Care of Patients with Mental Health Problems in Acute General Hospitals

Study protocol

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Introduction

Since the founding of the NHS in 1948, physical care and mental health care have largely been disconnected within delivery of healthcare services across the UK, leading to accusations that services operate in silos, and that people’s overall health care needs are often ignored. Throughout this time there has been an understanding of the benefits of integrating care across boundaries (eg health, social care, employment, housing), and today there is universal support in principle for better integrated health care across the UK. However good integrated care for people with mental health needs remains the exception rather than the rule.

From the patient’s perspective people with mental illness often report encountering negative attitudes among health care staff about their prognosis, associated in part with ‘physician bias’. ‘Diagnostic overshadowing’ also appears to be common in general health care settings, meaning there is misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to under diagnosis and incorrect treatment of the physical conditions.

The World Heath Organisation has reported that there is a 10-25 year reduction in life expectancy in patients with mental health problems, the vast majority of which relates to chronic physical illness.

It is now 7 years since the Academy of Royal Colleges recommended that patients in an acute hospital should have the same level of access to a consultant psychiatric opinion as they would have for an urgent medical or surgical referral. The same report made very important recommendations to Deaneries and Colleges for curricula and ongoing training in the acute sector, to reflect the essential competences for the care of patients with mental health problems. It is not clear whether the recommendations have been addressed in a systematic way across the country.

Patients with mental health problems represent up to 5% of all ED attendances and could represent as many as 40% of all hospital inpatients, due to the high prevalence of mental health problems in the elderly population, which make up nearly 65% of the hospital inpatient population.

There has been a national drive to improve the care of these patients and in 2011 the Department of Health in England published “No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages”, a policy paper on the mental health strategy for England. More recently they published “Making mental health services more effective and accessible”.

The DH in England has stated, “We want public services to reflect the importance of mental health in their planning, putting it on a par with physical health”. And a number of planned national work
streams and policy directives reflect this. Better access to mental health services and shorter waiting times was made a priority for NHS England and mental health was made part of the new national measure of wellbeing\(^9\), so it’s more likely to be taken into account when government creates policy. The government has pledged to provide £400 million between 2011 and 2015 to give more people access to psychological therapies\(^{10}\) - including adults with depression, and children and young people and up to £16 million of funding over 4 years for Time to Change\(^{11}\), the campaign against mental health stigma and discrimination.

The Kings Fund has also published a report on long-term conditions and mental health\(^{12}\). It seems much is being done with regard to the care of mental health in general, but little is being suggested to reduce the gap between mental health and acute care services. It has been acknowledged by the Royal College of Emergency Medicine that service provision for patients with mental health issues can be very challenging to resolve. Frequently ED and mental health are provided by discrete organisations, and offering a seamless service to the patient can seem impossible. Much of the commissioning structure for mental health is based around different geographical and logistical domains when compared to acute services. This often results in suboptimal or absent services to patients attending the ED with mental health needs. The College of Emergency Medicine has produced a toolkit aimed to provide several resources that doctors in the ED can use to develop and improve the care provided to patients with mental health issues\(^{13}\).

This study is being undertaken to help identify the areas of the patient pathway where there are currently difficulties in providing high quality care (that covers both the medical and mental health requirements) to individuals with mental health problems that are admitted to general hospitals. It will examine the whole pathway of an admission to hospital to discharge.

\(^{1}\)Mortality after hospital discharge for people with schizophrenia or bipolar disorder: retrospective study of linked English hospital episode statistics, 1999-2006. BMJ. 2011 Sep 13;343
\(^{4}\)“Managing urgent mental health needs in the Acute Trust” AOMRC 2008
\(^{5}\)WHO 2014 –WHO information sheet-Premature deaths among people with severe mental disorders
\(^{6}\)Liaison Psychiatry in the modern NHS (2012)Centre for mental health
\(^{7}\)https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
\(^{8}\)Making mental health services more effective and accessible
\(^{9}\)http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/index.html
\(^{10}\)https://www.gov.uk/government/publications/talking-therapies-a-4-year-plan-of-action
\(^{11}\)http://www.time-to-change.org.uk/
Aims and Objectives

