RCEM
Royal College of Emergency Medicine

Mental Health (Self-Harm)

2022-2023

RCEM National Quality Improvement Programme

Year 1 Interim Report

Published: March 2024

Contents

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Foreword

Dr Adrian Boyle, RCEM President

I am pleased to report on the performance of care surrounding mental health patients presenting with self-harm in UK Emergency Departments (EDs) from October 2022 to October 2023.

This Quality Improvement Programme (QIP) builds on a previous Mental Health (Self-Harm) QIP run in 2019/20 and will run for a two-year period, 2022/23 and 2023/24. This interim report provides an overview of the QIP's first year and creates a foundation for the programme to build upon.

The results show there have been key improvements since the 2019/20 QIP, such as lowering average of time taken for a mental health triage to take place and increased frequency of parallel assessments taking place. However the results also highlight key areas for concern and improvement as the QIP proceeds to its second year, especially as the risk of further harm and reattendance for this patient group is high. The standards were focused on both organisational policies and clinical care and highlights the importance in supporting this highly vulnerable patient group appropriately throughout their care in the ED.

The RCEM Quality Assurance and Improvement Committee are committed to continually evaluating the QIPs and improving them to best support you and improve patient care.

We welcome your feedback, ideas, and experiences to help us. The College is dedicated to improving the quality of care in our EDs through these important QIPs, undertaking all obligations to ensure the best measures of patient safety are obtained.

Dr Adrian Boyle

RCEM President

Dr Dale Kirkwood

Co-Chair of Quality Assurance & Improvement Subcommittee

Dr Fiona Burton

Co-Chair of Quality Assurance & Improvement Subcommittee

Dr James France

Chair of Quality in Emergency Care Committee

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Executive Summary - Interim Report 2022-23

The Royal College of Emergency Medicine (RCEM) would like to thank all 137 Emergency Departments (ED) that participated in Year 1 of this Quality Improvement Programme (QIP).

Overview

Patients presenting to an ED with a mental health (self-harm) presentation may have both physical and mental health needs to be met concurrently and some present with high risks of further self-harm and suicide. The mental health (self-harm) QIP was primarily designed to address the needs of this cohort of patients and considered measures (both process and outcome) that would be central to the care provided. The QIP is being run over a 2-year period. In comparison to previous years this should give participating ED's enough time to understand challenges faced and make changes that are effective and long lasting. The QIP aims to address 3 main standards, included below in the key findings and addresses other facets of safe, compassionate, and timely care.

Key Findings

This programme is running from 4th October 2022 to 3rd October 2024. This report presents data collected for the first year - from 4th October 2022 to 3rd October 2023. Data was collected on 18,684 patients who met the following eligibility criteria and presented to an ED:

- Patients aged 18 years or older.
- Presented to the ED having intentionally self-harmed and had a referral made by the ED for emergency mental health assessment by the organisation's specified acute psychiatric service.

Standard 1: Mental health triage

The mean time to mental health triage was 38.7 minutes. 29.06% had a mental health triage ≤15 minutes and 42.4% of patients underwent a mental health triage ≤ 30 minutes. The reason for capturing mental health triage for both ≤15 minutes and ≤ 30 minutes is explained under the result section of fundamental standard 1.

Standard 2: Proportion of medium or high-risk patients who had an appropriate level of observation (good evidence of continuous or intermittent observation, interaction, or care)

29% of patients who were at medium or high risk had documented evidence of appropriate level of observation.

Standard 3: Proportion of patients who had a brief risk assessment by ED clinicians of suicide and further self-harm and met the standards (4 out of 4)

30.3% conformed to standards. Of the 4 questions that formed part of this standard, documentation on future suicidal thoughts needs to be improved.

Discussion

74.6% had a mental health triage with a mean time of 38.7 minutes. This was an improvement from the last QIP report of 2019/2020 which had a mean time of 53 minutes. The proportion of patients with a completed mental health triage for ≤15 minutes was 29.06%. This was 35.8% in the 2019/2020 report. Some of the measures were newly introduced for the 2022-24 iteration of this QIP and given this is the interim report, the final report should be better placed to comment on how the chosen measures have performed over the 2-year period.

Overall, there is scope to improve on many of the process measures. The mean in majority of the measures is probably a reflection of what ED's are facing across the country. It's vital that evidence of compassionate care is captured better. The challenges faced including patient volume, lack of space and overcrowding, staffing and burnouts post COVID could all be contributing factors.

There have been positives from the QIP. 93.5% of patients had appropriate physical health assessment, relevant investigation and treatment carried out by the ED clinician which was appropriate to patient presentation. 88.8% of

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patients who were discharged by ED and not seen by an adult psychiatric liaison nurse had a safe discharge plan documented. 55.9% of patients had a parallel assessment. RCEM encourages parallel assessment, and we look forward to seeing how this performs in the final report next year.

Key Recommendations

- Accurate and timely (close to patient attendance) data entry.
- Participating ED's to focus on the 3 Fundamental standards.
- Parallel assessment should be encouraged and incorporated into practise.
- Evidence of compassionate and practical care to be captured better.
- Capacity assessment is the responsibility of all involved in care and not the sole responsibility of the triage nurse.
- Safeguarding / drug and alcohol concerns to be considered and addressed in all cases.
- Patients leaving prior to ED clinician or Adult Psychiatric Liaison Services review should have a follow up plan arranged and documented. General Practitioners (GP's) can be an option in some cases. They should not be the default position for all patients. Process should be in place for follow up of these patients.

Feedback

We want to thank everyone who has participated and congratulate you on what you've achieved. If all teams share their thoughts and feedback, we will have a wealth of learning to share with each other and improve future programmes. Please email us on rcemqip@rcem.ac.uk with any comments you can share regarding this programme or its reports.

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Introduction

Background

Mental health presentations account for a relatively low proportion of all ED attendances, however mental illness comprises the largest single cause of disability in the UK. The care that this patient group needs is complex, and it is important emergency medicine endeavours to promote parity of esteem, challenge stigma and improve the care of this very vulnerable patient group.

Patients presenting with a mental health presentation often requires input from both Emergency Medicine and Adult Psychiatric Liaison Services. This is sometimes expanded to requiring support from home treatment teams, Advanced Mental Health Practitioners, Security and at times the Police. Recent reports also highlight patients requiring a mental health bed admission are more than twice as likely to experience 12 hour waits than those waiting for a physical health bed. Unfortunately waits of over 24 hours are not uncommon.

The Royal College of Psychiatrists has produced a document co-signed by the RCEM and Royal College of Nursing advocating for side-by-side care. This means that mental health Liaison teams should be involved early in the management of the patient attending in mental health crisis, even at the triage level. NICE also advocate this in the Self-harm: assessment, management and preventing recurrence guideline (NG225).

The QIP plans to address issues faced by patients presenting with a history of mental health (Self-harm). The aim of the programme is for the participating units to identify where standards are not being reached so that they can do improvement work and monitor changes real time. The questionnaire has been designed considering both process and outcome measures that would help improve care for this cohort of patients including addressing the 6 pillars of quality in health care.

Feedback received from the previous mental health (self-harm) QIP (2019/2020) was taken on board while designing the questionnaire. The working group included both medical professionals and lay persons. The QIP was designed to capture clinical aspect of care provided and included safe and timely care. The questionnaire included capturing evidence of compassionate care that would be central to any patient care. Parallel assessment was encouraged as part of the QIP.

Unlike previous years the QIP is being run over 2 years. This should give enough time for participating units, time required for making the process iterative and allow multiple PDSA (plan-do-study-act) cycles to iron out any issues faced in the care provided. The platform provided for the QIP should real time show how a team is performing including comparison with the overall national mean. We encourage participating units to enter data that are accurate and real time.

Supporting Evidence:

1. Mental health in emergency departments - RCEM (April 2023)
2. Investigation into the provision of mental health care to patients presenting at the Emergency Department - HSIB (Nov 2018)
3. (Self-harm: assessment, management and preventing recurrence - NICE (Sept 2022)

National Drivers

- Side by side: A UK-wide consensus statement on working together to help patients with mental health needs in acute hospitals (February 2020)

Programme Focus

In this QIP, the primary focus included 3 main standards:

1. Improving the ED mental health triage process
2. Identifying at risk patients of further self-harm or absconding including observation of these patients while in ED
3. Quality of ED clinical assessment.

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The standards aim to evidence safe practice from initial triage, managing immediate risk, the crisis itself and through to discharge.
Objectives of the QIP includes:

1. Identifying current performance of ED's against the 3 main standards
2. Addressing the 3 main standards and other areas of care including parallel assessment and compassionate care.
3. Showing ED's their performance in comparison to national performance and to facilitate quality improvement.
4. Encouraging effective iteration central to a QIP and meaningful data entry

Methodology

For a detailed description of the methodology used in the QIP, please see the QIP information pack and Appendix 6.

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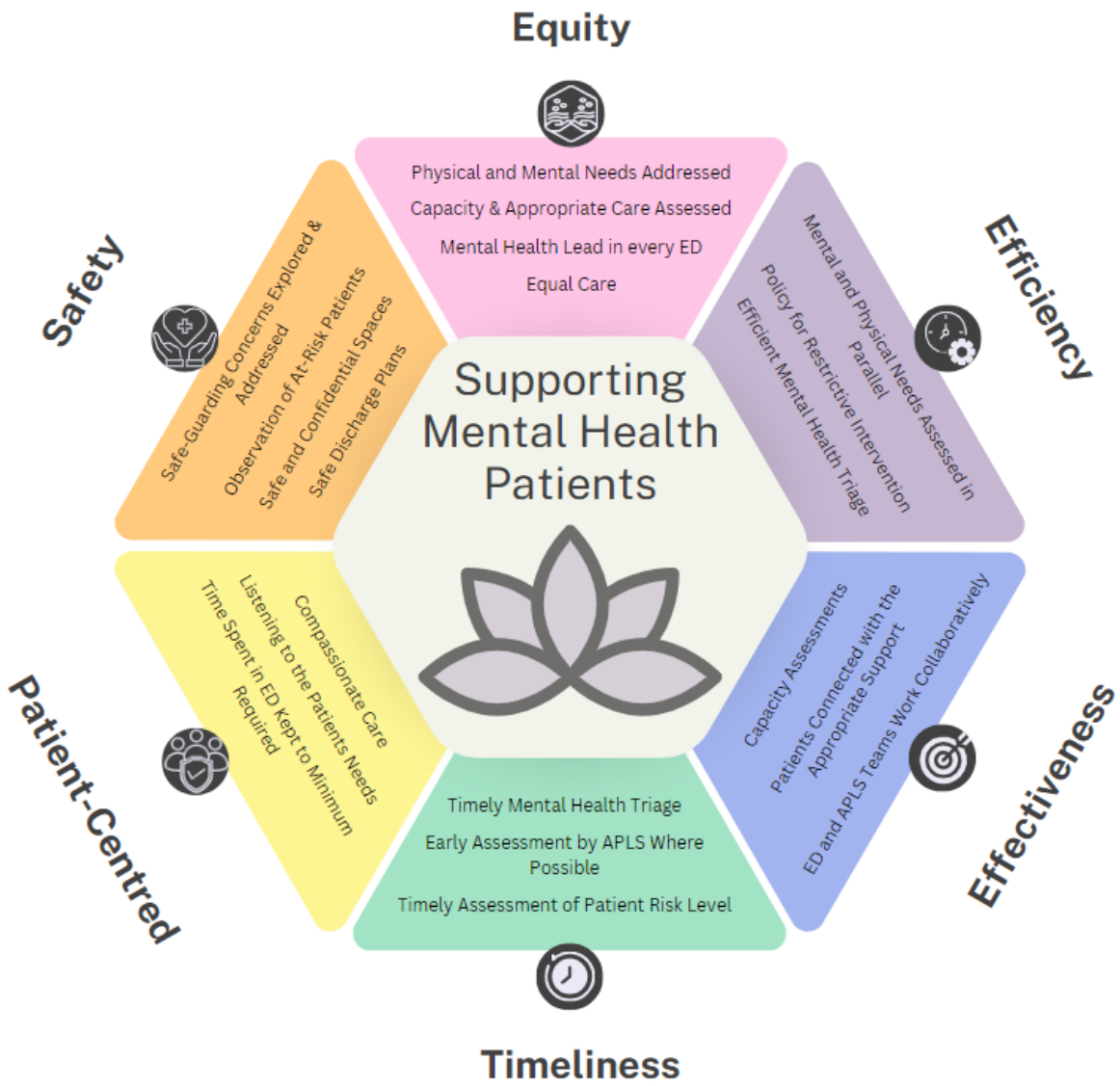
Mental Health Care in Emergency Departments



Mental Health and the Domains of Quality Care

Care for mental health patients can vary largely in Emergency Departments (ED), depending on each hospital's resources, training, and protocols.

No matter what ED a patient attends, their care should always be provided with compassion, expertise, and following a patient-centred approach.

EDs can do this by aspiring to the six domains of quality healthcare in their practice, as outlined by the Institute of Medicine (2001).

- Equity
- Efficiency
- Effectiveness
- Timeliness
- Patient Centred
- Safety

This QIP embodies these domains and provides insight to how these can be upheld when caring for mental health patients.

Case Study – Sarah and Yousef's Stories

Based on real patient experiences in UK Emergency Departments

Sarah's Story

Sarah attends an ED after self-harming, sustaining several superficial incisions to her wrists. She has a diagnosis of Emotionally Unstable Personality Disorder and is under the care of her community's complex care team.

Sarah is asked to wait in the waiting room for triage as the ED is busy. She is left to wait by herself, and no staff come to check on her. The wait for triage is over an hour - when a triage nurse calls for her, she is nowhere in the ED.

Four hours later, Sarah is brought back to the ED by ambulance, having taken a significant overdose of paracetamol.

Yousef's Story

Yousef attends an ED, having taken an overdose of 15 Ibuprofen two hours previously. He has been feeling increasingly anxious and suicidal over the past week.

He is triaged within 10 minutes and is identified as at high risk of further harm. Yousef is moved to a quieter mental health cubicle in the ED and informed an ED doctor and the Adult Psychiatric Liaison Services will see him soon. Until then, he will be supported and observed by a nurse with mental health training.

After 30 minutes waiting, Yousef is increasingly anxious and wants to leave. Adult Psychiatric Liaison Services and an ED doctor go into the cubicle to assess him. It is determined Yousef is still high risk and his level of distress would affect his ability to fully assess the risks of leaving; he is therefore deemed not having capacity to make this decision safely. Yousef agrees to a small dose of diazepam to help settle his anxiety.

Four hours since the overdose, Yousef is feeling less anxious and agrees to some blood tests. When his tests return with no concerns, they discuss discharge – He is given information about anxiety, linked to local 3rd sector resources and a safety plan is discussed. Yousef is feeling much better but still anxious, so it is decided he can leave with home treatment support.

What was the difference between Sarah and Yousef's care?

- Timely Triage
  - The longer the wait for triage and care in an ED, the more a mental health crisis can worsen. For Yousef, a quick triage and assessment ensured his needs and risk of further harm was understood. Subsequently he was moved to a quieter environment where observation and support was provided. If Sarah had been triaged as quickly, her risk level could have been flagged and potentially her reattending with an overdose could have been prevented.
- Risk Management and Parallel Assessment
  - Yousef's care involved risk management and parallel assessment from both the ED and Adult Psychiatric Liaison Services. Yousef's physical and mental needs were assessed early, and he was connected to both Adult Psychiatric Liaison Services and an ED doctor. At points where Yousef wanted to leave, the risk and capacity were assessed and managed. For Sarah, understanding her risk, physical, and mental needs would have supported her care more effectively.
- Compassionate Care
  - Yousef was shown compassion through his care and given hope: the staff ensured to keep him informed during his wait, discuss his anxieties when he raised them, and provided options and resources throughout his care. As a result, Yousef was supported to remain in the ED for support and care. In contrast, Sarah's attendance was largely in isolation, her needs not understood, and did not receive the compassion needed for her situation.

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Questions and Standards

Please see the QIP information pack for the full question set used to collect data.

