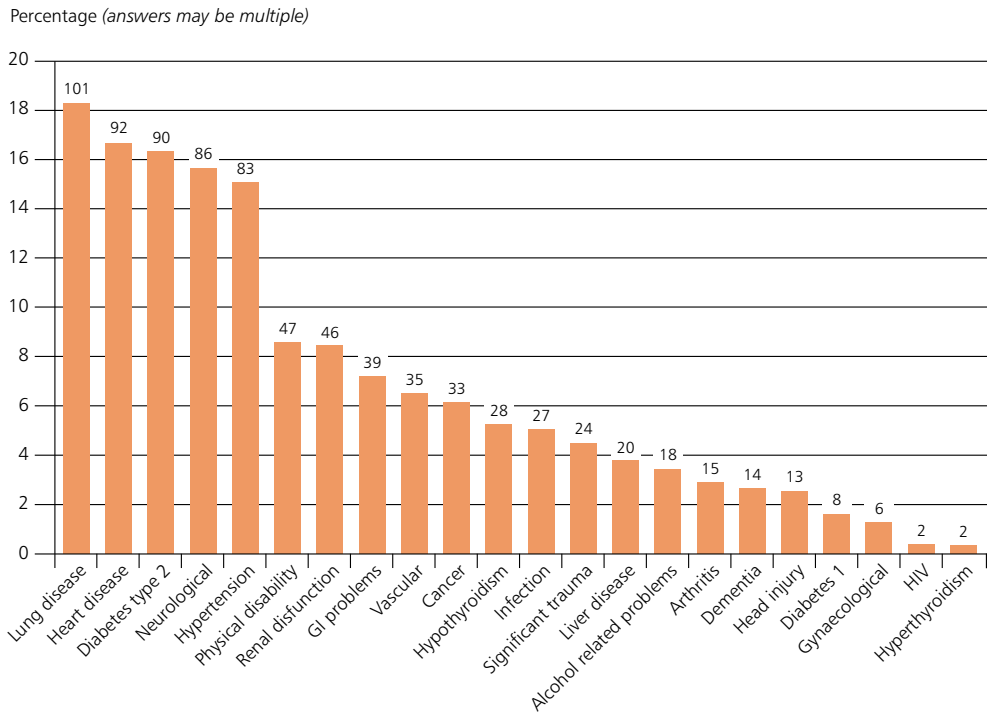

Figure 2.3 Type of physical co-morbidity present at admission

Mental health diagnoses

The use of diagnostic coding for mental health conditions in the general hospital setting is not robust.[25] ICD-10 coding is poorly completed and discharge notifications may include broad categories such as 'psychosis' or 'depression' without any more detailed information. Furthermore, a large number of patients with mental health presentations in the widest sense, may present and be labelled with a behaviour rather than a diagnosis, such as 'overdose' or 'other act of self-harm'. The following data attempt to describe the patient sample in a variety of ways highlighting mental health co-morbidities which were obtained through coding or from additional information in the clinical questionnaires and case notes. *It is important to remember that this study was not designed as an epidemiological survey and so the overall numbers describe the sample but do not describe prevalence of the conditions.*

Figure 2.4 (overleaf) shows the frequency of mental health conditions documented in the study population. Schizophrenia and bipolar affective disorder were two of the most common diagnoses; 37.0% (204/552) and 25.7% (142/552) respectively. Psychotic disorder/psychosis – other included a range of diagnoses including schizoaffective disorder and occurred in 10.3% (57/552) of the sample. Self-harm, as coded, accounted for 19.9% (110/552) of the sample. Although not specifically sampled by the study methodology, it can be seen that individuals with learning disabilities and dementia were also present in 4.5% (25/552) and 8.3% (46/552) of the sample, respectively. Depression, anxiety, alcohol and other substance misuse were also widely present in the sample.

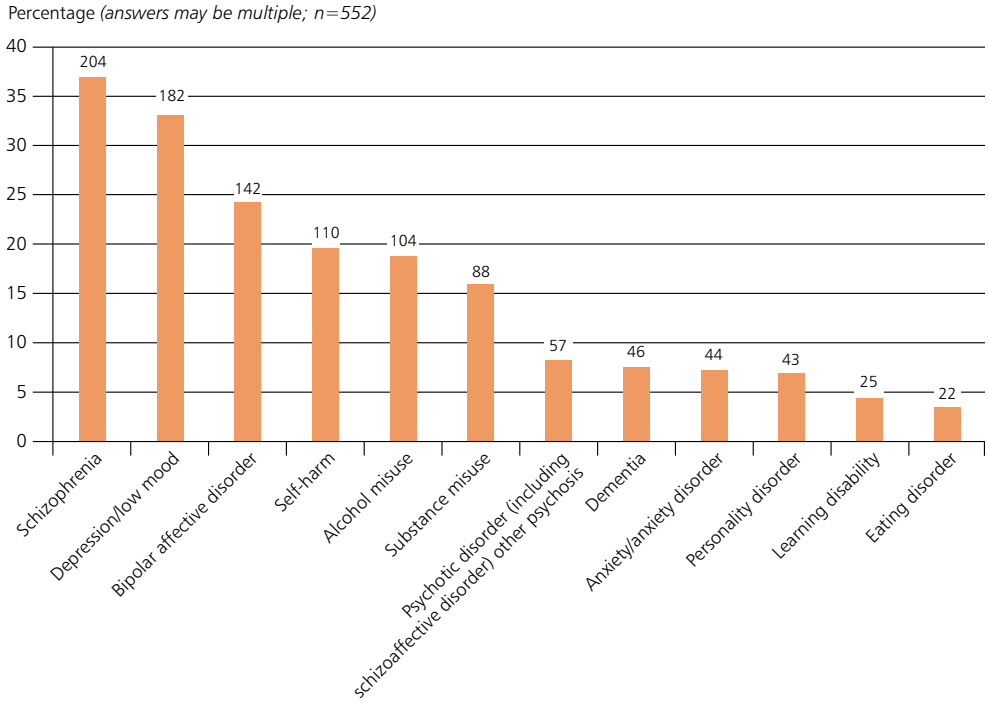

Figure 2.4 Mental health conditions documented in the study sample

Mental health co-morbidities

Given the level of multiple mental health conditions, Tables 2.3 to 2.5 describe the overlap between the main diagnoses. Each of the three tables describe co-morbidities within the sample.

Table 2.3 shows that small numbers of those patients diagnosed with schizophrenia or bipolar affective disorder also carried a diagnosis of personality disorder, which is possible in combination. However, other patients carried multiple diagnoses which were more likely to be part of diagnostic coding problems or perhaps changes in diagnoses over time, which had not been altered in the notes, such as diagnosis of schizophrenia and bipolar affective disorder.

Other important disorders were identified in the sample, eating disorders (specified in the study methodology), learning disability and dementia. These latter arise due to their prevalence in the population and would be expected looking at a sample population of this size.

It is possible to see from Table 2.4 that in the 22 patients with an eating disorder, 8 also had depression, 6 presented with self-harm, 9 with alcohol misuse and 7 with substance misuse. Schizophrenia or other psychotic disorder co-morbidities were absent. Of the 25 patients with a learning disability, the majority (14) also had a diagnosis of schizophrenia, a further 5 had another psychotic disorder, 3 bipolar affective disorder, 2 a personality disorder and 1 an eating disorder. In terms of dementia, 46 cases appeared in the sample despite the methodology not seeking to identify them specifically, which is an indication of its prevalence in hospital settings. As can be seen in Table 2.4, almost half of the sample (20/46) also had a diagnosis of schizophrenia, with 9 another psychotic disorder, 11 bipolar affective disorder and 12, depression.

Table 2.3 Matrix of mental health co-morbidities

Mental health condition (combined data)	Schizophrenia	Other psychosis	Bipolar affective disorder	Personality disorder
Schizophrenia (204)	**204**	11	4	4
Other psychosis/ psychotic disorder including schizoaffective disorder (57)	11	**57**	2	1
Bipolar affective disorder (142)	4	2	**142**	2
Personality disorder (43)	4	2	2	**43**
Depression/ low mood (182)	37	14	26	2
Anxiety/ anxiety disorder (44)	9	2	11	2
Self-harm (110)	8	1	4	12
Eating disorder (22)	0	0	1	4
Learning disability (25)	14	5	3	2
Dementia(46)	20	9	11	0
Substance misuse (88)	30	7	11	11
Alcohol misuse (104)	34	6	16	13

Table 2.4 Matrix of mental health co-morbidities

Mental health condition (combined data)	Eating disorder	Learning disability	Dementia
Schizophrenia (204)	0	14	20
Other psychosis/psychotic disorder including schizoaffective disorder (57)	0	5	9
Bipolar affective disorder (142)	1	3	11
Personality disorder (43)	4	2	0
Depression/ low mood (182)	8	5	12
Anxiety/ anxiety disorder (44)	1	2	2
Self-harm (92)	6	2	1
Eating disorder (22)	**22**	1	0
Learning disability (25)	1	**25**	3
Dementia (46)	0	3	**46**
Substance misuse (88)	7	3	2
Alcohol misuse (104)	9	3	1

Table 2.5 Matrix of mental health co-morbidities

Mental health condition (combined data)	Depression	Anxiety	Self- harm	Substance misuse	Alcohol misuse
Schizophrenia (204)	**37**	**9**	8	30	34
Other psychosis/ psychotic disorder including schizoaffective disorder (57)	6	2	**1**	7	6
Bipolar affective disorder (142)	23	11	4	**11**	16
Personality disorder (43)	21	2	12	11	**13**
Depression/ low mood (182)	**182**	29	59	34	43
Anxiety/ anxiety disorder (44)	29	**44**	1	8	12
Self-harm (110)	59	11	**110**	30	30
Eating disorder (22)	8	1	6	7	9
Learning disability (25)	5	2	2	3	3
Dementia (46)	12	2	1	2	1
Substance misuse (88)	34	8	30	**88**	43
Alcohol misuse (104)	43	12	30	43	**104**

Table 2.5 reveals further complexity in the sample with the prevalence of depression and anxiety along with alcohol and substance misuse and how they appear in a co-morbid manner with other mental health diagnoses.

Depression occurred in those patients with diagnoses of schizophrenia, other psychoses, bipolar affective disorder, personality disorders, anxiety and eating disorders. The same was true for anxiety but with lower numbers. A similar picture was revealed with alcohol and substance misuse diagnoses. The spread across the mental health diagnoses was marked, with co-morbid cases present in all other diagnostic categories.

These data reveal a level of complexity that the general hospital must attend to in terms of the range of mental health conditions presenting and also the level of co-morbidity within mental health alone. This highlights a significant skill-set necessary to identify, assess and manage the issues well. For example, although depression may have a core set of symptoms, the way in which it may manifest will be strikingly different if a patient has a learning disability, schizophrenia, alcohol problems or none of these. Furthermore, given the significant evidence now available about the undiagnosed prevalence of mental health conditions in general hospitals, these data are likely to be a conservative estimate.

History of alcohol use

The association of alcohol and substance misuse with mental health conditions is well established. A higher rate of hospital admission has also been noted in these patients.[26] History of alcohol use was noted in 337 patients in this study (Table 2.6). Alcohol misuse is defined as consuming more than the lower-risk limits of alcohol consumption, which is 14 units each week on a regular basis. Alcohol misuse was documented at admission in 104/337 (30.9%) patients in this study. However, only 17 of these patients were receiving any support from alcohol support services (Table 2.8).

A detailed history of alcohol use, or of other substances, helps in identifying those at risk of complications from it. It helps initiate measures like brief interventions and treatment to prevent complications like alcohol withdrawal syndrome. A history of alcohol use was noted in 61.1% (337/552) of patients, and of alcohol misuse in 30.9% (104/337) (Table 2.7). This is similar to the figures reported in the NCEPOD study of alcohol-related liver disease, "Measuring the Units" which found that an adequate history of alcohol intake was taken in just over half the patients (52.7%).[27]

Table 2.6 History of alcohol use recorded

History taken	Number of patients	%
Yes	337	61.1
No	215	38.9
Total	**552**	

Table 2.7 History of alcohol misuse recorded

Alcohol misuse recorded	Number of patients	%
Yes	104	30.9
No	233	69.1
Total	**337**	

When a patient is found to meet diagnostic criteria for alcohol misuse, the support of an alcohol misuse service should be sought. Access to such a service was provided to only 17/97 patients, as shown in Table 2.8. Similarly, in the opinion of the treating clinicians, there was evidence of adequate support in only a fifth of these patients (Table 2.9).

Table 2.8 Patient was in contact with the alcohol misuse service

Alcohol misuse service	Number of patients
Yes	17
No	35
Unknown	45
Subtotal	**97**
Not answered	7
Total	**104**

Table 2.9 Adequate alcohol misuse support provided – clinician's opinion

Adequate support	Number of patients
Yes	14
No	14
Unknown	38
Subtotal	**66**
Not answered	38
Total	**104**

Smoking and/or substance misuse

Current smoking was documented in 39.7% (164/413) of patients (Table 2.10). In comparison, about half that number (19%) of the general adult population in the UK smokes. Recent work has shown that despite consuming a large proportion of tobacco in the UK and being heavier smokers, only a minority of people with mental health conditions receive effective smoking cessation interventions.[28] This recommended that smokers with mental health conditions using primary and secondary care services, at all levels, should be identified and provided routinely and immediately with specialist smoking cessation behavioural support, and pharmacotherapy to relieve nicotine withdrawal, promote cessation and reduce harm.

Table 2.10 History of smoking status recorded

Smoking status	Number of patients	%
Ex-smoker >5 years	170	41.2
Current smoker	164	39.7
Ex-smoker <5 years	48	11.6
Never smoked	31	7.5
Subtotal	**413**	
Unknown	111	
No data	28	
Total	**552**	

A recent Home Office survey on drug misuse reported that 3.3% of all adults aged 16 to 59 were identified as frequent drug users.[29] In this study, Table 2.11 shows that a history of substance misuse was recorded in 15.9% (88/552) of patients, which may reflect its association with mental health conditions in this sample.

Table 2.11 History of substance misuse recorded

Substance misuse recorded	Number of patients	%
Yes	88	15.9
No	464	84.1
Total	**552**	

Key Findings

- Schizophrenia was the most common mental health condition recorded in the study sample (204/552; 37%) followed by depression (182/552; 33%), bipolar affective disorder (142/552; 25.7%) and self-harm 110/552 (19.9%)
- Alcohol history was recorded in 61.1% (337/552) of patients, of whom 104 had a history of alcohol misuse but of these only (14/66) patients were receiving adequate support in the view of the clinicians who saw them
- 164/413 (39.7%) of the study sample was a current smoker
- 88/552 (15.9%) patients in the sample were recorded as having a history of substance misuse.

3

Presentation to hospital

The majority of patients in this study presented to hospital through the emergency department (ED) (63.6%; 351/552). The remaining patients were referred for admission by their general practitioner (GP) (14.5%; 80/552), admitted from outpatient appointments (7.1%; 39/552) or transferred from another hospital (10.3%; 57/552), (Table 3.1).

Table 3.1 Presentation to hospital

Presentation	Number of patients	%
Via the emergency department	351	63.6
General practitioner referral	80	14.5
Out-patient appointment/ telephone consultation	39	7.1
Hospital transfer: mental health hospital	36	6.5
Hospital transfer: general hospital	21	3.8
Unknown	11	2.0
Other	36	6.5

Answers may be multiple; n=552

Referred via the general practitioner

Patients presenting to their GP would normally not include emergencies like self-harm or acute confusion due to alcohol or substance misuse, since most patients would attend hospital EDs either by themselves or by ambulance. In this study 80 patients were admitted on the request of their GP and a GP referral letter was available in the case notes of 50 patients (Table 3.2). The letters were considered to have adequate information in only 24 cases whilst the mental health diagnosis was mentioned in only 37. In 2 cases the GP did not recognise the urgency of the physical health condition and in the view of the reviewers, the referral was delayed because of the patient's mental health.

Table 3.2 GP referral letter – reviewers' opinion

GP referral letter	Number of patients
Was a referral letter included in case notes	50
Was the mental health condition described in the letter	37
All relevant Information included in letter	24

Answers may be multiple; n=80

Information considered important in a referral letter was missing in 26 cases (Table 3.3). For example, the mental health condition was missing in 11 cases, and the relevant medications were omitted in 12 cases (7 for the mental health condition). It was more common to find that the letter had omitted the mental health diagnosis than the relevant physical health condition.

Table 3.3 Missing information in the GP referral letter – reviewers' opinion

Omissions	Number of patients
Mental health condition	11
Mental health medications	7
Physical health medications	5
Physical health condition	1
Other	2

Answers may be multiple; n=26

Transfer from another hospital

During the study period, 57 patients were transferred to the general hospital from another general or mental health hospital (Table 3.4). Of these, 36 were planned transfers. The clinician referring (34/57) and receiving (43/57) the transfer was, in the view of the reviewers, of appropriate seniority and in 45/57 (referring hospital) and 43/57 (receiving hospital) of appropriate specialty (data not shown).

Table 3.4 Inter-hospital transfer – reviewers' opinion

Transfer details	Number of patients
Planned transfer	36
Appropriate grade of clinician at referring hospital	34
Appropriate grade of clinician at receiving hospital	43

Answers may be multiple; n=57

Problems were identified with the transfer of 7 patients. These included: inappropriate transfer, a lack of robust communication and handover, bed availability in the receiving hospital, staff shortages and transport issues. Multiple delays were noted in the transfer process of 3 patients. There was also evidence of delay in recognising the condition that led to the transfer, which contributed to delays in the transfer of a further 3 patients, (data not shown).

Arrival through the emergency department

Patients admitted as an emergency formed the majority of the study population (351/552). Those who were admitted through the hospital ED fell into two broad groups. One group included those with a diagnosis of self-harm or acute intoxication with alcohol and/or other substances. The other group of patients were those presenting with acute medical or surgical conditions who also had pre-existing mental health condition(s). Very few delays were noted during triage or senior review of these patients (Table 3.5). The majority of patients (95.7%; 265/277) were seen by an appropriate clinician in the view of the case reviewers. Only in the case of one patient was there a delay in care believed to be due to their mental health condition.

Table 3.5 Delays in triage or the ED – reviewers' opinion

	Triage		ED	
Delay	**Number of patients**	**%**	**Number of patients**	**%**
Yes	7	2.3	17	5.8
No	300	97.7	275	94.2
Subtotal	**307**		**292**	
Unknown	44		59	
Total	**351**		**351**	

Mental health condition documented in the emergency department

The Royal College of Emergency Medicine (RCEM) standards for mental health (2013) include the requirement to record previous mental health issues.[8] Of the 351 patients attending the ED, the mental health condition was recorded at triage in 200/296 (67.6%) patients and at a subsequent senior review in 265/312 (84.9%) patients, as seen in Table 3.6. The mental health condition was neither recorded at triage nor at senior review in 37 cases.

Case reviewers were of the opinion that the mental health condition was important enough that it should have been noted (but was not) in 47/96 patients at triage and 24/47 patients at senior review. However, it should be noted that not all patients are comfortable in disclosing their mental health conditions and will not necessarily do so if they do not think it is relevant to their acute medical presentation.

Table 3.6 Mental health recorded on arrival – reviewers' opinion

	At triage		At senior review	
Mental health condition recorded	**Number of patients**	**%**	**Number of patients**	**%**
Yes	200	67.6	265	84.9
No	96	32.4	47	15.1
Subtotal	**296**		**312**	
Not applicable	17		23	
Unknown	38		16	
Total	**351**		**351**	

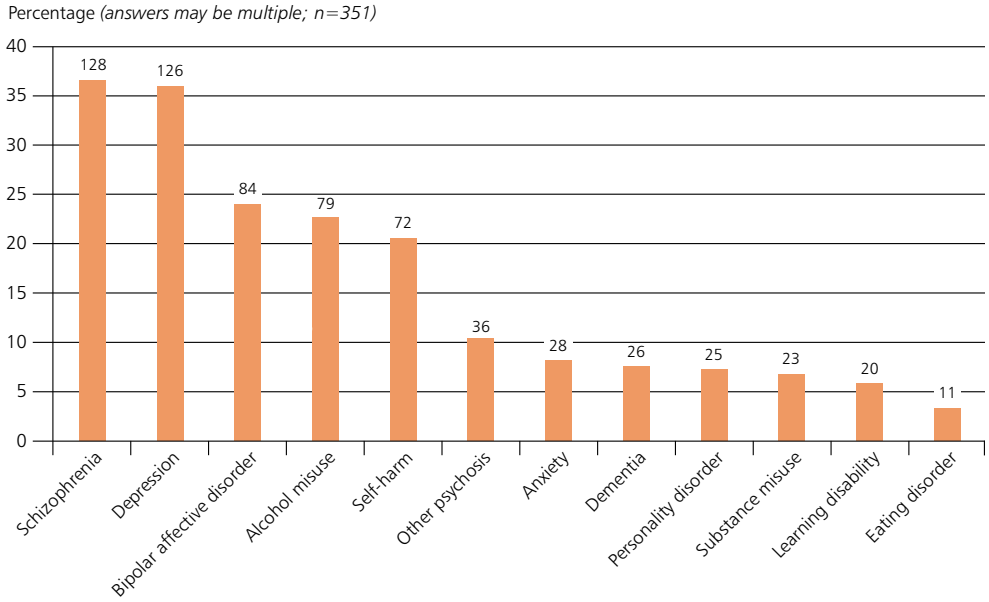

Figure 3.1 Mental health conditions of patients admitted via the ED

Figure 3.1 shows the mental health conditions of those patients who arrived into the hospital via the ED and are comparable with the overall study sample described in chapter 2.

Emergency department referral to liaison psychiatry

Case note reviewers looked at the view of ED clinicians with regards referring patients to liaison psychiatry. They were of the opinion that in addition to the 55 patients referred to liaison psychiatry services (Table 3.7) there were another 55 patients who would have benefitted from a referral at this

Table 3.7 Referral to the liaison psychiatry team from the ED

Referral made	**Number of patients**	**%**
Yes	55	16.8
No	272	83.2
Subtotal	**327**	
Noted but not made	5	
Insufficient data	19	
Total	**351**	

stage (Table 3.8). They were also of the opinion that the lack of timely referral adversely impacted the quality of care in 20 of the 55 patients.

