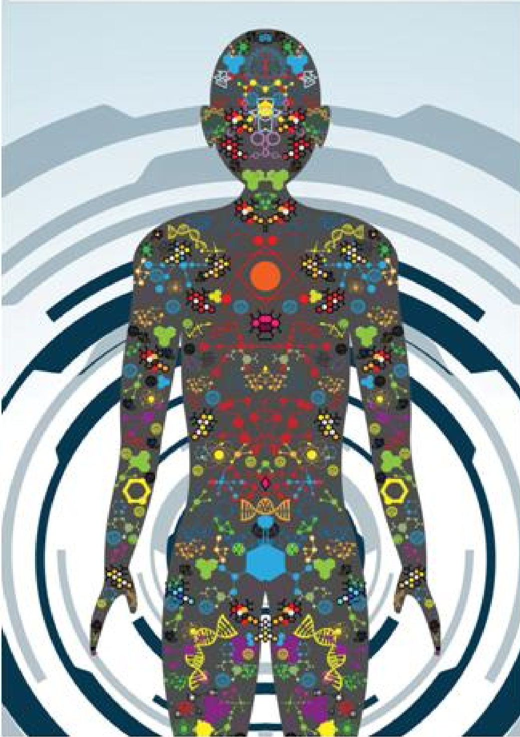
National Confidential Enquiry into Patient Outcome and Death

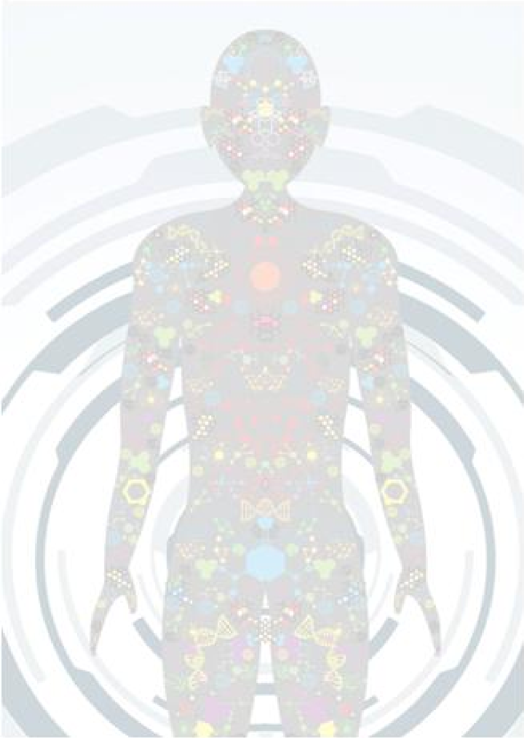


Treat as One

Bridging the gap between mental and physical healthcare in general hospitals

@ncepod
#MH

NCEPOD



Chapter 1
Background & Method
Hannah Shotton

NCEPOD

Background

- A large proportion of people are affected by poor mental health
- Link between physical and mental health in general hospitals
- Lack of integration between delivery of mental and physical healthcare
- Liaison psychiatry services

Definitions

- General hospitals
- Mental health conditions
- Liaison psychiatry team
- Mental health legislation

Aim

To explore the overall quality of mental and physical healthcare provided to patients with significant mental health conditions who are admitted to a general hospital.

Objectives

To explore the provision of organisational structures and policies:

1) Communication and sharing of relevant information
2) Systems, Services and facilities to deliver care to patients with mental health conditions
3) Training

Objectives

To explore remediable factors in the overall quality of care provided to this group of patients particularly focusing on the following areas:

1) Referral /review by liaison psychiatry and appropriate management by liaison psychiatry and general hospital staff

2) Communication and record sharing

Objectives

3) The assessment of mental capacity and deployment of mental health legislation
4) The management of medications, reconciliation and possible interactions
5) Discharge planning
6) The standard of care and treatment provided
7) Evidence of missed opportunities for intervention

Study population

Patients aged 18 + admitted to a general hospital for physical healthcare during the study period:

- Detained under mental health legislation during their admission to hospital

and/or

- Coded by ICD10 coding for a diagnosis of a listed mental health condition

Method

Patients identified

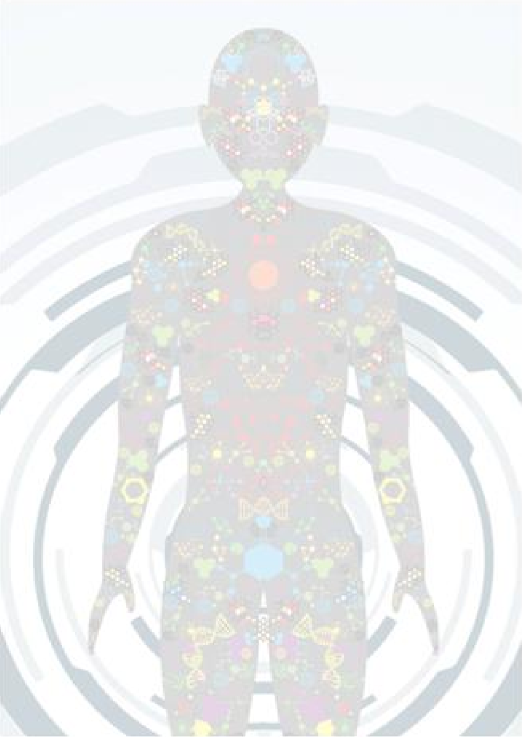
- Spreadsheet from each hospital participating
- Key information on patients who fit the study criteria

5 patients selected per hospital

- 1 who was admitted to critical care or who died
- 1 who was admitted from/discharged to a MH hospital
- 1 who was admitted due to self-harm
- 2 patients admitted for a stay longer than 72 hours

Method

- Clinician questionnaire
- Liaison psychiatry questionnaire where accessible
- Case notes/Case reviewer assessment form
- Organisational questionnaire
- On-line survey of training