Standards		Grade
1	Patients should have a mental health triage by ED nurses/clinician on arrival to briefly gauge their risk of self-harm and/or leaving the department before assessment or treatment is complete.	**F**
2	Patients at medium or high risk of further self-harm or of leaving before assessment and treatment are complete should be observed closely during the period that they are considered to be high-risk/medium-risk. There should be documented evidence of either continuous observation (1:1) or intermittent checks, interactions, and care delivery (recommended every 15 – 30 minutes)	**F**
3	When an ED clinician reviews a patient presenting with self-harm, they should record a brief risk assessment of suicide and further self- harm.	**F**

Grading Explained

F – Fundamental This is the top priority for your ED to get right. It needs to be met by all those who work and serve in the healthcare system. Behaviour at all levels of service provision, need to be in accordance with at least these fundamental standards. No provider should offer a service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

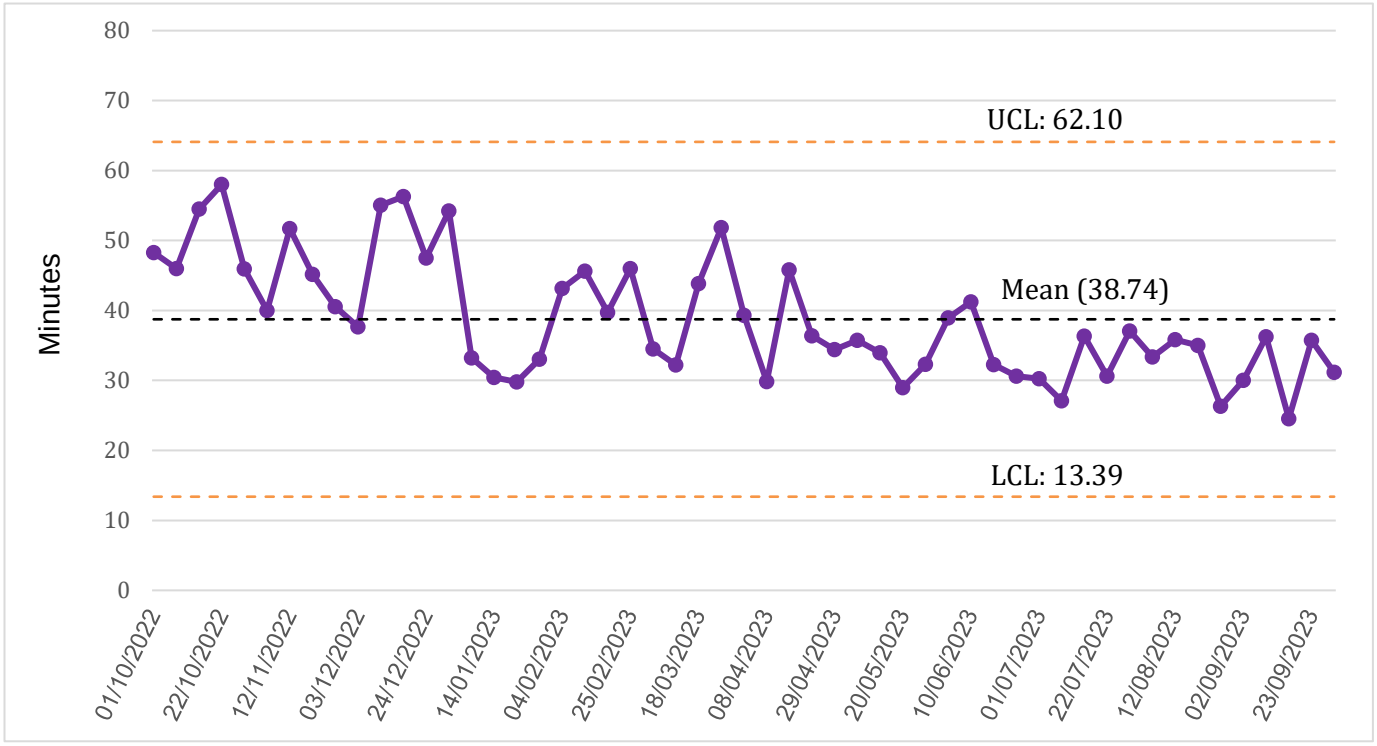
D - Developmental This is the second priority for your ED. It is a requirement over and above the fundamental standard.

A – Aspirational This is the third priority for your ED and is about setting longer term goals.

Performance Against Clinical Standards

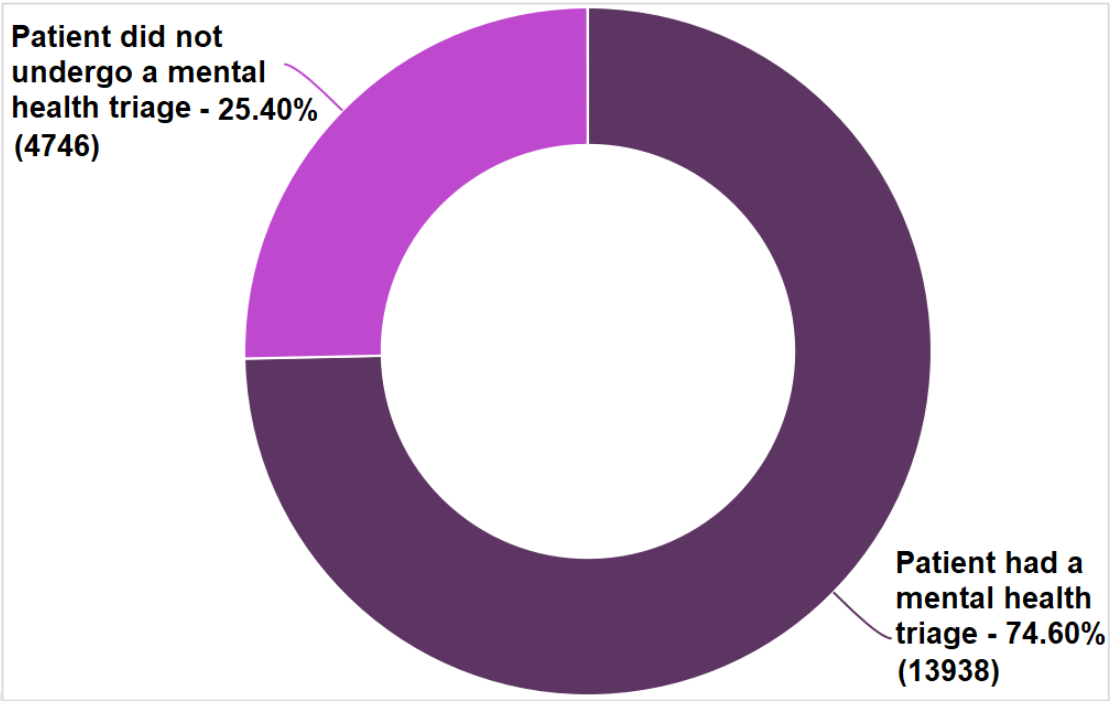
Fundamental standard

Standard 1 – Time to mental health triage



Fundamental standard

Standard 1 – Percentage of patients who had a mental health triage



Understanding SPC Charts

Time to mental health triage, N= 13938

All patients who received a mental health triage and the triage time was recorded.

Exclusions

Any patients who did not receive a mental health triage or the time of their mental health triage was not recorded.

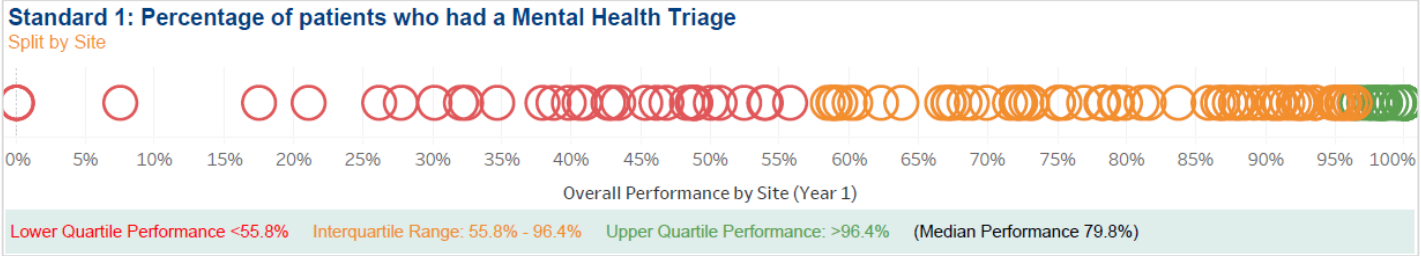
Percentage of patients who had a mental health triage, N= 18684

All patient cases.

Exclusions

None.

Site Performance



This graph shows the performance range for all participating EDs. For a further guidance on this chart, please see Appendix 5.

Commentary

74.60% of patients presenting with a mental health (self-harm) history had a mental health triage which included a brief risk assessment of self-harm and/or leaving the department before assessment or treatment is complete.

Mental health triage differs from other triages. This includes assessing the level of agitation, ongoing risk to self and others and risk of leaving the department prior to completion of further assessment and treatment of their physical needs due to self-harm. This will determine where the patient should be placed in the ED and level of observation required. Unlike other triages, mental health triage takes time and its vital this is addressed well.

The SPCC on time to mental health triage shows a mean time of 38.7 minutes. There is an obvious shift in the process from July 2023. This shift has persisted. The lower control limit (LCL) for the time to mental health triage is 13.3 minutes. This shows that there is scope for bringing the time to mental health triage further down by making small changes to local process. The previous mental health QIP (2019/2020) had a mean time of 53 minutes. Given the overall pressures facing EDs currently, this is an improvement when compared to the previous QIP. However, the SPCC represents only the patients who underwent a mental health triage. Those who did not have an actual mental health triage did not form part of the SPCC.

Recommendations

EDs across the UK have been overwhelmed over the last 2-3 years and this has had a bearing on triage times. Mental health triage takes time. This was fed-back during previous RCEM mental health QIP. It was in view the feedback, the QIP captured time to mental health triage for both ≤ 15 minutes and ≤ 30 minutes. From the interim report, we would encourage ED's to further explore what could be done to address a timely and quality mental health triage. This could include training triage nurses on mental health triage to help a succinct and

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effective mental health triage, increasing triage nursing numbers when demands are more, effective use of a recognised mental health triage toolkit and where appropriate prioritise patients if concerns flagged up from reception on patient presentation. E-triages are an option which can help identify those at risk. There needs to be agreed protocols when using them.

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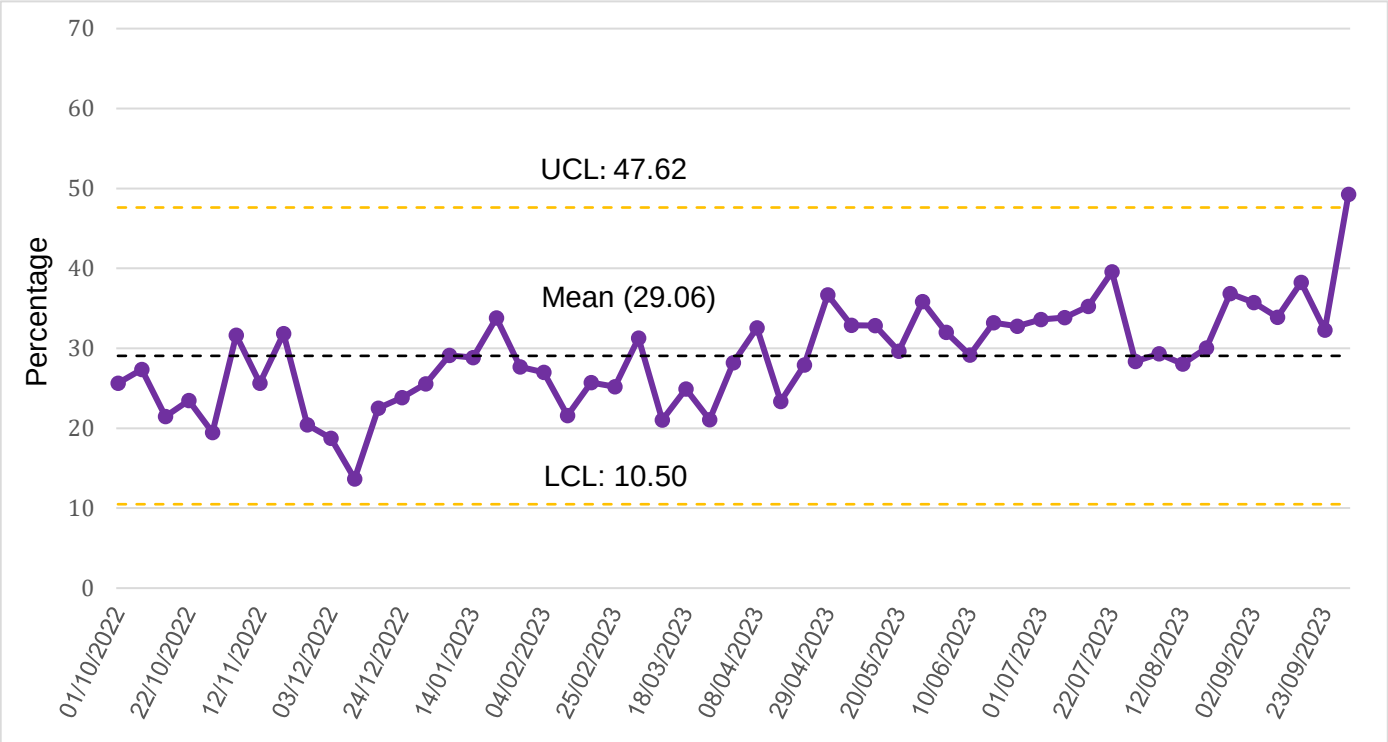
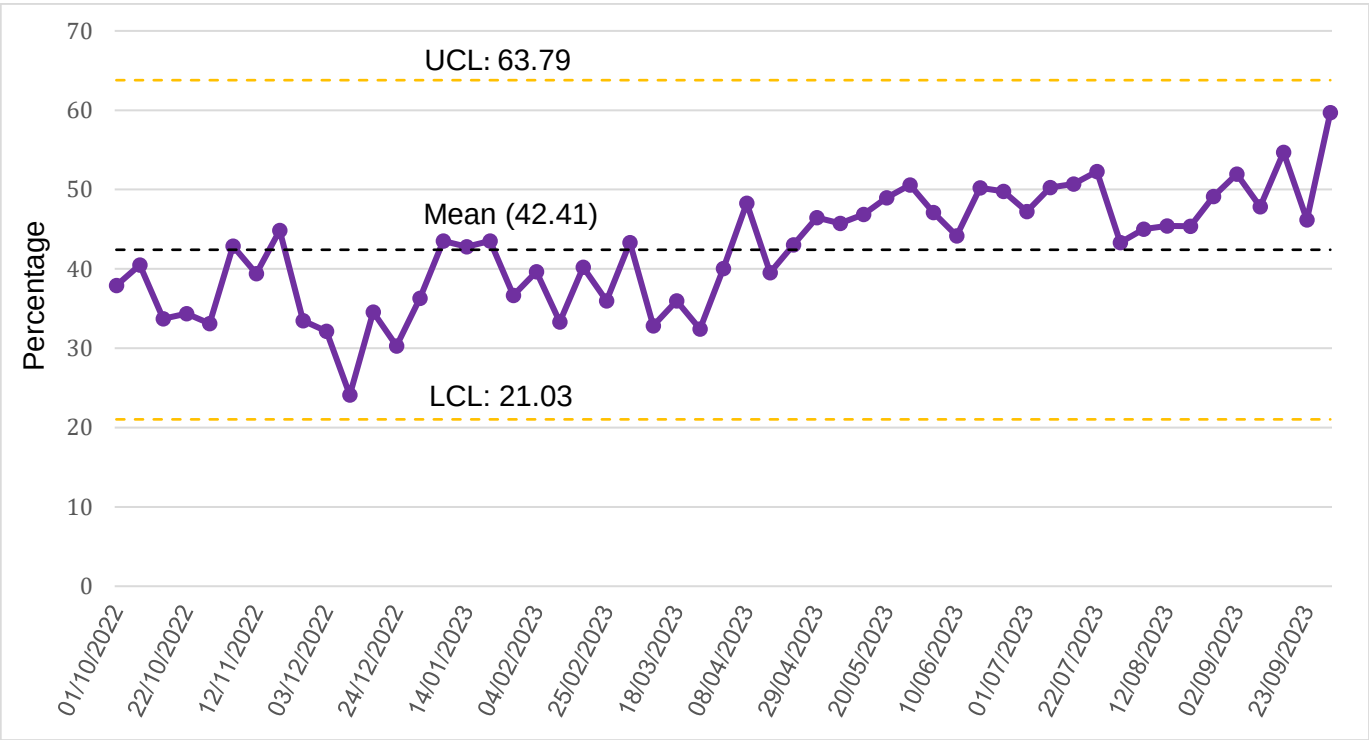
Fundamental standard

Standard 1a – Proportion of patients who had a complete mental health triage with risk assessment by ED nurses/clinician ≤ 15 minutes of arrival



Fundamental standard

Standard 1b – Proportion of patients who had a complete mental health triage with risk assessment by ED nurses/clinician ≤ 30 minutes of arrival



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Understanding SPC Charts

N= 13938

All patients who received a mental health triage including a risk assessment and the triage time was recorded.