Table 3.8 Patient should have been referred to liaison psychiatry – reviewers' opinion

Patient referral should have been made	Number of patients	%
Yes	55	23.3
No	181	76.7
Subtotal	**236**	
Unknown	36	
Total	**272**	

Table 3.9 Absence of referral to liaison psychiatry affected the quality of care – reviewers' opinion

Quality of patient care affected	Number of patients
Yes	20
No	18
Subtotal	**38**
Unknown	17
Total	**55**

Table 3.10 Reason the patient was not referred to liaison psychiatry – reviewers' opinion

Reason	Number of patients
Clinician did not consider that it was necessary	23
Unclear from the ED notes	21
Not medically fit for review	5
Reduced consciousness	4
No liaison psychiatry team at the hospital	3
Medical care took precedence	3
Patient did not meet local criteria	3
Awaiting review/ investigations	2
Other	3

Answers may be multiple; n=55

Reason for not making a referral to liaison psychiatry

The reasons for not making a referral to the liaison psychiatry service were undocumented in 21/55 cases. Where it was recorded, the predominant factor was that the treating team did not consider it necessary (23/55). The remaining themes were that the acute physical condition took priority or that the liaison psychiatry team would not attend until the patient was "medically fit".

Most referrals made to liaison psychiatry are based on the clinical situation, behavioural issues and mental health needs. The most common diagnoses in those patients referred to liaison psychiatry were associated with

CASE STUDY 1

Emergency department referral to liaison psychiatry

A middle-aged patient with diabetes and schizophrenia was brought to the emergency department with high blood sugar levels. The patient was known to refuse blood tests and insulin due to their own belief that they were not diabetic. Despite the best efforts of the emergency team the patient self-discharged against medical advice without any further investigations or treatment.

Case reviewers were concerned that the liaison psychiatry team was not called, since they could have helped try to gain the required blood tests and insulin therapy. They could have also provided support with de-escalation and consent for treatment. It was believed that appropriate mental health assessment and management at this stage would have facilitated better management of diabetes, both immediately and in the long-term.

depression, self-harm and alcohol or substance misuse. Dementia and learning disabilities were under represented because of the sampling method, where specific mental health conditions were selected for the study (Figure 3.2).

NICE guideline 16 advises that all patients who present with self-harm should be referred to liaison psychiatry before discharge.[30] However, 13 patients from this group were not referred, as seen in Figure 3.3. Depression, schizophrenia and bipolar affective disorder were prevalent in the cases that were not referred at this stage but should have been.

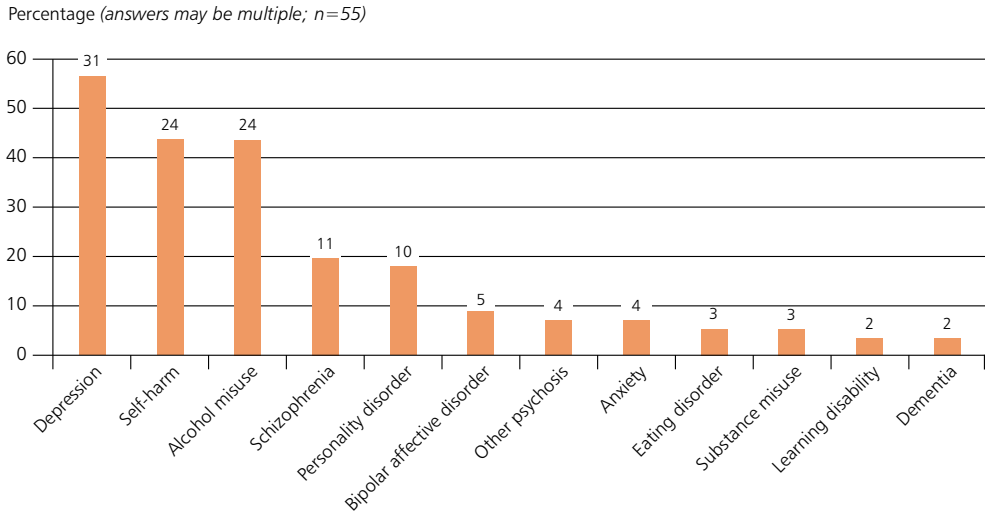

Figure 3.2 Mental health diagnosis of patients referred to liaison psychiatry

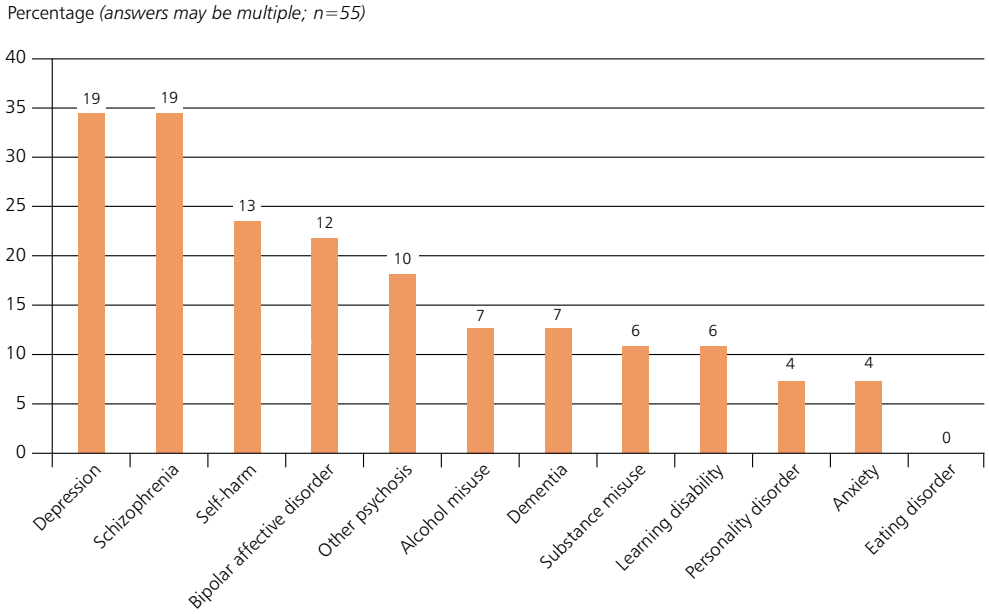

Figure 3.3 Mental health diagnosis of patients not referred but who should have been – reviewers' opinion

Liaison psychiatry team arrived on time

The Royal College of Emergency Medicine (RCEM) standards for mental health (2013) state that "*a member of the mental health team should see patients referred from the emergency department within one hour*". This has been reinforced by recent work.[8] Delays in attending to referrals may reflect the scale of service provision by the liaison psychiatry team in that hospital, for example, if the liaison psychiatry service was not adequately staffed or not available 24/7. Over a fifth of the case notes reviewed had insufficient data to assess this standard. In the remaining, liaison psychiatry arrived on time in 32/43 cases (Table 3.11). In 2 cases, this delay was considered to have resulted in poor quality of care.

Table 3.11 Liaison psychiatry arrived in the ED in an appropriate time – reviewers' opinion

Timely arrival	Number of patients
Yes	32
No	11
Subtotal	**43**
Insufficient data	12
Total	**55**

Some hospitals operate a system where patients are attended to by liaison psychiatry only after all physical conditions have been excluded or managed. This can lead to delay in managing the mental health issues in such patients and should be discouraged. All specialty teams should work collaboratively to achieve the best possible outcome in the shortest possible time. This issue is dealt with in more detail in subsequent sections.

Key Findings

- 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.

4

Admission and initial management

Admission to the ward

Day of the week

During the study period from 13 October 2014 to 13 November 2014, the pattern of admissions to the wards was similar to other general admissions to hospital, in that more emergency admissions occurred outside traditional working hours (Table 4.1).

Table 4.1 Time of admission to a ward

Time	Number of patients	%
Weekend and out of hours (21:00-07:59)	347	64.5
Weekday 08:00-17:59	134	24.9
Weekday 18:00-20:59	57	10.6
Subtotal	**538**	
Missing data	14	
Total	**552**	

Ward type

A total of 342/523 (65.4%) patients were admitted to acute wards (medical and surgical), predominantly to the acute medical ward (57.9%), reflecting the prevalence of medical patients from the acute/ emergency pathway. Ten percent of patients were admitted to surgical wards and 7.1% to critical care (HDU or ICU). Since the study selection criteria included patients admitted to critical care setting, this group is over-represented.

Case reviewers were of the opinion that all but 15/523 (2.9%) patients were admitted to an appropriate ward. Where the ward was inappropriate, the primary cause was a lack of beds at the time (for example a stroke patient admitted to acute medical unit). No cases were identified where the mental health condition resulted in admission to an inappropriate ward.

Table 4.2 Ward type the patient was admitted to

Ward type	Number of patients	%
Acute medical ward	303	57.9
Specialist ward/unit	49	9.4
Acute surgical ward	39	7.5
General medical ward	27	5.2
Intensive care unit	27	5.2
General surgical ward	14	2.7
High dependency unit	10	1.9
Other	55	10.5

Answers may be multiple; n=523 (not answered in 29)

Ward admission delayed

Delayed admissions can lead to delay in investigation and management plans, which can compromise physical and mental health outcomes of patients. This is especially true for patients who were admitted out of hours as an emergency, where the outcome was dependent on prompt responses.

Admission to the ward was delayed in 41/517 (7.9%) patients (Table 4.3). In 4 patients it was directly as a result of their mental health status at the time.

Table 4.3 Delayed admission to a ward – reviewers' opinion

Delay	Number of patients	%
Yes	41	7.9
No	476	92.1
Subtotal	**517**	
Insufficient data	35	
Total	**552**	

Medications

NICE published its guidelines on medicines optimisation (NG5) in March 2015. For acute settings it recommends that *"Clinicians accurately list all of the person's medicines (including prescribed, over the counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another."* It also advises that *"Organisations should ensure that medicines reconciliation is carried out by a trained and competent health professional – ideally a pharmacist, pharmacy technician, nurse or doctor – with the necessary knowledge, skills and expertise"*.[31]

In this study 82.7% (329/398) of patients were admitted with a complete list of medications for their physical health condition (Table 4.4) and 82.2% (323/393) for their mental health medications (Table 4.5). It is also important to note that data were deemed insufficient for reviewers to make an assessment in another 128 and 126 case notes respectively. Provision of some medications through specialist services could lead to difficulties in having a single consolidated list. An inadequate medication list or insufficient data for medicines reconciliation can have a serious impact on the patient's health and lead to avoidable harm.

Medicines reconciliation

In over half of the cases reviewed, the notes did not have sufficient data to allow assessment of whether medicines reconciliation had taken place at either initial assessment or consultant review. Where data were available, the case reviewers stated that medicines reconciliation occurred in 206/291 (70.8%) cases at initial assessment and in 144/211 (68.2%) cases by the time of consultant review (Table 4.6). However, it should be noted that there was a lack of adequate documentation in a large number of cases, so these figures may be overestimating the proportion of cases where medicines reconciliation took place. At worst, the figures could be as low as 206/531 (38.8%) and 144/495 (29.1%) respectively.

Table 4.4 List of medications for physical health conditions

List of medications available	Number of patients	%
Yes	329	82.7
No	69	17.3
Subtotal	**398**	
Not applicable	26	
Insufficient data	128	
Total	**552**	

Table 4.5 List of medications for mental health conditions

List of medications available	Number of patients	%
Yes	323	82.2
No	70	17.8
Subtotal	**393**	
Not applicable	33	
Insufficient data	126	
Total	**552**	

Table 4.6 Medicines reconciliation at initial assessment and consultant review

Medicines reconciliation	Initial assessment	%	Consultant review	%
Yes	206	70.8	144	68.2
No	85	29.2	67	31.8
Subtotal	**291**		**211**	
Not applicable	21		57	
Insufficient data	240		284	
Total	**552**		**552**	

CASE STUDY 2

Medicines reconciliation

A middle-aged patient was admitted with sepsis and acute kidney injury to intensive care. Blood tests revealed mild neutropaenia for which no cause could be found. Although the history of schizophrenia was known, a comprehensive drug history was not taken. It was only on day 4 when a referral to liaison psychiatry was made that it became clear that the patient was on Clozapine. The treatment and drug was then managed appropriately and the patient made a complete recovery.

Case reviewers were of the opinion that a complete drug history and medicines reconciliation would have helped with the diagnosis in this patient who also had kidney failure and prevented complications due to this known side effect of Clozapine.

Missed medication can have a serious impact on a patient's physical health and the risks associated with missed mental health medications can be serious. The general hospital team may not be familiar with the mental health medication and therefore be unaware that it has been missed. This problem could be mitigated to a large extent by sharing clinical records between mental health hospitals and general hospitals.

Initial assessment and consultant review

On admission to hospital the initial assessment and clerking is generally completed by a junior doctor, who also formulates a plan for further investigations and treatment. This is then reviewed by a senior clinician, usually a consultant. Based on the notes and new data available since admission, the consultant develops the investigation and treatment process further and provides a plan for the future management of the patient's condition. It is therefore common to find that the clinical notes made at consultant review supplement the junior doctor's initial notes rather than repeat all the information recorded. The consultant's notes are usually written (or typed) by a member of the consultant team, and would not duplicate all the details already noted by the initial clerking. However, it also introduces the possibility that some aspects of their opinions, the rationale behind their decisions or the finer aspects of their care plan may not be noted down in detail. The case reviewers' opinion of the adequacy of the reviews in this patient group are shown in Figure 4.1. The salient aspects of data gathered from the initial assessment and consultant review are presented in the Figures 4.2 to 4.5 overleaf.

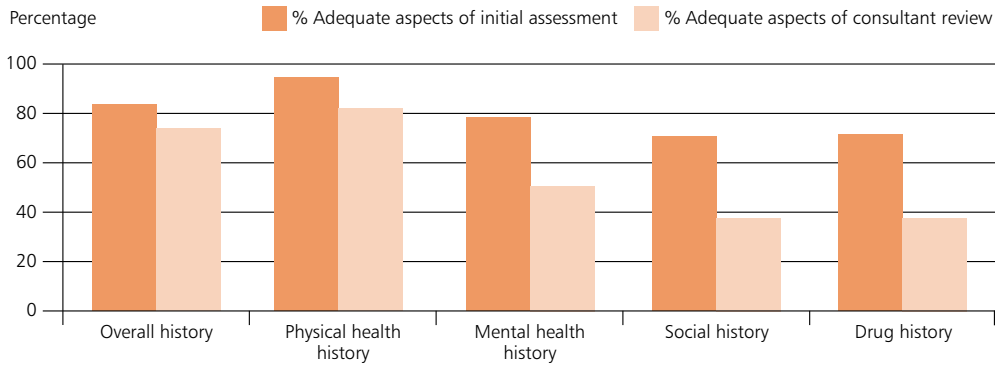

Figure 4.1 Adequacy of history taking in initial assessment and consultant review – reviewers' opinion

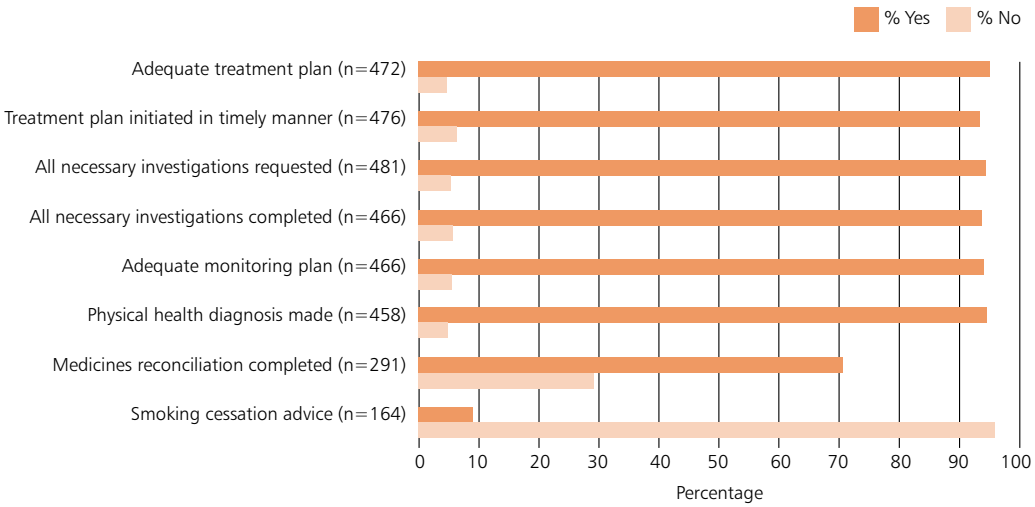

Figure 4.2 Aspects of physical health recorded at the initial assessment – reviewers' opinion

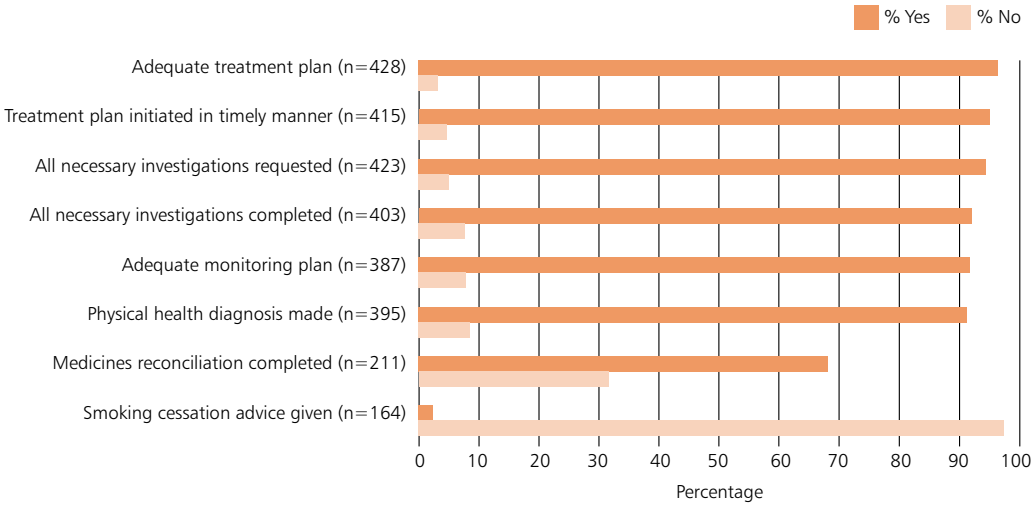

Figure 4.3 Aspects of physical health recorded at the consultant review – reviewers' opinion

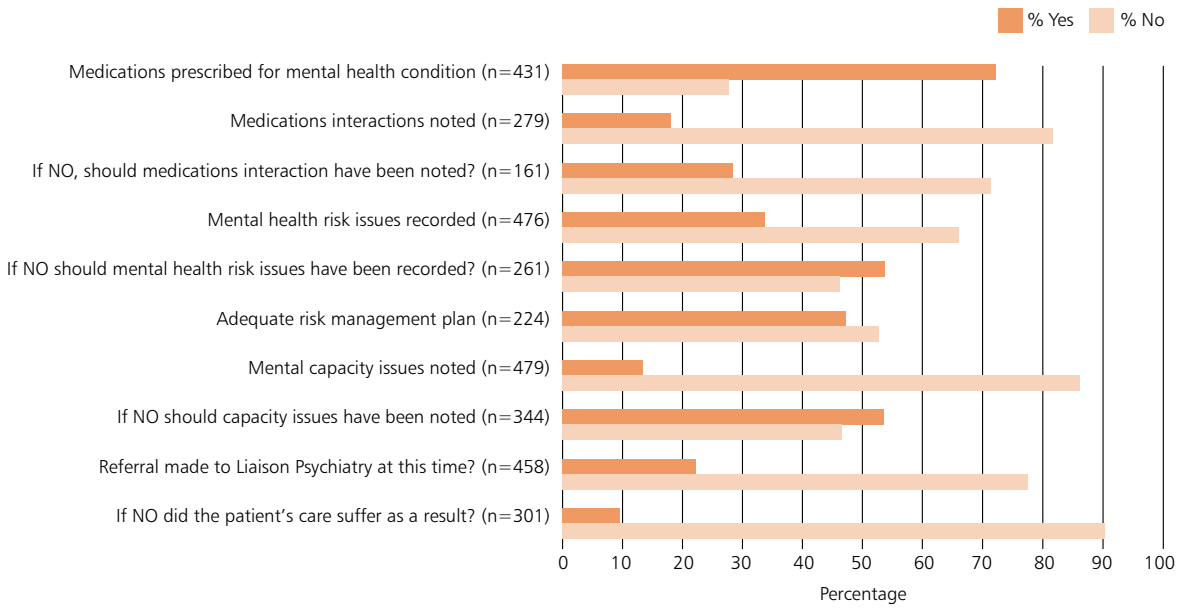

Figure 4.4 Aspects of mental health recorded at the initial assessment – reviewers' opinion

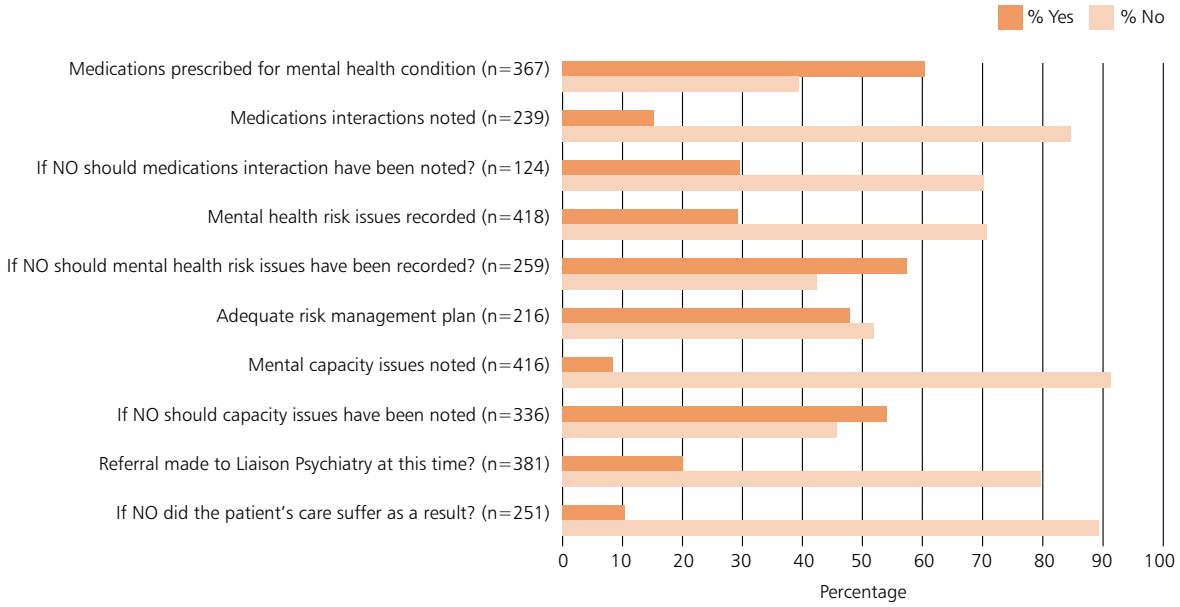

Figure 4.5 Aspects of mental health recorded at the consultant review – reviewers' opinion

The initial clerking and consultant review revealed wide differences between the physical and mental health aspects of history taking and data recording. For example, during the initial assessment an adequate physical health history was taken in nearly all patients (468/491; 95.3%) but relevant mental health history was missed in 21.4% (101/471) patients. Social and drug history was recorded in fewer cases. (social history: 342/483; 70.8%; drug history: 345/481; 71.7%) (Figure 4.1).

