In focus

Healthy London Partnership

Treat as One: Bridging the gap between mental and physical healthcare in general hospitals

19 April 2017 – Source: National Confidential Enquiry into Patient Outcome and Death

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has released a study looking at mental healthcare in the general hospital setting of patients on an acute inpatient pathway. It 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 is the first time the response from physicians and surgeons to mental health disorders of patients admitted to acute hospitals for management of their co-existing physical ill health has been critically examined.

Summary

The report focuses on the presentation of 552 cases of patients during mid-October to mid-November 2014 who presented to general hospitals across the UK with an array of physical health issues and who also had a significant mental health problem. Case notes were peer reviewed along with data collected and analysed from completed questionnaires from the discharging consultant and liaison psychiatrist. The study sought to identify the common themes that emerged in the general hospital setting. It concludes that those mental health patients being treated for physical disorders are seriously disadvantaged and the divide between mental and physical healthcare needs to reduce.

Key findings

The report highlights that mental health patients being treated for physical disorders are seriously disadvantaged; opportunities to identify patients with dual pathology were regularly missed despite clear evidence of a mental health disorder. In many cases it was observed that the mental health disorder was integral to the physical problem and neither could be treated optimally in isolation.

Presentation to hospital

- 40% of patients were smokers, 19% had a history of alcohol misuse and 16% of substance misuse.
- Most of the admissions to hospital (63.6%) occurred through the emergency department (ED); while 14.5% were referred by their GP and 10.3% transferred from a mental health or another general hospital.
- ED notes should have but did not mention the mental health condition in 49% of patients at triage and 51% of patients at a subsequent senior review.

- 17% were referred to liaison psychiatry, following which 74% of patients were seen by liaison psychiatry in an appropriate time. 23% patients were not referred to the liaison psychiatry team in the ED but should have been; the lack of liaison psychiatry input affected the overall quality of care of 52% of patients at this stage.

Admission and initial management

- The medical clerking on admission to a hospital ward lacked adequate mental health history in 21% of patients. Medicines reconciliation occurred at this stage in only 38.9% of patients and mental health medications were prescribed in only 72%. An important part of care for patients is drug interactions but this was noted in only 18% of patient records.
- Mental health risk assessments were recorded in only a third of patients. An adequate risk management plan was provided to only 47% of patients and the assessment and management of mental capacity was noted in only 14% of patients during an initial assessment.
- After a patient's initial physical assessment, 22% were referred to the liaison psychiatry team, of those patients who were not referred 10% should have been and their care was believed to have been impacted as a result.
- Complex needs assessments were carried out in 45% patients and most were deemed adequate however one to one mental health observations were found inadequate in 69% of cases.
- A liaison psychiatry team reviewed 46% patients during their hospital stay. There was found to be room for improvement in the following aspects: mental health risk assessments, mental capacity assessments, prescription of medications and advice to nursing staff
- The first assessment by liaison psychiatry was substantially delayed in 37% of patients which impacted the quality of care in 43% of patients.
- The most common reason for the delay in the first assessment was that 'the liaison psychiatry team would not attend until the patient was declared medically fit'.
- 12% patients were detained under the mental health act and in over 20% of the cases there were issues in the documentation of the process.

Discharge and death

- Multidisciplinary discharge planning has an important role to play in patients with complex physical and mental health needs but this only took place in 50% of the patients that were discharged.
- Management plans for the patient changed following multidisciplinary team me (MDT) meetings for 42% of patients, which demonstrates their value in discharge planning. However, liaison psychiatry teams were only involved in 18% of MDT meetings.
- Nearly 30% of discharge summaries lacked the mental health diagnosis as well as details of the mental health medications. No discharge summaries were copied to the relevant out of hospital psychiatry consultant.
- Readmission rates were lower than expected at just over 7%; however, analysis of discharge documents revealed inadequate discharge planning in over 60% of patients.

Training

- 46% of 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.

Overall quality of care

- The overall quality of care was rated as good in only 46% of cases reviewed.
- The effect of having a liaison psychiatry service, especially one that was PLAN accredited was positively associated with an improved quality of care.

Principle recommendations

The overarching theme of this report is ensuring that the divide between mental and physical healthcare is reduced in acute hospital settings. This will require long-term changes in organisation structures and individual clinical practice to produce a working environment where the mind and body are approached together. The authors suggest a key part of the solution is healthcare professionals in secondary care need to feel knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for their patients.

A full list of recommendations and the suggested organisations to own the recommendations can be found on page 87 of the full report. The authors of the report say the following can be undertaken immediately:

1. Patients who present with known co-existing mental health conditions should have these conditions documented and assessed along with any other clinical conditions. The conditions should be documented in referral letters to the hospital, in any Emergency Department assessments and in any documentation on admission to the hospital.

2. National guidelines should be developed outlining the expectations of general hospital staff in the management of mental health conditions. These should include the point at which a referral to liaison psychiatry should be made, what should trigger a referral to liaison psychiatry and what relevant information a referral should contain.

3. All hospital staff who interacts with these 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.

4. 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.

5. Record sharing (paper or electronic) between mental health hospitals and general hospitals needs to improve. As minimum, patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient.

Conclusions

This report is significant as 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 highlights the divide between physical and mental health care along all aspects of the acute inpatient pathway demonstrating that there is a long way to go to reach parity of esteem.

The recommendations aim to bring about long-term changes in both organisational structures and individual clinical practice. This will require stakeholders in the system to take ownership of the recommendations and for commissioners to take a role in enabling change as the complexities of fragmented commissioning services currently presents a major obstacle to providing good care for patients with dual pathology.

The system is already making changes to support the delivery of more holistic care addressing both physical and mental health needs. New mental health national standards have been introduced and a commitment has been made to delivering a ‘core 24’ standard of liaison mental health services for adults and older adults in emergency departments and general inpatient wards in at least 50% of acute hospitals by 2020/21. The ‘Core 24’ standard involves an on-site liaison psychiatry service that is commissioned to provide a one-hour response to emergency referrals and 24 hour response to urgent inpatient ward referrals. The implementation of this standard was recently supported by liaison psychiatry transformation funding, London did particularly well bidding for Core 24 transformation funding with all bids awarded. As a result, 17 of London’s Emergency Departments will meet the Core 24 standard by 2018/19. The Psychiatric Liaison Accreditation Network (PLAN) accreditation is reassuring to improve the quality of services and many London liaison psychiatry teams are progressing towards achieving this standard.

At a London-level, Healthy London Partnership is working in partnership with London’s crisis care system to address some of the challenges in the system for those detained under section 136. A pan-London section 136 pathway and Health Based Place of Safety specification was developed last year and launched in December 2016 by the Mayor of London, Sadiq Khan. The guidance sets the minimum standard of care for the section 136 pathway, it clarifies the roles and responsibilities of all stakeholders involved and covers how those detained under section 136 should be treated and cared for whilst in the Emergency Department.

To support local areas in implementing the section 136 pathway, Healthy London Partnership is providing multiagency training workshops to help staff understand their roles and responsibilities and support local areas in reviewing and updating local protocols to align to the pan-London guidance. The workshops are intended to be delivered over the next few months in partnership with each of London’s Mental Health Trusts and facilitated by mental health legal expertise who was involved in development of the pan-London pathway.

➔ **Download Mental Health in General Hospitals: Treat as One (2017) from the NCEOP website:** http://www.ncepod.org.uk/2017mhgh.html

For more information on Healthy London Partnerships crisis care work in this area please visit https://www.healthylondon.org/crisis-care

If links are no longer active, please refer to the source organisation’s website