Exclusions

Any patients who did not receive a mental health triage or the time of their mental health triage was not recorded. If a patient received a mental health triage but their risk level was not assessed or not recorded, they were excluded.

Commentary

Mental health triage includes assessing the level of agitation, ongoing risk to self and others and risk of leaving the department prior to completion of further assessment and treatment of their physical needs due to self-harm. It should also include capacity assessment This will determine where the patient should be placed in the ED and level of observation required. From previous RCEM mental health QIP, it was fed-back that addressing this takes time and realistically it's difficult to do all this ≤ 15 minutes. It was fed-back; it takes time to get a rapport due to their mental health crisis and rushing a triage does not help address all facets of a mental health triage. It was in view of the feedback, while designing the current QIP, options were given to capture mental health triage at both ≤ 15 minutes and ≤ 30 minutes.

The mean for mental health triage ≤ 15 minutes is 29.06% and ≤ 30 minutes, 42.4%.

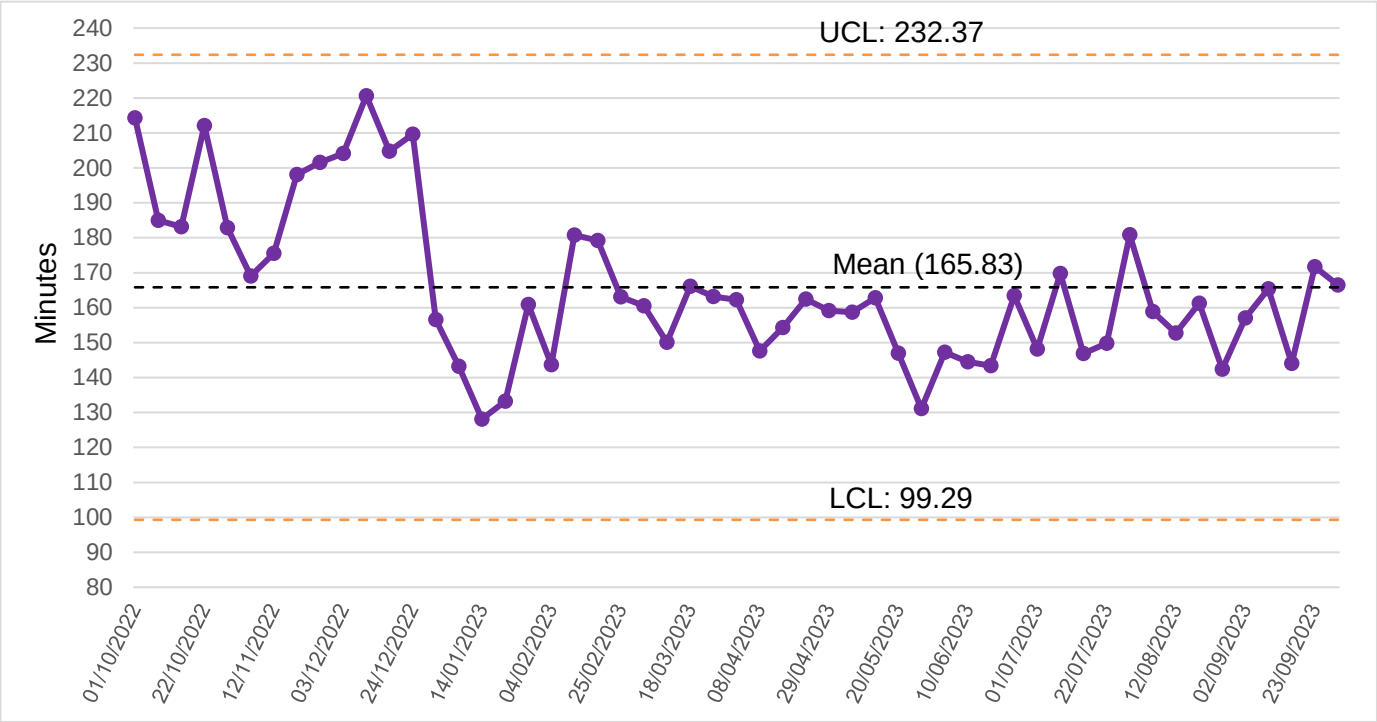
The SPCC for ≤ 30 minutes has shown a sustained shift since early July 2023. The upper control limit (UCL) is around 63.7%. This shows that with further changes to the system it's possible to increase this further.

The SPCC for ≤ 15 minutes had a shift between early April 2023 – end of July 2023. This was not sustained. However, the last few data points have been above the mean line and whether this might be another shift is difficult to ascertain as the data collection period for the interim report was closed. The UCL is 47.6%. This needs to be taken on board especially if we trying to get the mental health triage time in line with the other standard triages (≤ 15 minutes). It must be noted that the previous mental health QIP (2019/2020) mean for mental health triage ≤ 15 minutes was 35.8%.

Recommendations

Based on previous RCEM mental health (self-harm) QIP feedback, we had included % of patients undergoing a mental health triage for both ≤ 15 minutes and ≤ 30 minutes. Given the mean for both, there is scope to improve. As discussed under recommendation for time to mental health triage, this could include training of triage nurses in mental health triage process and consideration of increasing triage nursing numbers when requirements are maximum. The SPCC's are also a reflection of the challenges facing ED's nationally including over-reliance on ED's as a default setting due to accessibility to other services and over-crowding. Options could include designing of patient information leaflets which are nationally recognised or in conjunction with local mental health services that aid patients in decision making including where to seek help early. This can help in ED's not being a default position for future attendance.

Time to ED clinician review after triage



Understanding SPC Charts

N= 11115

All patients who received an ED clinician review following a mental health triage and both review times were recorded.

Exclusions

Any patients who did not receive a mental health triage, did not receive a review because they were referred directly to Adult Psychiatric Liaison Services or left before being reviewed, or the time of their triage and/or ED clinician review was not recorded.

Commentary

The mean time to clinician review after triage is around 2 hours 45 minutes (165 minutes). There appears a period of sustained escalating delays over the Nov' to Dec' 2022 period followed by a sharp improvement with best performance seen during the Jan' to Feb' 2023 period. Over the following months there appears to be minimal variation in the data with the best performance seen between Apr 2023 and Jul 2023.

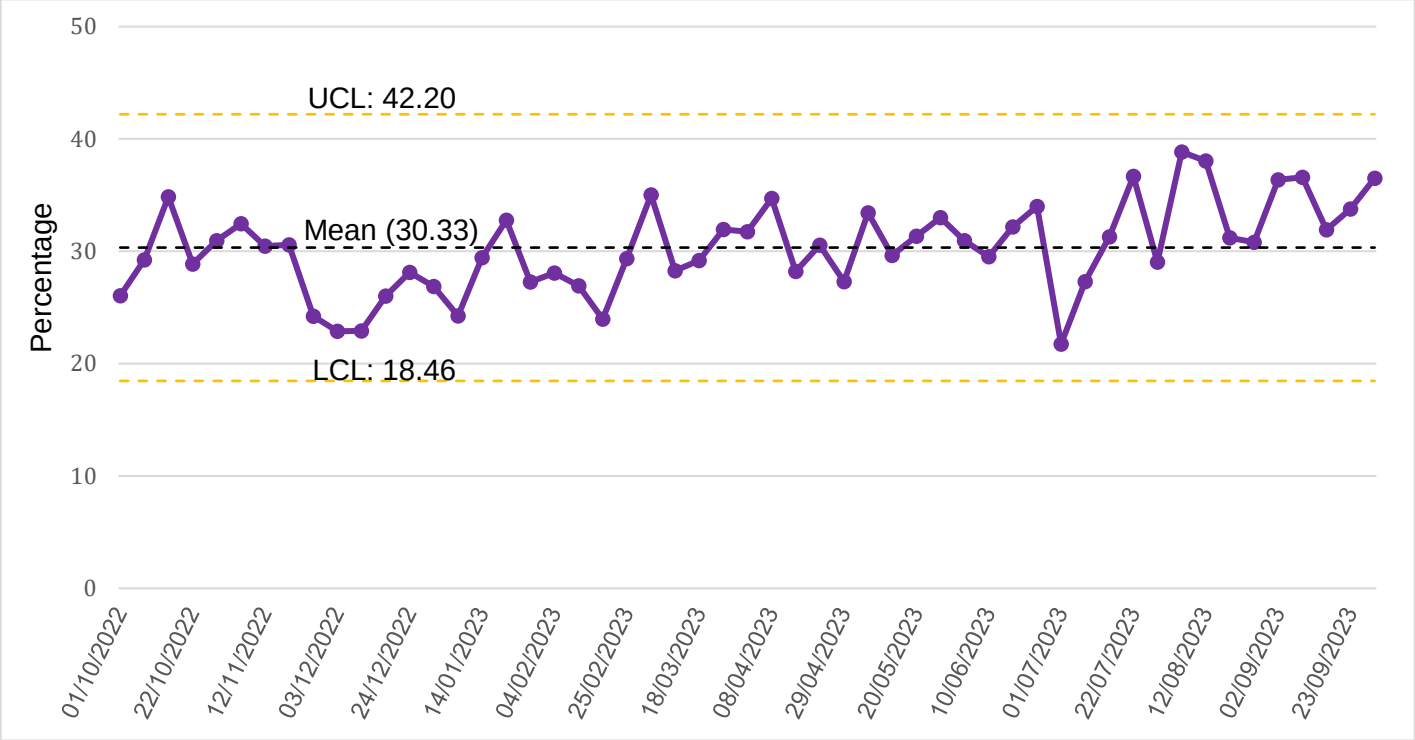
The overall mean to clinician review after triage at 165 minutes is good, considering general departmental pressures. The initial period of delays seen from Oct' to Dec' 2022, at times exceeding 200 minutes, followed by the sharp improvement from Jan' might reflect departments looking at their initial data with the inception of this QIP and putting into place improvement measures to address these delays. The best performance is not surprisingly seen during the spring and summer period, where departments generally tend to encounter fewer mental health presentations.

Recommendations

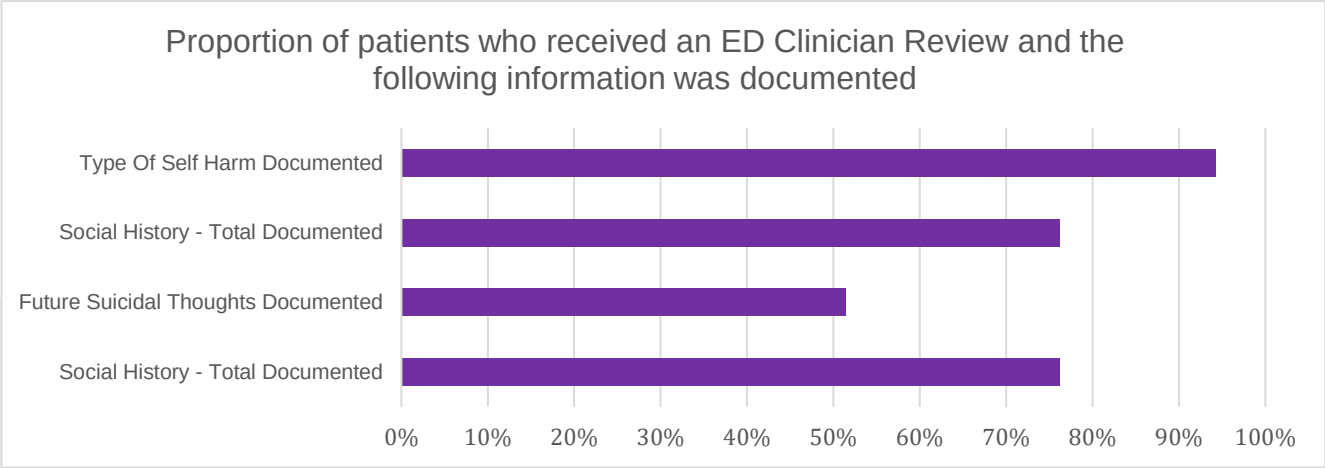
With rising waiting times, departments should consider novel means to accommodate mental health presentations to avoid significant delays. A further look to ensure that at least the moderate to higher risks patients are seen in timely manner during this high-pressure period might be a practical approach over the coming months. To be able to do this, individual departments to have a further look into their own data to see how soon the patients belonging to the different risk categories are seen.

Fundamental standard

Standard 3 – Proportion of patients who had a brief risk assessment by ED clinicians of suicide and further self-harm and met the standard (4 out of 4)



Proportion of patients who received an ED Clinician Review and the following information was documented.	Number of Patients	Proportion
Patients who received an ED clinician review	15298	-
Type of self-harm – Documented	14431	94.3%
Trigger For self-harm – Documented	11008	72%
Future suicidal thoughts – Documented	7862	51.4%
Social history – Documented	11664	76.3%



Understanding SPC Charts

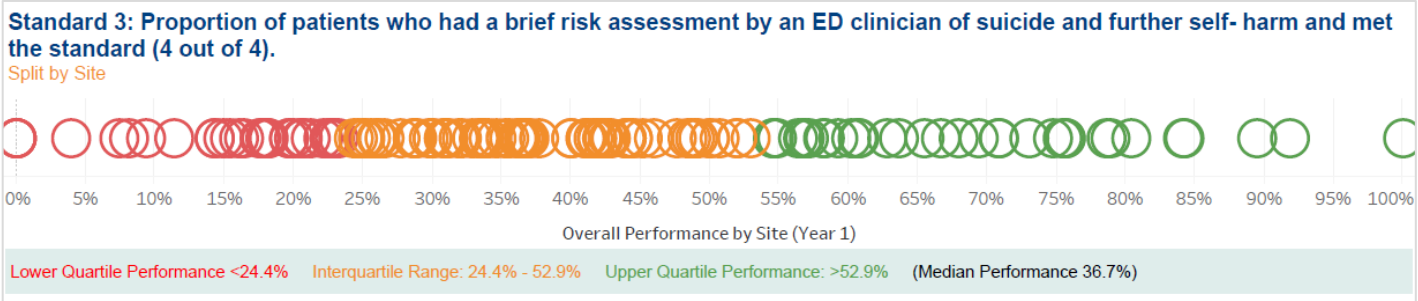
N= 15298

Any patient who was received an ED clinician review.

Exclusions

Any patient who was referred directly to the Adult Psychiatric Liaison Services or did not wait to be seen/self-discharged before their ED clinician review.

Site Performance



This graph shows the performance range for all participating EDs. For a further guidance on this chart, please see Appendix 5.

Commentary

Of 15713 records only 4696 records conformed to this fundamental standard with mean being 30.3%. Slightly poorer performance was seen during the Nov' 2022 to Jan' 2023 period with a period of promising improvement surfacing towards the end from Aug' 2023 to Sep' 2023. However, the data clearly suggest that there is significant scope for further improvement.

This standard has 4 subcomponents:

1. Type of self-harm
2. Reason / Trigger for self-harm
3. Future suicidal thoughts and plans
4. Has an adequate past psychiatric and social history been taken.