Less than 10% (15/164) of patients who were smokers received smoking cessation advice at this stage. Based on the severity of their mental or physical condition it may not be appropriate or possible to provide smoking cessation advice to all patients, but there was scope for improvement considering that to 39.7% (164/413) of patients in the study population were currently smoking.

Medication reconciliation was missed in 29.2% of patients (85/291) during the initial assessment and in 31.8% of patients (67/211) during the consultant review. Referral to liaison psychiatry occurred in about 20% of patients at the initial assessment (103/458; 22.5%) or consultant review (77/381; 20.2%) and it was considered that in 10% (30/301; 10% - initial assessment, 27/251; 10.8% - consultant review) of cases this resulted in their care suffering (Figures 4.2-4.5).

Aspects of clinical assessment that were neither carried out at initial assessment nor at first consultant review included the recording of mental health history (73/471; 15.5%), mental health risk issues (77/261; 29.5%) or mental capacity (103/344; 29.9% and social history (103/483; 21.3%). The variety of aspects demonstrates the gap between management of the physical and mental health of these cases.

Deficiencies in areas relevant to physical health such as medical history, investigations, monitoring, treatment and medicines prescription were below 10% in most aspects, and were also completed in a timely fashion. In contrast, the psycho-social aspects of assessment and care were missed at both initial assessment and consultant review in a much larger number of patients. Missed smoking cessation advice was prominent with the majority of smokers (149/164; 90.9%) not being offered it, although recognising that all patients may not be suitable for it at an early stage due to their physical condition. Most other aspects of assessment and management of the mental health condition also were missed at both assessments in 20% or more cases.

Time from admission to consultant review

Acute care guidance by the Royal College of Physicians of London and the Society for Acute Medicine UK recommends that acute admissions should be reviewed by a consultant within 14 hours of admission, and sooner if the admission is during working hours.[32] It is noteworthy that the relevant data were missing or unknown in 40.8% of the cases (225/552). Where information was available, this standard was met in 70% (191/262; 72.9%) of patients, and 47.7% (125/262) of patients were reviewed within 6 hours. Unfortunately, this standard was not met in 27% (71/262) of patients (Figure 4.6).

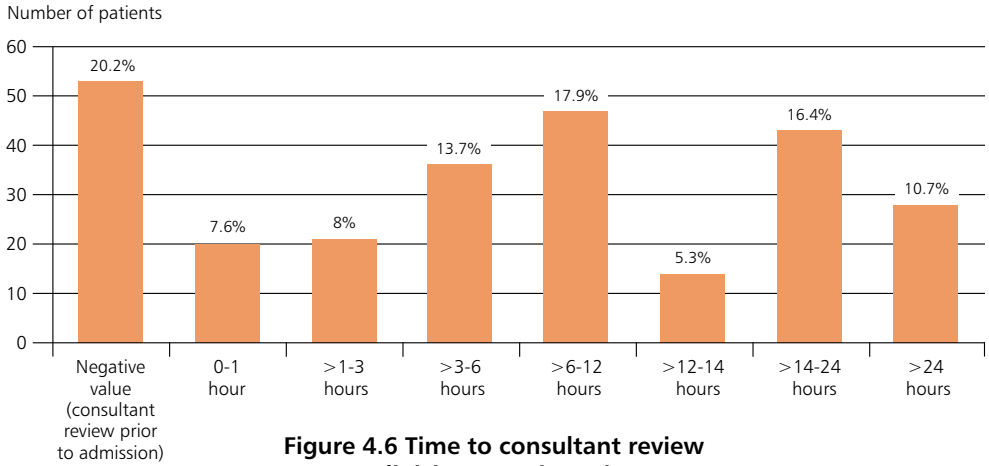

Figure 4.6 Time to consultant review – clinician questionnaire

Even if we account for the 7.1% (39/552) of elective admissions, where review may not have been urgently required, a large number of patients did not receive good care based on this criterion.

The case note reviewers were of the opinion that the delay in consultant review was significant in 8.4% (39/465) of patients despite the high percentage of patients being seen beyond 12-14 hours (Table 4.7).

Table 4.7 Delay in consultant review – reviewers' opinion

Delay	Number of patients	%
Yes	39	8.4
No	426	91.6
Subtotal	**465**	
Not applicable	65	
Insufficient data	22	
Total	**552**	

Impact of consultant review

Table 4.8 provides details on the impact of the consultant review. It demonstrates the range of changes that resulted at this stage. The consultant review initiated fewer changes in mental health aspects of management. For example, a risk assessment and mental capacity assessment occurred in very small proportion of cases only and the referral to liaison psychiatry was made in 11.1% (50/452).

Table 4.8 Impact of consultant review – reviewers' opinion

Impact	Number of patients	%
Initiation of relevant investigations	367	81.2
Treatment plan initiated	226	50.0
Physical health diagnosis	219	48.5
Changes to management plan	195	43.1
Prescription of medications (physical health)	73	16.2
Liaison psychiatry referral made	50	11.1
Mental health diagnosis	36	8.0
Risk assessment carried out	17	3.8
Capacity assessment	12	2.7
Other changes to management	50	11.1

Answers may be multiple; n=452

As would be expected in an early admission onto a general ward, nursing reviews accounted for the majority of the rest of the assessment and management work for these patients. Although some early reviews by the physiotherapy and occupational therapy services did also occur (Table 4.9). And these would help with care planning, rehabilitation and subsequent discharge.

Standards of inpatient care recommended by the Royal Colleges of Physicians and Surgeons include, *"Prompt screening of all complex needs inpatients to take place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multidisciplinary assessment to be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours. An overnight rota for respiratory physiotherapy must be in place."*[33,34]

Table 4.9 Ward reviews in first 24 hours

Discipline	Number of patients seen by each discipline	%
Nurse reviews	489	88.6
Occupation therapy reviews	94	17.0
Physiotherapy reviews	28	5.1
Dietitian reviews	20	3.6

Answers may be multiple; n=552

Table 4.10 Adequate history in nursing notes - first 24 hours after admission – reviewers' opinion

Adequate history	Number of patients	%
Physical health history	472/479	95.0
Social history	311/457	68.1
Drug history	277/422	65.6
Mental health history	252/459	54.9

The mental health condition was recorded in the nursing notes in 355/493 (72.0%) cases. Mental health history was noted in 54.9% (252/459) of cases compared with 95.0% (472/497) of cases documenting physical health history. Similar results were seen when reviewing the mental health aspects of the review with respect to the rest of the multidisciplinary team (data not shown).

Where data were available, complex needs assessment had been completed in fewer than half the patients (171/380; 45%). Table 4.11 shows that there was insufficient data to assess this aspect of care in over a fifth (125/552) of the study population. Whilst younger patients who were admitted with a diagnosis of self-harm may not require input from therapy services, this group could at best account for a fifth of the patients, which still meant a large number of patients unassessed. Furthermore, the assessment of complex needs was not considered adequate in 20.1% (34/169) of patients in the view of the case reviewers (Table 4.12).

Table 4.11 Assessment of complex needs

Assessment made	Number of patients	%
Yes	171	45.0
No	209	55.0
Subtotal	**380**	
Not applicable	47	
Insufficient data	125	
Total	**552**	

Table 4.12 Adequate assessment of complex needs – reviewers' opinion

Adequate assessment	Number of patients	%
Yes	135	79.9
No	34	20.1
Subtotal	**169**	
Insufficient data	2	
Total	**171**	

In reviewing the multidisiplinary assessment, there were noticeable gaps in addiction planning and assessment of self-harm risk (Table 4.13).

Observations and communication

Some patients with physical and mental health care needs require close observation, for example, if they are considered to be a risk to themselves or others. A suitably trained nurse is usually required to care for, and support, these patients on a one-to-one basis, which is also sometimes called "specialling". Case reviewers found inadequate one-to-one care in 68% (151/222) of cases (Table 4.14).

Adequate communication with patients, their family and carers is essential for good care, but this was considered as inadequate in 35.3% (127/360) of cases. Furthermore, the documentation of multidisciplinary case conferences were found to be inadequate in more than three quarters of cases (131/169; 77.5%).

Table 4.13 Aspects not included in the assessment of complex needs

Omissions in assessment	Number of patients	% not included	Subtotal	Not answered	Total
Self-harm risk	79	70.5	**112**	59	**171**
Addiction planning	44	81.5	**54**	117	**171**
Falls risk	11	8.5	**129**	42	**171**
Assessment of nutrition needs	10	7.5	**134**	37	**171**
Pressure sores	10	7.9	**127**	44	**171**
Management of smoking cessation	6	4.3	**138**	33	**171**
Assessment of hydration needs	6	4.3	**138**	33	**171**

Table 4.14 Adequacy of multidisciplinary care – reviewers' opinion

Aspects reviewed	Adequate	Inadequate	Inadequate %	Subtotal	Not applicable	Insufficiant data	Total
One-to-one observations/ "specialling"	71	151	68.0	222	250	80	552
Communication with patient/ family/ carer	233	127	35.3	360	53	139	552
Multidisciplinary case conference	45	194	81.2	239	222	48	552
Other	13	31	70.4	44	494	14	552

Liaison psychiatry review

Psychiatry reviews in general hospital settings have traditionally been described as liaison or consultation liaison, specifically because of the difference in the way mental health is commissioned and provided, with psychiatrists offering in-reach into general hospital settings. Over recent years, specific liaison psychiatry services based in general hospitals, (although commissioned and provided in different ways), have become more common. Once restricted to large teaching hospitals often with an academic unit attached, they are now seen in the majority of general hospitals but the range of services on offer varies markedly across the country. More detailed information is available in chapter 7 where the organisational structure of the general hospitals, liaison psychiatry services are presented.

In this study, 46.4% (256/552) of the patients received a liaison psychiatry review. Describing what is entailed in a liaison psychiatry review has been subject of debate and research.[35,36] Table 4.15 overleaf highlights some components of the liaison psychiatry review and shows what occurred. The table describes three things: (1) whether these interventions occurred at all; (2) whether there was room for improvement based on the case reviews (either in cases where they were carried out or in cases where they were not) and (3) whether in the view of the case reviewer this impacted the overall quality of care.

CASE STUDY 3

Risk assessment

A middle-aged patient was admitted with abdominal pain having a complex history of both gynaecological problems and recurrent self-harming behaviour. A referral to liaison psychiatry resulted in a request that the patient should be re-referred once she was 'medically cleared'. Recurrent expressions of thoughts of self-harm were noted in the nursing notes in the time prior to the eventual assessment by psychiatric services and the patient tried to leave the ward on multiple occasions, resulting in support from hospital security.

The case reviewers stated that it was not acceptable for liaison psychiatry services to wait for all medical or surgical issues to be resolved before getting involved as there is a danger that risk issues are left un-assessed and un-managed. Passing on information about a patient's known history or instituting an interim risk management plan such as a 1:1 observation can be an intermediary step prior to a full assessment if the patient has on-going physical health investigations or needs which precludes a full psycho-social assessment.

Table 4.15 Components of the liaison psychiatry review – reviewers' opinion

Components	Carried out	Not carried out	Carried out %	Room for improvement (aspect of assessment carried out)	%	Room for improvement (aspect of assessment not carried out)	%	Room for improvement impacted on overall quality of care
Mental health risk assessment	125	131	48.8	22	17.6	51	38.9	17
Mental health risk management	121	135	47.3	15	12.4	35	25.9	18
Discharge planning	110	146	43.0	13	11.8	11	7.5	9
Liaison with other mental health services	97	159	37.9	7	7.2	17	10.7	8
Advice to nursing/medical staff	86	170	33.6	20	23.3	25	14.7	22
Mental capacity assessment	53	203	20.7	11	20.8	57	28.1	15
Prescription/dose alter of mental health medication	48	208	18.8	11	22.9	21	10.1	13
Mental health observations	45	211	17.6	4	8.9	24	11.4	12
Deployment of mental health legislation	22	234	8.6	6	27.3	0	0.0	4
Advice for de-escalation of situation by liaison psychiatry	16	240	6.3	3	18.8	16	6.7	5
Multidisciplinary working	14	242	5.5	3	21.4	25	10.3	7
Rapid tranquilisation plan	10	246	3.9	4	40.0	13	5.3	7
De-escalation of situation by liaison psychiatry	6	250	2.3	1	16.7	3	1.2	3

Answers may be multiple; n=256

Mental health risk assessment and risk management were the two most frequent interventions at 48.8% (125/256) and 47.3% (121/256) respectively. It was thought by the reviewers that there was room for improvement, particularly in mental health risk assessment, in 17.6% (22/125) of the cases when it was carried out, and in 51/131 (38.9%) of cases when it was not carried out, but should have been; with it impacting on quality of care in 17/73 of these occasions.

The next level down in terms of frequency interventions was liaison with other psychiatry services in 37.9% (97/256) of the time with room for improvement in 7.2% (7/97) of cases (where it took place, and a further 10.7% (17/159) where it did not happen but should have), and advice to nursing and medical staff in 33.6% (86/256) of cases but with room for improvement in 23.3% (20/86) of cases where it took place.

Further interventions ranging from capacity assessments to psychotropic medication prescriptions and observation management occurred, and in each of them there was deemed to be room for improvement in a proportion of cases, both where they were performed but with errors and where they were not performed but should have been (Table 4.15).

A delay in the liaison psychiatry assessment was thought to have occurred in 37.2% (74/199) of cases as can be seen in Table 4.16, with a range of reasons listed in Table 4.17. The most common of these was that liaison psychiatry would not assess until the patient was medically fit or medically cleared. This was a stark finding and is not best practice. Delays in the assessment of a patient waiting for a medical issue to be resolved can lead to unacceptable and unknown risk being poorly managed, a patient receiving sub-optimal care and general hospital colleagues being unsupported. Full psycho-social assessments do not need to occur if the patient is not yet fit or strong enough to engage but this does not preclude interim risk assessments and plans being instituted or notes being shared. Increasingly the term 'fit for 'assessment', 'intervention', 'discharge' etc is a more helpful way of addressing concerns rather than a binary medically fit or cleared paradigm. As can also be seen from Table 4.18 it was thought that delay impacted the quality of care received by the patient on 22/51 of occasions.

Further information was gathered from the clinician questionnaire sent to the liaison psychiatry service with 168/256 (65.6%) questionnaires returned. Two components of this were seen to be of importance with regard to the impact of a consultant review in liaison psychiatry. There were 79/168 (47.0%) patients who had a series of added inputs carried out by a consultant, but not necessarily in person. In particular, advice around deployment of mental health legislation (12/79). The cases seen directly by a consultant at some point in the pathway was 103/168 (61.3%) where the focus was more on advice to medical and nursing colleagues (81/168) but where the whole range of interventions still occurred (data not shown). Given that many hospitals only have 1-2 liaison psychiatry consultants, this has implications for resourcing if all patients are to be seen by a consultant in line with general hospital care.

As can be seen in Table 4.19, most patients were only seen once, (60.0%; 135/225), with the remaining 90/225 patients seen multiple times. This was associated with length of stay and clinical complexity.

Table 4.16 Delay in liaison psychiatry review – reviewers' opinion

Delay	Number of patients	%
Yes	74	37.2
No	125	62.8
Subtotal	**199**	
Not applicable	42	
Insufficient data	15	
Total	**256**	

Table 4.17 Reason for delay in liaison psychiatry review

Reasons for delay	Number of patients
Liaison psychiatry would not attend until patient was medically fit	26
Poor documentation	20
Delay of several days - unknown cause	16
Medical team delayed referral for other reasons	15
Medical condition of the patient- medical team delayed referral	12
Out of hours referral	4
Referral only made after incident occurred	4

Answers may be multiple; n=74

Table 4.18 Delay in liaison psychiatry review impacted on the patient care – reviewers' opinion

Impact	Number of patients
Yes	22
No	29
Subtotal	**51**
Insufficient data	23
Total	**74**

Table 4.19 Patients reviewed multiple times

Multiple reviews	Number of patients	%
Yes	90	40.0
No	135	60.0
Subtotal	**225**	
Insufficient data	31	
Total	**256**	

Of those patients seen by the liaison psychiatry service 149/217 (68.7%) were thought by the reviewers to have had sufficient input, as can be seen in Table 4.20.

Table 4.20 Sufficient input from liaison psychiatry for those patients who were reviewed – reviewers' opinion

Sufficient input	Total	%
Yes	149	68.7
No	68	31.3
Subtotal	**217**	
Insufficient data	39	
Total	**256**	

Of those patients who were not seen by the liaison psychiatry service, the case reviewers stated that this was appropriate in 47.3% (86/182) of cases, but that in 96 cases (52.7%), the patients should have been reviewed by liaison psychiatry (Table 4.21).

Table 4.21 Patients not reviewed by liaison psychiatry who should have been – reviewers' opinion

Should have been reviewed	Total	%
Yes	86	47.3
No	96	52.7
Subtotal	**182**	
Insufficient data	114	
Total	**296**	

Legal frameworks: mental health legislation and mental capacity assessments

Mental health legislation

Mental health legislation varies across the UK. In this study, Scotland did not participate in the case review section (having just joined the work programme) and therefore only two pieces of legislation were relevant: The Mental Health Act (1983) revised in 2007 for England and Wales and the Mental Health (NI) Order of Northern Ireland. The generic term 'mental health legislation' will be used to describe both of these.

The legislation enables a view to be taken about the need for a patient to remain in hospital for assessment and/or treatment of their mental health condition and gives powers to enable this to occur. The hospital in question can be a mental health or general hospital. However, the procedures which need to be followed to ensure correct adherence to process are often complex. In general hospitals, where there is far less usage of the legislation than in mental health settings, there tends to be fewer administrative and support systems in place to ensure this legal compliance. It is important to follow legal procedures when the rights of a patient are being curtailed. Clear documentation of the processes and current legal situation should also be documented, however, there is often a significant knowledge and skills gap when in the general hospital setting.

Table 4.22 shows that the study group included 34/485 (7.0%) patients who were detained at admission under mental health legislation. Case reviewers recorded that appropriate documentation was noted in only 24 cases. In one example the only transfer documentation in the notes was 'inpatient at psychiatric hospital' (Table 4.23).

Table 4.22 Patient was detained under mental health legislation on admission to hospital

Detained under MH legislation	Number of patients	%
Yes	34	7.0
No	451	93.0
Subtotal	**485**	
Insufficient data	67	
Total	**552**	

Table 4.23 Detained at admission – clearly documented – reviewers' opinion

Clear documentation	Number of patients
Yes	24
No	10
Total	**34**

Table 4.24 shows that a total of 65 patients in this study were detained at any point. This includes those who were detained at the time of admission, meaning that 31 patients were detained in the general hospital from the study sample during the study period.

Table 4.24 Patient detained under mental health legislation at any point during the admission

Detained under MH legislation	Number of patients	%
Yes	65	12.0
No	476	88.0
Subtotal	**541**	
Unknown	11	
Total	**552**	

Of those detained, 15 patients did not have clear documentation in their case notes (Table 4.25). On review the procedures were followed incorrectly in 15/65 patients, with insufficient data available for 19 cases. These data would fit with concerns about use of the mental health legislation in general hospital settings and remains a concern.[37]

Table 4.25 Detained at any point – clearly documented

Clear documentation	Number of patients
Yes	50
No	15
Total	**65**

Of the patients being detained under mental health legislation during the hospital admission, a range of diagnoses were revealed including schizophrenia, other psychotic disorders, bipolar affective disorder, and depression.

CASE STUDY 4

Mental health legislation

A young patient with a history of personality disorder and recurrent overdoses was admitted, out of hours, in the middle of an obvious mental health crisis. The patient attempted to leave the hospital and a short-term, 72 hour, Section 5(2) form was filled out by an on-call medical doctor. The doctor stated that the patient was 'now detained' in the medical notes. The form was filed in the notes and the patient was seen by the liaison psychiatry team the next day.

Case reviewers commented that the form is not all that is required in this process. In this case the patient was not legally detained as the paperwork was not received by the hospital managers. As detention is a relatively rare event in a general hospital, systems are often not understood by medics, nursing staff and others, which can result in illegal detentions as described above. Investing in systems and better quality training are two necessary solutions to this problem.