Aim

“To explore the overall quality of mental health and physical health care provided to patients with significant mental disorder (listed in study population criteria) who are admitted to a general hospital during the study timeframe”

Organisational

To explore the provision of services and organisational structures and policies in place to facilitate the delivery of the best possible care (for both mental and physical health) to this group of patients, particularly focusing on the following areas:

1. Systems in place to identify patients with mental disorders and to provide safe and effective treatment including structured access to psychiatric care, where appropriate.
2. Systems in place to provide appropriate support to patients with mental disorders and to the healthcare professionals that are treating them.
3. The access to psychiatric care in the hospital: The make-up and role of the psychiatric liaison team; the extent to which mental health professionals are involved in hospital policy and leadership.
4. Systems to allow communication and sharing of relevant information, including history and medication records.
   - Between different healthcare providers: Acute medical hospitals, GPs, community mental health providers, inpatient mental health providers.
   - Between the psychiatric liaison teams and medical care teams working within the hospital.
5. Services and facilities available to facilitate the delivery of safe and effective medical care to patients with mental disorders.
6. Training, competences and confidence of healthcare professionals who may be providing care to patients with mental disorders.

Individual case:

To explore remediable factors in the overall quality of care provided to this group of patients particularly focusing on the following areas:
1. Access to psychiatric care within the general hospital, timely referral to and review by specialist psychiatric care where appropriate, and appropriate management by medical care staff taking into account the mental health needs of the patient.

2. Communication and record sharing between mental health and acute care providers and between acute care and psychiatric liaison teams within the hospital, including evidence of joint working of these teams.

3. Effective communication of relevant information to patients and relatives including around expectations and risk.


5. The management of medications, reconciliation and possible interactions.

6. Planning within the acute care hospital for safe/timely discharge.

7. The standard of care and treatment provided, where possible equivalent to patients without mental disorder.

8. Evidence of missed opportunities for intervention and escalation of care (for example to another specialty or critical care).

**Methodology**

**Population/Inclusions**

Patients aged 18 years and older who were admitted to a general hospital for medical care during the study period: 13/10/2014 - 13/11/2014 who were under section of the Mental Health Act during their admission to hospital and/or were coded by ICD10 coding for a diagnosis of a *significant* mental health condition (these will include schizophrenia, schizoid affective disorder, bipolar affective disorder, anorexia nervosa, some depressive episodes, personality disorders (identified by proxy) and others (listed in appendix 1).

**Exclusions**

Pregnant women up to 1 year post partum (covered by MBRRACE UK)

Day cases

**Case identification**

Local Reporters will be asked to complete a predefined spreadsheet listing all patients that meet the inclusion criteria.

**Sample size**
From the cases identified, a sample size of approximately 700-800 patients will be semi-randomly selected (5 per hospital) this will comprise the group for clinician questionnaire dissemination and case note review.

**Method of data collection**

*Spreadsheet*

The spreadsheet will collect details of: patient identifiers, primary diagnosis, any procedures undergone, the admitting/discharging clinicians, liaison psychiatrist (if available/applicable) /admission/ discharge dates, source of admission / discharge destination, status at 60 days from admission and dates of any hospital admissions in the previous year.

*Sample selection*

5 cases will be randomly* sampled from cases identified at each hospital. For these cases, clinician and psychiatrist questionnaires will be disseminated for completion and case notes requested for review.

*TBC*

*Clinical questionnaire*

A questionnaire will be sent to the consultant who was responsible for the patient’s care at the time of discharge. This will collect data around the study objectives relating to the case by case issues for the final/index admission during the time frame (from admission to discharge/ 30 days following admission) and looking back at admissions during the previous year.

*Questionnaire to liaison psychiatrist*

Where applicable/possible, the liaison psychiatrist the patient was referred to will be identified from central hospital records, case notes or via the network of Liaison Psychiatrist Study Contacts and sent a questionnaire to obtain their view on the care given during the admission.

*Questionnaire to community mental health team (if possible)*

Where applicable/possible, the lead for the community mental health team overseeing the care of each patient will be identified and sent a questionnaire for completion.