All 4 needs recorded for each patient for the standard to be met. This might be the reason why performance here might be poor with patients only getting part of the 4 recorded.

Recommendations

Individual departments could investigate which one of the 4 components is not being recorded consistently and formulate interventions to address that specifically.

Consider if part of this of these components can be completed in Triage e.g. Type of self-harm.

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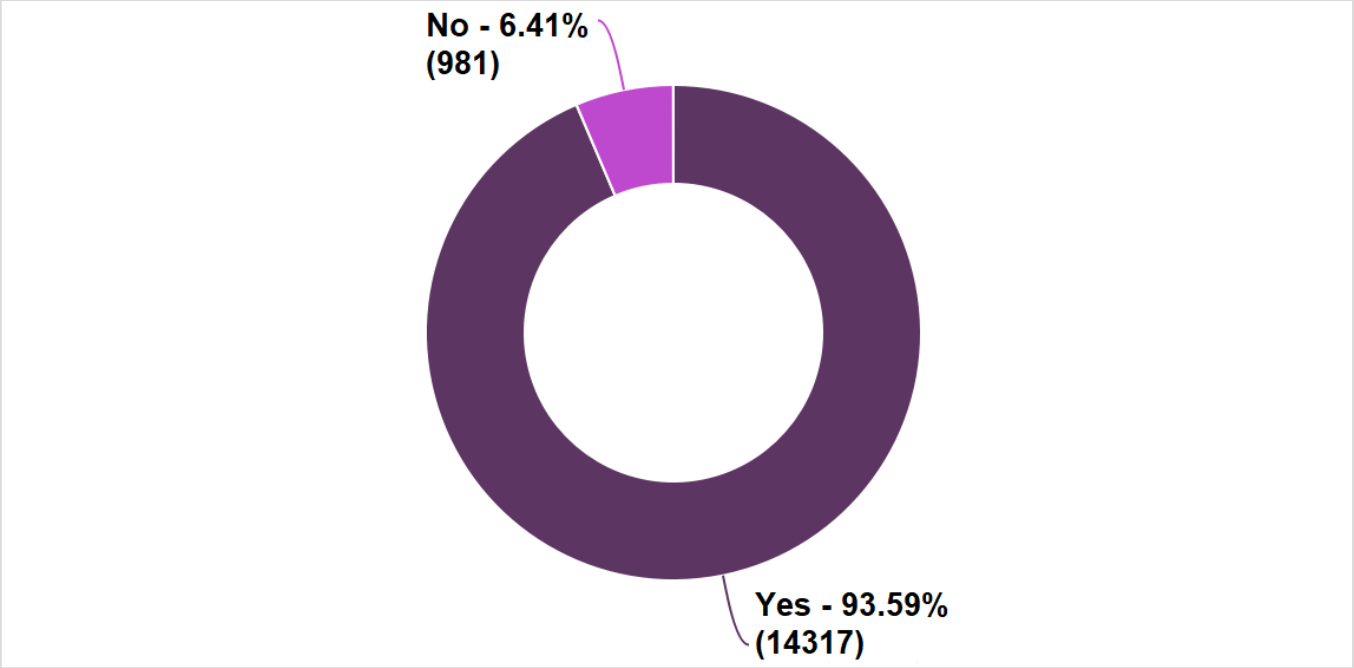
Evidence of appropriate physical health assessment, relevant investigation and treatment been carried out by the ED clinician appropriate to the patient's presentation



N= 15298

All patients who received an ED clinician review.

Exclusions

Any patient who was referred directly to the Adult Psychiatric Liaison Services or did not wait to be seen/self-discharged before their ED clinician review.

Commentary

93.59% of patients presenting with mental health (self-harm) had evidence of appropriate physical health assessment, relevant investigation and treatment carried out by the ED clinician appropriate to the patient's presentation. This is encouraging as its vital to address medical needs of the patient and not be rushed in to get the patient through the system. The medical care provided should be on par with other clinical presentations.

Recommendations

We would encourage participating ED's to continue focusing on the patient's self-harm presentation. Teaching sessions on common self-harm presentations including overdose and wound management will help address any short comings in the clinical care provided. Making use of shop floor teaching will largely address any learning gaps. Use of resources like departmental guidelines / Toxbase should be encouraged. Learning and feedback from cases where clinical care provided had fallen short of expected standards should be encouraged and shared within the ED team.

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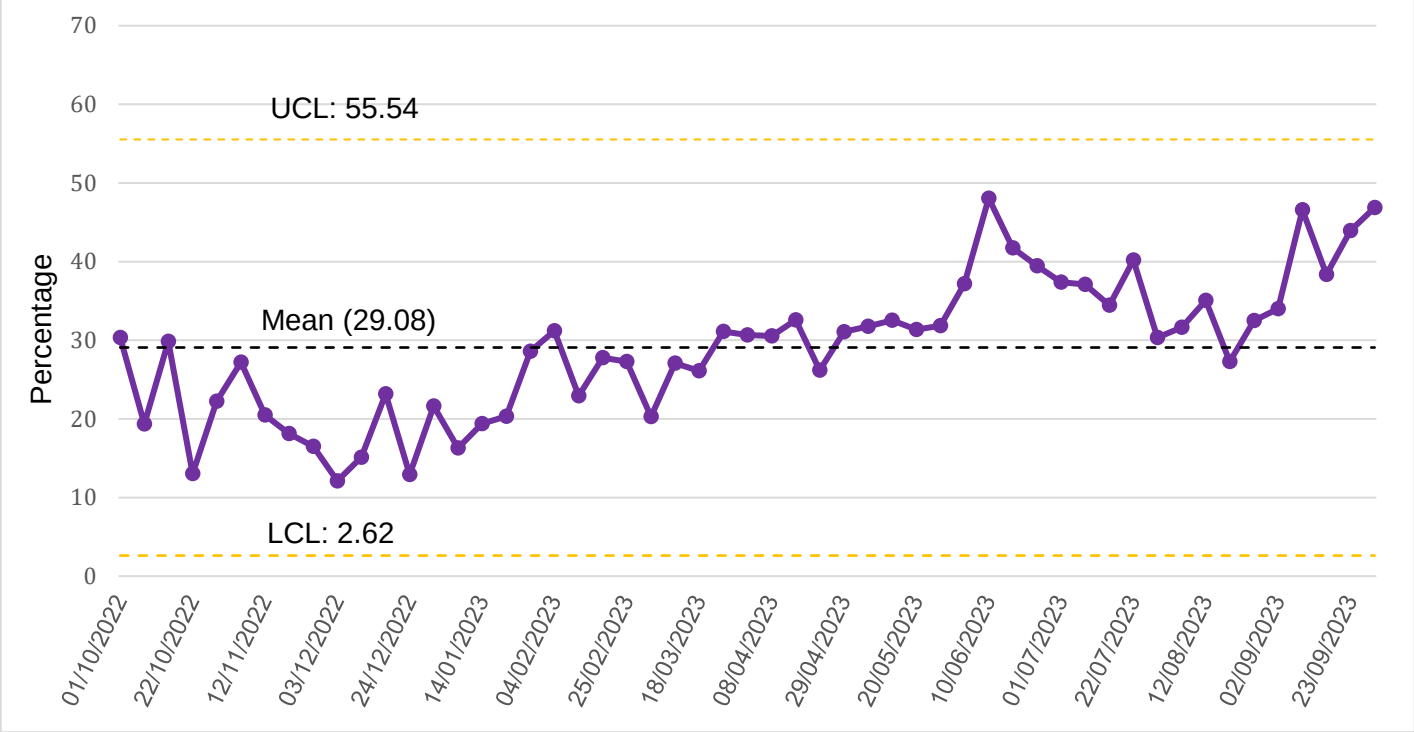
Fundamental standard

Standard 2 – Proportion of medium or high-risk patients who had an appropriate level of observation (good evidence of continuous or intermittent observation, interaction, or care)



Understanding SPC Charts

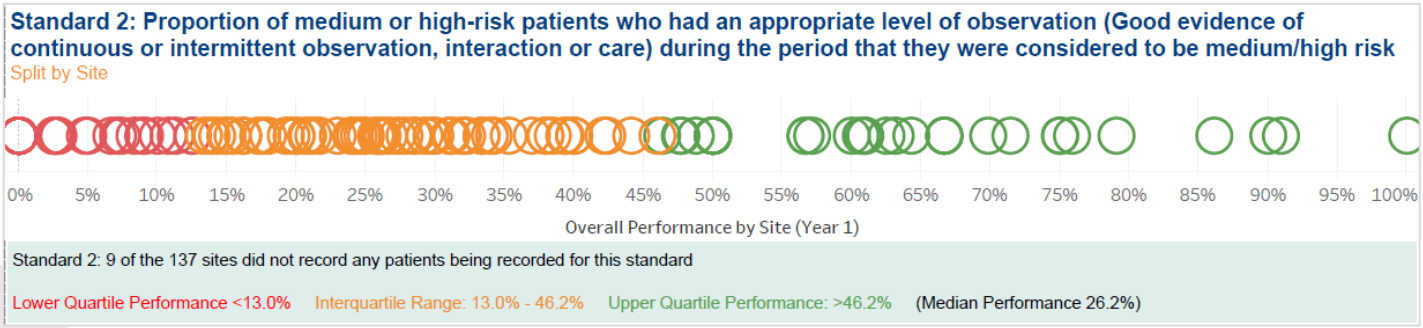
N= 5806

All patients who received a mental health triage and were identified as medium or high risk.

Exclusions

Any patient who did not receive a mental health triage or received a triage and their risk level was either low or not recorded.

Site Performance



This graph shows the performance range for all participating EDs. For a further guidance on this chart, please see Appendix 5.

Commentary

This standard applies to those patients who were likely to require observation within the ED. These were patients whose mental health triage identified them as being high or medium risk (of further self-harm or

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absconding) while waiting for assessment. The figure of 5806 eligible patients will therefore not include those patients who are assessed as low risk, who are unlikely to require this level of observation. It will also exclude those who left before their mental health assessment (but after their ED assessment). This is a group of patients we should be concerned about, with a different set of risks. The figures also exclude those who were referred directly to Adult Mental Health Services, which reflects different service models in different hospitals.

Of this group of patients, only 29% conformed to the standard, ranging from a low of 12% in December 2022, to a high of approximately 48% in June 2023.

The data suggests a steady improvement in performance over the first year of the QIP, with four early months (Nov-Feb) worth of data points consistently below the average (mean), and four later months of data (May-Aug) consistently above the average (mean), a 'shift' representing an improvement in this measure.

It is important to note the wording of the question in the mental health QIP data collection– "*Is there evidence* of appropriate observation, interactions, or care?"

When the data suggests that 40% of patients have had appropriate observation, this means that these interactions have been recorded in a way that is accessible to the reviewer. It is possible that a proportion of the remaining 60% of eligible patients were appropriately observed, but that this information was not consistently or systematically recorded. However, it is also possible that many of these patients were not appropriately observed.

Recommendations

It is appropriate that EDs have a policy for observing patients presenting with mental health problems who are in the higher risk categories, and it is helpful if such measures suggest an appropriate method and place to record this information. While this measure may help data collection for the QIP and may identify patients whose observation was not adequately recorded, more importantly a place to record observations and interactions may improve practice by acting as a prompt and reminder.

It is also important to consider those patients not included in these figures, especially those who left before a mental health assessment was carried out, who are a higher risk group of patients. EDs should therefor consider the reasons that patients are excluded from this chart. It is likely that more robust policies which prompt observation and interaction may reduce the numbers of patients who leave before assessment.

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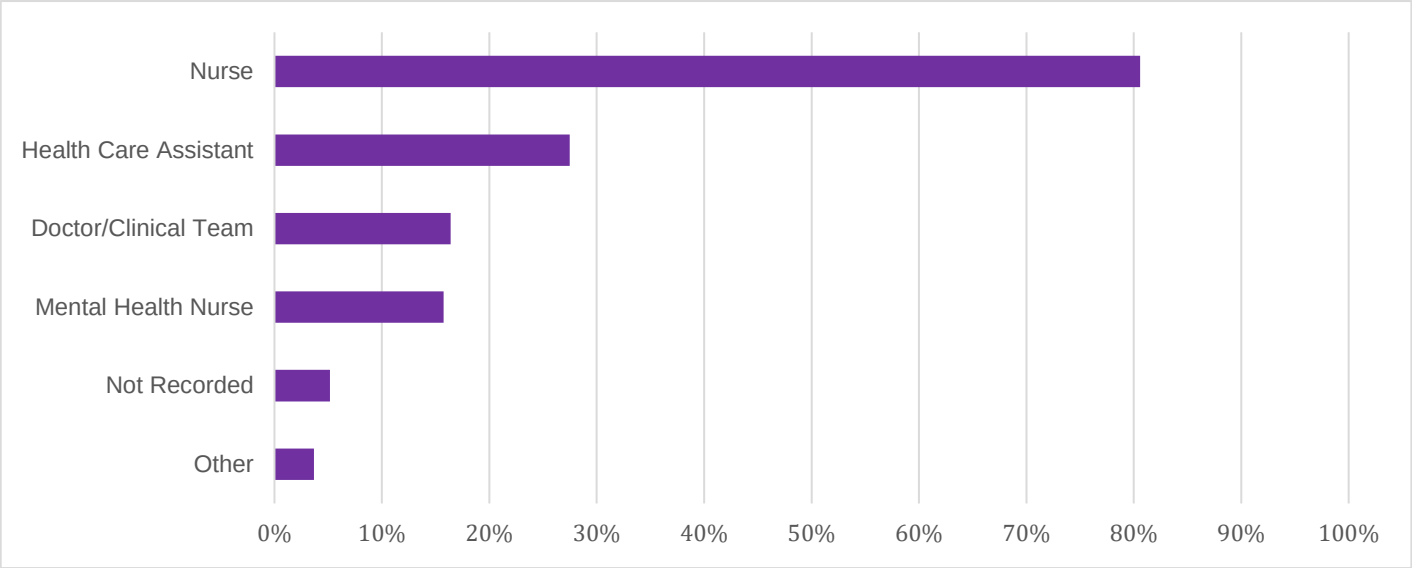
Persons taking part in carrying out observations for the patients at medium or high risk of further self-harm or leaving before assessment or treatment completion.



Staff Member	Number of Patients	Proportion
Nurse	3387	80.59%
Health Care Assistant	1156	27.50%
Doctor/Clinical Team	689	16.39%
Mental Health Nurse	662	15.75%
Not Recorded	217	5.16%
Other	155	3.69%

N= 4203

All patients who had their risk level documented at triage, was identified as medium or high risk, and there was good or partial evidence of appropriate observation.

If a patient was observed by more than one person or type of staff member, this was noted, and data entered for both types of staff.

Exclusions

Any patient who was identified as low risk or risk level was not recorded during triage, or if there was no evidence of appropriate observation having taken place.

Commentary

This chart relates to the same group of patients referred to in the previous question, i.e., those at medium and high risk (of further self-harm or absconding) while awaiting further assessment. It excludes patients deemed to be low risk, those who were referred directly to Adult Mental Health Assessment, and those who did not wait to be seen.

The QIP Information Pack states that “security staff should not be used for observation. This should be performed by health care personnel” which reflects guidance drawn from the RCEM Mental Health Toolkit.

Of these 4203 patients:

- 80.59% (3387 patients) had these observations carried out by a nurse.
- 27.50% (1156 patients) had these observations carried out by a healthcare assistant.

- 16.39% (689 patients) had these observations carried out by other members of the ED clinical team (including doctors)

A small number of patients (3.69% or 155 patients) were observed by unspecified 'others' who presumably were not ED clinical staff. It is reassuring that this is a small number and may reflect individual circumstances, or different models of care within the ED

A further group of patients (15.75% or 662 patients) were observed within ED by mental health nurses. This figure is likely to represent a model of care where parallel assessment of physical and mental health needs takes place, and where mental health staff are embedded within Emergency Medicine.

There are many factors which contribute to the discussion of who should take responsibility for observing patients within the ED who are waiting for a mental health assessment. These factors will include departmental geography, availability of space, availability of trained and untrained staff, and other pressures, priorities and demands within the department.