Chapter 2
Sample population

NCEPOD

Data returns

Questionnaires

11,950 cases notified to NCEPOD

1064 cases selected for inclusion

346 liaison psychiatry clinician questionnaires returned

782 general hospital clinician questionnaires returned

Peer review

788 returned case notes for peer review

552 cases peer reviewed by case reviewers and included in analysis

Figure 1.1 Data returns

305 Organisational questionnaires disseminated 231 Organisational questionnaires returned

1340 responses to the online survey of training

Population

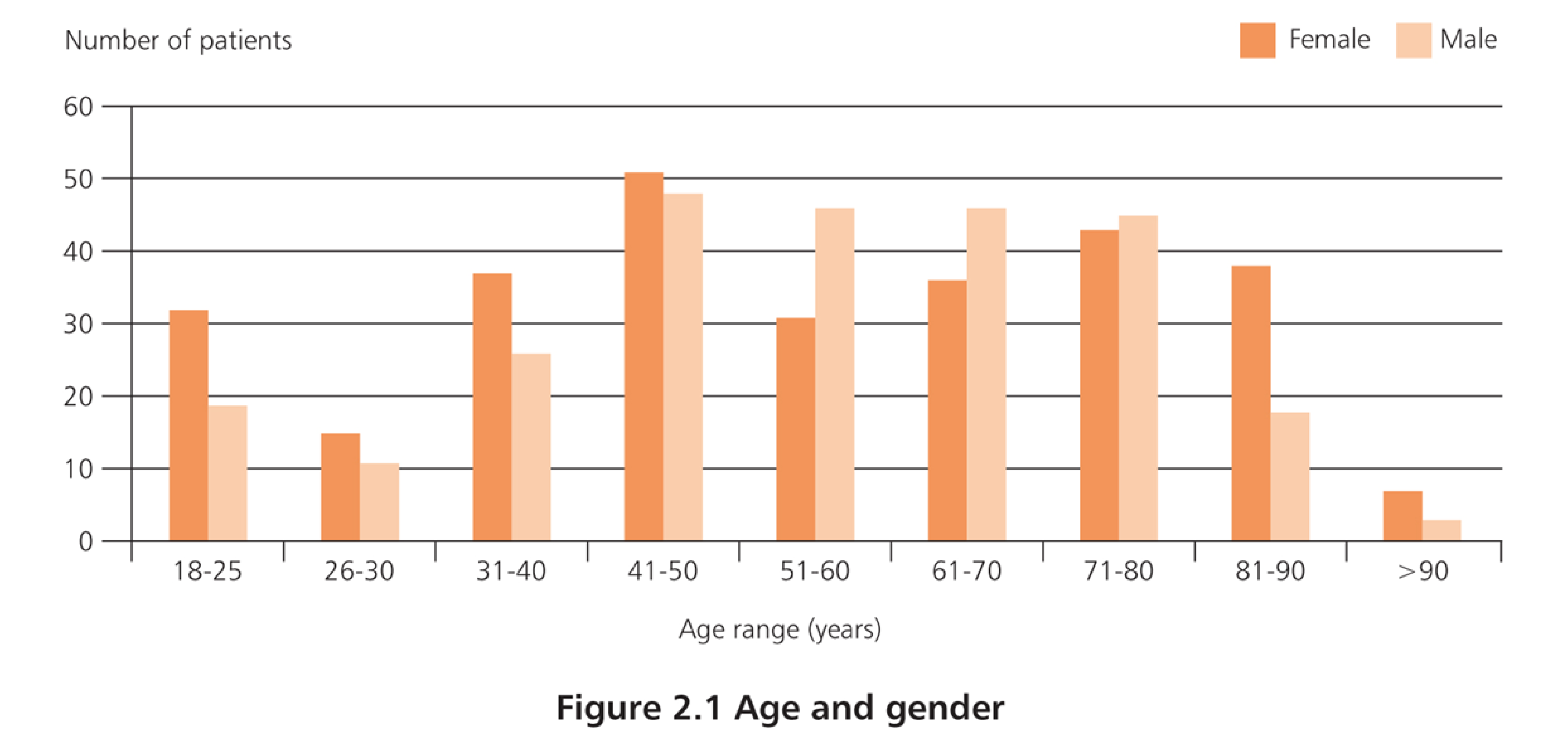


Figure 2.1 Age and gender

Primary medical reason for admission

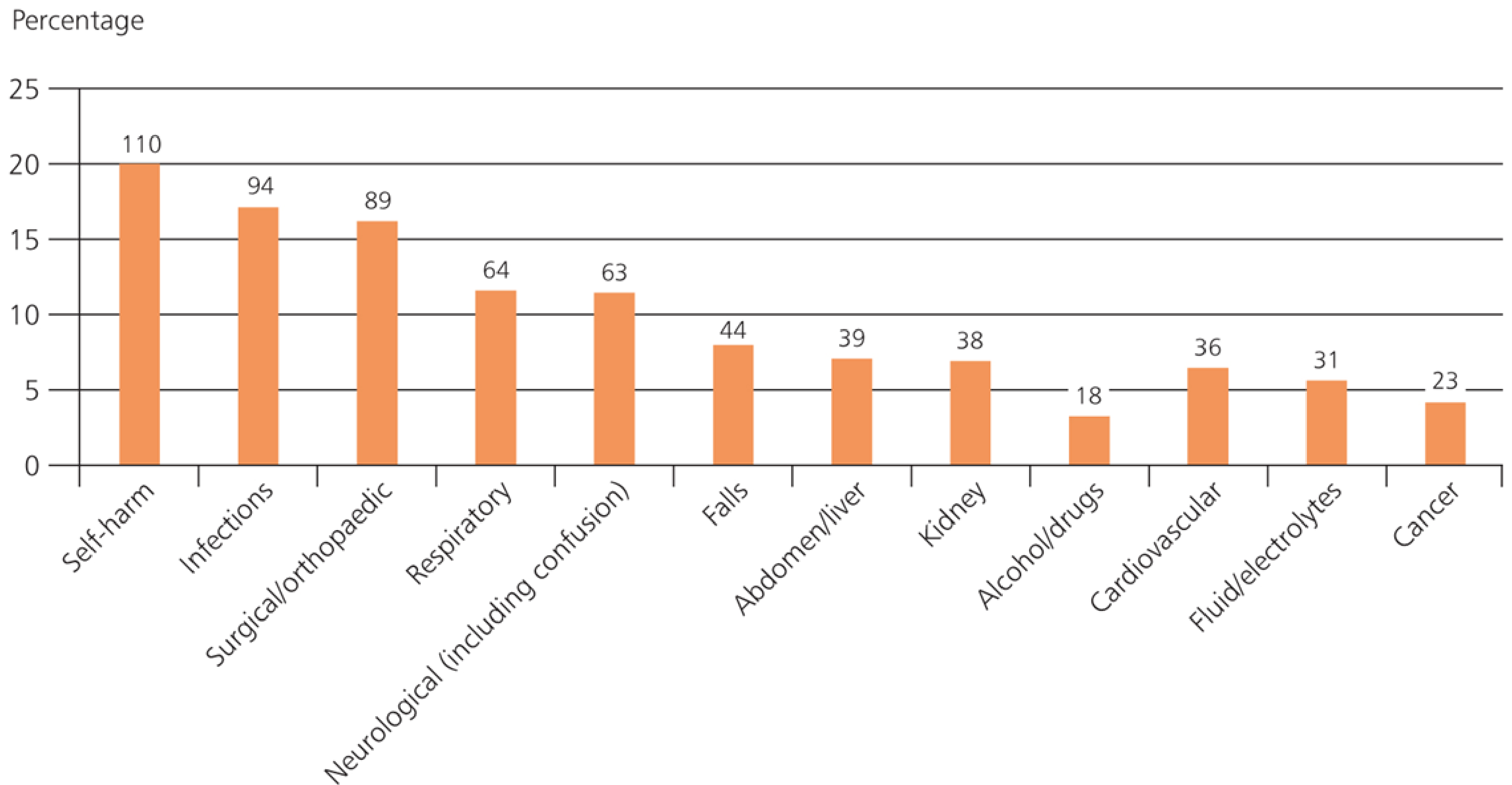


Figure 2.2 Primary medical reason for admission ***(answers may be multiple; n=552)***

Physical health co-morbidities

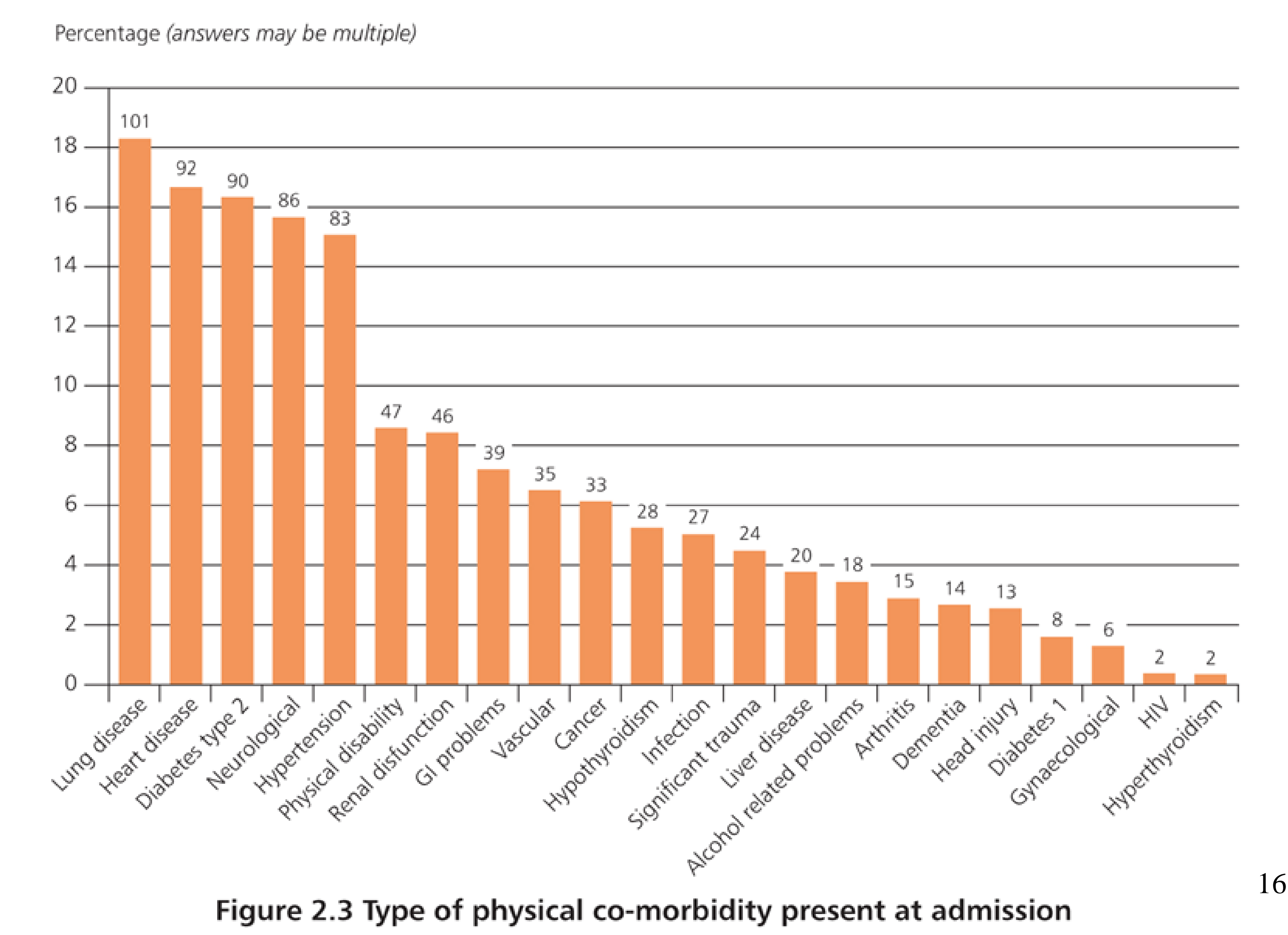


Figure 2.3 Type of physical co-morbidity present at admission

Mental health conditions in the sample population

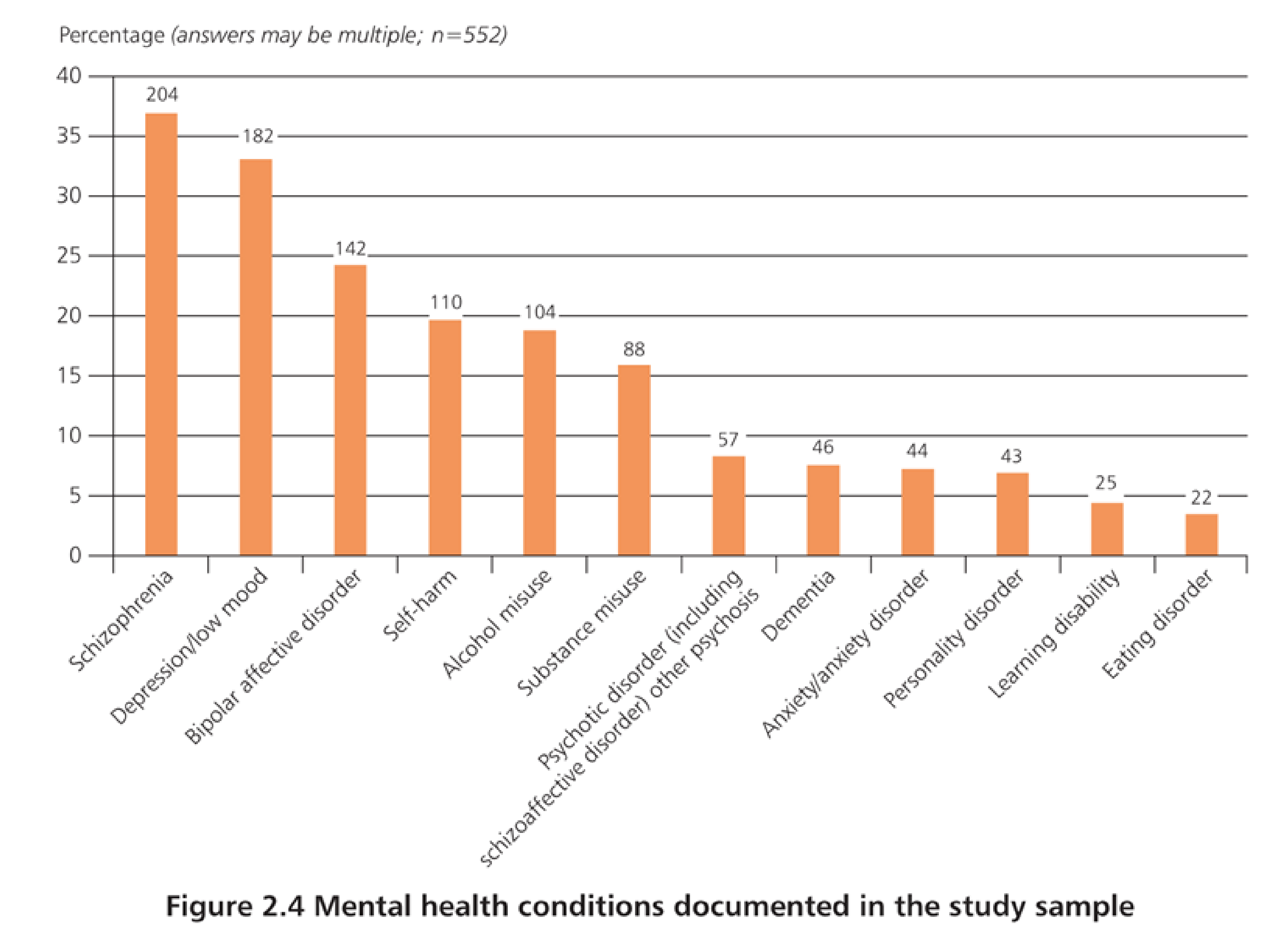
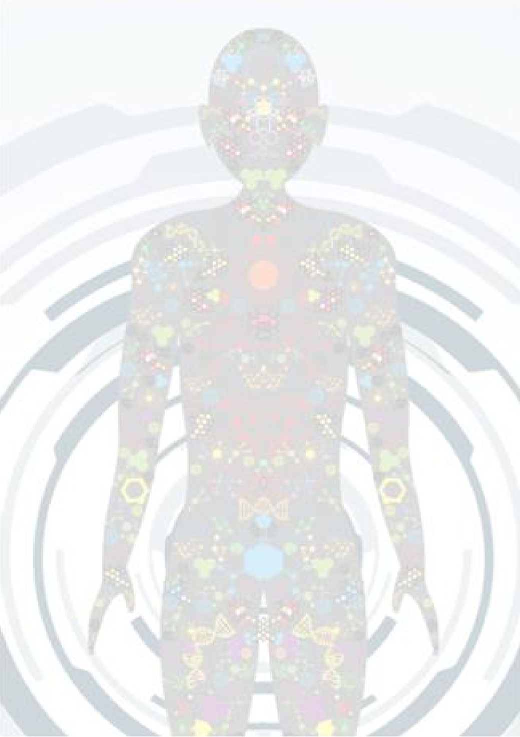