Mental capacity legislation

The assessment of mental capacity in the general hospital is a more common event. Again the legal frameworks vary across the UK. The Mental Capacity Act (2007) of England and Wales covered the vast majority of cases. Scotland did not take part in the case review section of this study and in Northern Ireland the Northern Ireland Mental Health Order (1986) was the legal approach until the new Mental Capacity Act (Northern Ireland) came into force in 2016.

The 2007 act stipulates when and how capacity should be assessed with a key principle that it should be assessed in relation to something specific – with the commonest events in a general hospital occurring around refusal of investigation and / or treatment and decisions around when and where discharge should occur. As such there is a significant overlap between mental capacity legislation and mental health legislation. This is an area which generates much debate in the academic literature as well as discussion in real clinical cases in hospitals. All medical professionals undertaking care of patients are required to have skills and confidence in mental capacity assessments but where there is overlap with mental disorder, it can become complex and is often core to the work of liaison psychiatry teams.

In this study, mental capacity assessments were documented as having occurred in 150 cases reviewed. Unlike Mental Health Act assessments, mental capacity assessments are required to be documented in the clinical notes by clinicians rather than via a formal process of completing statutory forms (although forms are used in some hospitals and this practice varies).

The treating hospital team was responsible for the assessment of capacity in 50.3% (75/149) of cases, but liaison psychiatry was also responsible for 23.5% (35/149) of documented capacity assessments (Table 4.26).

Table 4.26 Personnel who made the assessment

Assessment undertaken by	Number of capacity assessments	%
Treating general hospital team	75	50.3
Treating liaison psychiatry team	35	23.5
Other consultant (general health)	17	11.4
Nurse	12	8.1
Other psychiatrist	8	5.4
Multidisciplinary team	2	1.3
Subtotal	**149**	
Not answered	1	
Total	**150**	

The most common reasons for requiring a mental capacity assessment in this sample are described in Table 4.27. "Part of the consent process for an intervention" was the single most common reason, followed by "wishing to leave against medical advice" (14.4%; 18/125) and "refusal of treatment" (11.2%; 14/125) and "refusal of investigation" (6.4%; 8/125), although "other" had the highest number (41/125. In this group there were a range of other issues from aggression to financial matters.

Table 4.27 Reasons for requiring a mental capacity assessment

Reason	Number of capacity assessments	%
Part of consent process for an intervention	25	20.0
Wishing to leave against medical advice	18	14.4
Refusing treatment	14	11.2
Reason not documented	10	8.0
Refusing investigation	8	6.4
Routine process	7	5.6
Refusing nutrition/hydration	2	1.6
Other	41	32.8
Subtotal	**125**	
Not answered	25	
Total	**150**	

Case reviewers considered that 40.0% (42/105) of assessments had room for improvement (Table 4.28) and the most common reason was poor documentation of the process.

Table 4.28 Room for improvement in mental capacity assessment – reviewers' opinion

Room for improvement	Number of capacity assessments	%
Yes	42	40.0
No	63	60.0
Subtotal	**105**	
Unknown	45	
Total	**150**	

Communication and information sharing

All the cases in this study, by the nature of the selection criteria, and co-morbidities could be viewed as complex. Involvement of the multidisciplinary team (MDT) in a case discussion or meeting often occurs in such cases. In this study group, MDT documentation occurred in 21.1% (107/508) of cases (Table 4.29).

Table 4.29 Documentation of the involvement of the multidisciplinary team in a case discussion

MDT meeting documented	Number of patients	%
Yes	107	21.1
No	401	78.9
Subtotal	**508**	
Insufficient data	44	
Total	**552**	

Of the 107 cases, liaison psychiatry was present at the meeting in 20 cases (Table 4.30). However, when taking the study sample as a whole, this meant that liaison psychiatry was involved in an MDT discussion for only 20/552 (3.6%) patients.

Table 4.30 Representation of liaison psychiatry at the MDT meeting

Representation of liaison psychiatry	Number of patients
Yes	20
No	75
Subtotal	**95**
Insufficient data	12
Total	**107**

The case reviewers stated that in the 107 cases where an MDT meeting occurred, subsequent management of the patient's care changed in 45 cases (Table 4.31).

Table 4.31 Management plan changed following the MDT meeting – reviewers' opinion

Management plan changed	Number of patients
Yes	45
No	19
Subtotal	**64**
Insufficient data	43
Total	**107**

CASE STUDY 5

Mental capacity assessment

A middle-aged patient with co-morbid schizophrenia and non-insulin dependent diabetes was admitted on the acute care pathway because of poor glycaemic control and a foot ulcer. During the first two days of the admission the patient refused IV antibiotics intermittently and politely. There was disagreement between medical staff about whether the patient had the mental capacity to make the decision to refuse the treatment. The involvement of liaison psychiatry in a joint assessment with the primary medical team resulted in a much more appropriate treatment plan being instigated, which also involved addressing the patient's unvoiced and irrational fears about intravenous medications as well as liaising with the patient's community mental health team. The intravenous medications were subsequently given without the need for restraint.

The case reviewers highlighted that mental capacity should always be assessed for specific interventions or procedures and be led by the treating team who have expertise in the management of the condition. However, the presence of significant mental illness means that joint mental capacity assessments with liaison psychiatry can ensure that the influence of mental disorder which may not be fully understood by general hospital staff does not stop the best care being offered.

Case reviewers gave an opinion on whether information was passed to the patient from the hospital about their physical health condition. It is possible to see that 74.9% (340/454) of patients were thought to have been given sufficient information directly, followed by 54.4% (191/351) to their relatives and 46.5% (80/172) to their carers. This opinion was also expressed in terms of information being passed from the hospital about the patient's mental health condition, where the figures were lower: 46.6% (180/386) of patients were thought to have been given sufficient information directly, followed by 32.2% (96/298) to their relatives and 25.0% (42/168) to their carers. However, the data are insufficient to draw firm conclusions (Figure 4.7).

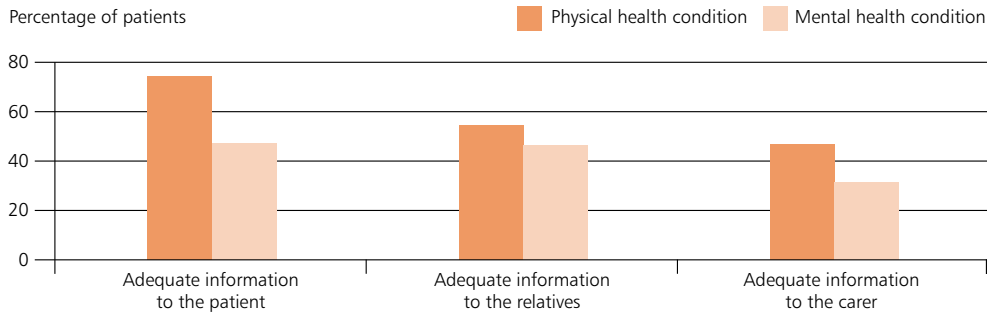

Figure 4.7 Information given to the patient or their carers – reviewers' opinion

4

Key Findings

- 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
- 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.

5

Ongoing care

Incidents and management challenges

There were 154 patients who refused some aspect of care. Refusal of nutrition, physiological observations, investigations and interventions were the most common challenges identified in the case record (Table 5.1).

Table 5.1 Challenges in care due to refusal by the patient

Patient refused	Number of patients	%
Nutrition	44	28.6
Interventions	43	27.9
Investigations	41	26.6
Physiological observations	40	26.0
Assessment	30	19.5
Medications	23	14.9
Hydration	22	14.3
Fluid balance	7	4.5
Other	24	15.6

Answers may be multiple; n=154

The reviewers were of the opinion that the mental health of the patient was a contributing factor to the refusal of care in 91.3% (136/149) of these challenges (Table 5.2).

Table 5.2 Mental health condition was a contributing factor to the refusal of care – reviewers' opinion

Contributing factor	Number of patients	%
Yes	136	91.3
No	13	8.7
Subtotal	**149**	
Insufficient data	5	
Total	**154**	

Table 5.3 Prevention of incidents of refusal – reviewers' opinion

Incident could have been prevented by	Number of patients	%
Better access to liaison psychiatry staff	50	32.5
Better training of general hospital staff	45	29.2
Better communication between staff	27	17.5
Other	20	13.0
Total	**154**	

Answers may be multiple; n=154

It was the view of the case reviewers that 32.5% (50/154) of the incidents could have been avoided by better access to liaison psychiatry services and 29.2% (45/154) avoided by better training of general hospital staff, neither of which were mutually exclusive answers (Table 5.3).

Table 5.4 overleaf shows that there was a marked overlap in the patient sample of those involved in incidents. For example, of the 48 patients who attempted to leave against medical advice 12/48 were also involved in a call to security, 21/48 patients refused treatment and 4/48 were also physically restrained.

The demography of the patients involved was also available and showed that incidents were split relatively evenly between genders and without any obvious skews in terms of ethnicity (data not shown). Further analysis of the sample by diagnosis revealed that calls to security and attempts to leave were higher in the depression, self-harm, alcohol and substance misuse groups than those with schizophrenia. However, refusal of treatment was higher in those with schizophrenia and dementia (data not shown).

Table 5.4 Overlap in incidents that occurred (in the same patients)

Incidents	Physical restraint (n=13)	Refused treatment (n=11)	Call to security (n=23)	Attempt to leave (n=48)	Self-harm (during hospital stay) (n=8)	Refusal of treatment (n=84)	Other incident (n=19)
Physical restraint (n=13)	~	3	3	4	1	9	0
Refused treatment (n=11)	3	~	2	3	1	7	0
Call to security (n=23)	4	2	~	12	3	7	1
Attempt to leave (n=48)	4	3	12	~	3	21	2
Self-harm (during hospital stay) (n=8)	1	0	3	3	~	4	1
Refusal of treatment (n=84)	9	7	7	21	4	~	6
Other incident (n=19)	0	0	1	2	1	6	~

Table 5.5 Room for improvement across incidents

	Physical restraint (n=13)	Refused treatment (n=11)	Call to security (n=23)	Attempt to leave (n=48)	Self-harm (during hospital stay) (n=8)	Refusal of treatment (n=84)	Other incident (n=19)
Liaison psychiatry called	3	5	6	8	3	14	3
Room for improvement in management	3	5	5	22	4	38	8

If a situation becomes unsafe, then restraint may need to occur which would obviously be a terrifying experience for patients and a traumatic one for staff. Documentation of the legal framework used at this time is important. In the case notes restraint was recorded as having occurred in 13 patients. Appropriate staff were present in most but not all of cases reviewed (7 patients). In 11 patients, rapid tranquilisation using injectable medication occurred. There was a view that there was room for improvement in 5 of those situations. Haloperidol and lorazepam were the drugs most commonly used for this purpose, although there was also an example of anaesthetic staff involvement in which midazolam and propofol were used.

Actual events of self-harm in the general hospital, whilst the patient was admitted, was recorded in 8 sets of case notes.

Security staff from the hospital were directly involved in 23 cases reviewed; however, there was also a large proportion of insufficient data on this. This also opens up the question of education and training once more, for a group of staff with little or no training in this area dealing with the most complex of situations.

The liaison psychiatry team was called to the full range of incidents but not in all cases, most frequently for the management of those attempting to leave against medical advice and refusal of treatment. The reviewers found there was room for improvement in all categories (Table 5.5).

Complications in hospital

During their stay in hospital, 80 patients developed unexpected complications (Table 5.6). In the opinion of case reviewers, the mental health comorbidity contributed to this complication in 20 patients.

Medical complications are more common as the hospital stay gets longer. Hospital acquired infections were common (n=10), frequently involving the respiratory or urinary tracts. The mental health condition contributed to the complications in 28 cases (Table 5.7). This included complications related to drug toxicity (like diabetes insipidus), neuroleptic syndrome, or refusal to take medication. Other common physical complications were worsening of the medical/surgical condition at admission, such as kidney failure.

Table 5.6 Unexpected complications

Unexpected complications	Number of patients	%
Yes	80	18.4
No	355	81.6
Subtotal	**435**	
Insufficient data	117	
Total	**552**	

Table 5.7 Contributors to the complication

Complication	Number of patients
Physical complication	64
Mental health complication	28
Medications	15
Death	14
Infection	10
Fall	7

Answers may be multiple; n=80

Surgery and interventional procedures

Surgical or other interventional procedures were required in 135 patients. Table 5.8 shows the urgency of the procedure. Only 35 procedures were elective. This appeared to be a small number of procedures, in comparison to the amount of elective surgery undertaken each day and could reflect poor coding of mental health conditions in elective surgical admissions, or that mental health conditions were under represented.

Table 5.8 Urgency of surgery or intervention required

Urgency of surgery/ intervention	Number of patients	%
Urgent	61	46.6
Elective	35	26.7
Expedited	18	13.7
Immediate	17	13.0
Subtotal	**131**	
Insufficient data	4	
Total	**135**	

CASE STUDY 6

Incidents and management challenges

A middle-aged patient with anxiety and depression was admitted with alcohol withdrawal. On the ward the patient repeatedly refused to have their vital parameters checked or blood samples taken. The patient was also noted to be abusive and disruptive, so the ward staff decided to leave them alone. The patient collapsed 48 hours after admission. Blood tests at this time revealed acute liver failure considered to be due to a missed paracetamol overdose.

Review of the case notes suggested that regular clinical assessment and monitoring could have prevented this catastrophe. Training the ward team to provide them with confidence to treat such patients, and early involvement of liaison psychiatry are important measures to ensure such situations do not arise.

The surgical procedures/interventions were undertaken to treat injuries as a result of the underlying mental health condition(s) in 16 patients (Table 5.9). Examples of these procedures included debridement of self-inflicted burn, intubation/haemofiltration due to overdose, insertion of a nasogastric tube for feeding in patients with eating disorders and repair of other self-inflicted cuts/injuries.

Table 5.9 Surgery/intervention a result of mental health condition e.g. self-harm

Intervention due to MH condition	Number of patients	%
Yes	16	12.5
No	112	87.5
Subtotal	**128**	
Insufficient data	7	
Total	**135**	

Consent for surgery

Issues around consent and mental capacity specific to a surgical procedure can be challenging, especially if the surgical procedure is required as an emergency. Room for improvement in taking consent for surgery was found in a 22% (24/109) of patients (Table 5.10). Similarly, challenges around administration of essential medications were encountered in 16 patients (Table 5.11).

Table 5.10 Room for improvement in taking consent – reviewers' opinion

Room for improvement	Number of patients	%
Yes	24	22.0
No	85	78.0
Subtotal	**109**	
Insufficient data	26	
Total	**135**	

CASE STUDY 7

Surgical pathway

A young patient with bipolar affective disorder was admitted with fracture of the tibia after jumping off a building. Whilst in the operating theatre, the patient refused anaesthesia and surgery. The team realised that informed consent had not been taken pre-operatively and the patient was returned to the ward.

In the opinion of case reviewers, the treating team should have considered this patient's mental capacity and ability to give consent when the decision for surgery was made. In situations where obtaining consent is anticipated to be an issue, early involvement of the liaison psychiatry team would help in understanding and addressing any concerns. They could have also advised if deployment of mental health legislation would have been appropriate.

Table 5.11 Continuity of essential drugs compromised

Continuity compromised	Number of patients	%
Yes	16	14.4
No	95	85.6
Subtotal	**111**	
Insufficient data	24	
Total	**135**	

Postoperative care

In the view of the case reviewers there was room for improvement in the postoperative care of patients, specifically in acute pain management (3), drug interactions (9) and 'other' (12), 7 of which in the 'other' group could have been addressed by closer working with the liaison psychiatry team. Examples included, lack of psychiatry input in a patient with active mental health needs, the surgical team not identifying a vulnerable adult, patient refusal of essential medication and intravenous fluids and another who refused surgery on reaching the operation theatre.

Clinical deterioration

Deterioration in physical health was noted in 146/546 (26.7%) patients (Table 5.12), the majority of whom were referred to and assessed by the critical care team (89/146). Overall, 122 patients were considered for critical care and 77/122 were accepted (Table 5.13). In 12 patients not considered for critical care who should have been, the mental health condition was a contributing factor to the decision in one patient. Of those considered for critical care but not accepted the case reviewers felt this decision was inappropriate in only one patient.

Table 5.12 Clinical deterioration

Deterioration	Number of patients	%
Yes	146	26.7
No	400	73.3
Subtotal	**546**	
Insufficient data	6	
Total	**552**	

Table 5.13 Considered for critical care

	Considered		Accepted	
Critical care	Number of patients	%	Number of patients	%
Yes	122	24.5	77	71.3
No	375	75.5	31	28.7
Subtotal	**497**		**108**	
Insufficient data	55		14	
Total	**552**		**122**	

There was room for improvement of the critical care in 8/77 patients. Specific examples included management of antipsychotic medication, need for liaison psychiatry input in supporting a vulnerable adult, no consideration being given to mental health and no mental capacity assessment or mental health risk assessment being undertaken (data not shown). Extra measures were taken in critical care to account for the patient's mental health condition and facilitate discharge in only 9/50 patients (Table 5.14).

Table 5.14 Measures to facilitate ICU discharge - taking into account the patient's mental health condition – reviewers' opinion

Measures undertaken	Number of patients
Yes	9
No	41
Subtotal	**50**
Insufficient data	16
Not applicable	11
Total	**77**

Key Findings

- 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.

6

Discharge and death

Discharge planning

Discharge planning should start as soon as people enter hospital. In this study the majority of patients were discharged to their usual place of residence (333/502; 66.3%) (Table 6.1). The next most common discharge destination was a mental health hospital (98/502; 19.5%), which was almost three times the number of patients transferred from a mental health hospital for admission (36/552; 6.5%). One of the study inclusion criteria was patients who were either admitted from or discharged to a mental health hospital. The majority of these 98 patients had an underlying mental health condition which deteriorated whilst in the general hospital.

Table 6.1 Discharge destination

Destination	Number of patients	%
Usual place of residence	333	66.3
Transferred to a mental health hospital	98	19.5
Nursing/care home	29	5.8
Transferred to another general hospital	19	3.8
Residential home	15	3.0
Sheltered accommodation	7	1.4
Hospice	1	<1
Subtotal	**502**	
Died in hospital	50	
Total	**552**	

There were 502 patients who were discharged from hospital alive. Of these, the case reviewers noted that multidisciplinary discharge planning occurred in roughly half the patients, and included the input of a range of healthcare professionals (Table 6.2).

Table 6.2 Multidisciplinary discharge planning

Multi disciplinary planning	Number of patients	%
Yes	209	49.4
No	214	50.6
Subtotal	**423**	
Insufficient data	79	
Total	**502**	

Table 6.3 shows that physiotherapists and occupational therapists were the most frequently required members of the discharge planning process. Ensuring they have the knowledge and skills to deal with patients with mental health conditions is essential.

Table 6.3 Disciplines involved in discharge planning

Disciplines	Number of patients	%
Physiotherapy	80	38.3
Social services	61	29.2
Occupational therapy	58	27.8
Liaison psychiatry	54	25.8
Community mental health services	43	20.6
Rehabilitation service	18	8.6
Other psychiatry	13	6.2
Other community services	11	5.3
Clinical psychology	4	1.9
Other	38	18.2

Answers may be multiple; n=209

In the view of the case reviewers, discharge planning was less than satisfactory in 22.8% (106/464) of patients (Table 6.4). The most common reasons were: lack of risk assessment, lack of involvement of mental health teams and lack of communication with community teams. There was no evidence that any discharge letters were copied to the named psychiatrist or community mental health team. It is good medical practice to copy discharge letters to all clinicians involved in the care of a patient as it forms part of the handover of care. This is expected to occur as a matter of course in physical healthcare. Not copying the letter to the relevant mental health consultant increases the risk of delayed or missed diagnosis and treatment.

Table 6.4 Appropriate discharge planning – reviewers' opinion

Appropriate discharge planning	Number of patients	%
Yes	358	77.2
No	106	22.8
Subtotal	**464**	
Insufficient data	38	
Total	**502**	

The discharge of 65/443 (14.7%) patients was delayed, in most cases by less than a week (Table 6.5). However, in 5 cases the patient's discharge was delayed by more than four weeks (Table 6.6). Management of the mental health condition directly contributed to the delayed discharge in 25/57 cases (Table 6.7).

Inadequate discharge planning can jeopardise the ongoing recovery of patients who have chronic conditions. Therefore the risk of deterioration or relapse increases with longer hospital stay and poor discharge planning where there is no plan for ongoing care in the community. In the worst case, the patient has to be readmitted to hospital.

Case reviewers stated that risk assessment at discharge was not adequate in 47.8% (193/404) of patients (Table 6.8). And an appropriate follow up plan was not set up for 14.6% (52/356) of patients, risking clinical deterioration and readmission (Table 6.9).

Table 6.5 Delay in discharging patients

Delay	Number of patients	%
Yes	65	14.7
No	378	85.3
Subtotal	**443**	
Insufficient data	59	
Total	**502**	

Table 6.6 Number of days in the delay to discharge

Number of days	Number of patients
0-1 days	11
>1-3 days	17
>3-7 days	12
>7-14 days	11
>14-28 days	6
>28 days	5
Missing data	3

Table 6.7 Mental health condition contributed to delay in discharge – reviewers' opinion

MH condition contributed	Number of patients
Yes	25
No	32
Subtotal	**57**
Insufficient data	8
Total	**65**

Table 6.8 Appropriate risk assessment at discharge – reviewers' opinion

Appropriate	Number of patients	%
Yes	211	52.2
No	193	47.8
Subtotal	**404**	
Insufficient data	98	
Total	**502**	

Table 6.9 Appropriate plan for review appointment – reviewers' opinion

Appropriate	Number of patients	%
Yes	304	85.4
No	52	14.6
Subtotal	**356**	
Not applicable	72	
Insufficient data	74	
Total	**502**	

Table 6.10 summarises the information included in the discharge summaries available to reviewers (347). The majority of these documents mentioned the physical health diagnosis (330/337; 97.9%) but the list of physical health medications was complete only in 83% (268/323). Fewer summaries mentioned the mental health diagnosis (72.1%; 245/340) or provided a list of mental health medications (70.8%; 218/308). Absence of appropriate documentation puts patients at risk of missed diagnoses and an abrupt end to medications. This can result in relapse of disease or accelerated decline in health.