Recommendations

It might be appropriate to allocate the responsibility for recording observations and interactions with each patient to an individual, rather that have it as a collective responsibility of clinical staff and have a clear mechanism for handing-over that role appropriately, e.g. on breaks, or change of shifts.

Different patient also have different risks. These might include absconding, further self-harm, or, less commonly, violence. Many patients presenting to ED with mental health problems may be accompanied by friends or relatives. It is often appropriate to allow these 'significant others' to wait with the patient, a measure which may minimise risk, although it is always important to be alert for situations where the presence of another person seems to increase agitation and distress and therefore risk.

Patients are often frustrated by long waits, which can also lead to increasing distress, and within Emergency Medicine this is often compounded by the unpredictability of these waiting times. Nevertheless, it is important to keep patients as well informed as possible about potential delays to their service.

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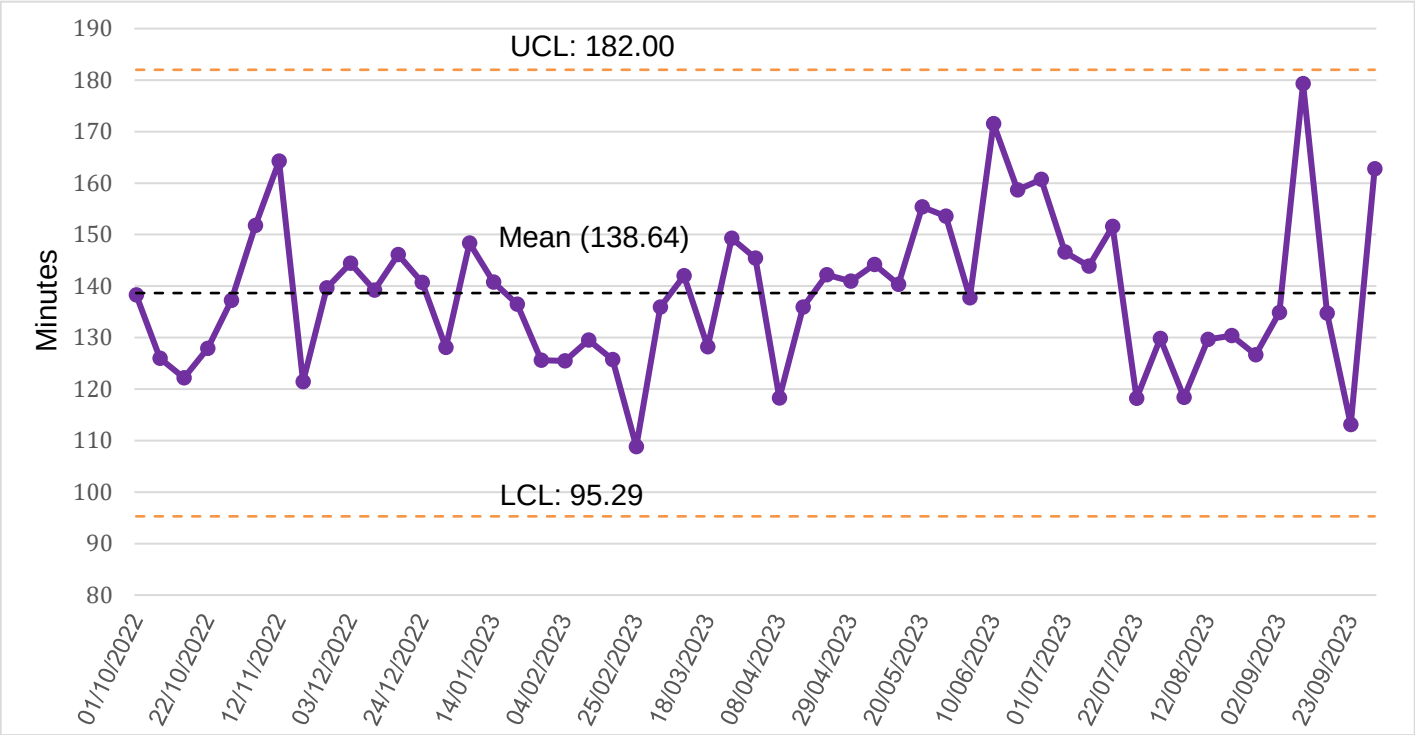
Time to Adult Psychiatric Liaison Service patient review in the ED following referral.



Understanding SPC Charts

N= 9621

All patients who received an Adult Psychiatric Liaison Service review following a referral and both the time of referral and review were recorded.

Exclusions

Any patients who did not receive an Adult Psychiatric Liaison Service patient review and/or referral. If a patient received both a review and referral, they were excluded if either or both times were not recorded.

Commentary

These figures relate to a little over half of all patients entered into the study (9621 of 18684 – 51.5%).

This chart documents the time between the patient's referral either by a triage nurse or ED clinician and their review by the Adult Psychiatric Liaison Service. With a mean of 2hrs and 18mins, (138 mins) a lower confidence limit of 1hr 35 mins (95 mins) and an upper confidence limit over 3 hours (182 mins), these prolonged waits for specialist review times make a very significant contribution to patients' total time within the ED.

Shorter wait times between the end of July and the beginning of September are likely to represent a change in the pattern of mental health presentations due to better weather and summer holidays, (although the shortest average waiting time charted occurred in late February). Following this, there was a steady increase in waiting times from March to July. It is disappointing that following the improvement over the summer holidays, two of the three highest average delays were recorded, reaching nearly three hours in September. These results mean that there is little evidence of improvement in the years' worth of data charted above. The swings in the average figures from week to week can also be quite steep, suggesting there are multiple variables contributing to these delays.

There are several reasons that nearly half of the patient cohort are not included in this data. This may simply be administrative – relating to the failure to record times of assessment and referral, or more concerning,

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because patients did not wait for either medical or Adult Psychiatric Liaison Service review before taking their own discharge. This is a high-risk group of patients and a cohort which should be considered separately.

More positively, patients may have been excluded from this data in centres with different service models, e.g. where parallel assessment takes place. This can result in Adult Psychiatric Liaison Service review taking place independently of ED clinician review and is not dependent on ED clinician referral. Patients may also be excluded from this cohort if the model of care involves transfer out of the ED for a mental health assessment.

Recommendations

There are multiple service models where mental health professionals respond to referrals from the ED. These vary across the four nations of the UK, between different regions and hospitals, and services within the same department may even vary depending on time of day or day of week. It is therefore difficult to make a general recommendation which are likely to be broadly applicable to all hospitals. These prolonged waiting times could possibly be reduced by changing or streamlining processes within individual departments but will require co-operation and collaboration with other services. This is best addressed locally based on issues identified.

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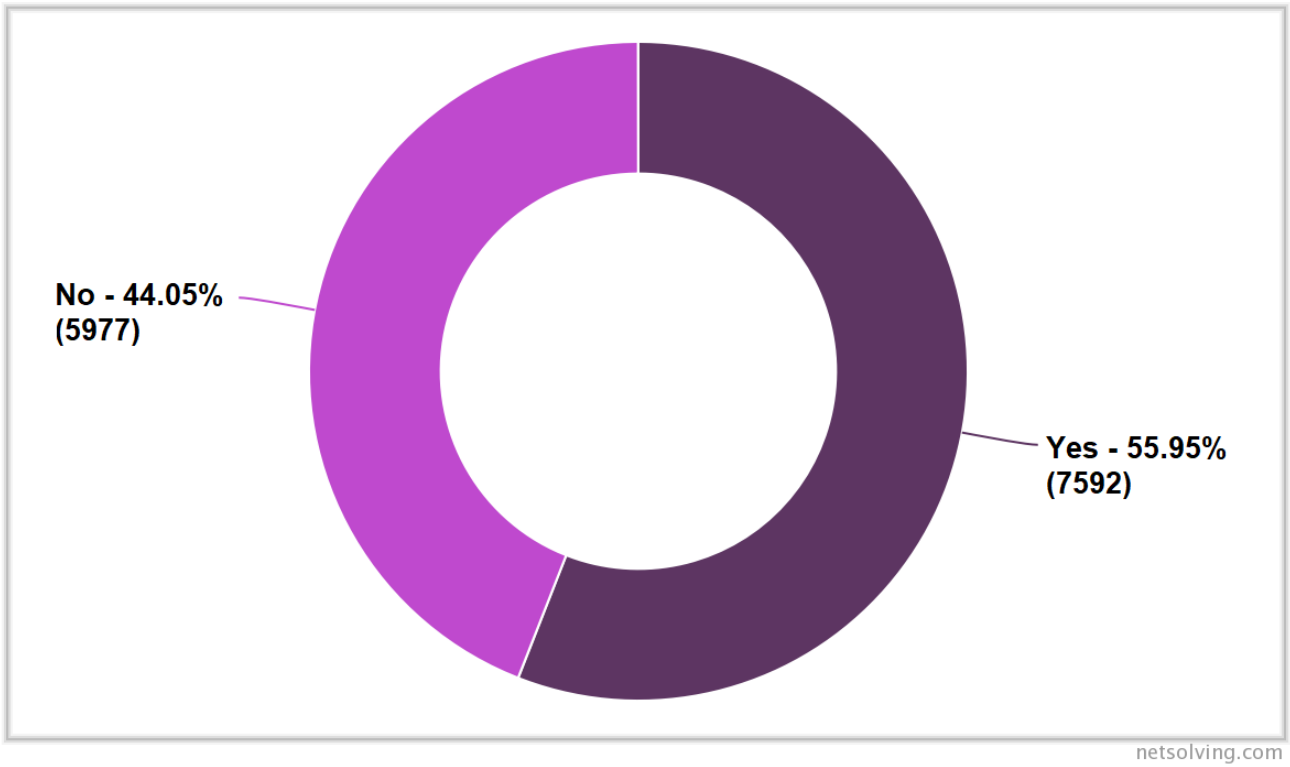
Parallel Assessment



N= 13569

All patients who were identified as being able to have their mental health and physical health needs addressed in parallel.

Exclusions

Any patient identified as not able to have their mental health and physical health needs addressed in parallel.

Commentary

The data from this year's QIP shows that 55.95% of patients presenting with mental health needs received a parallel assessment. This shows that the implementation of parallel assessment processes is feasible and effective in some instances. These successes can be built upon to improve the number of patients receiving a parallel assessment.

Parallel assessment is an important concept that when implemented effectively, can reduce the time patients with mental health needs wait to see specialist mental health practitioners and receive definitive care for their mental health needs. This can reduce the number of patients who leave before being seen and therefore reduce adverse mental health outcomes. It can also help to reduce ED crowding, and importantly, improve patient experience for this vulnerable group of patients.

Recommendations

Co-creating a parallel assessment pathway requires collaboration between ED staff, Adult Psychiatric Liaison Services, and wider system stakeholders. Staff awareness and training are essential, focusing on patient identification and process implementation. Regular reviews of the pathway are required, using staff and patient feedback for continuous improvement. Additionally, integrating technology can support the pathway's efficiency. Ensuring sufficient system-wide support is fundamental for the pathway's success and improved patient outcomes.

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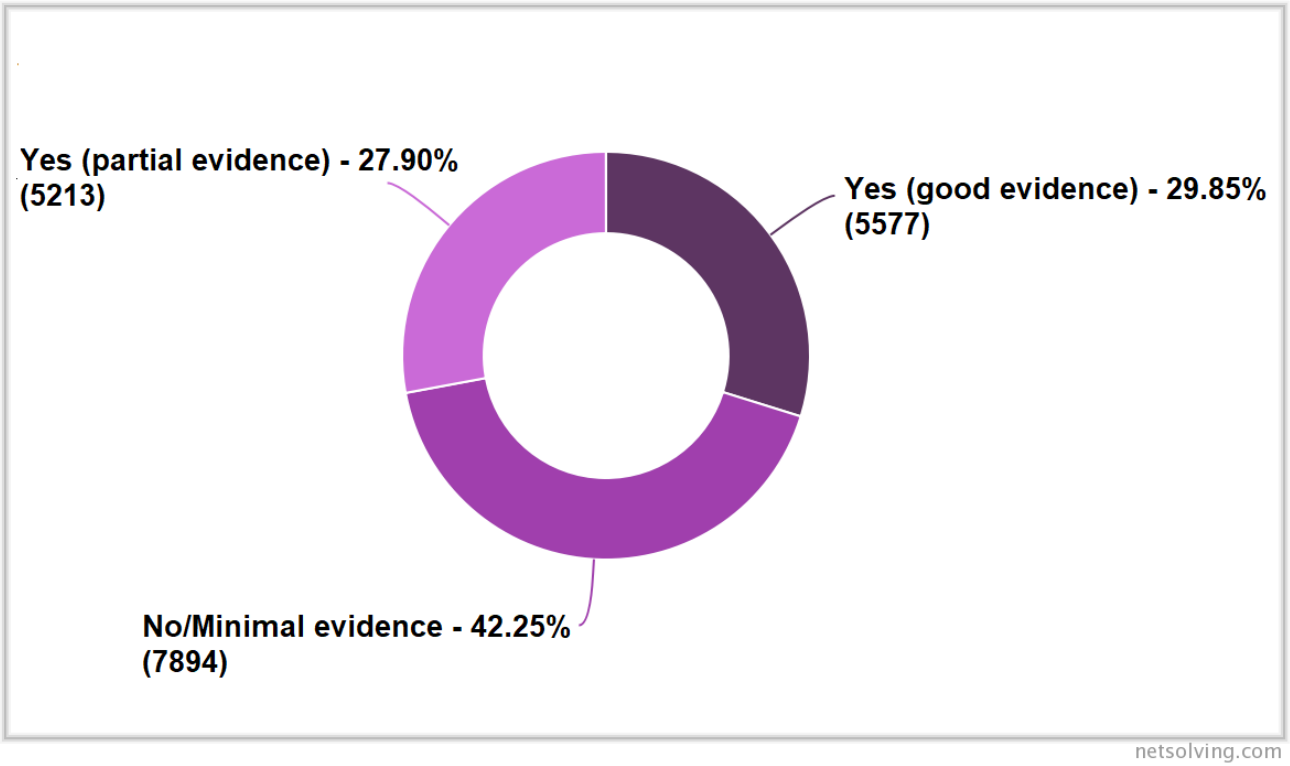
Evidence of compassionate and practical care



N= 18684

All patient cases.

Exclusions

None.

Commentary

The data presents a critical perspective on compassionate and practical care for patients presenting with mental health needs in the ED. With only 29.85% of cases showing good evidence of such care, there is significant potential for improvement in addressing patients' emotional and practical needs. The situation is further highlighted by the fact that 42.25% of instances showed no evidence of this type of care, while 27.90% exhibited only partial evidence. This indicates a significant gap in our healthcare system's ability to provide holistic care for patients presenting with mental health needs.

Compassionate and practical care is essential, especially for this vulnerable group of patients with complex healthcare needs, as it directly impacts patient outcomes and satisfaction. The lack of such care affects the quality of the healthcare experience and can lead to decreased patient engagement and compliance with management plans. The data suggests an urgent need for system-based improvements to ensure compassionate and practically supportive healthcare delivery.

Recommendations

To effectively address the gaps in compassionate and practical care, healthcare systems must prioritise enhanced training for healthcare staff, focusing on the importance of compassionate care. Implementing patient feedback mechanisms can provide valuable insights for healthcare improvement. It is crucial to adopt patient-centred care models where patients actively participate in their care. This approach should be supported with adequate resources, staffing, and infrastructure. New staffing models can be considered. These strategies are key to ensuring the healthcare system effectively meets the holistic needs of patients, leading to better patient experience and outcomes.