Figure 2.4 Mental health conditions documented in the study sample



Chapter 3
Presentation to hospital
Vivek Srivastava

NCEPOD

Presentation to hospital

- 351/552 (63.6%) via the emergency department
- 80/552 (14.5%) via a GP referral

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

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

Mental health conditions recorded in the ED

- MH condition recorded at triage in 67.6% (200/296) of patients and at senior review in 84.9% (265/312) of patients

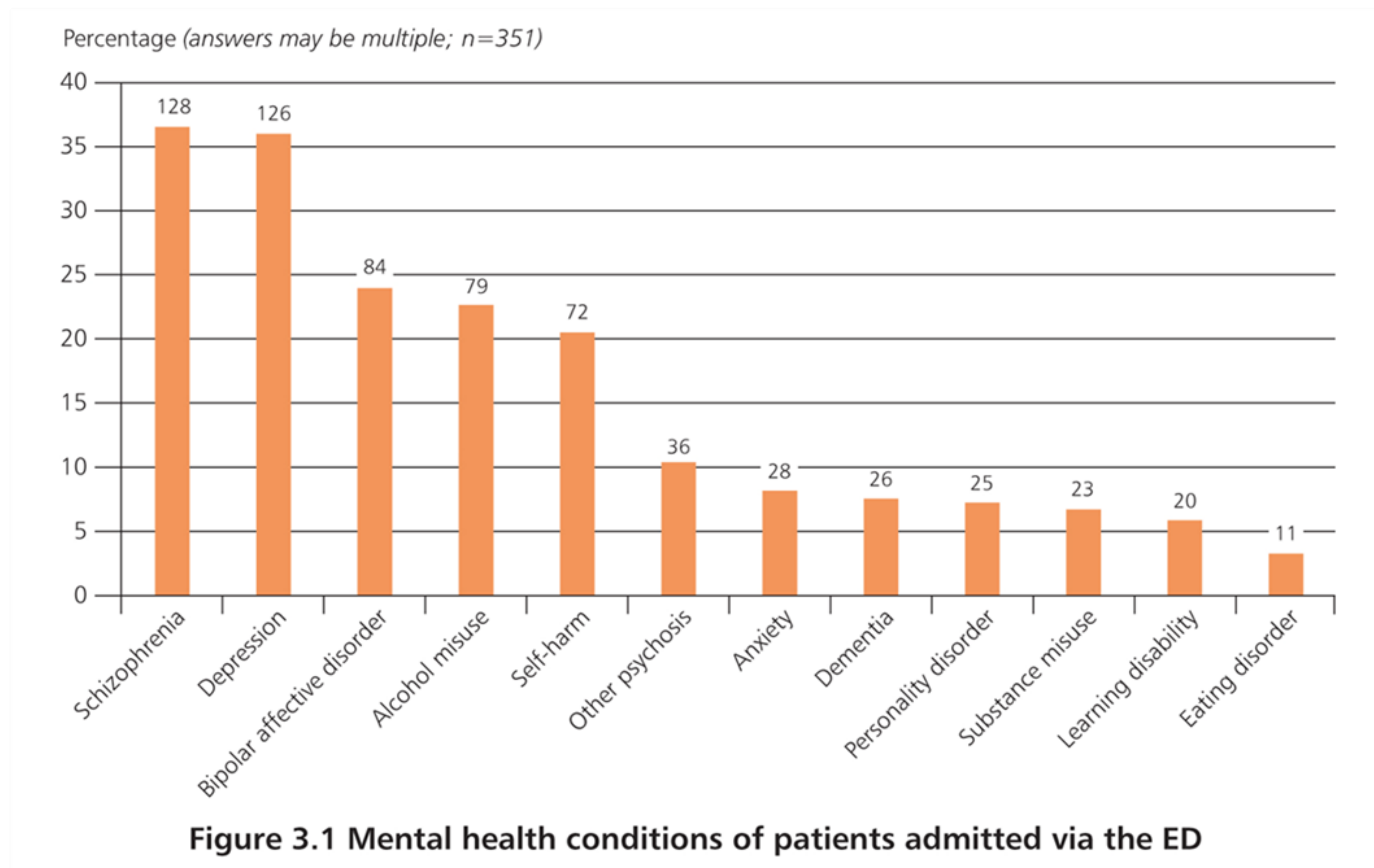


Figure 3.1 Mental health conditions of patients admitted via the ED

Referral made to the liaison psychiatry team

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**	

Referral to liaison psychiatry

- Referral made to liaison psychiatry in 55/327 (15.8%) 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**	

- Quality of care affected in 20 patients

Reason patient was not referred to liaison psychiatry

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

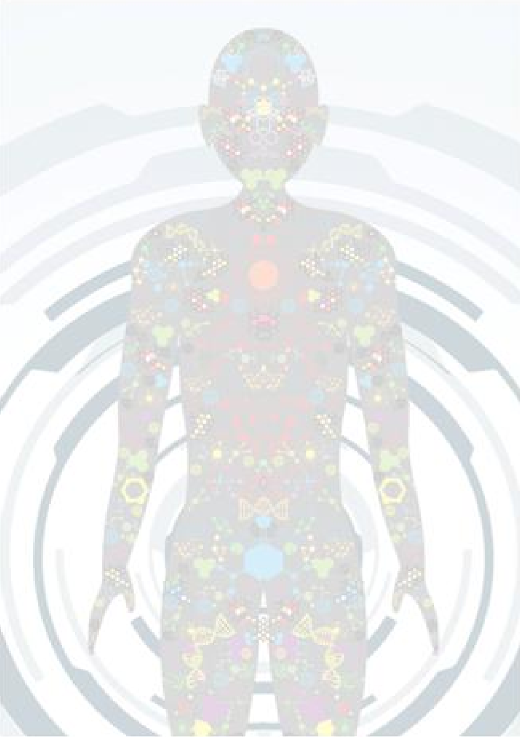
Reason	Number of patients
Clinician did not consider that it was necessary	23
Unclear from the ED notes	21
Not medically fit for review	5
Reduced consciousness	4
No liaison psychiatry team at the hospital	3
Medical care took precedence	3
Patient did not meet local criteria	3
Awaiting review/ investigations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

Answers may be multiple; n=55

Arrival of liaison psychiatry in the ED

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**



Chapter 4
Admission & initial management

NCEPOD

Listed medications

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**	

Medicines reconciliation

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.

Physical health recorded at initial assessment

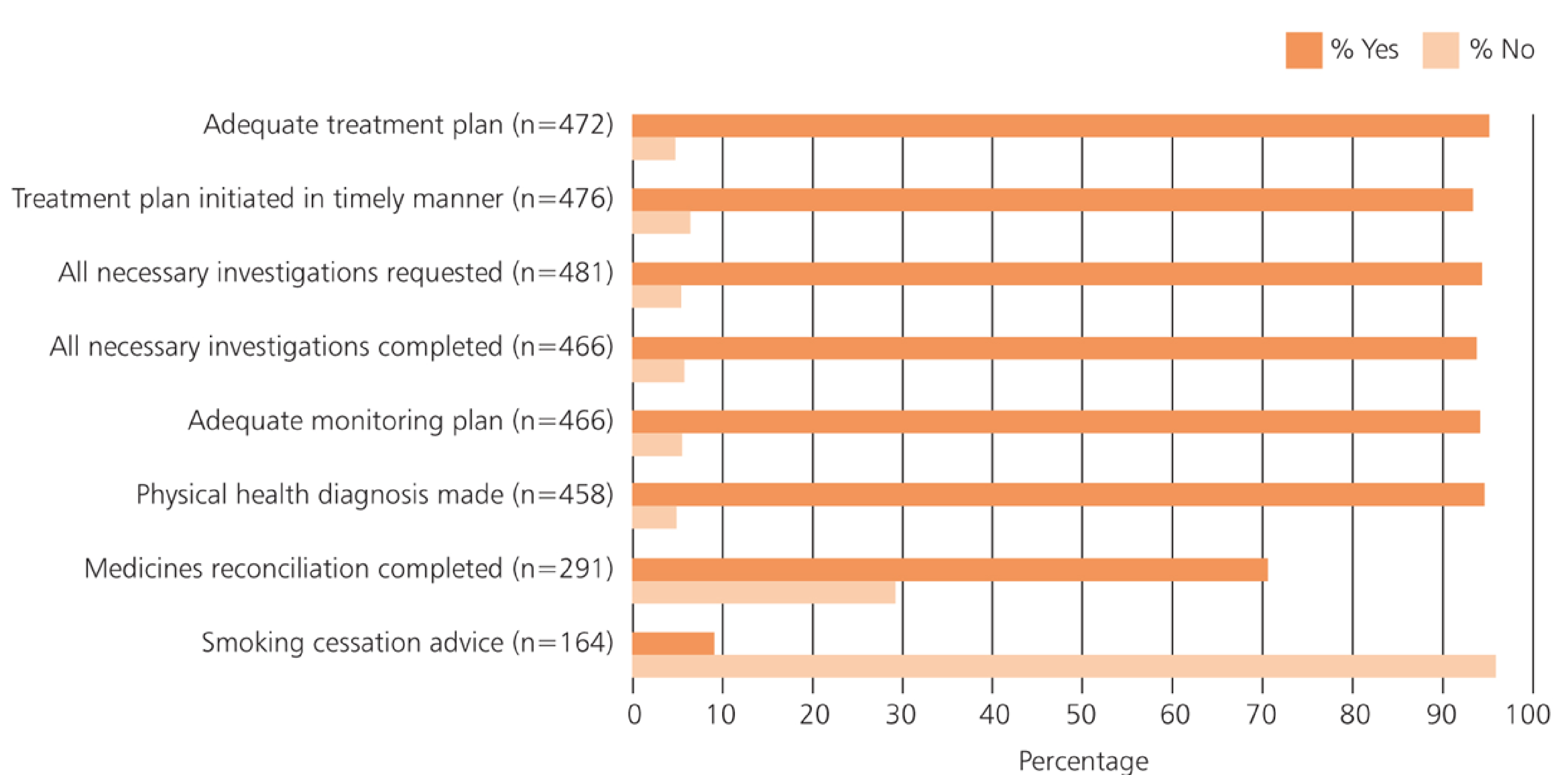


Figure 4.2 Aspects of physical health recorded at the initial assessment – reviewers' opinion