CASE STUDY 8

Discharge planning

A middle-aged patient was admitted with a paracetamol overdose. The patient was known to have depression and referred to the crisis team. Whilst in hospital the ward multidisciplinary team carried out a falls assessment and nutritional assessment but no consideration was given to a mental health risk assessment. The crisis team refused to look after the patient and the patient was discharged, being "medically fit", and reached home at midnight.

Case note review revealed that the hospital did not have a liaison psychiatry service on-site. Mental health reviews were undertaken only after patients were "declared medically fit". No mental state assessment was done in the hospital, only an assessment by the crisis team. Also, the crisis team assessment was not documented in adequate detail. The past history of depression and suicidal risk noted in the GP notes was not taken into consideration. Case reviewers were of the opinion that this patient should have been assessed and managed by the psychiatry team in collaboration with the medical team, with comprehensive discharge planning.

Table 6.10 Information included in the discharge summary

Information	Yes	%	No	%	Subtotal	Not applicable	Insufficient data	Total
Physical health diagnosis	**330**	97.9	**7**	2.1	**337**	8	2	**347**
Complete list of physical health medications	**268**	83.0	**55**	17.0	**323**	16	8	**347**
Mental health diagnosis	**245**	72.1	**95**	27.9	**340**	3	4	**347**
Complete list of mental health medications	**218**	70.8	**90**	29.2	**308**	26	13	**347**

Readmissions

Unplanned readmissions within 30 days of hospital discharge are an indicator of quality of clinical care and discharge planning. Preventing readmissions should be a priority for all healthcare providers, to improve the quality of care and to improve patient experience. The discharge planning process should therefore identify and mitigate risk factors for readmission.

Readmitted after the study period

In this study 37 patients were identified from the case notes to have been readmitted to the same hospital in the following 30 days after the defined study inclusion period (Table 6.11). This represents 8.7% (37/424) of the patients in this study who were discharged from hospital; which is similar to national readmission figures in emergency and acute care. It is possible that this number is an underestimate because some patients may have been readmitted to a different hospital. It was the view of the reviewers that the readmission could have been prevented in 9 patients.

Table 6.11 Patient readmitted within 30 days

Readmitted	Number of patients	%
Yes	37	8.7
No	387	91.3
Subtotal	**424**	
Not applicable	27	
Insufficient data	51	
Total	**502**	

On correlating readmissions with their discharge planning process it was found that 23/37 patients readmitted had not received appropriate discharge planning. Analysis of the details showed that 15/23 patients had no multidisciplinary discharge planning and 13/23 patients did not have an appropriate risk assessment prior to discharge.

Previous admissions within the past 12 months

In order to further look at discharge planning, discharge documentation was requested for any recorded admission at the same hospital that had occurred in the year preceding the current hospital admission under review.

In total, 239/552 (43.3%) patients included in this study were admitted to the same hospital in the preceding 12 months (Table 6.12). Again, it is possible that these data underestimate previous admissions, because some patients may have been admitted to other hospitals. In the preceding year, these patients were readmitted on average 2.4 times (562 episodes/239 patients), with a range of 1-15 readmission episodes.

Table 6.12 Previous admissions within the previous 12 months

Previous admission	Number of patients	%
Yes	239	43.3
No	313	56.7
Total	**552**	

The average length of stay in hospital during previous admissions was 5.7 days (median=2 days). Figure 6.1 indicates that just over 70 patients (20.8%; 72/346) were discharged on the day of admission. In addition, about half of those admitted were discharged in the first 48 hours of hospital stay (Figure 6.2). It is possible to manage some patients with such a short hospital stay as day-attenders in ambulatory care units and acute medical or surgical clinics. The average length of stay of others can be shortened by utilising acute care pathways specific to the condition they presented with, like infections being managed with antimicrobials administered at home or on out-patient basis. Ambulatory care units allow patients to be seen as day cases, with easy access to diagnostic tests, clinical assessment and review by a senior decision maker (e.g.

CASE STUDY 9

Readmission

An elderly patient arrived by ambulance with generalised seizures. Ambulance notes mentioned that this was their fifth admission in one year. A previous diagnosis of learning difficulty and psychosis was also noted. The patient was observed in hospital for 24 hours and discharged the next day.

Case reviewers were of the opinion that the complexity of this case was not addressed. There was no attempt at assessing mental capacity because the patient had stopped antidepressants on their own and compliance with anti-epileptic medications was an issue too. No contact was made with liaison psychiatry to ask for help with on-going care to prevent further readmissions.

consultant) with the aim to prevent admission to hospital if it is not required. Shorter stays in general hospital would promote better continuity with the primary mental health team and prevent any deterioration of the mental health condition due to multiple handovers.

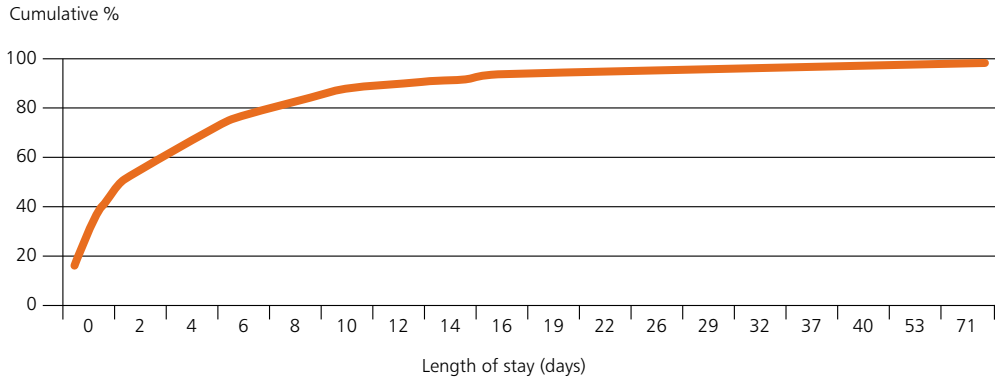

Figure 6.1 Cumulative percentage of the length of stay for previous admissions in 12 months prior to current admission (n=346)

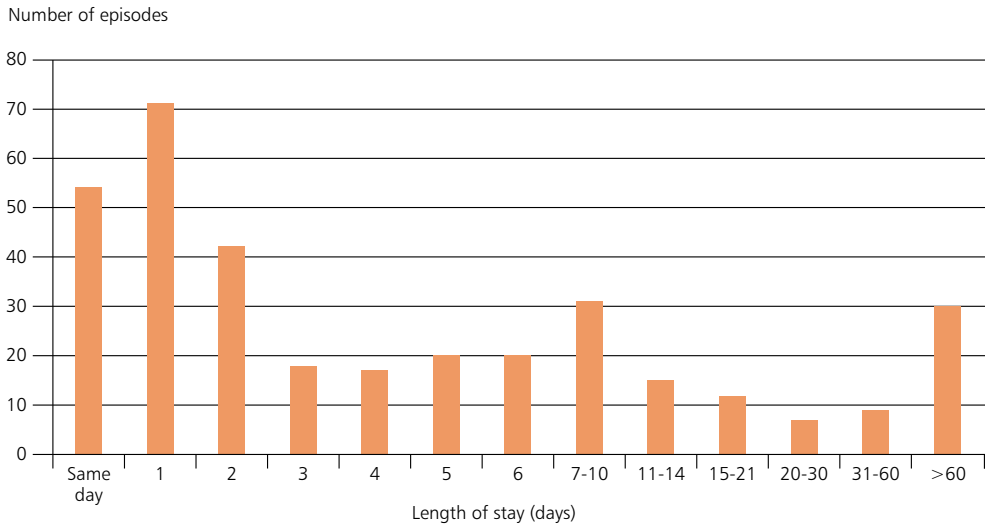

Figure 6.2 Length of stay - previous admissions in 12 months prior to current admission (n=346)

Details in previous discharge summary

Hospitals were asked to send discharge letters linked to previous admissions, 134/239 were received. Case reviewers found these discharge summaries were of variable quality, details of which are listed in Table 6.13. Standards for discharge summaries should be followed, for example, those provided by the Scottish Intercollegiate Guidelines Network.[38] Poor documentation of medications, for physical and mental health will affect the rate of readmissions. Poor communication with the GP and community care team would lead to poor ongoing care, missed medications and poor patient experience.

Table 6.13 Information recorded in discharge summaries of previous admissions

Information	Number of episodes	%
Physical diagnosis	100	74.6
Medications for physical health condition	71	53.0
Details of mental health condition	71	53.0
Medications for mental health condition	55	41.0
Community mental health team	14	10.4
None of above	12	9.0
Other community services e.g. drug/ alcohol related	8	6.0
Named psychiatrist	5	3.7
Other	8	6.0
Not applicable	3	2.2

Answers may be multiple; n=134

Room for improvement in previous discharge

Case reviewers were of the opinion that there was insufficient data in 24 discharge summaries to make an assessment in whether there was room for improvement. Review of the remaining discharge summaries suggested that there was room for improvement in 68/110 (61.8%) cases (Table 6.14). In these 68 patients the main issues were related to discharge planning for the mental health condition. These included inadequate information sharing with the liaison psychiatry and community team before discharge or in the discharging documentation (Table 6.15).

Table 6.14 Room for improvement in discharge process – reviewers' opinion

Room for improvement	Number of episodes	%
Yes	68	61.8
No	42	38.2
Subtotal	**110**	
Not applicable	3	
Insufficient data	21	
Total	**134**	

Table 6.15 Reasons for room for improvement in the discharge summary

Reason	Number of admissions
Incomplete/ inadequate information on discharge summary	17
Inadequate care management plan for mental health	17
Insufficient liaison with psychiatry/ community mental health team	14
No mention of mental health condition on discharge summary	6
Insufficient liaison with care home	4
Inadequate information/safety netting for physical health	3
Other	7

Answers may be multiple; n=68

Death and end of life care

One of the case selection criteria for the study was to include patients who died in hospital. Fifty patients who died in hospital with a mental health co-morbidity were included in this study, representing 9% of the study sample. The primary cause of death in hospital is shown in Table 6.16.

It was noteworthy that a small but important number of patients who died in hospital were found dead with no obvious cause.

Table 6.16 Primary cause of death

Primary cause of death	Number of patients
Infection/sepsis	29
Stroke/cardiac disease	6
Cancer	4
Liver disease	3
Dementia	3
No obvious cause/documentation	5
Total	**50**

Eighteen patients in the sample were managed on an end of life care pathway. Case reviewers were of the opinion that there was room for improvement in the care at the end of life of 13 patients, including 2 patients who were placed on an end of life care pathway (Table 6.17). Reasons given for the room for improvement included communication with the patient's family (3 cases), documentation (4 cases), insufficient involvement of palliative care team and lack of consideration of pain management (2 cases).

Table 6.17 Room for improvement in end of life care – reviewers' opinion

Room for improvement	Number of patients
Yes	13
No	26
Subtotal	**39**
Insufficient data	11
Total	**50**

Key Findings

- 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.

7

Organisational data and survey of training

A key component of the case review data in the previous chapters focused on the skill set required by general hospital staff in dealing with the complexity of mental and physical health co-morbidities, and subsequently their ability to refer to and access appropriate mental health professionals. Therefore as part of this study, an organisational questionnaire was sent to all hospitals to gather information on the services they provide. In addition, an on-line survey on education and training was completed by a range of professionals to better understand the training available and whether those professionals believed it was adequate for the needs of the patients they see and for their own competence.

Type of hospital from which a questionnaire was received

An organisational questionnaire was received from 231 hospitals. Table 7.1 shows that 83.5% (193/231) were recorded as 'general hospitals'. This term included a range of larger teaching hospitals as well as those traditionally labeled as district general hospitals – none were mental health hospitals. Tertiary specialist centres comprised 6.5% (15/231) of the sample and the remaining 10% (23/231) were independent sector hospitals.

Table 7.1 Type of hospital from which a questionnaire was received

Hospital type	Number of hospitals	%
General hospital	193	83.5
Independent hospital	23	10.0
Tertiary specialist centre - stand alone	15	6.5
Total	**231**	

As an indicator of the size of the hospital, the majority reported they had 500 beds or fewer (Table 7.2).

Table 7.2 Number of beds as an indicator of hospital size

Number of beds	Number of hospitals	%
≤ 500 beds	136	59.4
500-1000 beds	80	34.9
1000-1500 beds	9	3.9
1500-2000 beds	4	1.7
Subtotal	**229**	
Not answered	2	
Total	**231**	

Emergency departments

Emergency departments (ED) were located in 175/231 (75.8%) of the hospitals, which was a major source of entry into the acute care pathway for this study. It has previously been estimated that a small proportion of those presenting to the ED would have a primary mental health reason, with an even larger proportion having a degree of mental disorder in addition to their primary health presentation.[39]

Assessment rooms in the ED

Assessment and management of primary mental health presentations in the ED can involve challenges to services in terms of safety and privacy and as such standards have evolved around the physical space requirements.[8] Only 67.4% (118/175) of hospitals with an ED reported the availability of a specific assessment room for patients with a mental health condition. However, of the 53 hospitals which reported no such room, 21 reported that there was a designated area for mental health presentations. This means that excluding the 4 hospitals that did not answer the question, 16% of hospitals (28/175) had no specific facilities at all.

Table 7.3 Assessment room requirements

Room requirements	Yes	%	No	%	Subtotal	Not answered	Total
Equipped with a panic button/emergency alarm system	108	92.3	9	7.7	**117**	1	**118**
Empty of anything that could be used as a missile	101	85.6	17	14.4	**118**	0	**118**
Equipped with an observation panel	98	83.1	20	16.9	**118**	0	**118**
Free of ligature points	95	80.5	23	19.5	**118**	0	**118**
Fitted with a two way opening entrance	95	80.5	23	19.5	**118**	0	**118**
Heavy immovable furniture	85	72.0	33	28.0	**118**	0	**118**
Not a room that doubles as an office or for any other purpose	83	70.3	35	29.7	**118**	0	**118**

The specific requirements of the room, which are all key to ensuring high levels of safety, are shown in Table 7.3. Whilst some scored highly, such as the room being equipped with a panic button or alarm system at 92.3% (108/117), or being free of ligature points at 85.6% (101/118), none of these features were present in all rooms.

Liaison psychiatry service

Of the 23 hospitals from where data had been returned, 80.4% (185/230) reported the presence of a liaison psychiatry service, with the remainder of hospitals receiving psychiatry cover from a local community mental health team or other part of the local mental health service (Table 7.4). This relates to the data from chapter 3 in that this 80.4% of hospitals accounted for 92.2% of cases referred to psychiatry, indicating that the presence of a liaison psychiatry service is more likely to result in referrals.

Table 7.4 Liaison psychiatry service at this hospital

Liaison psychiatry	Number of hospitals	%
Yes	185	80.4
No	45	19.6
Subtotal	**230**	
Not answered	1	
Total	**231**	

Co-location of liaison psychiatry services in the general hospital is seen as important for both response time and for developing a culture of presence and integration rather than as a visiting team from elsewhere. Liaison psychiatry services had on-site coverage in 145/185 (78.4%) hospitals, and of these services 131/143 (91.6%) had designated office space (Table 7.5). Of the 12 that had no office space, a mix of answers were given as to where they were based, such as shared office with another team, presence in a separate building or in the local mental health unit.

Table 7.5 Separate office space in the hospital for liaison psychiatry where they provide on-site coverage

Separate space	Number of hospitals	%
Yes	131	91.6
No	12	8.4
Subtotal	**143**	
Not answered	2	
Total	**145**	

Table 7.6 shows that in terms of coverage of the general hospital, the vast majority of hospitals reported that liaison psychiatry covered the whole hospital (84.9%; 157/185). Although of these, 4 did not cover paediatrics and 8 did not cover outpatients. In 3 hospitals it was reported that liaison

psychiatry covered the ED only but a higher proportion, 8.1% (15/185) covered the ED and acute admission wards only. Of the remaining 10 hospitals, a series of place specific information was returned such as sole coverage of poison units, or a mix of certain wards within the hospital with crisis teams offering coverage to the ED.

Table 7.6 Areas of the hospital covered by the liaison psychiatry team

Areas	Number of hospitals	%
The whole hospital	157	84.9
Emergency department/acute wards	15	8.1
Emergency department only	3	1.6
Other	10	5.4
Total	**185**	

Availability of the liaison psychiatry service

Mental healthcare needs can occur throughout the 24 hour period, especially for those hospitals with an ED. In this study a large proportion of patients were admitted outside of traditional 9-5 working hours (Table 4.1). In terms of the period of time of covered by psychiatry services, results were divided almost equally in terms of whether a 24/7 service was available (Table 7.7). Out of hours services were deemed to be any specific services present and available in the general hospital setting, which will vary enormously across the country from nursing staff only, to psychiatry doctors in training or a mix of the two.

Table 7.7 Coverage of the liaison psychiatry team 24 hours/day, 7 days/week

24/7 coverage	Number of hospitals	%
Yes	94	51.1
No	90	48.9
Subtotal	**184**	
Not answered	1	
Total	**185**	

However, of the 90 hospitals that did not report a 24/7 service, the majority did operate in some form of extended hours, either later in the working day or into the weekends, with only a minority of 26 hospitals having a Monday through Friday working hours structure only (Table 7.8). This obviously addresses some of the concerns about when patients present and require assessment or an intervention.

Table 7.8 If not 24/7, hours during which there is cover by the liaison psychiatry team

Coverage	Number of hospitals
Mon-Sun extended working hours	31
Mon-Fri working hours	26
Mon-Sun working hours	17
Mon-Fri extended working hours	1
Other	8
Subtotal	**83**
Not answered	7
Total	**90**

Composition of the liaison psychiatry service

Significant work has been undertaken elsewhere, especially in the national surveys of liaison services, to identify numbers of different staff members contributing to the composition of liaison psychiatry services. These comprise consultants, doctors in training at all levels including those in psychiatry training programmes and those in their foundation years, staff grade doctors, psychiatry liaison nurses, psychologists and other allied health professionals such as occupational therapists and others. Specialists are also available in some centres for older adult services* and substance misuse services.

**Child and adolescent services are part of a separate NCEPOD study and are not included in these data.*

Table 7.9 Personnel comprising the liaison psychiatry team

Incidents	Normal working hours Mon-Fri				Out of hours/ weekends			
	On-site	%	Off-site/on call	%	On-site	%	Off-site/on call	%
Consultant liaison psychiatrist	118	63.8	33	17.8	8	4.3	48	25.9
Staff grade	44	23.8	10	5.4	4	2.2	15	8.1
Trainee	109	58.9	14	7.6	25	13.5	56	30.3
Liaison psychiatry nurse	143	77.3	15	8.1	108	58.4	26	14.1
Allied health professional	67	36.2	20	10.8	7	3.8	12	6.5
Older persons' service (doctor/nurse)	120	64.9	26	14.1	24	13.0	16	8.6
Substance misuse service (doctor/nurse)	61	33.0	6	3.2	8	4.3	4	2.2
Other	22	11.9	1	<1	6	3.2	4	2.2

Answers may be multiple, n=185

Table 7.9 details the presence of any of these individuals, rather than the quantity, in terms of their on-site presence or off-site availability for both normal working hours and out of hours. As can be seen, as with most services in the hospital setting there was a marked reduction in seniority and specialties from 'in hours' to 'out of hours' working with the majority of out of hours work provided by nursing staff and trainees. Specialist input from drug and alcohol teams or psychologists was rare at these times.

Referrals to the liaison psychiatry service

Table 7.10 shows the mechanism by which hospital staff undertook referrals to the liaison psychiatry service. Multiple ways were accepted, but as can be seen, 93.9% (155/165) were accepted directly by telephone, with a minority only using e-proformas at 36.7% (47/128), which perhaps demonstrated the absence of an integrated IT system. A majority also used faxes at 60.5% (89/147). A variety of others mechanisms were also described including: paper referrals from boxes with daily collection, emails, letters and multidisciplinary team meetings.

Table 7.10 How patients were referred to the liaison psychiatry service

Referral process	Yes	%	No	%	Subtotal	Not answered	Total
By telephone	155	93.9	10	6.1	**165**	20	**185**
In person/bleep/pager	149	88.2	20	11.8	**169**	16	**185**
By fax proforma	89	60.5	58	39.5	**147**	38	**185**
By e-proforma	47	36.7	81	63.3	**128**	57	**185**

There is debate in liaison psychiatry services about whether it is possible to adequately gain information on the patient from referral details or whether every referred patient should be seen. This is exacerbated by the often limited access to mental healthcare records on the patient that the referrer will have. Mental health records are most commonly held by the local mental healthcare provider. This opens up the possibility of different levels of referral from requests for information to requests for review.

Over half of hospitals with liaison psychiatry services were reported to have a policy or protocol specifying which patients should be referred to liaison psychiatry (57.3%; 102/178). Table 7.11 shows who was responsible for developing this protocol or policy. A mix of authors were identified for determining the referral specification: the liaison team itself in 34 hospitals, with the mental health Trust/Health Board and acute Trust/Health Board hospital each being acknowledged as the source in a small proportion of cases, and the most common being a jointly developed policy in 35 hospitals.