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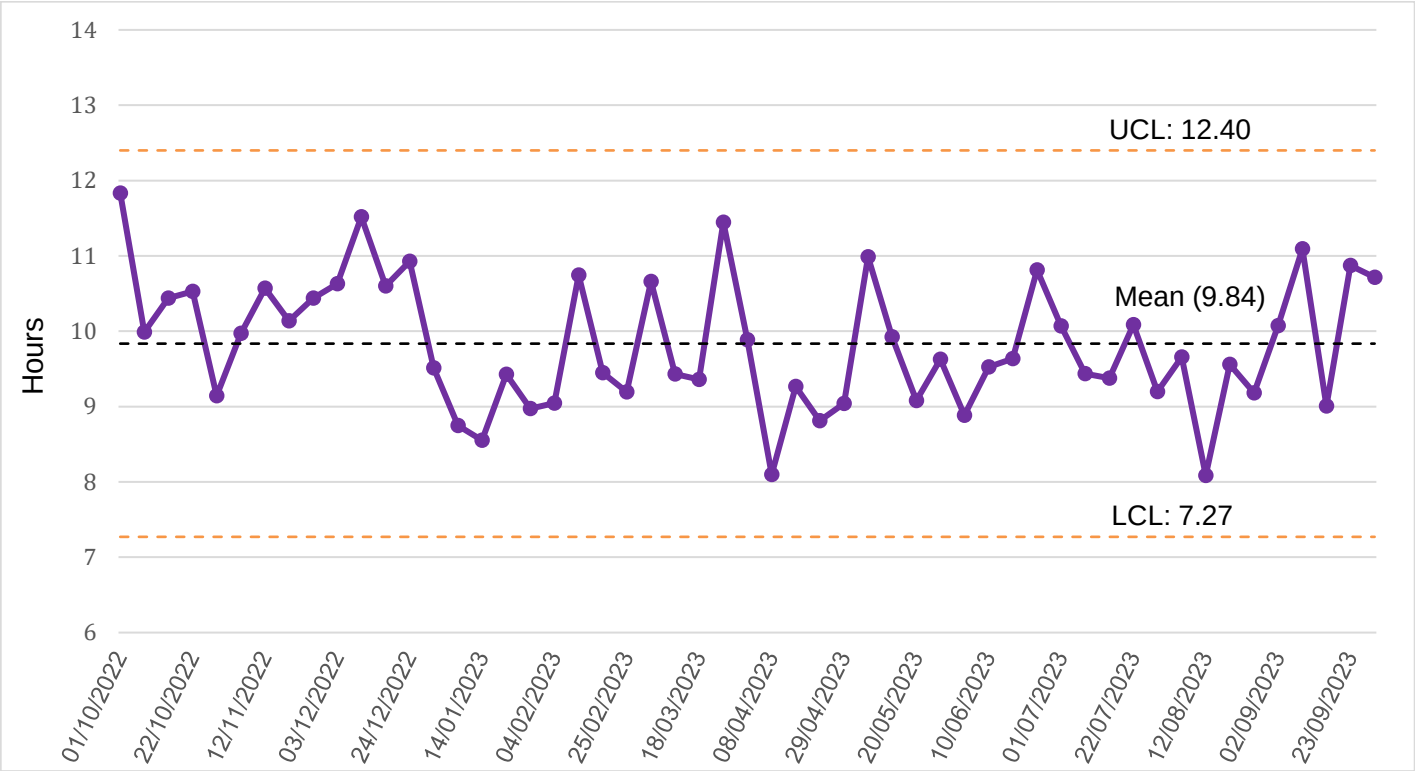
Total time spent in ED before either discharged / admitted / transferred off site



Understanding SPC Charts

N= 17416

All patients where their time leaving the ED was recorded.

Exclusions

Any patients where their time of leaving the ED was unknown or not recorded.

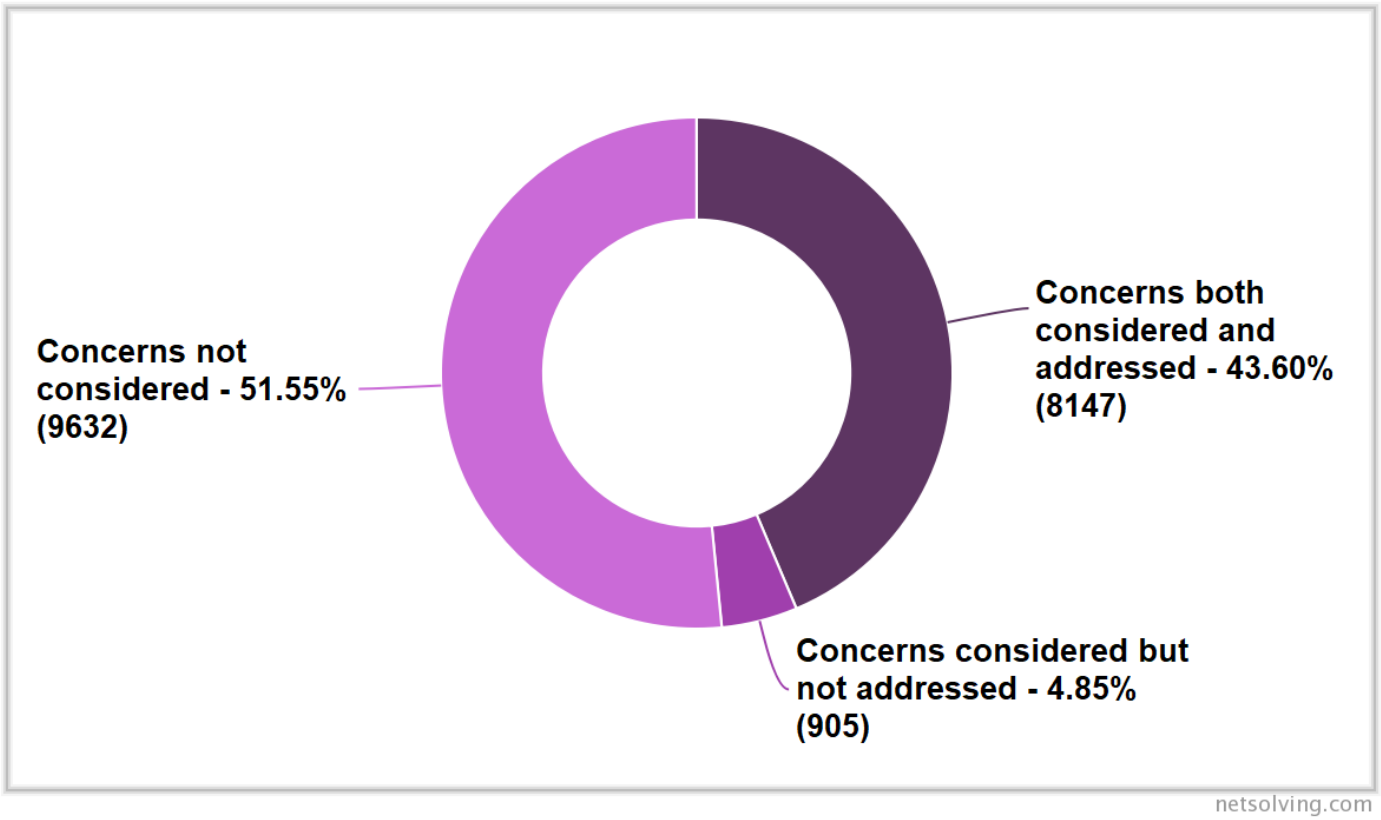
Commentary

The data from the SPC chart reveals a significant issue with the total time patients spend in the ED. With an average duration of 9.84 hours, and the upper control limit at 12.4 hours, and a lower control limit of 7.27 hours, it's clear that patients are experiencing prolonged wait times. This not only impacts individual patient experience and outcomes but adds additional needs for the ED in terms of space and clinical care. These figures suggest a lack of capacity within the healthcare system and inefficiencies in patient processing that need to be improved.

Recommendations

To address the prolonged length of stay in ED, efforts must focus on three key areas: Firstly, reducing demand through clinical pathways that allow patients having mental crises to see mental health practitioners directly. In addition, increasing capacity to allow for more community care should prevent some mental health crises from developing. Secondly, improving efficiency within the ED by shortening the time to triage and allowing streaming from triage directly to mental health practitioners. Finally, increasing the capacity and efficiency of mental health services will support timely assessments and onward referrals.

Safeguarding concerns



N= 18684

All patient cases.

Exclusions

None.

Commentary

Concerningly, the results indicate that safeguarding concerns were not considered for over half (51.55%) of patients and 4.85% of patients had safeguarding concerns considered but these were not addressed.

43.60% of patients had safeguarding concerns considered and addressed. It should be noted that this figure also includes those patients who had safeguarding concerns considered, but no concerns were raised and thus it was appropriate that no action was taken.

Recommendations

The current performance is alarmingly low given the implication of missing safeguarding concerns. It is vital that safeguarding concerns are considered when a patient presents to the ED following self-harm. Consider amending triage documentation to prompt staff to consider if a safe-guarding concern needs to be addressed. Where possible this can be created by introducing additional windows on electronic records. This could prompt users (both at triage and the clinician while discharging) to address if any safeguarding concerns need to be raised.

Systems and processes including local pathways, should be reviewed to ensure they are robust and fully embedded for patients where safeguarding concerns are raised and require addressing.

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The results may be impacted by a lack of documentation where safeguarding concerns were discussed but not recorded in the patient's records. This can be improved by raising awareness amongst the team of the importance of accurate documentation.

Explore locally if there are trends which may result in a drop in compliance with the standard e.g. does compliance differ by designation of staff member, agency staff, access to training, attendance out of hours, staff levels, capacity within the department and awareness. This will allow targeted interventions at a local level. This recommendation is also applicable for drug and alcohol concerns.

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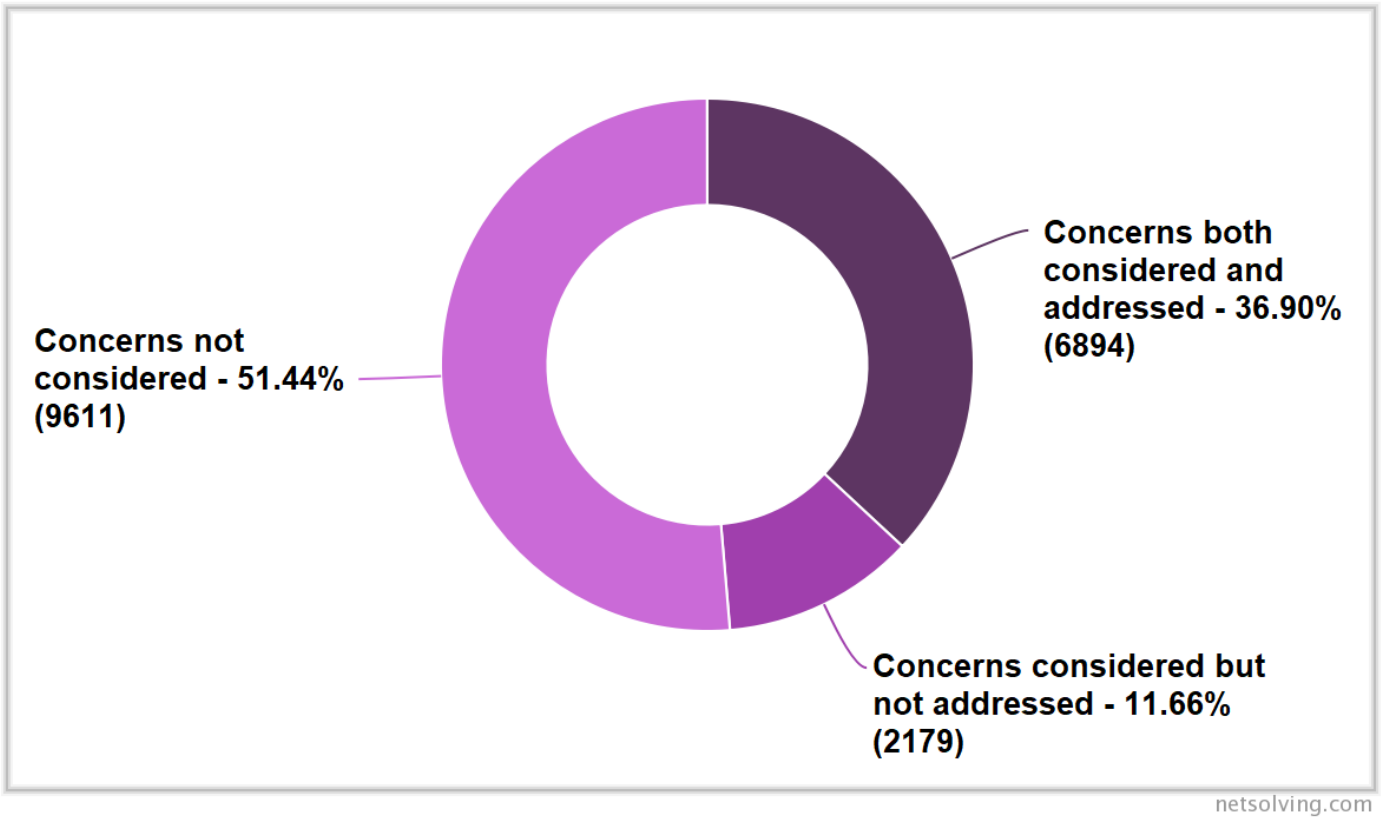
Drug and alcohol concerns



N= 18684

All patient cases.

Exclusions

None.

Commentary

The results indicate that drug and alcohol concerns were not considered for over half (51.44%) of patients. A further 11.66% of patients had drug and alcohol concerns considered but these were not addressed. This may be for a variety of reasons such as availability or capacity of specialist services or the patient preference; it is important that any contributary reasons are documented in the patient records.

36.90% of patients nationally had drug and alcohol concerns considered and addressed. It should be noted that this figure includes those patients who had alcohol / drug concerns considered, but no concerns were raised and thus it was appropriate that no action was taken.

Recommendations

With the recognised link between drug / alcohol concerns and mental health, it is important that this is considered when patients present to the ED with mental health (self-harm) concerns. Consider amending triage documentation to prompt discussion around drug and alcohol issues. Where possible this can be created by introducing additional windows on electronic records. This could prompt users (both at triage and the clinician while discharging) to address if any safeguarding concern need to be raised. Systems and processes including local pathways, should be reviewed to ensure they are robust and fully embedded for patients where drug / alcohol concerns are identified and require addressing.

The results may be impacted by a lack of documentation where alcohol / drug concerns were discussed but not recorded in the patient's records. This can be improved by raising awareness amongst the team of the importance of accurate documentation.

Explore locally if there are trends which may result in a drop in compliance with the standard e.g. does compliance differ by designation of staff member, agency staff, access to training, attendance out of hours, staff levels, capacity within the department and awareness. This will allow targeted interventions at a local level. This recommendation is also applicable for safeguarding concerns.

Support from the Alcohol liaison team at the front end should benefit these patients including continuation of support in the community on discharge from ED. Triage nurses and ED clinicians should be encouraged to contact alcohol liaison teams to review this cohort of patients.