Mental health recorded at initial assessment

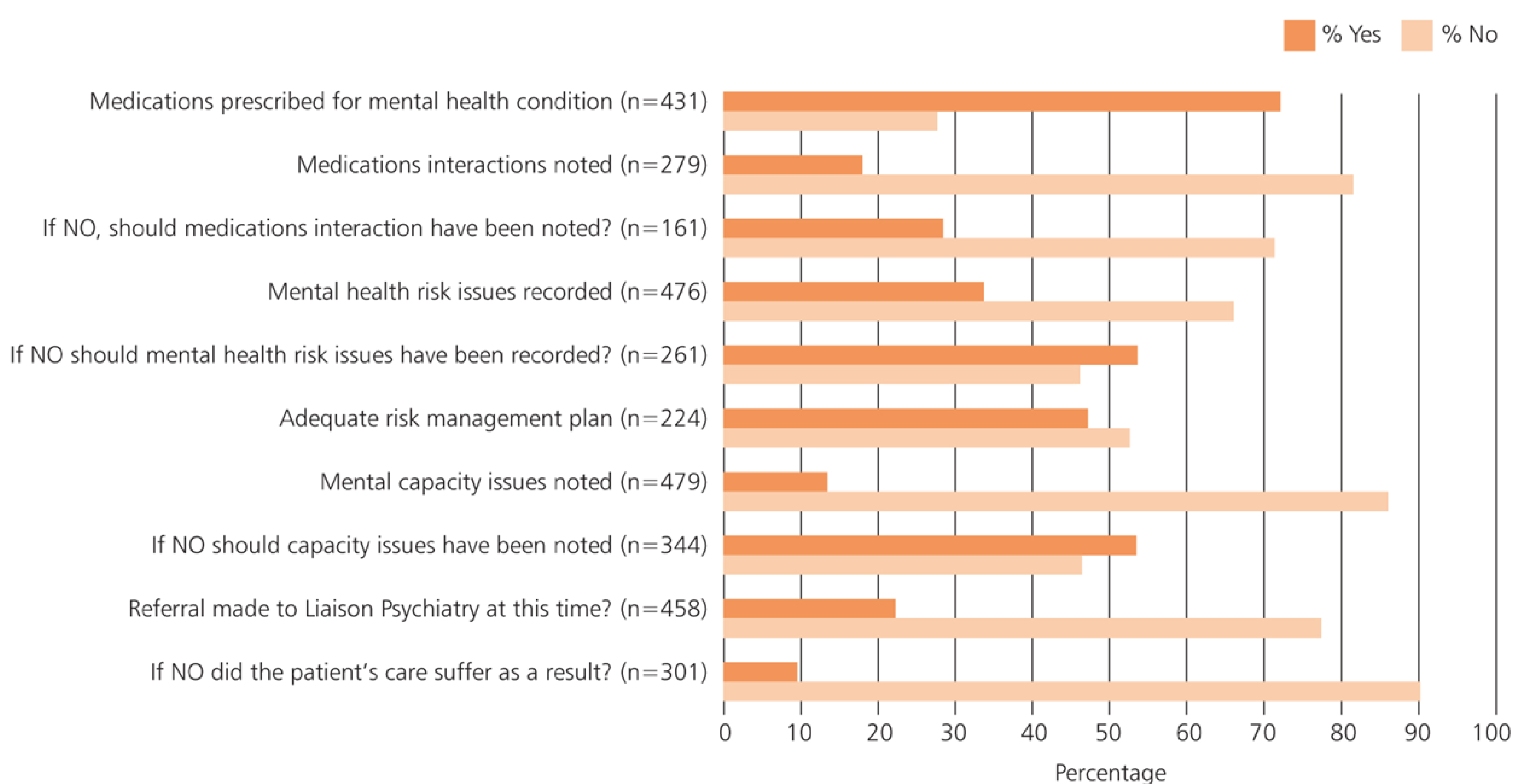


Figure 4.4 Aspects of mental health recorded at the initial assessment – reviewers' opinion

Physical health recorded at consultant review

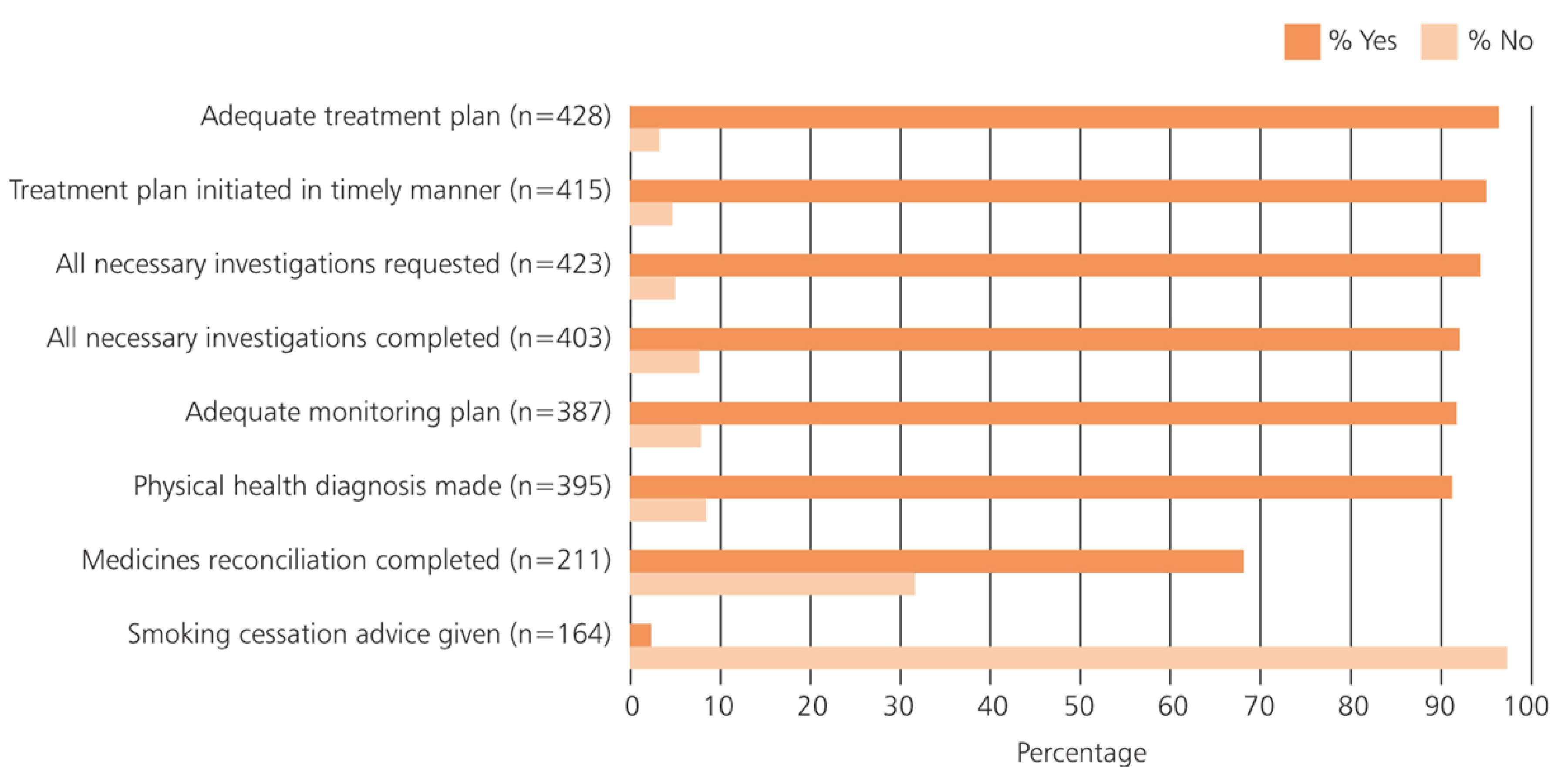


Figure 4.3 Aspects of physical health recorded at the consultant review – reviewers' opinion