Table 7.11 Protocol/policy specifying which patients should be referred to liaison psychiatry

Protocol/policy for liaison psychiatry referral specified by	Number of hospitals
Jointly developed policy	35
Specified by the liaison psychiatry team	34
Specified by this hospital Trust/Health Board	12
Specified by the mental health Trust/ Health Board	12
Subtotal	**93**
Not answered	9
Total	**102**

Triggers for referral to a liaison psychiatry service are shown in Table 7.12. Automatic referrals were rare, but not absent. The highest automatic referral trigger noted was for self-harm, which fits with existing NICE guidance.[30] However, only 68.5% (122/178) of hospitals reported this as automatic. The other triggers with higher than single figure automatic referral rates, were for behaviour problems rather than diagnostic focused concerns. 'Challenging' or 'threatening' behaviour were reported to result in automatic referrals to liaison psychiatry in 21.9% (39/178) and 17.8% (32/180) of hospitals respectively without describing a definitive link to mental ill health. For the majority of cases there was no automatic referral of a particular mental health diagnosis, although it was described as automatic in 8.1% (13/161) of hospitals for schizophrenia, 12.5% (20/160) of hospitals for severe depression and 7.3% (13/177) for patients exhibiting confusion. Other reasons for referral at discretion of doctor or nurse included a range of issues: eating problems, medically unexplained symptoms and frequent attendance.

Table 7.12 Triggers for a referral to the liaison psychiatry team

Referral triggers	Automatic referral	%	Discretion of doctor/nurse	%	Subtotal	Not answered	Total
Every patient with a mental health condition diagnosed	7	4.2	159	95.8	**166**	19	**185**
All patients with schizophrenia	13	8.1	148	91.9	**161**	24	**185**
All patients with severe depression	20	12.5	140	87.5	**160**	25	**185**
All patients with personality disorder	7	4.3	154	95.7	**161**	24	**185**
All patients with severe anxiety	11	6.9	148	93.1	**159**	26	**185**
All self-harm patients	122	68.5	56	31.5	**178**	7	**185**
Patients exhibiting challenging behaviour	39	21.9	139	78.1	**178**	7	**185**
Patients exhibiting threatening behaviour	32	17.8	148	82.2	**180**	5	**185**
Patients with capacity issues	11	6.4	162	93.6	**173**	12	**185**
Patients exhibiting acute confusion	13	7.3	164	92.7	**177**	8	**185**

Table 7.13 Activities the liaison psychiatry team are regularly involved with

Activities	Yes	%	No	%	Subtotal	Not answered	Total
Supporting staff in caring for patients with mental health needs	174	96.7	6	3.3	**180**	5	**185**
Formal teaching	157	87.2	23	12.8	**180**	5	**185**
Writing/reviewing mental health related policy, protocols or guidelines for the general hospital	143	79.4	37	20.6	**180**	5	**185**
Incident investigation	129	72.5	49	27.5	**178**	7	**185**
Committees	128	71.9	50	28.1	**178**	7	**185**
Other pertinent activities	64	57.7	47	42.3	**111**	74	**185**

Due to the fact that many liaison services are funded and employed by the local mental healthcare provider, the involvement of the service in the general hospital governance structure is not taken as automatic, but where it does exist it can be seen as a marker of good integration. Table 7.13 shows that a majority of liaison psychiatry services did engage in such activities as protocol construction, incident investigations, teaching and committee work. However, 28.1% (50/178) of services were not represented on hospital committees, 27.5% (49/178) were not involved in incident investigation and 20.6% (37/180) were not involved in the writing or reviewing of mental health related protocols and polices. 'Other' pertinent activities included a very wide range of activities from specific meeting attendances to disease specific pathway and strategic work, all of which demonstrated a degree of institutional integration.

Psychiatric Liaison Accreditation Network (PLAN)

The PLAN programme continues to expand nationally and provides a series of standards and quality assurance interventions for liaison psychiatry services. Table 7.14 shows that only 30.9% (54/175) of hospitals reported that their liaison psychiatry service was PLAN accredited, and 19 hospitals were currently under review. Of the 102 not accredited 53 were working towards achieving it (Table 7.15). This therefore left 38 liaison psychiatry services reported in this study that were neither accredited by PLAN nor working towards achieving it. There were a variety of responses in this group as to why. These ranged from a reported lack of funding, to a perceived lack of priority, a lack of belief in the value of it or a view that it was unnecessary.

Table 7.14 PLAN accreditation of the liaison psychiatry team

PLAN accredited	Number of hospitals	%
Yes	54	30.9
No	102	58.3
Currently under review	19	10.9
Subtotal	**175**	
Not answered	10	
Total	**185**	

Table 7.15 If not PLAN accredited then working to try to achieve this

Working towards PLAN accreditation	Number of hospitals
Yes	53
No	38
Subtotal	**91**
Not answered	11
Total	**102**

Protocols and policies for mental healthcare in the general hospital

Of all the hospitals from which a response was received, 123 (58.3%) reported that protocol and policies were available for the treatment of patients with mental health conditions (Table 7.16). Details about what these protocols and policies covered are listed in Table 7.17.

Table 7.16 Protocol(s)/policy specifically covering the treatment of mental health patients who are admitted for physical health problems

Protocol/policy	Number of hospitals	%
Yes	123	58.3
No	88	41.7
Subtotal	**211**	
Not answered	20	
Total	**231**	

Table 7.17 Protocol details for treatment of mental health patients admitted for physical healthcare problems

Protocol details	Yes	%	No	%	Subtotal	Not answered	Total
Assessing capacity of patients with mental health conditions	106	87.6	15	12.4	**121**	2	**123**
The management of self-harm patients	91	77.8	26	22.2	**117**	6	**123**
Observations/1:1 supervision of patients with mental health conditions	88	75.9	28	24.1	**116**	7	**123**
Documentation of the patients mental health condition in their clinical record	78	67.2	38	32.8	**116**	7	**123**
The prescription/administration of psychotropic medications	63	52.5	57	47.5	**120**	3	**123**
A transfer protocol for patients with mental health conditions	63	52.5	57	47.5	**120**	3	**123**

Mental capacity

A protocol for assessing the mental capacity of patients with mental health conditions was the most prevalent in 87.6% (106/121) of hospitals, followed by the management of self-harm in 77.8% (91/117). Observation/supervision, prescription and administration of psychotropic medications and transfer protocols were also reported. If the 88 hospitals without protocols and policies relating to mental health patients are taken into account, there were 103/211 (48.8%) hospitals that did not have a protocol for assessing the capacity of patients with mental health conditions and 114/211 (54.0%) hospitals that did not have a protocol on the management of self-harm.

For those hospitals that had a protocol for assessing mental capacity in mental health patients, the details can be seen in Table 7.18 overleaf. Where it could be answered, the vast majority noted the importance of the treating team in the general hospital taking a lead on this issue (92/98 hospitals) but a large proportion also described the possibility of joint assessments between general hospital staff and liaison psychiatry services (78/96). An important finding was that a small proportion (8 hospitals) reported a protocol stating that capacity is assessed solely by the liaison psychiatry service.

Table 7.18 Protocol covering assessment of capacity of patients with MH conditions

Protocol actions	Yes	%	No	%	Subtotal	Not answered	Total
Routinely assessed by treating general hospital team	92	93.9	6	6.1	**98**	8	**106**
Joint assessment with general hospital treating team and liaison psychiatry	78	81.3	18	18.8	**96**	10	**106**
Routinely assessed by the liaison psychiatry team	30	34.9	56	65.1	**86**	20	**106**
Solely by the liaison psychiatry team	8	9.9	73	90.1	**81**	25	**106**

Observation and supervision of patients with mental health conditions

Observation and supervision of patients with mental health conditions is an important component of management in general hospitals and 88/231 (38.1%) hospitals had a protocol for this. The aspiration of the protocol must be to ensure a safe stay for the patient with the potential options of therapeutic interventions which can range from simple monitoring of mental state through to more complex psychological interventions.

Figure 7.1 shows that there was a great deal of similarity in the personnel who undertook this important role whether in or out of traditional hours. Hospital healthcare assistants were the staff most commonly used for this task, followed by general hospital nursing staff. Under the current training curricula personnel in both of these roles may have had minimal amounts of mental health training. The mental health trained staff most commonly used for this task were agency Registered Mental Health Nurses, which may pose issues around quality assurance. The common practice seen in these data, of the use of hospital security in almost half of those hospitals reporting was highlighted as a major concern by the reviewers.

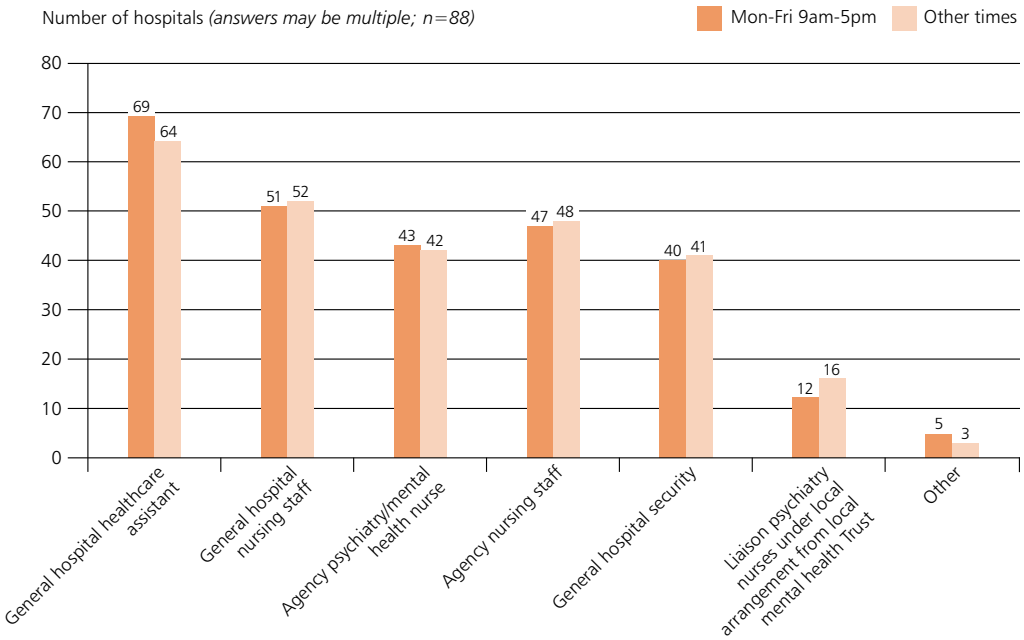

Figure 7.1 Personnel undertaking observation and supervision of patients with mental health conditions in hospitals that had a policy for observations/supervision of patients with mental health conditions

Table 7.19 Proforma or space on the clerking proforma to write details of the patient's mental health condition/assessment of mental capacity

Proforma/space	Yes	%	No	%	Subtotal	Not answered	Total
Available to write details of patients mental health condition	105	59.7	71	40.3	**176**	55	**231**
For assessment of mental capacity	95	56.5	73	43.5	**168**	63	**231**

Clerking

The routine paperwork used to clerk admitted patients were reviewed to see whether there was a specific space available to write about a patient's mental health history and about their mental capacity. These could be seen as a marker of whether these were priorities for the hospital. Table 7.19 shows that it was in 59.7% (105/176) and 56.5% (95/168) of hospitals respectively.

Addictive substances replacement

The use and abuse of substances can be a cause of significant conflict in inpatient settings. Table 7.20 highlights the presence of protocols governing the use of the two primary replacement regimens commonly used. These were available in 64.6% (117/181) of hospitals.

Table 7.21 demonstrates that 82/104 (78.8%) hospitals that had such protocols did so for opiate replacement. Whilst opiate replacement with methadone and other substances are used for a very small proportion of patients, nicotine replacement is much more commonly required and the fact that only 80 hospitals had one is of concern for two reasons. Firstly, hospitals are an obvious place to engage in brief interventions around smoking cessation, especially for those with severe and enduring mental health problems where the rates of smoking far exceed the background population. A protocol is a marker of whether institutionally a hospital is aware of this issue. Secondly, and much more pragmatically, smoking is often a source of conflict around a discussion about going outside for a cigarette. Increasingly, as hospitals go fully 'smoke free' this means actually leaving the hospital site, which can have major implications for the risk management of many patients, especially but not solely with mental health problems. This reinforces the need for a policy or protocol in this area.

Table 7.20 Policy/protocol for addictive substance replacement

Protocol/policy for addictive substance replacement	Number of hospitals	%
Yes	117	64.6
No	64	35.4
Subtotal	**181**	
Not answered	50	
Total	**231**	

Table 7.21 What the protocol/policy for addictive substance replacement covers

Policy details	Yes	%	No	%	Subtotal	Not answered	Total
Nicotine replacement	80	76.9	24	23.1	**104**	13	**117**
Methadone/opiate replacement	82	78.8	22	21.2	**104**	13	**117**

Record keeping

Mental healthcare records for patients who have a mental health history will often be kept on a separate record system. Sharing of information between a mental health Trust/Health Board and general hospital teams for those with records in both is problematic. It was of note that almost a quarter of hospitals did not answer this question. The vast majority of those who did stated that information was shared either on a case-by-case basis or facilitated directly by the liaison psychiatry service (Table 7.22). Summary care records or direct access to one another's record systems was rare. This is a focus of much IT focused transformation work nationally and pilot projects exist, but more must be done to improve this obvious governance problem.[40]

Table 7.22 How records and other clinical data were managed in this group of patients

Management of records	Number of hospitals	%
Liaison psychiatry staff provide MH records on request (electronic/paper)	98	51.6
On a case by case basis individual records shared by MH Trust on request (electronic/paper)	74	38.9
Shared and complete access to both general hospital and MH records (electronic/paper)	21	11.1
Summary case records shared from MH Trust	18	9.5
Poor-limited access	11	5.8
Acute/general hospital treating team has access to complete MH records (electronic/paper)	8	4.2
Other	4	2.1

Answers may be multiple; n=190 (41 not answered)

Hospital transfer

The transfer of patients between general hospital settings and mental health institutions is common for those with high levels of need. Only 68/231 (29.4%) hospitals had a transfer protocol for such a situation. As can be seen from Table 7.23, 40/59 hospitals, where it was answered, reported sharing this with the local mental health provider.

Table 7.23 Protocol for patients with MH conditions (where present) was shared with the local mental health inpatient hospital

Protocol shared	Number of hospitals
Yes	40
No	19
Subtotal	**59**
Not answered	9
Total	**68**

Not only were there a minority of hospitals that had transfer protocols, but also a minority of hospitals reported any joint clinical governance processes between them and the local mental health inpatient hospital, as can be seen in Table 7.24.

Table 7.24 Joint clinical governance processes in place (between the mental health inpatient hospital and this general hospital/acute Trust/Health Board)

Joint clinical governance	Number of hospitals	%
Yes	77	38.3
No	124	61.7
Subtotal	**201**	
Not answered	30	
Total	**231**	

Following on from simple data sharing to the sharing which occurred when a transferred patient moved between hospitals, Table 7.25 shows that printed notes sent with the patient was the most common way of transferring information in 64.6% (128/198) of hospitals. This was due to the lack of ability to access electronic records by both hospitals.

As can be seen in Figure 7.2, there were no routine ways of sharing electronic notes in the vast majority of cases.

Table 7.25 Arrangements in place for the sharing of clinical data of patients transferred both to and from the mental health unit and the general hospital

Clinical data shared	Number of hospitals	%
Printed notes transferred with the patient	128	64.6
Discharge/transfer summary sent with patient	119	60.1
Patient accompanied by the mental health staff who can handover in person	93	47.0
Electronic notes (mental health and general hospital notes are accessible on both hospital systems)	41	20.7
Other	39	19.7

Answers may be multiple; n=198 (33 not answered)

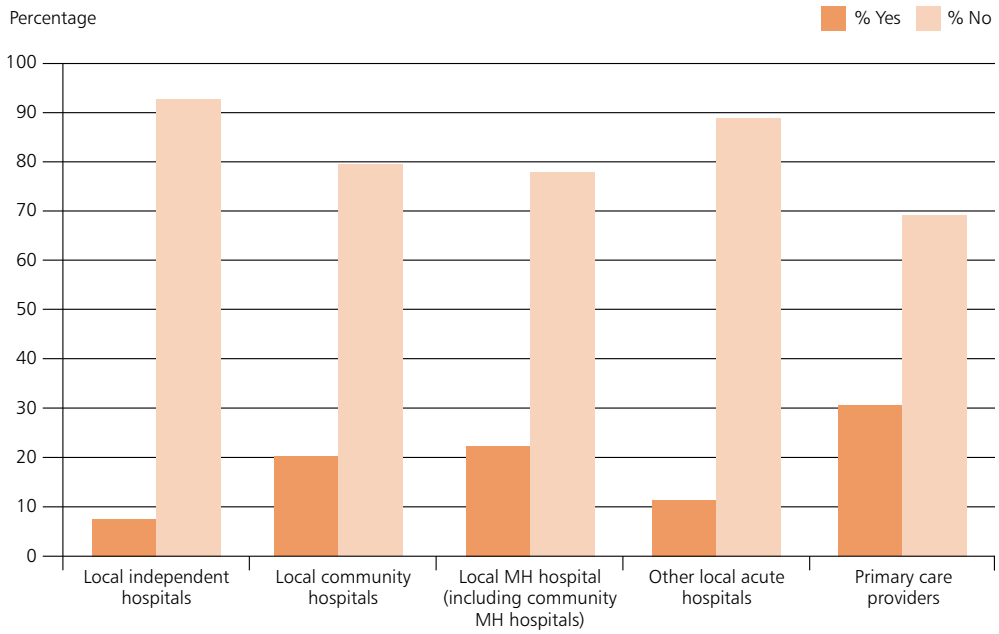

Figure 7.2 Ability to share clinical records with different providers

n= 231, Subtotals: Local independent hospitals = 195; Local community hospitals = 195; Local mental health hospitals (including community mental health) = 196; Other local acute hospitals = 192; Primary care providers = 190

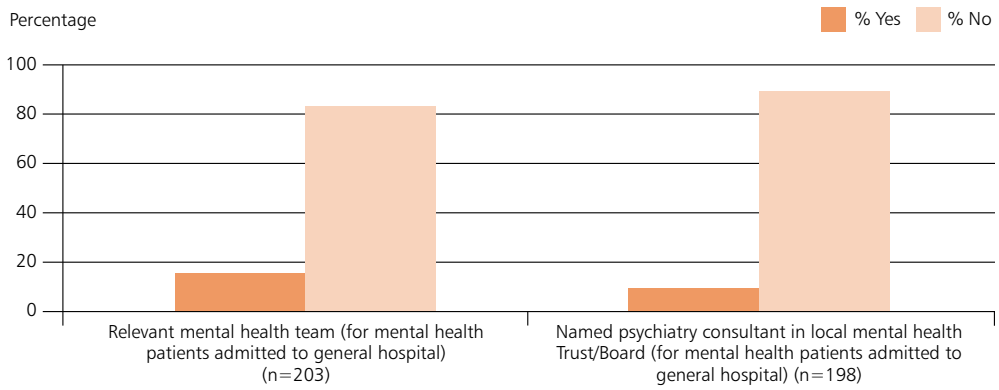

Figure 7.3 Discharge summary routinely copied to the relevant mental health team/named psychiatry consultant in the local mental health Trust/Health Board

Discharge summaries

Routine discharge summaries from general hospital admissions are an important mechanism of communicating between healthcare providers. They are sent to the patient's GP and often copied to a range of other clinicians from the general hospital if they have other teams involved in their care. However, Figure 7.3 shows that the discharge summary was routinely copied to mental health teams in only a small number of occasions 33/203 (16.3%) and an even smaller proportion to the named psychiatrist of the patient if relevant 20/198 (10.1%). This is a further marker of separation between the services and likely due to a lack of knowledge about who, or where, to send information.

When asked if there was ongoing work locally to improve information sharing between providers, 57.9% (113/195) of hospitals reported 'yes' as can be seen in Table 7.26.

Mental health legislation

Mental health legislation is complex and most mental health hospitals will have specialist teams for its proper administration. Only 42.2% (79/187) of hospitals reported that there was a central database of patients detained under mental health legislation in their hospital (Table 7.27).

Table 7.26 Ongoing work locally to improve information sharing between primary care, secondary care and mental health Trust/Health Board

Ongoing work	Number of hospitals	%
Yes	113	57.9
No	82	42.1
Subtotal	**195**	
Not answered	36	
Total	**231**	

Table 7.27 Central database in the general hospital of patients detained under mental health legislation (MH Act or equivalent)

Central database	Number of hospitals	%
Yes	79	42.2
No	108	57.8
Subtotal	**187**	
Not answered	44	
Total	**231**	

It was reported that shared learning opportunities did exist between mental health teams and the general hospital, in 38.7% (75/194) of occasions which is an important source of potential improvement (Table 7.28).

Table 7.28 Arrangements for shared learning with community MH teams and primary care

Arrangements for shared learning	Number of hospitals	%
Yes	75	38.7
No	119	61.3
Subtotal	**194**	
Not answered	37	
Total	**231**	

Table 7.29 shows that 39.2% (80/204) of hospitals reported a programme of rolling audits relating to patients with mental health conditions.

Table 7.29 Rolling audits taking place at the general hospital relating to patients admitted to this hospital with a mental health condition

Rolling audits conditions	Number of hospitals	%
Yes	80	39.2
No	124	60.8
Subtotal	**204**	
Not answered	27	
Total	**231**	

Table 7.30 reported that a similar number of hospitals (32.8%; 64/195) monitored readmissions of mental health patients and in Table 7.31 it can be seen that 49.3% (99/201) of hospitals reported that they keep adverse incident (AI) or serious incident (SI) records of events relating to mental health patients.

Table 7.30 Hospital monitors readmissions/outcomes of patients admitted with a mental health condition

Readmissions monitored	Number of hospitals	%
Yes	64	32.8
No	131	67.2
Subtotal	**195**	
Not answered	36	
Total	**231**	

Table 7.31 Hospital keeps a record of AI and SI specifically related to patients with mental health conditions

AI/SI related to MH conditions recorded	Number of hospitals	%
Yes	99	49.3
No	102	50.7
Subtotal	**201**	
Not answered	30	
Total	**231**	

Independent hospitals

There were 40 independent sector hospitals included in this review answering a separate set of questions and 20/40 stated that a patient with a pre-existing mental health condition would be admitted (Table 7.32).