*Case-notes: For the entire Index admission or up to 30 days following admission*

- All inpatient annotations/medical notes
- Ambulance notes/Ambulance Service Patient Report Form
- GP (or other) referral letter (if applicable)
- Other correspondence relating to the admission
- Emergency Department clerking proforma
- Nursing notes
- Observation charts
- Care pathway proforma (e.g. for psychiatric patients)
- Operation/procedure notes/Aneesthetic charts
- Consent forms
- Fluid balance charts/Blood transfusion records
- Drug charts
- Nutrition/Dietitian notes
- Discharge letter/summary
- Post Mortem report if applicable
- Datix or other Incident reporting (if possible)
- Physiotherapy, occupational therapy, Speech and language therapy

Any other professional notes
Plus psychiatric notes (if possible*)
Plus GP notes (if possible*)
Plus records of MHA/MHO and “sectioning” records (if possible*)

Organisational questionnaire
A questionnaire will be sent to the Local Reporter in each hospital to complete with the help of relevant staff in order to obtain data on the provision of services for this group of patients.

Online Survey
Data on the training, experience, education, competencies, available support systems and daily practice of Acute (medical, surgical and emergency medicine) care doctors, nurses and ancillary staff will be collected via an on-line survey, the link to which will be distributed by the relevant associations to their members as appropriate.

Participating sites
Data will be collected from all hospitals in England, Wales, Northern Ireland, the Channel Islands and the Isle of Man. Scotland has recently been included in the work of NCEPOD and will be included in the study to the extent that is possible. Data will be collected from NHS acute hospitals And additionally some information will be collected from community hospitals and independent hospitals for certain organisational aspects of care.

Piloting the data collection methods/forms
The questionnaires and data collection spreadsheet will be piloted widely to ensure they are robust.

Review of cases and analysis
Case Reviewer group
A multidisciplinary case reviewer group will be recruited to review the data and to provide expert opinion on the process of care and management of patients who been diagnosed with a mental
health condition. The case reviewers should include liaison psychiatrists, physicians: acute, general, and emergency medicine; surgeons: orthopaedic, plastics, general; nurses, psychologists*, pharmacists*, liaison mental health nurses*, specialists in over-represented specialties eg. cardiovascular, diabetes, oncology, plastics, surgeon, critical care, obstetrics & gynaecology.*TBC

Assessment form
For each case included in the peer review the Case reviewers will be asked to complete a questionnaire outlining details of the case and giving their opinion on the quality of care provided to the patient.

Analysis
Questionnaire data will be electronically scanned into a preset database. Data will be analysed quantitatively and qualitatively

Confidentiality and data protection
Once the data have been extracted by the NCEPOD researchers, the questionnaires and casenotes will be anonymised to remove patient identifiers prior to review by the Case Reviewer Group.

All electronic data are held in password protected files and all paper documents in locked filing cabinets. As soon as possible after receipt of data NCEPOD will encrypt electronic identifiers and anonymise paper documents. Section 251 approval has been obtained to perform this study without the use of patient consent.

Dissemination
On completion of this study a report will be published and widely disseminated.

Timescale
1st EG meeting
Write the protocol
Design the questionnaires
Advertise the study
Advertise for Advisors
Create the database
Test data collection methods
2nd EG meeting
Final protocol to SG, IAG, ROCR & HRA
Start data collection
Run Advisor meetings
Data analysis
Presentation to EG and Adv.
Presentation to SG
CORP IAG
Write the report
First draft to reviewers
Second draft to reviewers
Report design and print
Embargo copies sent
Publish the report
### Appendix 1: included mental health conditions and ICD10 codes