Mental health recorded at consultant review

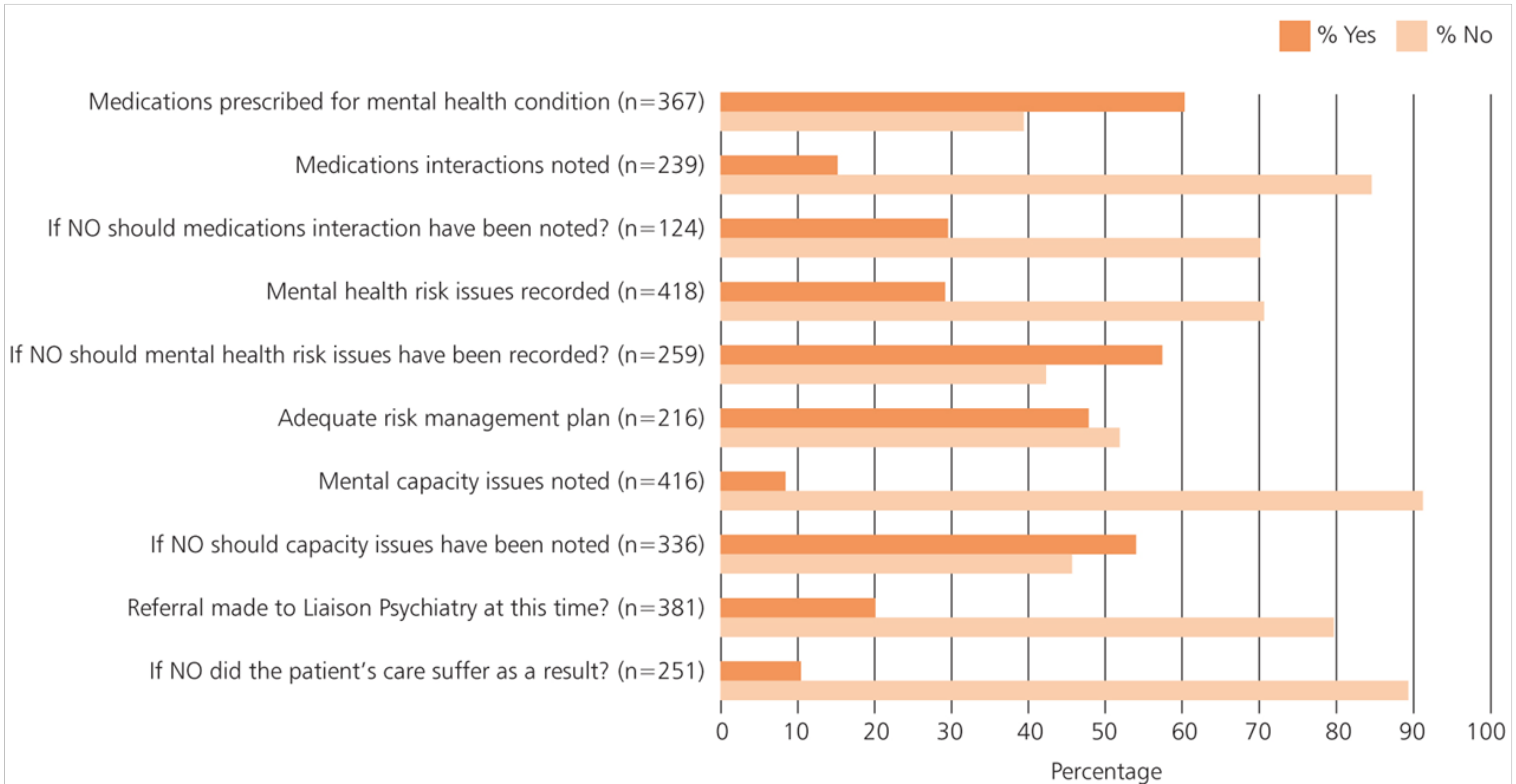


Figure 4.5 Aspects of mental health recorded at the consultant review – reviewers' opinion

Clerking proforma – organisational data

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**

Adequate history in nursing notes

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

Impact of consultant review

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

Adequate assessment of complex needs

- Complex needs assessment undertaken in 171 patients
- Inadequate in 34 patients

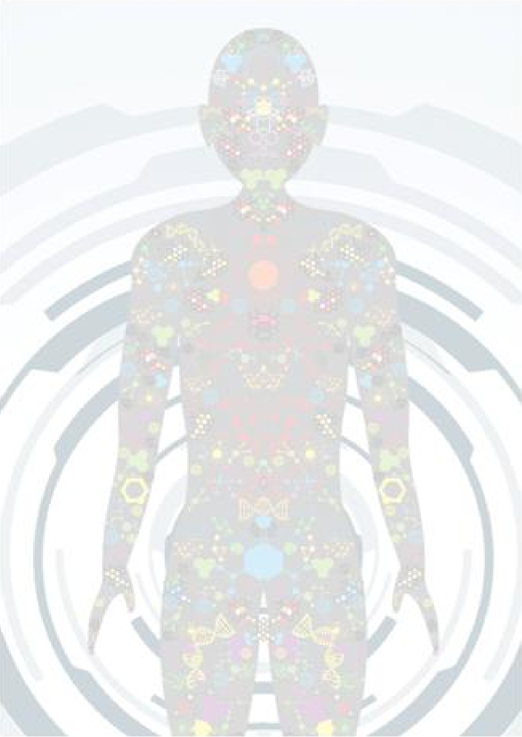
Table 4.13 Aspects not included in the assessment of complex needs

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**

Multidisciplinary care

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

Sean Cross

NCEPOD

Components of the liaison psychiatry review

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

Delay in liaison psychiatry review

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**	

Reason for delay in liaison psychiatry review

- Delay in liaison psychiatry review in 74/199 (37.2%) patients

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

Sufficient input from liaison psychiatry

- Delay impacted on the quality of care of 22 patients
- Patients seen only once by liaison psychiatry in 135/225 (60%)

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**	

Patients who were not reviewed by liaison psychiatry but should have been

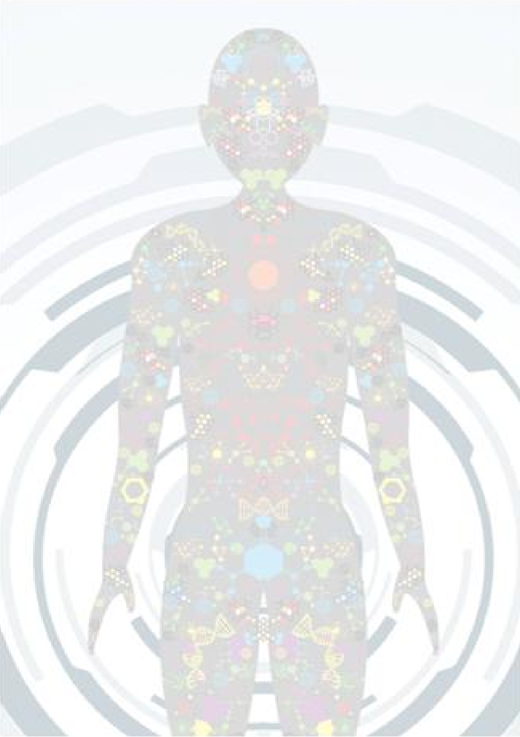
Table 4.21 Patients not reviewed by liaison psychiatry who should have been – reviewers' opinion

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

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.



Legal frameworks

NCEPOD

Patient was detained under mental health legislation

Table 4.25 Detained at any point – clearly documented

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

- 34 patients were detained at admission with details documented in 24 cases

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.

Personnel assessing mental capacity

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**	

Reason for assessing mental capacity

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**	

Room for improvement in mental capacity assessments

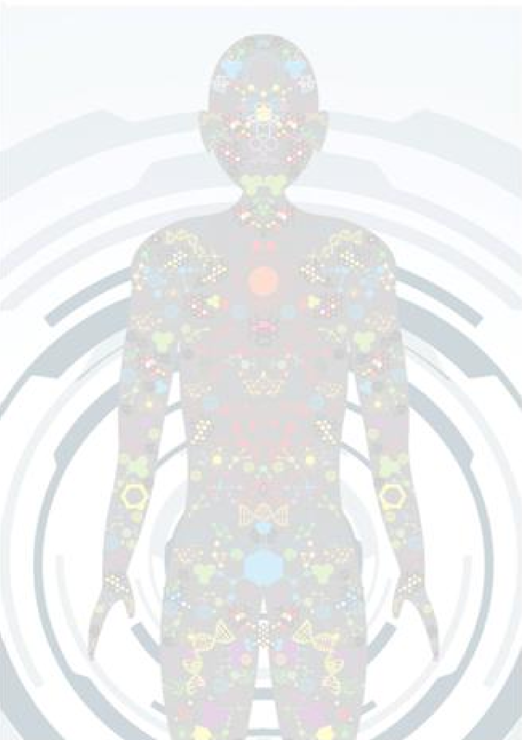
Table 4.28 Room for improvement in mental capacity assessment – reviewers' opinion

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

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.



Communication

MDT inclusion

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**	

Liaison psychiatry in the MDT

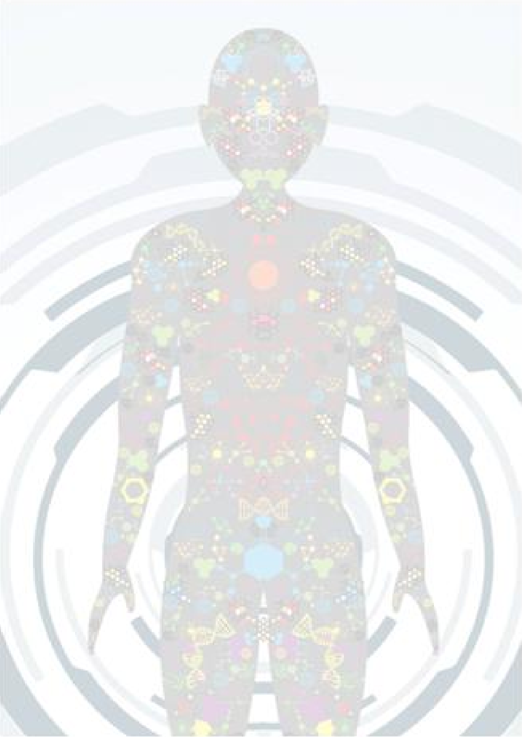
Table 4.30 Representation of liaison psychiatry at the MDT meeting

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

MDT changed the management plan

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**



Chapter 5
Ongoing patient care

NCEPOD

Care refused by the patient

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

- Mental health was a contributing factor in 136/149 (91.3%) patients

Could have been prevented

Table 5.3 Prevention of incidents of refusal – reviewers' opinion

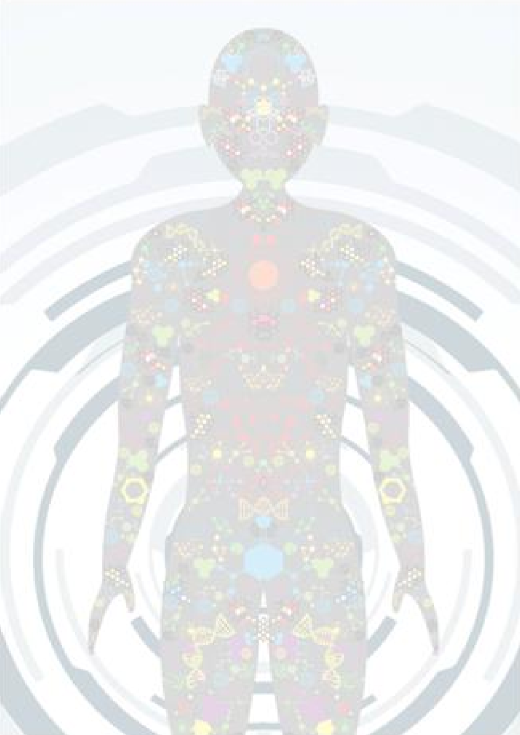
Incident could have been prevented by	Number of patients	%
Better access to liaison psychiatry staff	50	32.5
Better training of general hospital staff	45	29.2
Better communication between staff	27	17.5
Other	20	13.0
Total	**154**	

Answers may be multiple; n=154

Multiple incidents in the same patients

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	~
Room for improvement							
Liaison psychiatry called	3	5	6	8	3	14	3
Room for improvement in management	3	5	5	22	4	38	8



Chapter 5
Surgery & other interventions
Vivek Srivastava

NCEPOD

Surgery/intervention as a result of a mental health condition

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**	

- Room for improvement in consent in 24/109 (22.0%) cases reviewed

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.