Table 7.32 Hospital would admit patients with a pre-existing mental health condition

Patients with a pre-existing mental health condition	Number of Independent Hospitals
Yes	20
No	10
Other	10
Total	**40**

Furthermore, 9 of these hospitals reported that they had a policy or protocol stating what to do if the patient developed a mental health condition whilst admitted (Table 7.33).

Table 7.33 Hospital had a policy/ protocol to state what happens if a patient develops a mental health condition whilst admitted to this hospital

Policy for MH conditions developing in hospital	Number of Independent Hospitals
Yes	9
No	31
Total	**40**

A further 10 hospitals had a policy in place for the care of those with a well controlled pre-existing mental health condition (Table 7.34).

Table 7.34 Hospital had policies in place regarding the care of patients with (well managed/ controlled pre-existing) mental health conditions

Policy for controlled MH conditions	Number of Independent Hospitals
Yes	10
No	29
Subtotal	**39**
Not answered	1
Total	**40**

Only half of the independent hospitals reported links with a local mental health provider (Table 7.35).

Table 7.35 Hospital has informal links with the local mental healthcare providers

Informal links	Number of Independent Hospitals
Yes	18
No	18
Subtotal	**36**
Not answered	4
Total	**40**

Education and training

Education and training holds a key role in trying to bridge the gap that exists in terms of knowledge, skills and confidence of the general hospital workforce in offering services that meet the mental health needs of patients. In this section data from the organisational questionnaire are joined by further data from a separate on-line survey that was completed by individual healthcare professionals.

Table 7.36 shows that 54.3% (113/208) of hospitals reported that there was no mandatory training for staff with regard to any aspect of the management of patients with mental health conditions.

Table 7.36 Mandatory training regarding the management of mental health patients in this general hospital

Mandatory training	Number of hospitals	%
Yes	95	45.7
No	113	54.3
Subtotal	**208**	
Not answered	23	
Total	**231**	

Of all hospitals surveyed, area of training came close to occurring in all hospitals. Table 7.37 shows that training in mental health law and mental capacity occurred in 63.6% (147/231) of hospitals with doctor inductions being the most frequent place it was offered. Lower rates of training in these areas existed for nurses and other allied health professionals.

All other areas of non-mandatory training occurred in fewer than half of hospitals and all occurred at lower rates for nurses than doctors and lower again for allied health professionals. This training was reported to be undertaken by members of the liaison psychiatry team in 112/231 (48.5%) hospitals or by staff affiliated with the local mental health Trust/Health Board in 19.0% (44/231) of others.

The on-line survey of education and training was sent out to clinicians with a request to complete it based on their own experience of receiving training in this area. All staff

Table 7.37 Training offered in the general hospital by staff groups

Hospital offers training for following staff groups	New junior doctors/ induction	Other doctors	New nursing staff/ induction	Allied health professionals	Other staff groups
Identifying patients with mental health conditions/ mental health awareness	98 (42.4%)	69 (29.9%)	69 (29.9%)	51 (22.1%)	17 (7.4%)
Management of patients with specific mental health conditions in the acute trust	87 (37.7%)	68 (29.4%)	53 (22.9%)	40 (17.3%)	12 (5.2%)
De-escalation of challenging behaviours	97 (42.0%)	86 (37.2%)	105 (45.5%)	79 (34.2%)	18 (7.8%)
Medicines management and reconciliation	89 (38.5%)	56 (24.2%)	71 (30.7%)	38 (16.5%)	12 (5.2%)
Substance/alcohol misuse management	62 (26.8%)	47 (20.3%)	43 (18.6%)	24 (10.4%)	11 (4.8%)
Mental health law and capacity issues and consent	147 (63.6%)	132 (57.1%)	118 (51.1%)	105 (45.5%)	22 (9.5%)
Other training	34 (14.7%)	25 (10.8%)	27 (11.7%)	25 (10.8%)	8 (3.5%)

Answers may be multiple; n=231

were general hospital based rather than mental health professionals. In total 1340 responses were received. Table 7.38 shows the range of professionals who completed the survey. Doctors accounted for 45.5% (596/1311), 32.0% (420/1311) were nurses. The 'other' group included a range of professions including radiographers, technicians, pharmacists and dentists. The grade of professional is detailed in Table 7.39. Consultants formed the majority of 'doctor' survey responders.

Table 7.38 Profession of person completing the survey of training – on-line survey

Profession	Number of patients	%
Doctor	596	45.5
Nurse	420	32.0
Physiotherapist	140	10.7
Other healthcare worker	93	7.1
Other allied health professional	34	2.6
Occupational therapist	28	2.1
Subtotal	**1311**	
Not answered	29	
Total	**1340**	

Table 7.39 Grade of clinician completing the on-line survey

Grade	Number of answers	%
Consultant	434	33.4
Registered general nurse	137	10.5
Trainee	127	9.8
Nurse specialist	125	9.6
Junior allied healthcare professional	94	7.2
Senior allied healthcare professional	86	6.6
Senior staff nurse	65	5.0
Other senior nurse	48	3.7
Other doctor	39	3.0
Other	145	11.2
Subtotal	**1300**	
Not answered	40	
Total	**1340**	

Table 7.40 Training received – on-line survey

Training	Undergraduate training	%	Post graduate training	%	Workplace training	%	None of the above	%	Total	Not answered
Basic mental health awareness	897	67.8	344	26.0	608	46.0	151	11.4	1323	17
Self-harm training	534	41.8	238	18.7	304	23.8	497	38.9	1276	64
Mental capacity assessment training	345	26.6	382	29.5	826	63.8	274	21.2	1295	45
Mental health legislation	336	26.6	229	18.2	636	50.4	395	31.3	1261	79
Risk assessment training	587	46.5	322	25.5	234	18.5	523	41.4	1263	77
Psychotropic medication	272	22.0	104	8.4	267	21.6	727	58.9	1234	106
Structure of services	468	36.9	313	24.6	625	49.2	321	25.3	1270	70
Safeguarding-adults	241	18.6	278	21.5	1122	86.6	60	4.6	1295	45
Safeguarding-children	279	21.6	318	24.7	1040	80.6	142	11.0	1290	50
Dealing with violence/aggression	305	23.5	185	14.3	869	66.9	248	19.1	1298	42

Answers may be multiple

Table 7.40 describes responses around training in various aspects of caring for patients with mental health conditions within a general healthcare setting, looking at both whether and when they occurred in the career of the respondent.

Regarding basic mental health awareness, a majority, 67.8%, undertook this training at an undergraduate level with only a minority doing so later in career: only 26.0% in any kind of postgraduate training programme and 46.0% in any workplace CPD training. Most notably, 11.4% of respondents described getting no training in basic mental health awareness. Qualitative responses included the following: *"I do not recall any specific training beyond undergraduate psychiatry attachment" and "I don't know what liaison psychiatry is"*.

Self-harm is one of the commonest presentations of mental health in the general hospital, but as can be seen 38.9% (497/1276) of respondents stated they had not had any training in the area at either undergraduate, postgraduate or continued professional development stages of their careers.

Mental capacity assessment training was reported at low levels at undergraduate and postgraduate training, but at higher levels in terms of workplace training where 63.8% (826/1295) of respondents surveyed reported receiving training. Given the sample described in this survey it is unsurprising as in England, the Mental Capacity Act (2007) was only introduced in the last decade, since then large scale attempts at training in the workplace have been undertaken. Mental health legislation training occurred at a similar rate at undergraduate level to mental capacity assessment training, but occurred at a lower level in the workplace.

Risk assessment training did not occur at all for almost half of respondents (523/1263; 41.4%). Regarding psychotropic medication training, this did not occur in 58.9% (727/1234) of resondents and only a fifth (21.6%; 267/1234) had any workplace-based training. Given the issues around stopping certain psychotropic medications, in particular clozapine, and the issues that can arise, this was of concern.

The way in which mental health services are structured differs with many service configurations in the general hospital setting as was described earlier. Knowledge of these is often low and yet could be helpful for patients. For example, the level of knowledge about how to access services such as IAPT (Improving Access to Psychological Therapies) by general hospital staff could help ensure more adequate addressing of mental health concerns. A quarter of respondents (25.3%; 321/1270) reported that they had never had any training here.

Safeguarding training, in both adults and children, is mandatory for a large section of the workforce and this is reflected in the very high level of workplace training at over 80%. Dealing with violence and aggression training also occurred at a high rate in terms of workplace training.

Organisational summary

The expansion of liaison psychiatry has been at the forefront of trying to ensure higher quality care is offered to this patient group. This study has looked at one specific part of a general hospital, the acute inpatient care pathway, rather than out-patient or community focused work, which will be a crucial area for future service development. As such the focus in terms of mental health staff of this part of the pathway tends to be skewed towards psychiatrists (consultants and trainees) and nursing staff rather than other members of a broader team such as psychologists, who although are fewer in number, often have a crucial role in out-patient or community focused work.

In addition to these organisational data there have been, and continue to be investigations, research studies and initiatives to attempt to spread the presence of higher quality mental healthcare in the general hospital setting.[41] What has emerged has been a wide range of different service configurations. For example, earlier work resulted in a four level description of configuration which has enabled a framework for commissioning of different levels of liaison psychiatry services'.[42] The CORE 24 framework from this model is currently seen as a minimum standard for all hospitals in England by NHSE.[16] Many other pieces of important work have been undertaken recently, all attempting to address various components of improving and enhancing liaison psychiatry, psychology and mental health services in the general hospital setting.[43,44] Furthermore, the Royal College of Psychiatrists through its PLAN (Psychiatric Liaison Accreditation Network) has offered a significant initiative to provide a benchmarking and quality accreditation process for all liaison psychiatry services.[45]

Key Findings

- 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.

8

Overall quality of care

Examples of good clinical practice were noted in 17.9% (93/521) of patients in this study (Table 8.1). These included good communication, multidisciplinary team working and regular interaction between liaison psychiatry and general hospital teams. Early involvement of liaison psychiatry team and comprehensive management planning. Collaborative discharge planning, documentation and nursing care were also noted in many cases.

Table 8.1 Examples of good practice – reviewers' opinion

Examples of good practice were noted in the case	Number of patients	%
Yes	93	17.9
No	428	82.1
Subtotal	**521**	
Insufficient data	31	
Total	**552**	

Quoted below are some of the comments provided by case reviewers in response to the reviews.

"Mental health team saw the patient on the ward and documented background history without being asked - also provided details of community workers and current package of care."

"I was impressed with the liaison facility; the patient was admitted with a simple medical illness that would have taken 2 or 3 days of antibiotics to fix, and the fact that their mental health was deteriorating slowly was recognised and acted upon promptly."

"Exceptional assessment and management of a very challenging patient by ICU nurses including, guided by good communication with senior medical staff and psychiatric services."

"The medical team was aware of the mental health condition impacting on the patient's physical ailment and inpatient psychiatry input was requested."

"The discharge letter was very good. The patient was jointly assessed with liaison psychiatry and alcohol services."

"Physiotherapist on the ward able to initiate the referral to liaison psychiatry."

"Integrated physical and mental healthcare with integrated notes."

"Excellent support provided to the surgical team by daily visits and integration of care by psychiatric team. Refreshing."

"Calm empathic approach by surgical team when patient got distressed."

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**	

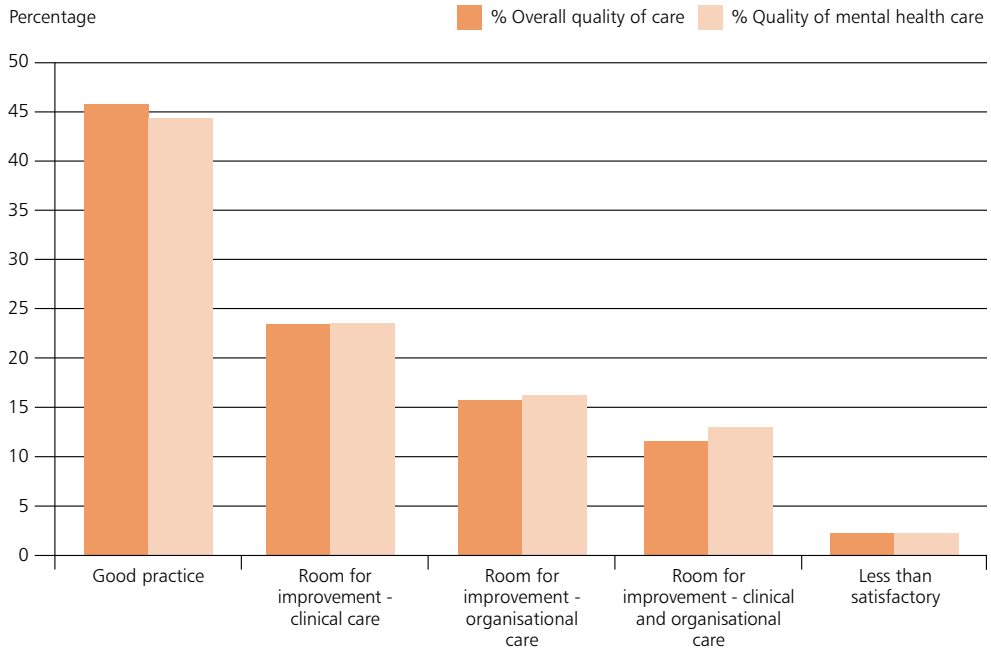

Figure 8.1 Overall quality of care and overall quality of mental healthcare – reviewers' opinion

An analysis was undertaken on the quality of care scoring and whether or not the cases were from a hospital which had a liaison psychiatry service or not and if so, whether that liaison psychiatry service was accredited under the Psychiatric Liaison Accreditation Network (PLAN).

Setting aside whether or not a patient was actually seen by a liaison psychiatry clinician, a cross analysis of the organisational and case data revealed that of the 552 cases received, 390 were received from hospitals where the organisational questionnaire stated that a liaison psychiatry service was present. Of these 390 cases, 106 cases were received from hospitals where it was stated that their liaison psychiatry services were PLAN accredited and 216 stated that they were not. Missing data accounted for the rest. As can be seen in Table 8.3 and Figure 8.2, there was a gradient towards a higher level of overall quality of care from those hospitals with no liaison psychiatry service, through to those cases with a liaison psychiatry service but no PLAN accreditation through to a PLAN accredited

Table 8.3 Overall quality of care assessed by availability of a psychiatric liaison team and whether PLAN accreditation had been achieved – reviewers' opinion

Overall quality of care	No Liaison psychiatry team	%	Liaison psychiatry team - Not PLAN accredited	%	PLAN-accredited liaison psychiatry team	%
Good practice	21	39.6	96	44.4	61	57.5
Less than good practice	32	60.4	120	55.6	45	42.5
Total	**53**		**216**		**106**	

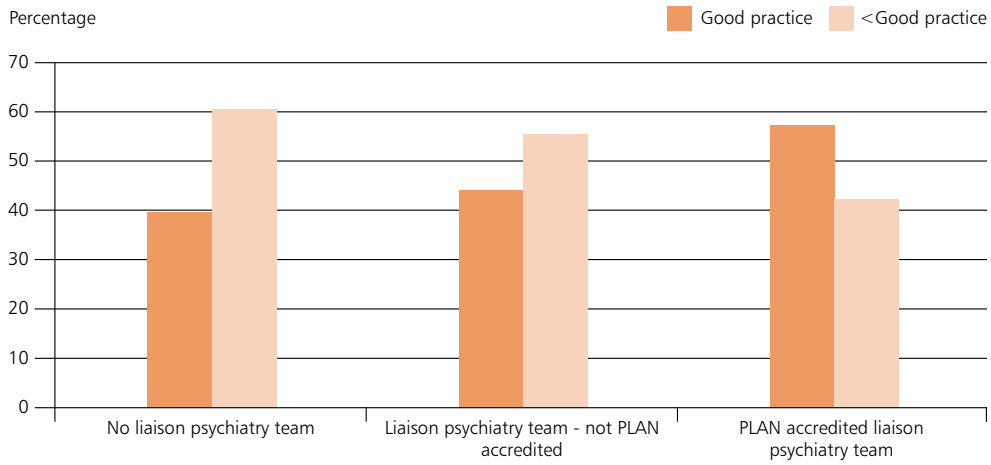

Figure 8.2 Overall quality of care assessed by PLAN accreditation – reviewers' opinion

service for the overall quality of care, and a similar picture for the overall quality of mental healthcare (Table 8.4 and Figure 8.3). These data imply that the presence of a liaison psychiatry service, and more so those accredited, were associated with higher quality of care in the view of the case reviewers. These data do need to be interpreted carefully, whilst it is a positive trend that can be seen, the study was not designed for this purpose and it is perhaps a more general reflection of the culture of the general hospital or the services presence in adding value in other areas such as teaching and management.

Table 8.4 Overall quality of mental healthcare assessed by availability of a psychiatric liaison team and whether PLAN accreditation had been achieved – reviewers' opinion

Overall quality of mental healthcare	No liaison psychiatry team	%	Liaison psychiatry team - Not PLAN accredited	%	PLAN-accredited liaison psychiatry team	%
Good	20	40.8	97	46.1	58	59.8
Less than good	29	59.2	113	53.8	39	40.2
Subtotal	**49**		**210**		**97**	
No answer	4		6		9	
Total	**53**		**216**		**106**	

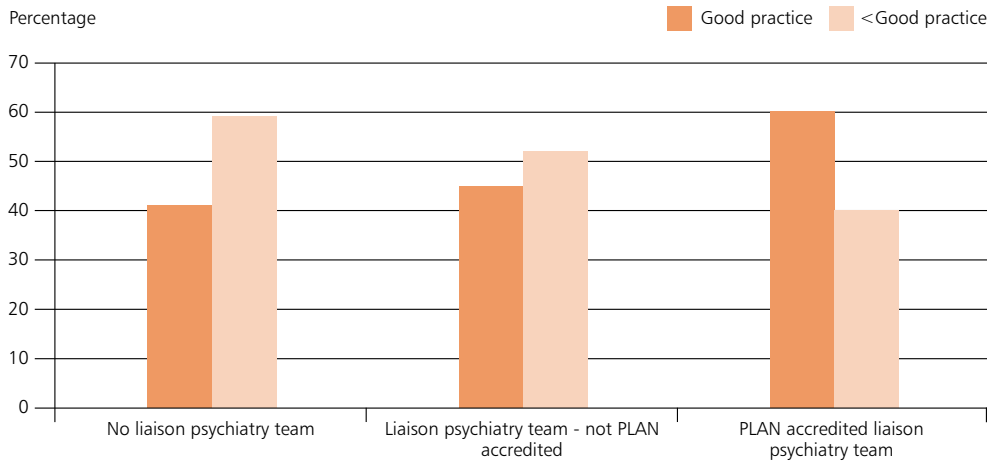

Figure 8.3 Overall quality of mental healthcare assessed by availability of a psychiatric liaison team and whether PLAN accreditation has been achieved

Key Findings

- 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)*

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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Appendices

Glossary

Term	Abbreviation	Definition
Co-morbidities		The presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder
Level 2	HDU	High dependency unit
Level 3	ICU	Intensive care unit
Sepsis		A life-threatening condition that arises when the body's response to infection injures its own tissues and organs.
Liaison psychiatry		Liaison psychiatry is the sub-specialty which provides psychiatric treatment to patients attending general hospitals, whether they attend out-patient clinics, accident & emergency departments or are admitted to in-patient wards. Therefore it deals with the interface between physical and psychological health.
IAPT		Improving Access to Psychological Therapies – a large country wide community based expansion of psychotherapy services
PLAN		Psychiatric Liaison Accreditation Network
Psychotropic		Relating to or denoting drugs that affect a person's mental state
CORE 24		Core liaison services that have the minimum specification likely to offer the benefit suggested by the literature where there is sufficient demand across the 24 hours period to merit a full service. Typically these acute health care systems are hospital based in urban or suburban areas with a busy emergency department. This model mainly serves emergency and unplanned care pathways.
Clozapine		An antipsychotic medication
Mental Capacity Act	MCA	The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Term	Abbreviation	Definition
Mental Health Act	MHA	However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.
Haloperidol		An antipsychotic medication
Midazolam		A sedative
Propofol		A drug that reduces conciousness
Lorazepam		A drug used to treat anxiety
Neutropaenia		An abnormally low concentration of neutrophils in the blood. Neutrophils make up the majority of circulating white blood cells
Haemofiltration		A renal replacement therapy which is used in the intensive care setting

Appendix 1 - Included mental health conditions and ICD10 codes

ICD10 code	Description of code
F20.0	Paranoid schizophrenia
F20.1	Hebephrenic schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.6	Simple schizophrenia
F20.8	Other schizophrenia
F20.9	Schizophrenia, unspecified
F21.X	Schizotypal disorder
F25.0	Schizoaffective disorder, manic type
F25.1	Schizoaffective disorder, depressive type
F25.2	Schizoaffective disorder, mixed type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28.X	Other nonorganic psychotic disorders
F29.X	Unspecified nonorganic psychosis
F30.1	Mania without psychotic symptoms
F30.2	Mania with psychotic symptoms
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar affective disorder, current episode hypomanic
F31.1	Bipolar affective disorder, current episode manic without psychotic symptoms
F31.2	Bipolar affective disorder, current episode manic with psychotic symptoms
F31.4	Bipolar affective disorder, current episode severe depression without psychotic symptoms
F31.5	Bipolar affective disorder, current episode severe depression with psychotic symptoms
F31.6	Bipolar affective disorder, current episode mixed

ICD10 code	Description of code
F31.6	Bipolar affective disorder, current episode mixed
F31.8	Other bipolar affective disorders
F31.9	Bipolar affective disorder, unspecified
F32.3	Severe depressive episode with psychotic symptoms
F32.2	Severe depressive episode without psychotic symptoms
F33.2	Recurrent depressive disorder, current episode severe without psychotic symptoms
F33.3	Recurrent depressive disorder, current episode severe with psychotic symptoms
F50.0	Anorexia nervosa
F50.1	Atypical anorexia nervosa
F50.2	Bulimia nervosa
F50.3	Atypical bulimia nervosa
F60.2	Anti-social/Dissocial personality disorder
F60.3	Emotionally unstable personality disorder
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified

Appendix 2 - Useful links

Psychiatric Liaison Accreditation Network (PLAN)

The Psychiatric Liaison Accreditation Network (PLAN) works with services to assure and improve the quality of psychiatric liaison in hospital settings. PLAN engages staff and patients in a comprehensive process of review, through which good practice and high-quality care are recognised and services are supported to identify and address areas for improvement.