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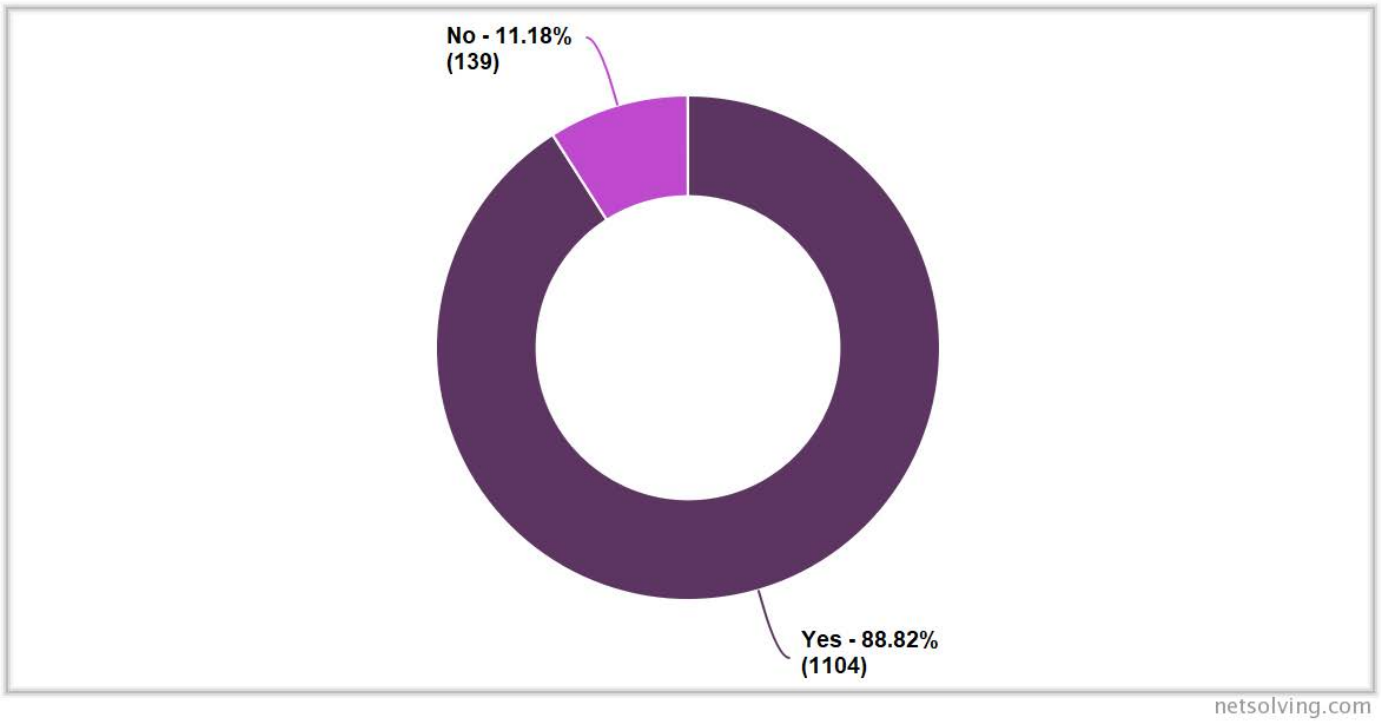
If not seen by the Adult Psychiatric Liaison Service and discharged by ED: was this documented and an acceptable safe discharge plan made?



N= 1243

All patients who received an ED clinician review, the review date was recorded, and it was identified an Adult Psychiatric Liaison Service review was not applicable.

Exclusions

Any patient who did not receive an ED clinician review, the ED clinician review or review date was not recorded, or the patient received an Adult Psychiatric Liaison Service.

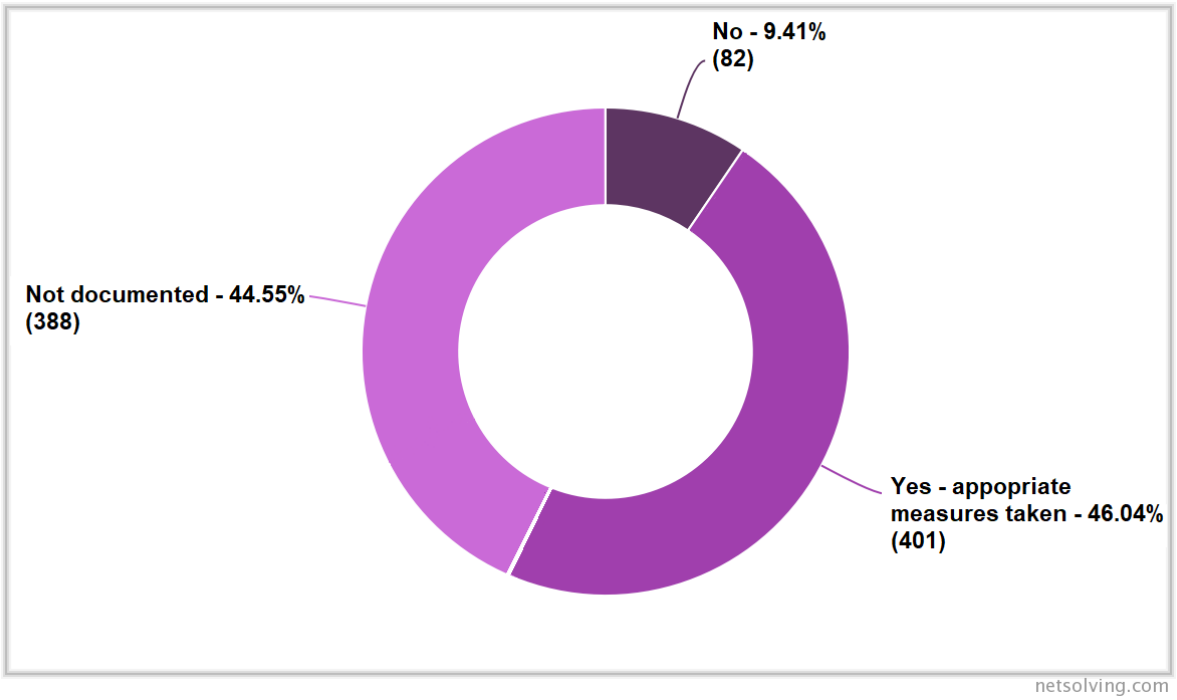
Commentary

88.82% of patients who were discharged by ED and not seen by Adult Psychiatric Liaison Services had an acceptable safe discharge plan made and documented. Safely discharging patients where appropriate avoids prolonged waiting times in ED's waiting for an Adult Psychiatric Liaison Services review following management of their medical needs.

Recommendations

We would continue to encourage departments to safely discharge patients whenever possible with an appropriate follow up plan that addresses the patient's mental health needs. There needs to be a local system in place that has been agreed with the Adult Psychiatric Liaison Services. Patients should not be advised to follow up with their General Practitioner (GP) as a routine following ED management of their medical needs.

If patient left before ED clinician review, was this acted on?



N= 871

All patients who did not wait/self-discharged before receiving an ED clinician review or their ED clinician review was not recorded.

Exclusions

Any patients who did receive an ED clinician review or may not have received a review but remained in the ED for other support and/or reviews.

Commentary

46.04% of patients who had left before an ED clinician review had appropriate action taken. This could have been in the form of a welfare check by police, discussion with Adult Psychiatric Liaison Services regarding patient presentation and appropriate further course of action and includes arranging follow up with the community mental health team. In cases where the patient is not known to the Adult Psychiatric Liaison Services and there are no significant concerns following discussion with Adult Psychiatric Liaison Services, options include a discharge summary to the GP for follow up. However, as stated previously this should not be a routine practise in all cases of patients who did not wait or self-discharged. It's vital this is addressed especially if there are ongoing medical concern due to their self-harm in addition to their underlying mental health presentation. They can be at risk to not only themselves but in some cases to others.

Recommendations

We encourage teams to follow up on this cohort of patients including documenting what was done. The reasons could be multi-factorial including prolonged waiting times. Promoting parallel assessment should at times encourage patient to stay and have their medical needs addressed. There needs to be local policy in place especially if a patient were to leave prior to an ED clinician review. Effective triage, capacity assessment, close monitoring and prioritising certain subset of patient deemed at risk might help address this issue.

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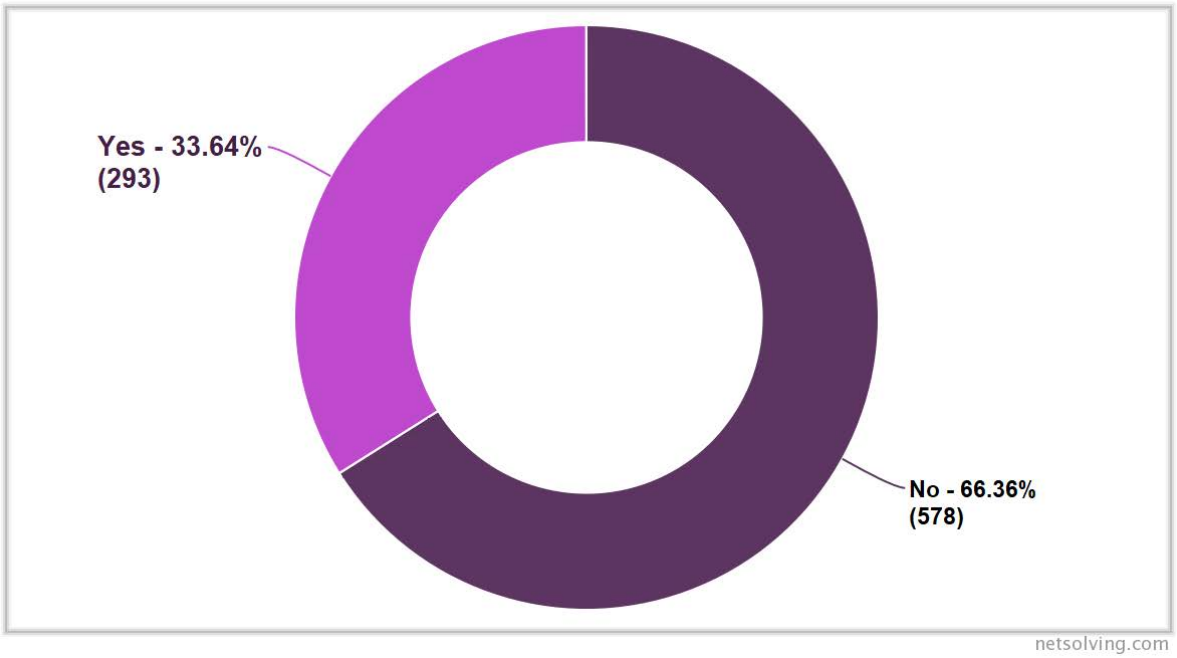
If patient left before ED clinician review, was a capacity assessment documented?



N= 871

All patients who did not wait/self-discharged before receiving an ED clinician review or their ED clinician review was not recorded.

Exclusions

Any patients who did receive an ED clinician review or may not have received a review but remained in the ED for other support and/or reviews.

Commentary

66.36% of patients who had left before an ED clinician review did not have a mental capacity assessment documented. This documentation is vital as any concerns regarding capacity should warrant closer observation of the patient while in ED. Further this can flag up patients and help prioritise them for an early ED clinician review. Parallel assessment should be encouraged if the patient's mental health is leading to lack of capacity rather than an actual clinical cause.

Recommendations

Patients should have a mental capacity assessment done at triage. This should identify patients who are at risk of leaving prior to completion of treatment or of further self-harm. Local process should be put in place for those who are deemed lacking capacity.

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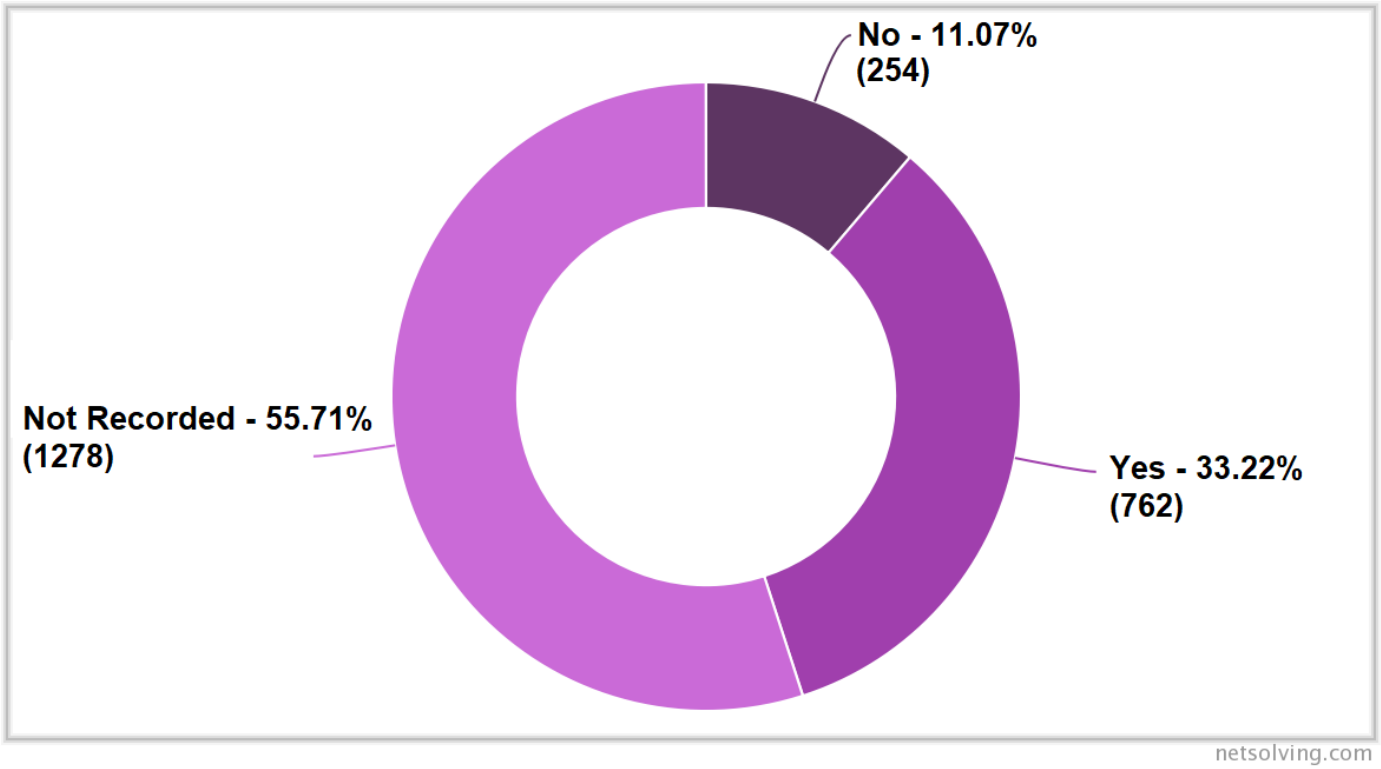
Seen by ED clinician/triage nurse but left before Adult Psychiatric Liaison Services review, was this acted on?



N= 2294

All patients who received an ED clinician review and did not have an Adult Psychiatric Liaison Services review for a reason other than it being deemed not applicable to the patient.

Exclusions

Any patient who received both an ED clinician review and Adult Psychiatric Liaison Services review, did not receive an ED clinician review, or an Adult Psychiatric Liaison Services review was found not applicable to the patient.

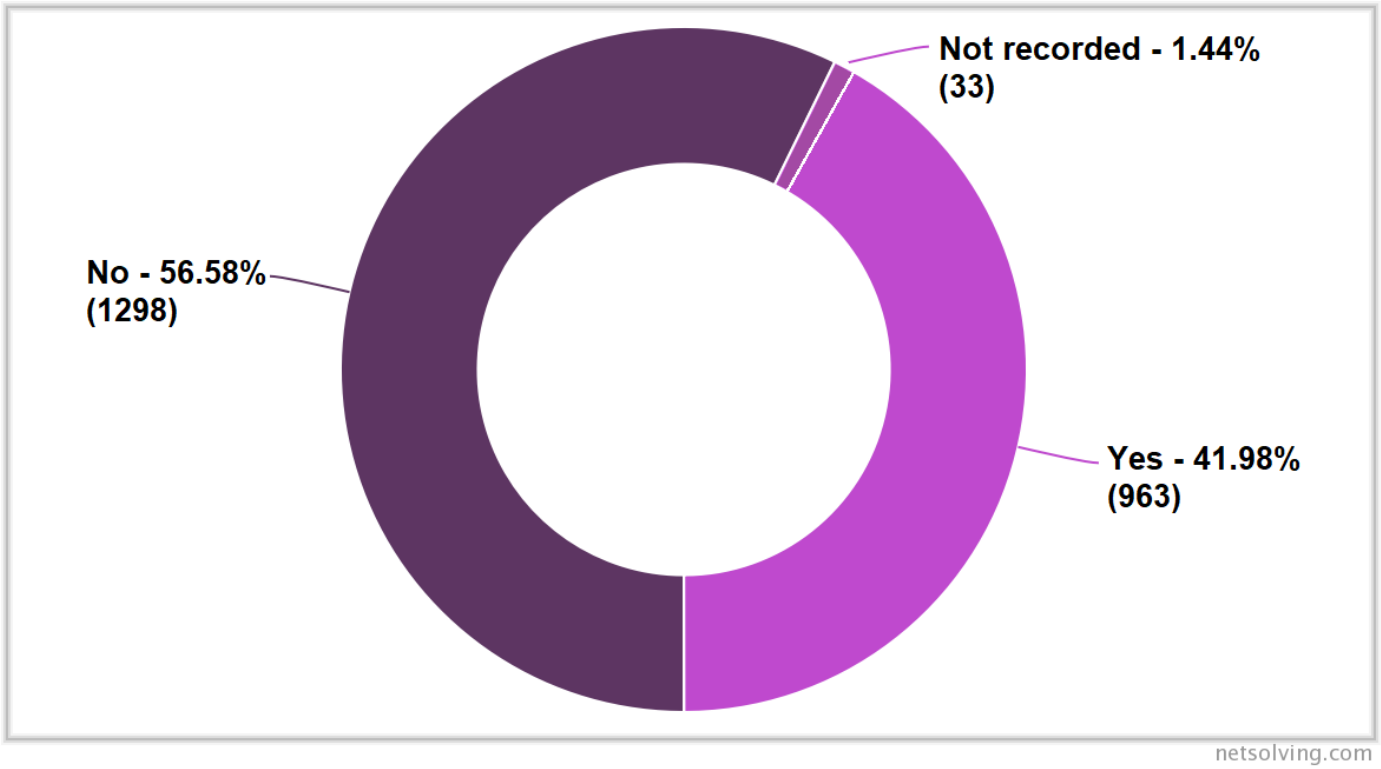
Commentary

33.22% of patients had a follow up plan documented if they left prior to Adult Psychiatric Liaison Services review. Documentation is vital given the risk of further self-harm and potentially to others in some instances.