Continuity of essential drugs

Table 5.11 Continuity of essential drugs compromised

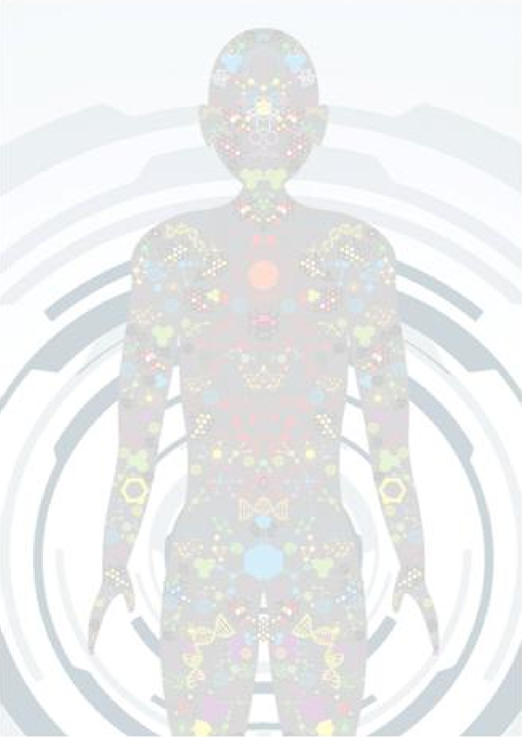
Continuity compromised	Number of patients	%
Yes	16	14.4
No	95	85.6
Subtotal	**111**	
Insufficient data	24	
Total	**135**	

Clinical deterioration

Table 5.12 Clinical deterioration

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

- 1 patient not admitted to critical care due to their mental health condition



Chapter 6
Outcomes

NCEPOD

Discharge destination

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**	

Delay in discharging patients

- Delay in discharge in 65/443 (14.7%) patients

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**

Appropriate risk assessment at discharge

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**	

Plan for review appointment

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**	

Information included in the discharge summary

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**

CASE STUDY 8

Discharge planning

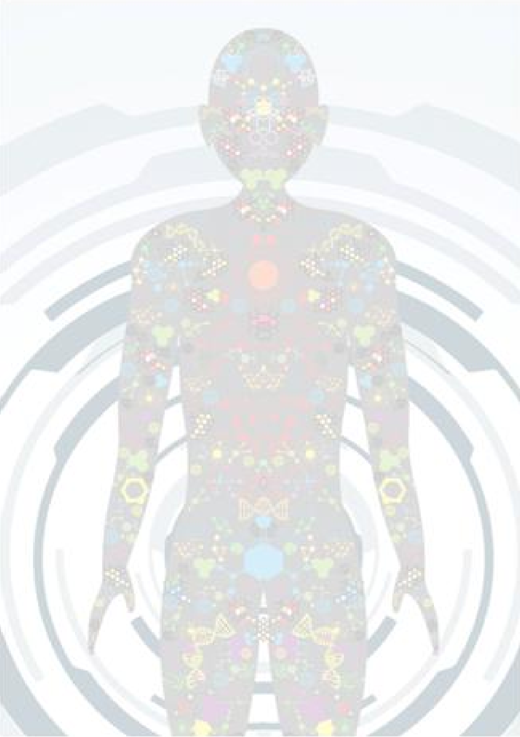
A middle-aged patient was admitted with a paracetamol overdose. The patient was known to have depression and referred to the crisis team. Whilst in hospital the ward multidisciplinary team carried out a falls assessment and nutritional assessment but no consideration was given to a mental health risk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

End of life care

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**

- Sepsis/infection was the most common cause of death (29/50)



Chapter 7
Organisational data
Sean Cross

NCEPOD

Type of hospital

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**	

Liaison psychiatry service

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**	

Liaison psychiatry service

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**	

Liaison psychiatry service

- 24/7 liaison psychiatry in 94/184 (51.1%) general hospitals

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**

Liaison psychiatry service

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

Triggers for referral to the liaison psychiatry service

- 102/185 hospitals had a policy for who should be referred to liaison psychiatry

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**

Non-clinical activities of the liaison psychiatry service

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**

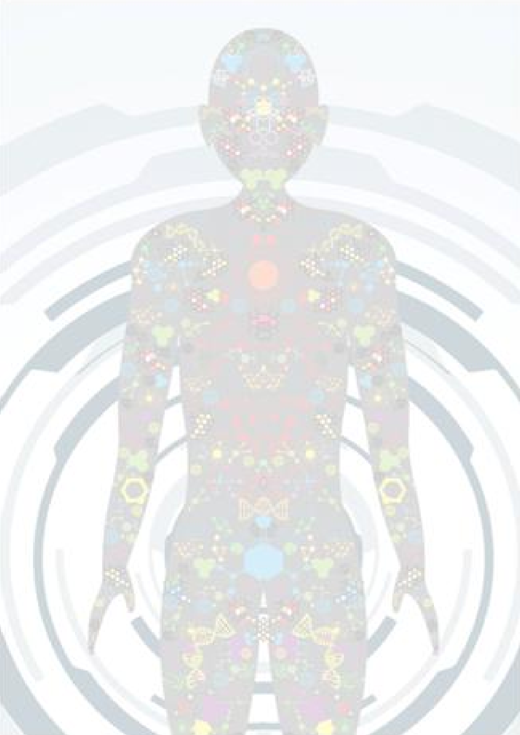
PLAN accreditation

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

NCEPOD

Protocols for physical health and mental health

- 123/211 (58.3%) hospitals had protocols covering the treatment of patients with mental health conditions who are admitted for physical health conditions

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**

Protocol covering mental capacity

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

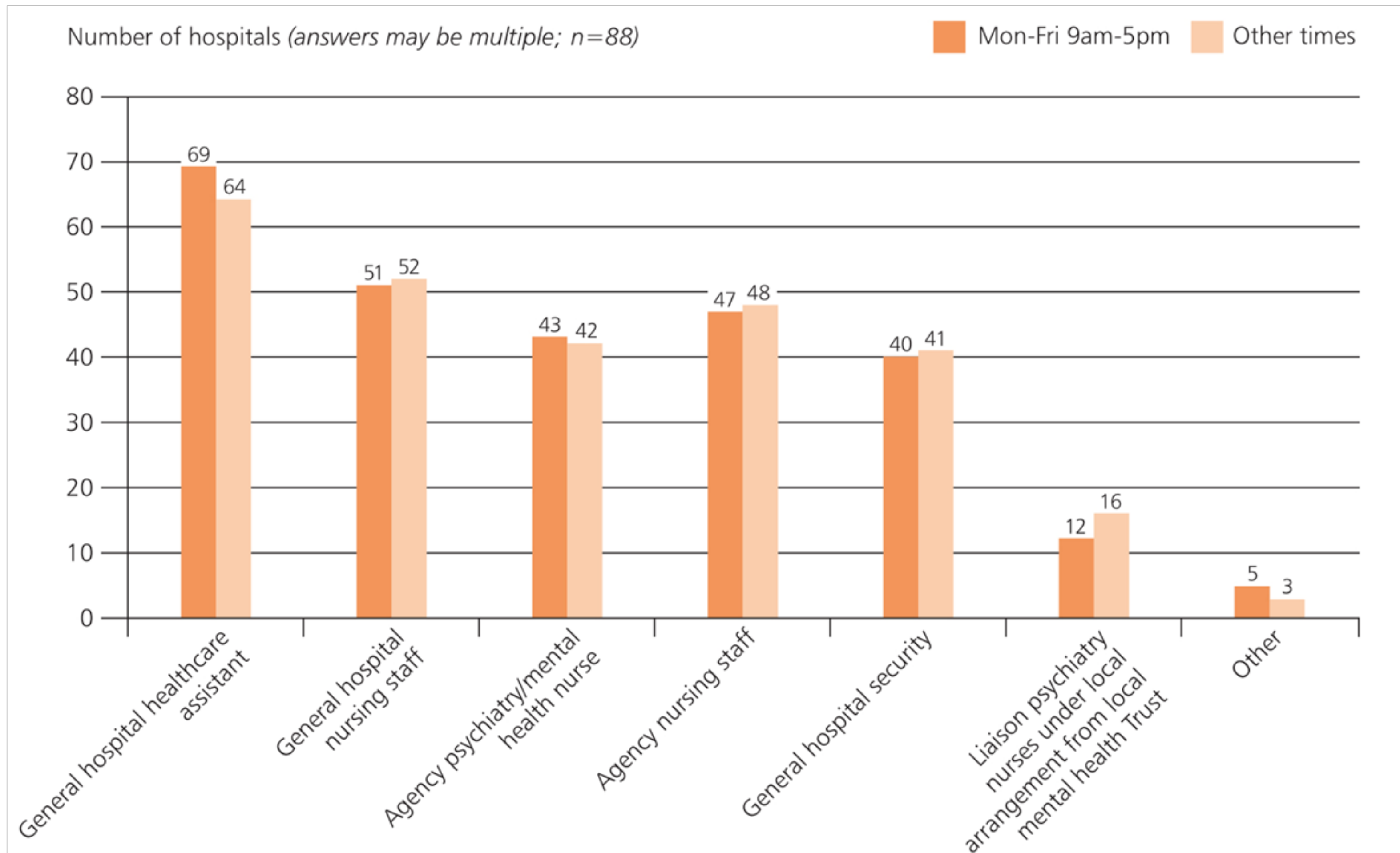


Figure 7.1 Personnel undertaking observation and supervision of patients with mental health conditions in hospitals that had a policy for observations/supervision of patients with mental health conditions

Policy for addictive substance replacement

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**	

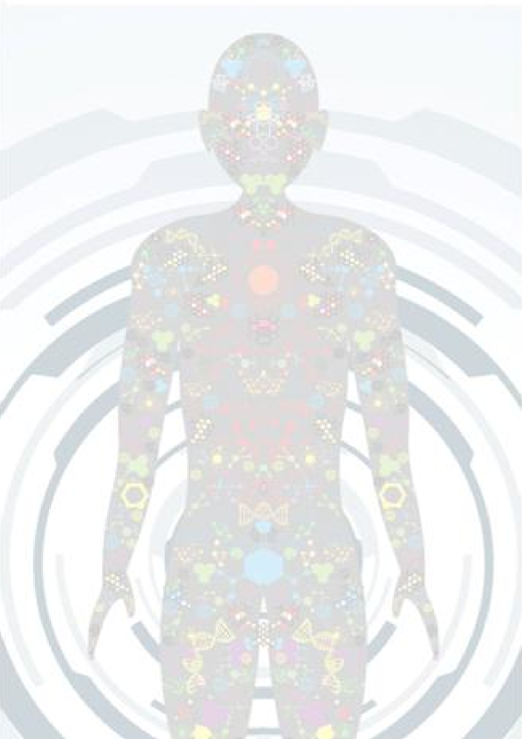
Table 7.21 What the protocol/policy for addictive substance replacement covers

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**

History of smoking status

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**	



Record keeping

NCEPOD

Records management

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)