Find out more here:
www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx

Download a leaflet here:
www.rcpsych.ac.uk/pdf/PLAN%20leaflet%202014.pdf

Royal College of Emergency Medicine - Mental Health in the ED Standards and Toolkit

Standards

1. Patients who have self-harmed should have a risk assessment in the ED
2. Previous mental health issues should be documented in the patient's clinical record
3. A Mental State Examination (MSE) should be recorded in the patient's clinical record
4. The provisional diagnosis should be documented in the patient's clinical record
5. Details of any referral or follow-up arrangements should be documented in the patient's clinical record
6. From the time of referral, a member of the mental health team will see the patient within 1 hour
7. An appropriate facility is available for the assessment of mental health patients in the ED

Toolkit
www.rcem.ac.uk/docs/RCEM%20Guidance/CEM6883-Mental%20Health%20in%20ED_Toolkit.pdf
This toolkit also includes an example proforma for documenting mental health conditions.

Information sharing – an example of good practice

The Local Care Record
The Local Care Record enables care professionals to share of information faster view a patient's medications, previous treatments, test results and any other relevant care information, at the touch of a button.

Professor John Moxham, Director of Clinical Strategy at King's Health Partners, said: "The Local Care Record is an excellent example of how partnership working can make a real difference to the lives of our patients in south east London."

Find out more here:
http://www.kingshealthpartners.org/localcarerecord

NHS England – Five Year Forward View for Mental Health in England

The FYFV for Mental Health in England recommends new funding and implementation guidance to support the expansion of acute hospital liaison mental health services so that by 202, no hospital is without an all age service, and at least 50% of hospitals meet the core 24 service standard for adults and older adults; improving physical healthcare for people with severe mental illness; and the development of integrated physical and mental healthcare pathways.

Implementation plan for Five Year Forward View for Mental Health:
www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
New liaison funding and implementation guidance:
www.england.nhs.uk/mentalhealth/resources/

Clinical guidance relating to patients with a mental health condition in a general hospital

Find out more here:
http://www.rcpsych.ac.uk/healthadvice/physicalandmentalhealth/acutephysicalhealthcare/clinicalguidance.aspx

Appendix 3 - The role and structure of NCEPOD

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent body to which a corporate commitment has been made by the Medical and Surgical Colleges, Associations and Faculties related to its area of activity. Each of these bodies nominates members on to NCEPOD's Steering Group.

Steering Group as at 26th January 2017

Dr A Hartle	Association of Anaesthetists of Great Britain and Ireland
Mr F Smith	Association of Surgeons of Great Britain and Ireland
Mr K Altman	Faculty of Dental Surgery, Royal College of Surgeons of England
Vacancy	Faculty of Public Health Medicine
Mr S Barasi	Lay Representative
Ms S Payne	Lay Representative
Dr J Fazackerley	Royal College of Anaesthetists
Dr J Butler	Faculty of Intensive Care Medicine
Dr C Mann	Royal College of Emergency Medicine
Dr D Cox	Royal College of General Practitioners
Mrs J Greaves	Royal College of Nursing
Dr E Morris	Royal College of Obstetricians and Gynaecologists
Mr W Karwatowski	Royal College of Ophthalmologists
Dr I Doughty	Royal College of Paediatrics and Child Health
Dr L Igali	Royal College of Pathologists
Mr M McKirdy	Royal College of Physicians and Surgeons of Glasgow
Dr M Jones	Royal College of Physicians of Edinburgh
Dr A McCune	Royal College of Physicians of London
Dr M Ostermann	Royal College of Physicians of London
Dr M Cusack	Royal College of Physicians of London
Dr J Carlile	Royal College of Psychiatrists
Dr S Ingram	Royal College of Radiologists
Mr W Tennant	Royal College of Surgeons of Edinburgh
Mr J Abercrombie	Royal College of Surgeons of England
Mr M Bircher	Royal College of Surgeons of England

Observers

Dr D Sharpstone	Coroners' Society of England and Wales
Mr J Campbell	Healthcare Quality Improvement Partnership
Miss V Seagrove	Healthcare Quality Improvement Partnership

Trustees

Professor L Regan - Chair
Dr D Mason - Honorary Treasurer
Mr I Martin
Ms J Barber
Professor R Endacott
Professor T J Hendra

Company Secretary Dr M Mason

NCEPOD is a company, limited by guarantee (Company number: 3019382) and a registered charity (Charity number: 1075588)

Clinical Co-ordinators

The Steering Group appoint a Lead Clinical Co-ordinator for a defined tenure. In addition there are 11 Clinical/Nursing Co-ordinators who work on each study. All Co-ordinators are engaged in active academic/clinical practice (in the NHS) during their term of office.

Lead Clinical Co-ordinator	Dr M Juniper (Medicine)
Clinical Co-ordinators	Dr V Srivastava (Medicine)
	Dr K Wilkinson (Anaesthesia)
	Dr A P L Goodwin (Anaesthesia)
	Mr M Sinclair (Surgery)
	Dr S McPherson (Radiology)
	Ms G Ellis (Nursing)
	Dr S Cross (Liaison Psychiatry)
	Dr K Horridge (Paediatrics)
	Dr M Allsopp (Adolescent Psychiatry)
	Dr A Michalski (Paediatric Oncology)

Commissioning and supporting organisations

The Clinical Outcome and Review Programme into Medical and Surgical Care is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Health and Social Care division of the Scottish Government, the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS), the States of Jersey, the Bailiwick of Guernsey, and the Isle of Man.

Members of the Clinical Outcome Review Programme into Medical and Surgical Care Independent Advisory Group:

Rachel Binks
Mike Dent
Mark Ferreira
Margaret Hughes
Donal O'Donoghue
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Aspen Healthcare
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BUPA Cromwell
East Kent Medical Services Ltd
Fairfield Independent Hospital
HCA International
Hospital of St John and St Elizabeth
King Edward VII's Hospital Sister Agnes
New Victoria Hospital
Nuffield Health
Ramsay Health Care UK
Spire Health Care
St Anthony's Hospital
St Joseph's Hospital
The Horder Centre
The London Clinic
Ulster Independent Clinic

Appendix 4 – Participation

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
Abertawe Bro Morgannwg University Health Board	4	17	17	17	17	4	16
Aintree Hospitals NHS Foundation Trust	2	5	5	5	5	2	5
Airedale NHS Foundation Trust	1	5	5	5	5	0	0
Aneurin Bevan University Health Board	3	13	13	8	6	3	13
Ashford & St Peter's Hospital NHS Trust	1	5	5	5	5	1	1
Aspen Healthcare	4	0	0	0	0	4	0
Barking, Havering & Redbridge University Hospitals NHS Trust	2	0	0	0	0	2	0
Barnsley Hospital NHS Foundation Trust	1	4	4	4	4	1	4
Barts Health NHS Trust	4	14	14	0	0	0	0
Basildon & Thurrock University Hospitals NHS FoundationTrust	2	5	5	5	5	0	0
Bedford Hospital NHS Trust	1	0	0	0	0	1	0
Belfast Health and Social Care Trust	4	14	14	11	12	0	0
Benenden Hospital	1	0	0	0	0	0	0
Betsi Cadwaladr University Local Health Board	5	13	13	4	1	3	0
Blackpool Teaching Hospitals NHS Foundation Trust	1	5	5	5	5	1	0
BMI Healthcare	52	0	0	0	0	21	0
Bradford Teaching Hospitals NHS Foundation Trust	2	5	5	1	0	1	1
Brighton and Sussex University Hospitals NHS Trust	3	11	11	10	11	2	0
Buckinghamshire Healthcare NHS Trust	2	9	9	9	9	2	9
BUPA Cromwell Hospital	1	0	0	0	0	1	0
Burton Hospitals NHS Foundation Trust	2	4	4	4	4	2	0
Calderdale & Huddersfield NHS Foundation Trust	2	9	9	8	8	2	8
Cambridge University Hospitals NHS Foundation Trust	1	4	4	2	4	1	4
Cardiff and Vale University Health Board	2	9	9	4	7	2	4
Care UK	7	0	0	0	0	2	0
Central Manchester University Hospitals NHS Foundation Trust	4	10	10	4	1	2	10
Chelsea & Westminster NHS Foundation Trust	2	5	5	2	0	2	0
Chesterfield Royal Hospital NHS Foundation Trust	1	4	4	4	4	1	0

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
Christie NHS Foundation Trust	1	0	0	0	0	1	0
City Hospitals Sunderland NHS Foundation Trust	2	5	5	5	5	2	5
Clatterbridge Cancer Centre NHS Foundation Trust	1	0	0	0	0	1	0
Colchester Hospital University NHS Foundation Trust	1	5	5	4	2	0	0
Countess of Chester Hospital NHS Foundation Trust	1	5	5	5	5	1	0
County Durham and Darlington NHS Foundation Trust	3	15	15	11	15	3	15
Croydon Health Services NHS Trust	1	5	5	5	5	1	0
Cwm Taf University Health Board	2	8	8	7	8	2	2
Dartford & Gravesham NHS Trust	1	0	0	0	0	0	0
Derby Teaching Hospitals NHS Foundation Trust	1	5	5	5	4	1	3
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	2	8	8	6	3	0	0
Dorset County Hospital NHS Foundation Trust	1	1	1	1	1	1	0
East & North Hertfordshire NHS Trust	2	5	5	5	5	0	0
East Cheshire NHS Trust	1	3	3	3	3	0	0
East Kent Hospitals University NHS Foundation Trust	5	13	13	12	13	5	13
East Kent Medical Services	1	0	0	0	0	0	0
East Lancashire Hospitals NHS Trust	2	7	7	4	2	2	0
East Sussex Healthcare NHS Trust	3	9	9	7	9	3	0
Epsom and St Helier University Hospitals NHS Trust	2	13	13	3	0	1	0
Fairfield Independent Hospital	1	0	0	0	0	1	0
Frimley Health NHS Foundation Trust	5	13	13	9	12	1	10
Gateshead Health NHS Foundation Trust	1	5	5	5	1	1	0
George Eliot Hospital NHS Trust	1	1	1	0	0	0	0
Gloucestershire Hospitals NHS Foundation Trust	2	2	2	1	1	2	1
Great Western Hospitals NHS Foundation Trust	2	3	3	3	2	2	3
Green Lanes Clinic	1	0	0	0	0	0	0
Guy's & St Thomas' NHS Foundation Trust	2	10	10	10	10	2	0
Hampshire Hospitals NHS Foundation Trust	2	9	9	5	2	2	0
Harrogate and District NHS Foundation Trust	1	5	5	5	5	1	2

Appendix 4 – Participation (continued)

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
HCA International	7	0	0	0	0	1	0
Heart of England NHS Foundation Trust	3	13	13	13	13	3	0
Hillingdon Hospitals NHS Foundation Trust (The)	2	4	4	3	1	1	4
Hinchingbrooke Health Care NHS Trust	1	5	5	5	5	1	4
Homerton University Hospital NHS Foundation Trust	1	3	3	0	0	0	0
Hospital of St John and St Elizabeth	1	0	0	0	0	0	0
Hull and East Yorkshire Hospitals NHS Trust	2	7	7	5	5	2	0
Hywel Dda University Health Board	4	19	19	18	19	4	4
Imperial College Healthcare NHS Trust	5	17	17	14	15	5	10
Ipswich Hospital NHS Trust	1	5	5	5	5	1	0
Isle of Wight NHS Trust	1	5	5	2	2	1	4
Isle of Man Department of Health & Social Security	2	4	4	0	0	1	0
James Paget University Hospitals NHS Foundation Trust	1	5	5	5	5	1	0
Kettering General Hospital NHS Foundation Trust	1	3	3	2	2	1	3
King Edward VII's Hospital Sister Agnes	1	0	0	0	0	1	0
King's College Hospital NHS Foundation Trust	3	10	10	7	4	2	4
Kingston Hospital NHS Trust	1	5	5	5	5	1	0
Lancashire Teaching Hospitals NHS Foundation Trust	2	9	9	7	4	0	0
Leeds Teaching Hospitals NHS Trust	4	9	9	8	9	4	4
Lewisham and Greenwich NHS Trust	2	9	9	4	8	2	4
Liverpool Heart and Chest Hospital NHS Trust	1	0	0	0	0	1	0
Liverpool Women's NHS Foundation Trust	1	1	1	1	1	1	0
London Clinic	1	0	0	0	0	0	0
London North West Healthcare NHS Trust	3	12	12	12	12	3	12
Luton and Dunstable Hospital NHS Foundation Trust	1	3	3	3	2	0	0
Maidstone and Tunbridge Wells NHS Trust	2	8	8	7	8	2	0
Medway NHS Foundation Trust	1	5	5	5	5	1	0

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
Mid Cheshire Hospitals NHS Foundation Trust	1	5	5	4	2	1	0
Mid Essex Hospitals NHS Trust	1	5	5	3	3	1	0
Mid Yorkshire Hospitals NHS Trust	3	10	10	7	10	0	0
Milton Keynes University Hospital NHS Foundation Trust	1	5	5	1	5	1	0
Moorfields Eye Hospital NHS Foundation Trust	1	3	3	3	3	1	0
New Victoria Hospital	1	0	0	0	0	1	0
Newcastle upon Tyne Hospitals NHS Foundation Trust	3	10	10	9	10	0	10
NHS Ayrshire & Arran	1	0	0	0	0	0	0
NHS Dumfries & Galloway	1	0	0	0	0	0	0
NHS Fife	1	0	0	0	0	1	0
NHS Forth Valley	1	0	0	0	0	1	0
NHS Lanarkshire	3	0	0	0	0	3	0
NHS Lothian	1	0	0	0	0	1	0
NHS Orkney	1	0	0	0	0	0	0
NHS Shetland	1	0	0	0	0	1	0
NHS Western Isles	1	0	0	0	0	0	0
Norfolk & Norwich University Hospital NHS Trust	2	5	5	3	5	1	5
North Bristol NHS Trust	1	5	5	5	5	1	5
North Cumbria University Hospitals NHS Trust	2	9	9	6	6	0	6
North Middlesex University Hospital NHS Trust	1	4	4	3	3	1	0
North Tees and Hartlepool NHS Foundation Trust	2	7	7	7	5	2	0
Northampton General Hospital NHS Trust	1	5	5	5	5	1	5
Northern Devon Healthcare NHS Trust	1	5	5	5	5	1	5
Northern Health & Social CareTrust	3	0	0	0	0	2	0
Northern Lincolnshire & Goole NHS Foundation Trust	3	10	10	10	10	3	0
Northumbria Healthcare NHS Foundation Trust	4	14	14	12	11	4	5
Nottingham University Hospitals NHS Trust	2	9	9	8	8	2	0
Nuffield Health	30	0	0	0	0	8	0
Oxford University Hospitals NHS Foundation Trust	4	16	16	6	6	4	0
Papworth Hospital NHS Foundation Trust	1	5	5	5	5	0	0
Pennine Acute Hospitals NHS Trust (The)	4	19	19	9	17	0	0

Appendix 4 – Participation (continued)

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
Peterborough & Stamford Hospitals NHS Foundation Trust	1	0	0	0	0	1	0
Phoenix Hospital Group	1	0	0	0	0	1	0
Plymouth Hospitals NHS Trust	1	5	5	4	5	1	0
Poole Hospital NHS Foundation Trust	1	5	5	3	0	1	0
Portsmouth Hospitals NHS Trust	1	4	4	4	4	0	0
Princess Alexandra Hospital NHS Trust	1	5	5	5	5	1	0
Queen Elizabeth Hospital King's Lynn NHS FoundationTrust	1	4	4	2	4	1	3
Queen Victoria Hospital NHS Foundation Trust	1	3	3	3	3	1	0
Ramsay Health Care UK	29	0	0	0	0	10	0
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1	2	2	1	1	0	2
Rotherham NHS Foundation Trust	1	5	5	5	5	1	5
Royal Berkshire NHS Foundation Trust	1	5	5	5	5	1	5
Royal Bolton Hospital NHS Foundation Trust	1	5	5	3	5	0	0
Royal Bournemouth and Christchurch Hospitals NHS Trust	1	5	5	5	5	1	0
Royal Brompton and Harefield NHS Foundation Trust	2	9	9	9	5	0	0
Royal Cornwall Hospitals NHS Trust	3	4	4	4	4	1	3
Royal Devon and Exeter NHS Foundation Trust	1	5	5	5	5	1	5
Royal Free London NHS Foundation Trust	3	14	14	14	14	3	5
Royal Liverpool & Broadgreen University Hospitals NHS Trust	1	3	3	3	3	1	2
Royal Marsden NHS Foundation Trust (The)	2	2	2	0	0	2	0
Royal National Orthopaedic Hospital NHS Trust	1	3	3	3	3	1	1
Royal Surrey County Hospital NHS Trust	1	5	5	4	4	1	5
Royal United Hospitals Bath NHS Foundation Trust	2	5	5	5	5	1	0
Royal Wolverhampton Hospitals NHS Trust	1	4	4	2	0	1	0
Salford Royal Hospitals NHS Foundation Trust	1	4	4	3	4	1	0
Salisbury NHS FoundationTrust	1	5	5	5	5	1	0

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
Sandwell and West Birmingham Hospitals NHS Trust	2	10	10	8	8	1	10
Sheffield Teaching Hospitals NHS Foundation Trust	3	10	10	10	10	3	10
Sherwood Forest Hospitals NHS Foundation Trust	1	5	5	5	5	1	0
Shrewsbury and Telford Hospitals NHS Trust	2	10	10	8	10	0	0
South Eastern Health & Social Care Trust	3	10	10	7	6	0	4
South Tees Hospitals NHS Foundation Trust	2	9	9	4	7	2	0
South Tyneside NHS Foundation Trust	1	5	5	5	5	1	0
South Warwickshire NHS Foundation Trust	1	5	5	5	3	1	0
Southend University Hospital NHS Foundation Trust	1	3	3	3	3	1	0
Southern Health & Social Care Trust	2	9	9	9	9	0	0
Southport and Ormskirk Hospitals NHS Trust	1	5	5	5	5	1	5
Spire Healthcare	34	0	0	0	0	11	0
St George's University Hospitals NHS Foundation Trust	2	4	4	4	4	1	0
St Helens and Knowsley Teaching Hospitals NHS Trust	1	5	5	5	5	1	0
St Joseph's Hospital	1	0	0	0	0	0	0
States of Guernsey Committee for Health & Social Care	1	4	4	4	2	1	0
States of Jersey Health & Social Services	1	5	5	5	5	1	5
Stockport NHS Foundation Trust	1	4	4	1	0	1	0
Surrey & Sussex Healthcare NHS Trust	1	3	3	2	1	1	3
Tameside and Glossop Integrated Care NHS Foundation Trust	1	5	5	5	5	1	0
Taunton & Somerset NHS Foundation Trust	1	5	5	4	4	1	0
The Dudley Group NHS Foundation Trust	1	4	4	4	4	1	0
The Horder Centre	1	0	0	0	0	0	0
The Hospital Management Trust	2	0	0	0	0	0	0
The University Hospitals of the North Midlands NHS Trust	2	8	8	5	1	2	0
The Walton Centre NHS Foundation Trust	1	0	0	0	0	0	0

Appendix 4 – Participation (continued)

Trust Name	Number of hospitals	Number of cases included	Number of clinician questionnaires sent	Number of clinician questionnaires received	Number of sets of cases notes received	Number of organisational questionnaires received	Number of liaison psychiatry questionnaires received
Torbay and South Devon NHS Foundation Trust	1	1	1	1	0	0	1
Ulster Independent Clinic	1	0	0	0	0	0	0
United Lincolnshire Hospitals NHS Trust	3	15	15	15	15	3	0
Univ. Hospital of South Manchester NHS Foundation Trust	1	5	5	5	5	1	0
University College London Hospitals NHS Foundation Trust	4	11	11	11	11	3	0
University Hospital Southampton NHS Foundation Trust	2	5	5	5	5	0	0
University Hospitals Birmingham NHS Foundation Trust	1	5	5	5	5	1	0
University Hospitals Coventry and Warwickshire NHS Trust	2	6	6	6	6	2	5
University Hospitals of Bristol NHS Foundation Trust	4	5	5	3	0	0	4
University Hospitals of Leicester NHS Trust	3	14	14	8	12	3	0
University Hospitals of Morecambe Bay NHS Trust	2	0	0	0	0	2	0
Velindre NHS Trust	1	0	0	0	0	1	0
Walsall Healthcare NHS Trust	1	5	5	1	1	0	2
Warrington & Halton Hospitals NHS Foundation Trust	2	6	6	3	0	2	0
West Hertfordshire Hospitals NHS Trust	3	5	5	3	1	2	3
West Suffolk NHS Foundation Trust	1	5	5	3	5	0	0
Western Health & Social Care Trust	3	8	8	3	3	2	2
Western Sussex Hospitals NHS Foundation Trust	2	8	8	4	5	1	0
Weston Area Health Trust	1	4	4	3	0	1	0
Whittington Health	1	5	5	5	5	1	0
Wirral University Teaching Hospital NHS Foundation Trust	1	5	5	5	5	1	5
Worcestershire Acute Hospitals NHS Trust	2	10	10	6	9	2	9
Wrightington, Wigan & Leigh NHS Foundation Trust	2	4	4	3	4	0	4
Wye Valley NHS Trust	1	5	5	3	3	1	0
Yeovil District Hospital NHS Foundation Trust	1	1	1	1	1	1	0
York Teaching Hospitals NHS Foundation Trust	2	9	9	7	7	2	0

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