<table>
<thead>
<tr>
<th>ICD10 code</th>
<th>Description of code</th>
</tr>
</thead>
<tbody>
<tr>
<td>F20.0</td>
<td>Paranoid schizophrenia</td>
</tr>
<tr>
<td>F20.1</td>
<td>Hebephrenic schizophrenia</td>
</tr>
<tr>
<td>F20.2</td>
<td>Catatonic schizophrenia</td>
</tr>
<tr>
<td>F20.3</td>
<td>Undifferentiated schizophrenia</td>
</tr>
<tr>
<td>F20.5</td>
<td>Residual schizophrenia</td>
</tr>
<tr>
<td>F20.6</td>
<td>Simple schizophrenia</td>
</tr>
<tr>
<td>F20.8</td>
<td>Other schizophrenia</td>
</tr>
<tr>
<td>F20.9</td>
<td>Schizophrenia, unspecified</td>
</tr>
<tr>
<td>F21.X</td>
<td>Schizotypal disorder</td>
</tr>
<tr>
<td>F22.0</td>
<td>Delusional disorder</td>
</tr>
<tr>
<td>F22.8</td>
<td>Other persistent delusional disorders</td>
</tr>
<tr>
<td>F23.1</td>
<td>Acute polymorphic psychotic disorder with symptoms of schizophrenia</td>
</tr>
<tr>
<td>F23.2</td>
<td>Acute schizophrenia-like psychotic disorder</td>
</tr>
<tr>
<td>F23.3</td>
<td>Other acute predominantly delusional psychotic disorders</td>
</tr>
<tr>
<td>F23.8</td>
<td>Other acute and transient psychotic disorders</td>
</tr>
<tr>
<td>F23.9</td>
<td>Acute and transient psychotic disorder, unspecified</td>
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<tr>
<td>F25.0</td>
<td>Schizoaffective disorder, manic type</td>
</tr>
<tr>
<td>F25.1</td>
<td>Schizoaffective disorder, depressive type</td>
</tr>
<tr>
<td>F25.2</td>
<td>Schizoaffective disorder, mixed type</td>
</tr>
<tr>
<td>F25.8</td>
<td>Other schizoaffective disorders</td>
</tr>
<tr>
<td>F25.9</td>
<td>Schizoaffective disorder, unspecified</td>
</tr>
<tr>
<td>F28.X</td>
<td>Other nonorganic psychotic disorders</td>
</tr>
<tr>
<td>F29.X</td>
<td>Unspecified nonorganic psychosis</td>
</tr>
<tr>
<td>F30.0</td>
<td>Hypomania</td>
</tr>
<tr>
<td>F30.1</td>
<td>Mania without psychotic symptoms</td>
</tr>
<tr>
<td>F30.2</td>
<td>Mania with psychotic symptoms</td>
</tr>
<tr>
<td>F30.8</td>
<td>Other manic episodes</td>
</tr>
<tr>
<td>F30.9</td>
<td>Manic episode, unspecified</td>
</tr>
<tr>
<td>F31.0</td>
<td>Bipolar affective disorder, current episode hypomanic</td>
</tr>
<tr>
<td>F31.1</td>
<td>Bipolar affective disorder, current episode manic without psychotic symptoms</td>
</tr>
<tr>
<td>F31.2</td>
<td>Bipolar affective disorder, current episode manic with psychotic symptoms</td>
</tr>
<tr>
<td>F31.3</td>
<td>Bipolar affective disorder, current episode mild or moderate depression</td>
</tr>
<tr>
<td>F31.4</td>
<td>Bipolar affective disorder, current episode severe depression without psychotic symptoms</td>
</tr>
<tr>
<td>F31.5</td>
<td>Bipolar affective disorder, current episode severe depression with psychotic symptoms</td>
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<tr>
<td>F31.6</td>
<td>Bipolar affective disorder, current episode mixed</td>
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<tr>
<td>F31.8</td>
<td>Other bipolar affective disorders</td>
</tr>
<tr>
<td>F31.9</td>
<td>Bipolar affective disorder, unspecified</td>
</tr>
<tr>
<td>F32.3</td>
<td>Severe depressive episode with psychotic symptoms</td>
</tr>
<tr>
<td>F32.2</td>
<td>Severe depressive episode without psychotic symptoms</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F33.3</td>
<td>Recurrent depressive disorder, current episode severe with psychotic symptoms</td>
</tr>
<tr>
<td>F50.0</td>
<td>Anorexia nervosa</td>
</tr>
<tr>
<td>F50.2</td>
<td>Atypical anorexia nervosa</td>
</tr>
<tr>
<td>F50.3</td>
<td>Bulimia nervosa</td>
</tr>
<tr>
<td>F60.2</td>
<td>Anti-social/Dissocial personality disorder</td>
</tr>
<tr>
<td>F60.3</td>
<td>Emotionally unstable personality disorder</td>
</tr>
<tr>
<td>X60</td>
<td>Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics</td>
</tr>
<tr>
<td>X61</td>
<td>Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified</td>
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</table>