Clinical record sharing

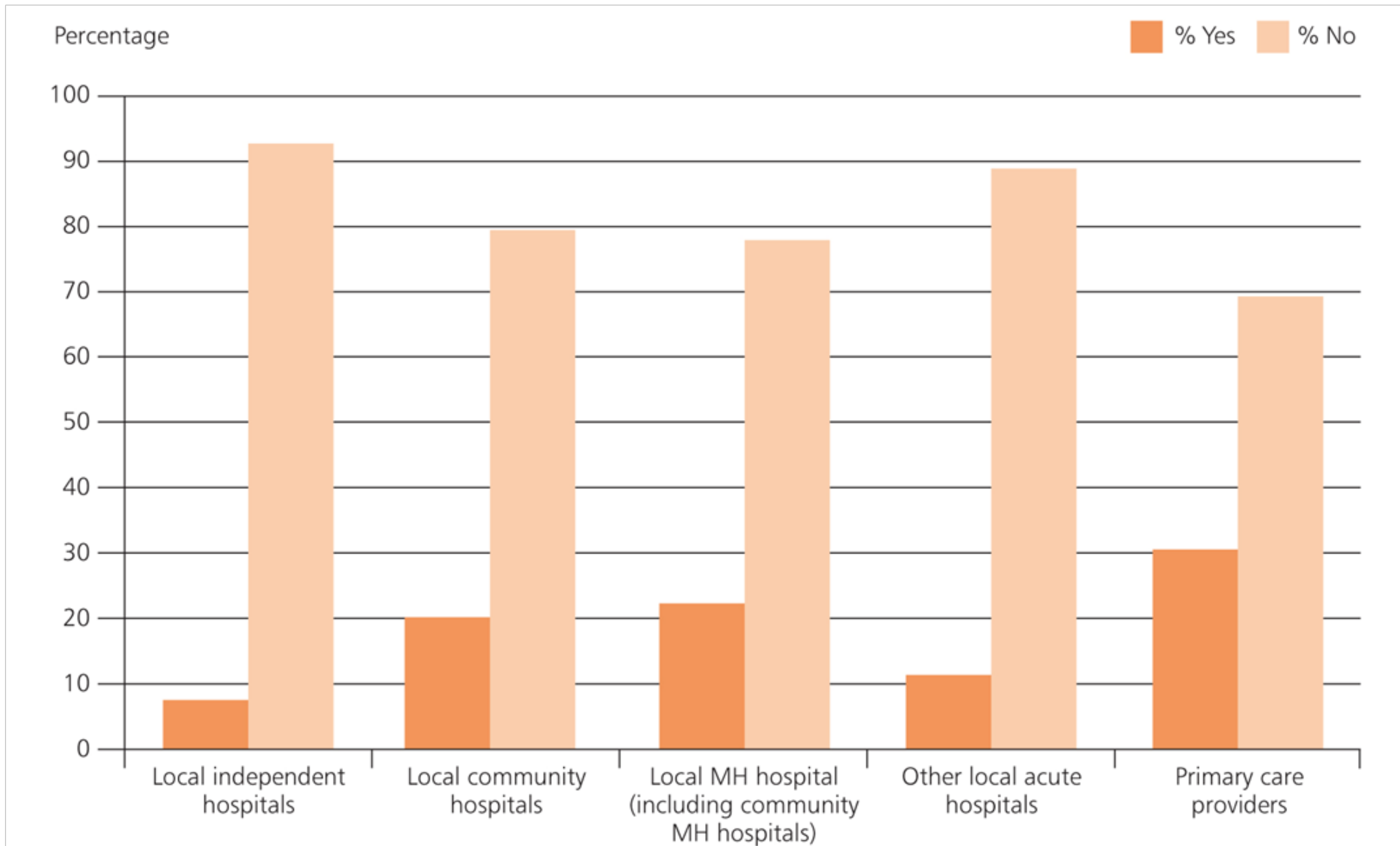


Figure 7.2 Ability to share clinical records with different providers

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

Discharge summaries copied to community

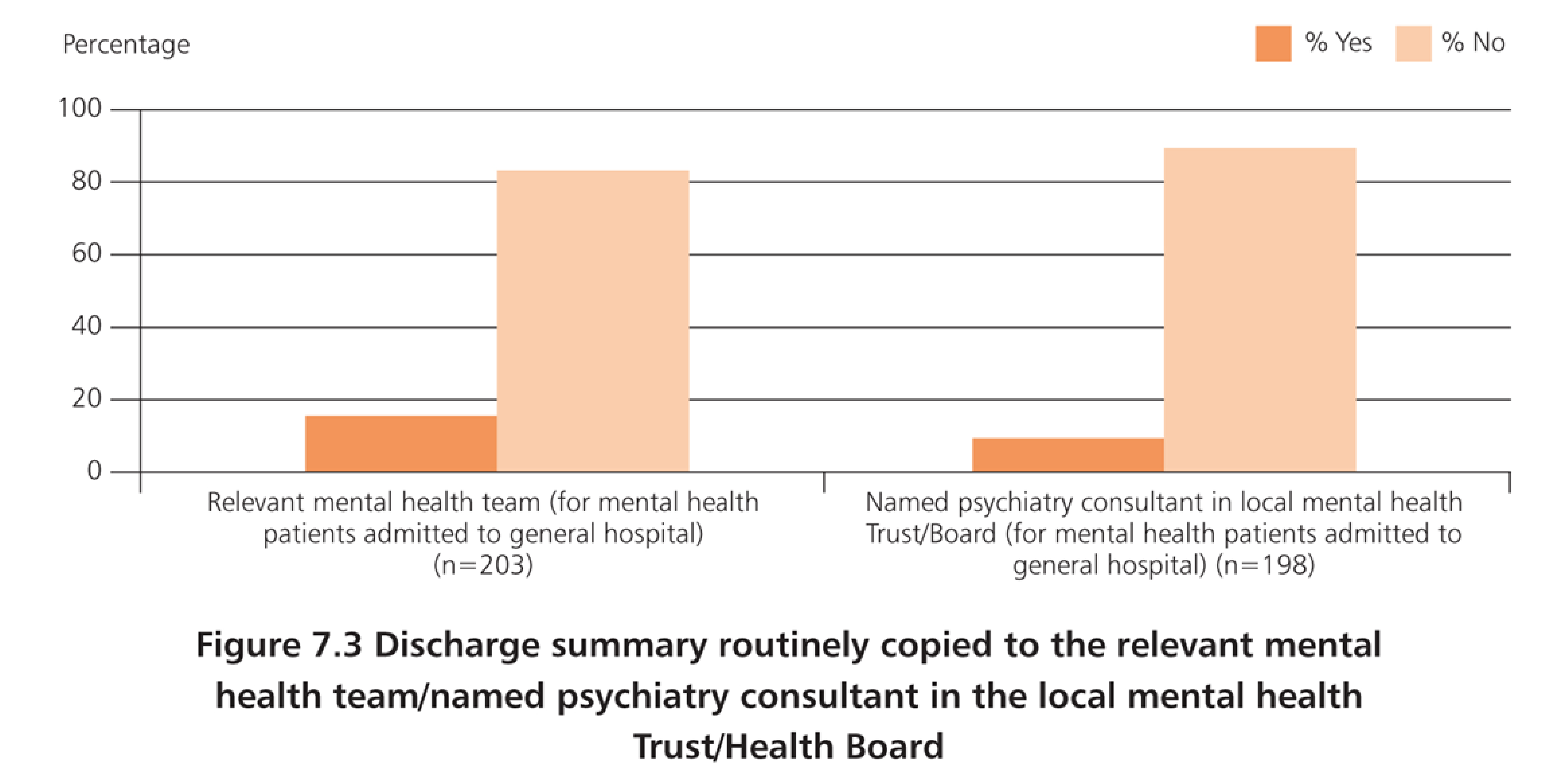


Figure 7.3 Discharge summary routinely copied to the relevant mental health team/named psychiatry consultant in the local mental health Trust/Health Board

Improvements being made in record sharing

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**	

Central database for MH legislation requirements

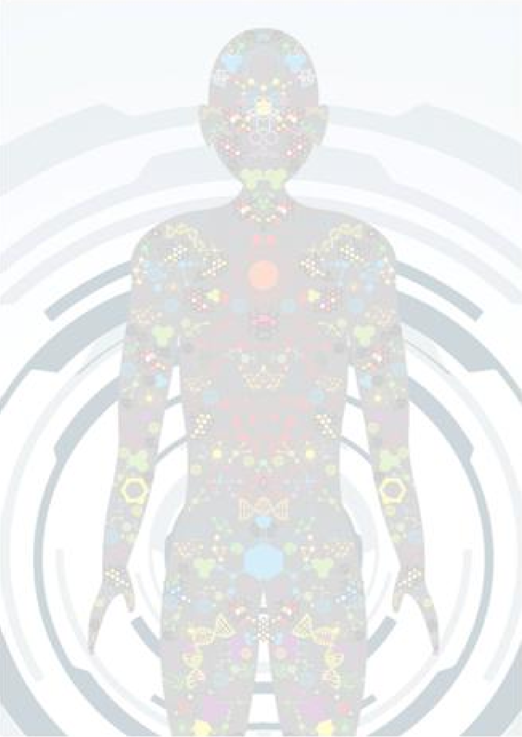
Table 7.27 Central database in the general hospital of patients detained under mental health legislation (MH Act or equivalent)

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

Clinical governance

Hospitals reported:

- No joint governance in 124/201 (61.7%)
- No shared learning with primary care in 119/194 (61.3%)
- No rolling mental healthcare audits in 124/204 (60.8%)
- No monitoring of readmissions/outcomes in 131/195 (67.2%)
- No monitoring of adverse/ serious incidents in 102/201 (50.7%)



Education and training

NCEPOD

Mental health training

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**	

Mental health training

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

Mental health training

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**	

Mental health training

Table 7.39 Grade of clinician completing the on-line survey

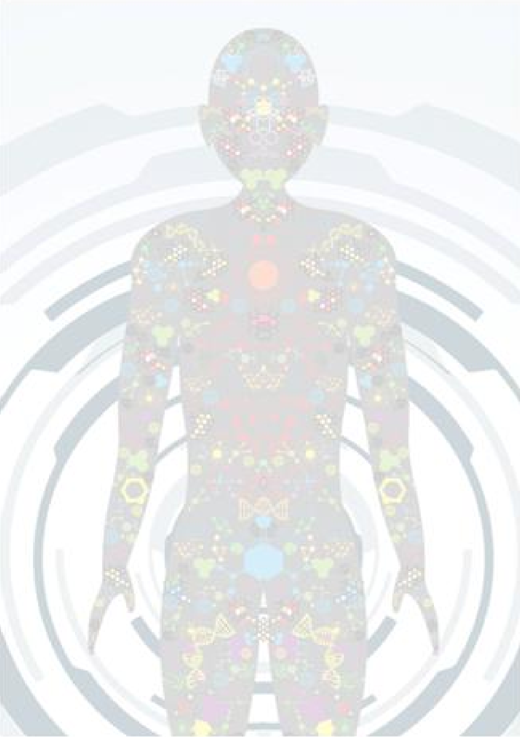
Grade	Number of answers	%
Consultant	434	33.4
Registered general nurse	137	10.5
Trainee	127	9.8
Nurse specialist	125	9.6
Junior allied healthcare professional	94	7.2
Senior allied healthcare professional	86	6.6
Senior staff nurse	65	5.0
Other senior nurse	48	3.7
Other doctor	39	3.0
Other	145	11.2
Subtotal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

Mental health training

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



Chapter 8
Overall quality of care
Vivek Srivastava

NCEPOD

Overall quality of care

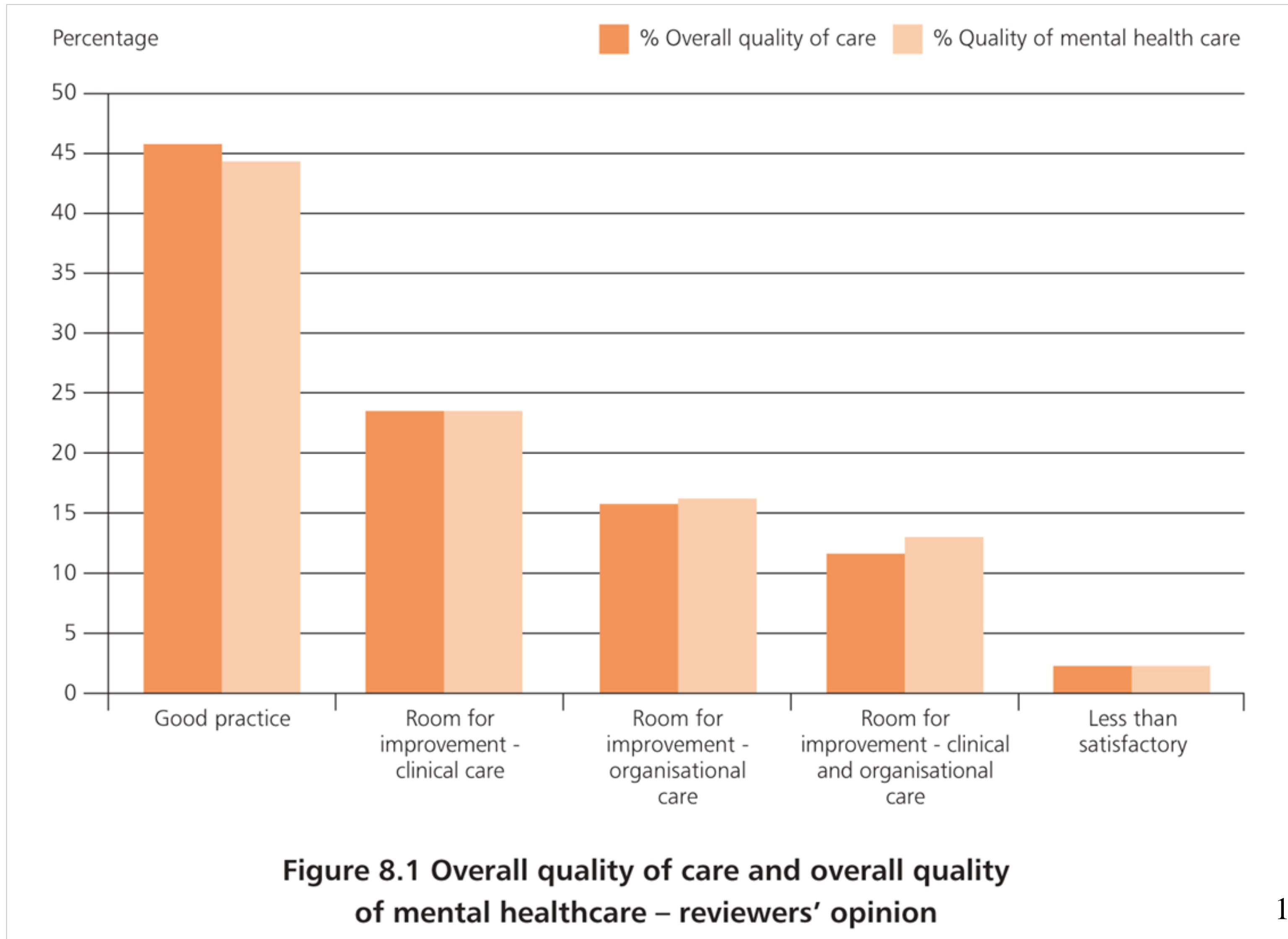


Figure 8.1 Overall quality of care and overall quality of mental healthcare – reviewers' opinion

Overall quality of care by PLAN accreditation

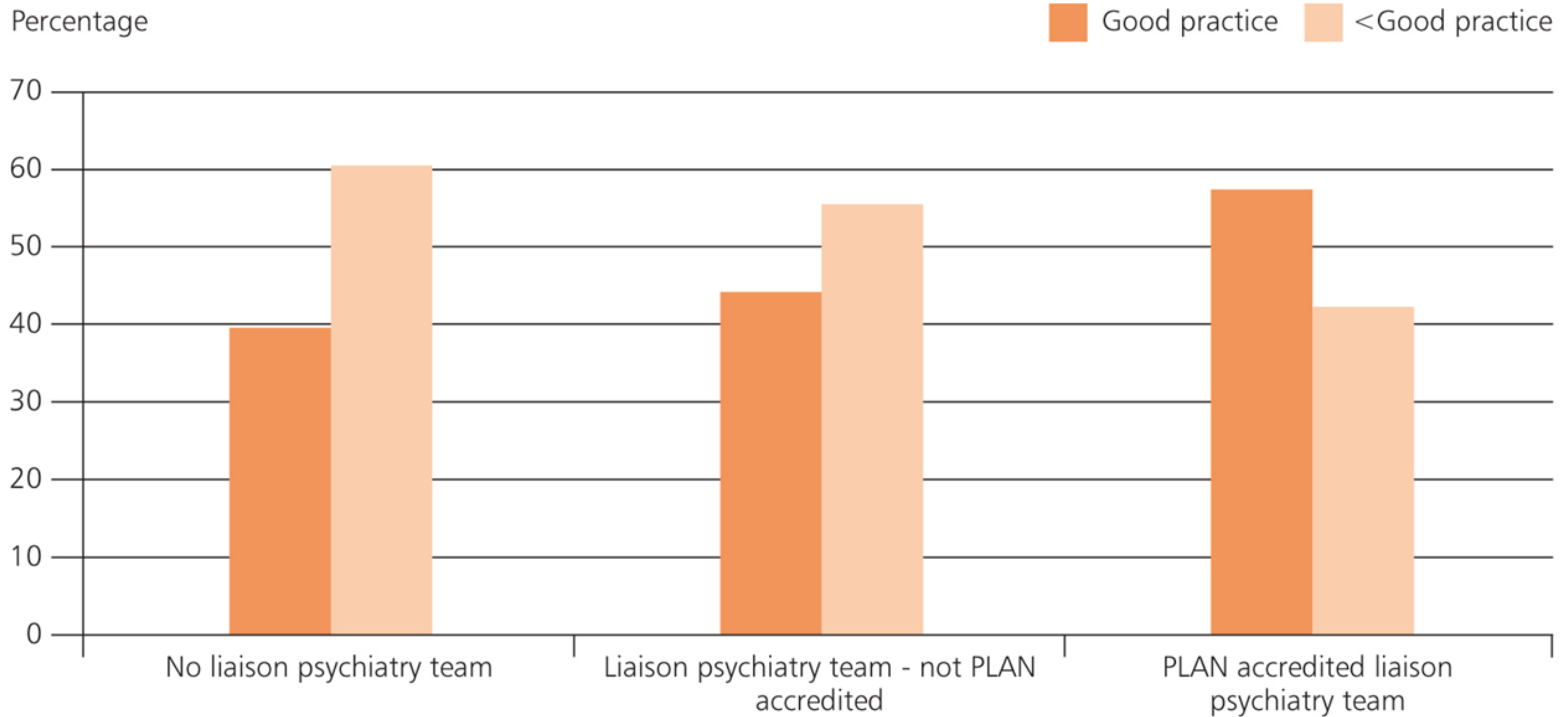
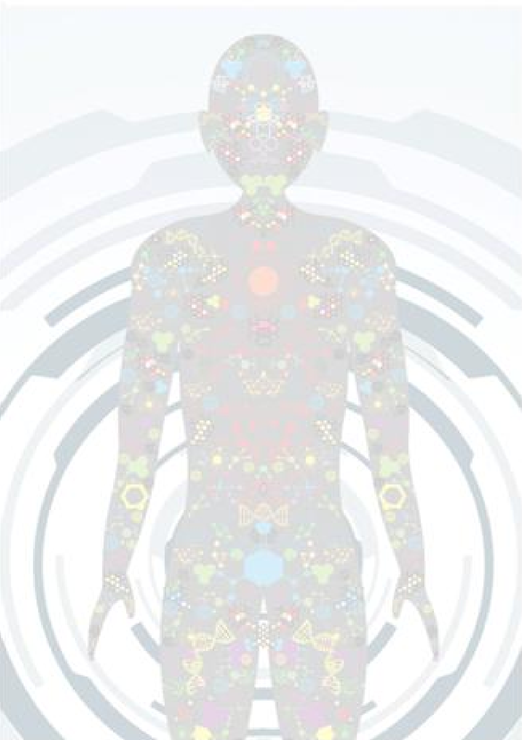


Figure 8.2 Overall quality of care assessed by PLAN accreditation – reviewers' opinion



Recommendations

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Recommendation

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

Recommendation

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
c. What relevant information a referral should contain

Recommendation

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

Recommendation

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

Recommendation

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.

Recommendation

In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals.

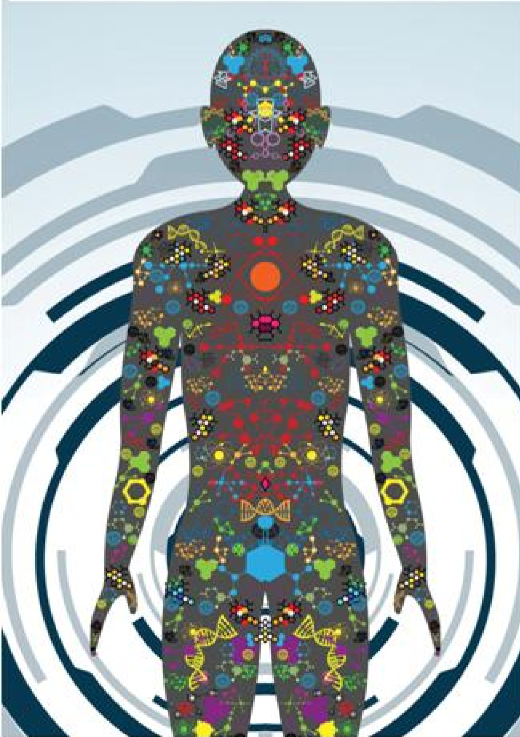
The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team.

Recommendation

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.

National Confidential Enquiry into Patient Outcome and Death



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