Recommendations

Patients leaving prior to Adult Psychiatric Liaison Services review will need this to be acted upon. This must be discussed with the consultant/senior on floor. The outcome of the discussion will need to be documented. This has been discussed in part under ‘’If patient left before ED clinician review, was this acted on?’’. Options include discussion with the Adult Psychiatric Liaison Services and a suitable follow up plan arranged. Review of ‘did not wait’s’ should help pick up on those leaving prior to Adult Psychiatric Liaison Services review as part of governance. Parallel assessment should be encouraged rather than awaiting a medical clearance from an ED clinician.

Seen by ED clinician/triage nurse but left before Adult Psychiatric Liaison Services review, was a capacity assessment documented?



N= 2294

All patients who received an ED clinician review and did not have an Adult Psychiatric Liaison Services review for a reason other than it being deemed not applicable to the patient.

Exclusions

Any patient who received both an ED clinician review and Adult Psychiatric Liaison Services review, did not receive an ED clinician review, or an Adult Psychiatric Liaison Services review was found not applicable to the patient.

Commentary

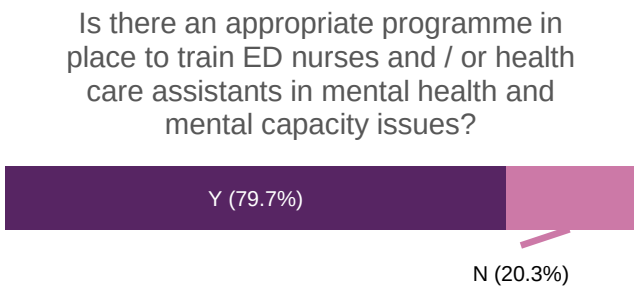
56.58% did not have a capacity assessment documented if they left prior to an Adult Psychiatric Liaison Services review. Any concerns regarding capacity should warrant closer observation of the patient while in ED.

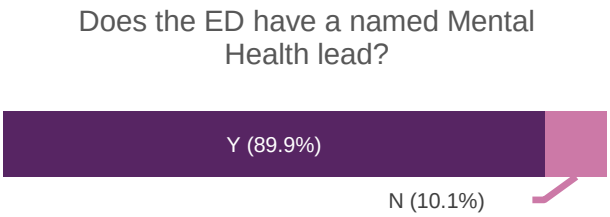
Recommendations

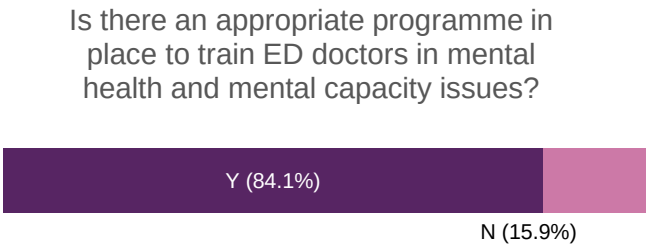
It's important that capacity is documented, ideally at triage. However, this should not be the responsibility of triage alone. The ED clinician reviewing the patient also has a role to play in assessing capacity as this can fluctuate in some cases. Any concerns should result in closer observation of the patient.

Performance Against Organisational Standards

Staffing and Training for EDs







N = 69

All complete ED submissions.

Exclusions

Any EDs who did not complete or partially completed their organisational submission.

Site Performance

ED Responses	Y	N
Is there an appropriate programme in place to train ED nurses and / or health care assistants in mental health and mental capacity issues?	55	14
Is there an appropriate programme in place to train ED doctors in mental health and mental capacity issues?	58	11
Does the ED have a named mental health lead?	62	7

Commentary

89.9% of ED's who had completed the organisational data entry had a named mental health lead. 84.1% had an appropriate training programme in mental health and mental capacity for doctors. This was 79.7% for ED nurses and / or health care assistants. It's essential training in mental health and capacity, measures to other area of care like Paediatrics, trauma, and life support. Focus should be on nurses as they often are the first point of contact for majority of our patients.

Recommendations

Introducing training in mental health and capacity during induction for doctors should help address some of the measures included in the QIP. Further training in mental health and especially capacity assessment for

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nurses would be central to how they administer an effective triage process. Study days designed should address these facets of training. The RCEM mental health Sub-committee highly values and recommends the APEx (Acute Psychiatric Emergencies) Course. The course covers assessment and management of patients with acute mental health illness in an emergency setting.

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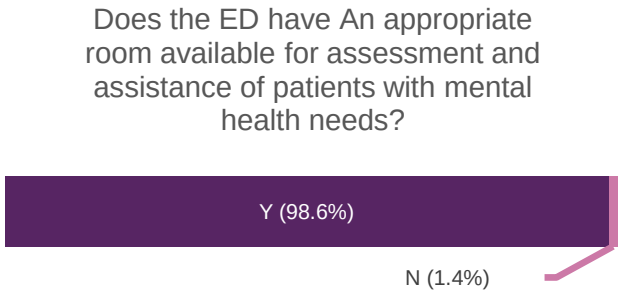
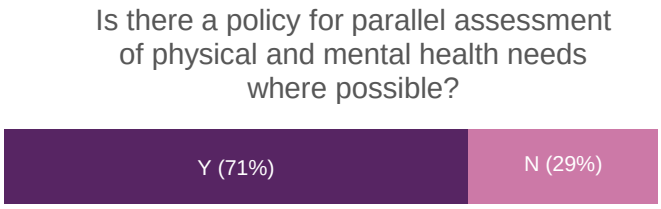
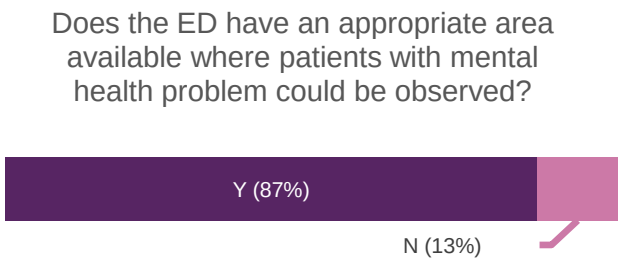
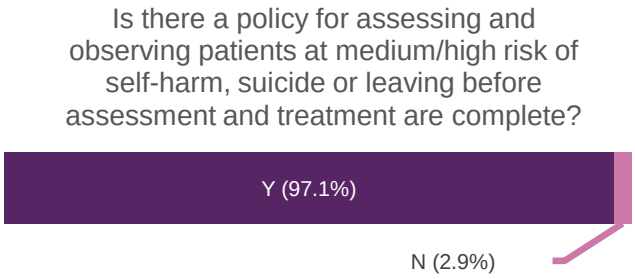
Resources and Policies for Supporting Mental Health Care









N = 69

All complete ED submissions.

Exclusions

Any EDs who did not complete or partially completed their organisational submission.

Site Performance

ED Responses	Y	N
Is there an appropriate room available for assessment and assistance of patients with mental health needs?	68	1
Is there an appropriate area in ED available where patients with mental health problem could be observed?	60	9
Is there a policy in place for assessing and observing patients at medium/high risk of self-harm, suicide or leaving before assessment and treatment are complete?	67	2
Does the ED have a policy of parallel assessment of physical and mental health needs where possible?	49	20

Commentary

98.6% of ED's who had completed the organisational audit had an appropriate room for assessment of patient with mental health needs. This data is encouraging as often this requirement falls short, even though it is a core element of providing a therapeutic and safe environment to this patient group.

87% had an appropriate area where patients could be observed. Given the pressures ED's are facing, RCEM would like to thank participating ED's to have prioritised and taken steps to ensure safe patient care.

97.1% had a policy for assessing and observing patients at medium/high risk of self-harm/suicide/leaving. Only 71% had a policy for parallel assessment.

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Recommendations

We would encourage participating ED's to continue and improve on the 4 organisational data mentioned above. ED and Adult Psychiatric Liaison Services should have joint pathways which promote parallel assessment of patients with both physical and mental health needs. Terms such as "medically fit" or "medical clearance" should not be used to delay this.

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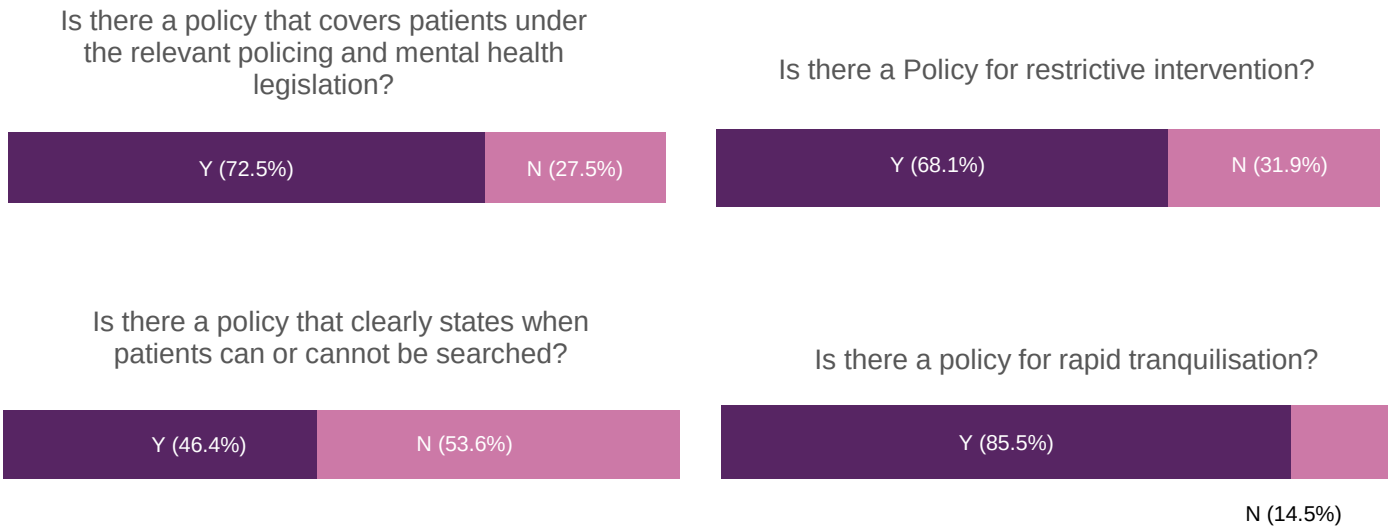
Policies to Support Mental Health Patients



N = 69

All complete ED submissions.

Exclusions

Any EDs who did not complete or partially completed their organisational submission.

Site Performance

ED Responses	Y	N
Does the ED have a policy for patients under the relevant policing and mental health legislation? *Including section 297 (Scotland), section 130 (Northern Ireland) or section 136 (England and Wales) to ensure safety, dignity, and timely management.*	50	19
Is there a policy in place which clearly states when patients can or cannot be searched?	32	37
Is there a Policy in place for restrictive intervention?	47	22
Is there a Policy in place for rapid tranquilisation?	59	10

Commentary

85.5% of ED's who had entered organisational data had a policy in place for rapid tranquilisation.

72.5% had a policy for patients under the relevant policing and mental health legislation. This is essential to ensure the safety, dignity, and timely management of these patients.

Only 46.4% of ED's had a policy in place which clearly stated when patients can or cannot be searched. 68.1% of ED's had a policy in place for restrictive intervention.

Recommendations

ED's should be used for patients brought in by police under relevant section, only if they have an acute healthcare need. Otherwise, it should be expected that mental health services should provide an assessment suite, or alternative space within the mental health unit, where these patients can be appropriately assessed.

RCEM agrees that police custody is not a suitable alternative. Systems should be in place for good handover if police where to bring patients to ED, not using a mental health legislative framework.

ED's should have a policy on restrictive and physical intervention. All episodes of physical intervention (restraint) should be monitored and inappropriate uses of restraint and / or rapid tranquilisation should be investigated, and outcomes shared.

Patients at risk of self-harm should be searched (with consent) to check for objects or medications that may be used for further self-harm. Searches which are for the clinical safety of the patient should be conducted by clinical staff rather than security guards.

We encourage participating ED's to review their organisational data and address any concerns. The data will be published again at the end of the 2-year period (final report).

Further Information

Thank you for taking part in this QIP. We hope that you find the process of participating and results helpful.

If you have any queries about the report, please e-mail RCEMQIP@rcem.ac.uk.

Details of the RCEM QIP Programme can be found on RCEM - Quality Improvement.

Give Your Feedback

We would like to know your views about this report and participating in this QIP. Please email RCEMQIP@rcem.ac.uk or complete our anonymous feedback form linked below.

RCEM QIPs - Your Thoughts and Feedback

We will use your comments to help us improve our future topics and reports.

Useful Resources

- Site-specific report – available to download from the QIP portal (registered users only)
- Online dashboard charts – available from the QIP portal (registered users only).
    - The dashboard remains open after the end of the national QIP so you can keep monitoring local performance and doing PDSA cycles.
- Local data file – available from the QIP portal (registered users only)
- RCEM Quality Improvement Guide – guidance on PDSA cycles and other quality improvement methods

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Appendices

Appendix 1: Glossary of terms and abbreviations

Term	Definition
Abscond	Leaving an ED or a clinical setting without informing staff
Adult Psychiatric Liaison Services	This term can vary across trust's and include adult psychiatric liaison nurse, mental health services or crisis liaison team. They are services within a trust responsible for reviewing the patient for a mental health assessment following ED management of the patient's physical needs
Capacity	"*The ability to use and understand information to make a decision, and communicate any decision made."* NHS - Assessing Capacity (December 2022)
Did not wait / self-discharged	Patient chose not to wait for review/treatment and made the decision to leave the Emergency Department
ED	Emergency Department
GP	General Practitioner
LCL	lower control limit
Mean	The average in a set of values
Parallel assessment / Side-by-Side care	Assessing and/or treating both a patients physical and mental needs at the same time where possible.
PDSA cycle	plan-do-study-act cycle
Pillars of quality in health care	(equity, efficiency, effectiveness, timeliness, patient-centred, safety)
QIP	Quality Improvement Programme
RCEM	Royal College of Emergency Medicine
Safeguarding concerns	A concern regarding the safety of a person or persons connected to them.
SPCC	Statistical process control chart
UCL	upper control limit

Appendix 2: National Breakdown of Participation

Nationally, 18684 cases from 137 EDs were included in this QIP.

Country	Number of relevant EDs	Number of cases *
National total	137	18684
England	123 (89.78%)	17491
Scotland	4 (2.92%)	390
Wales	7 (5.11%)	565
Northern Ireland	3 (2.19%)	238
Isle of Man / Channel Islands	0 (0%)	0
* Analysis includes complete cases only		

Data Excluded Post-Validation

The data used to create the charts in this report contains only the cases that have been submitted within the data entry period. The records submitted were also validated to ensure poor quality data was excluded to prevent distortion of the means and charts. Some of the cases submitted during the data collection period have been removed due to incomplete information and data entry errors that were not identified by the data entry system. This has been explained under the key findings section above.

Appendix 3: EDI Monitoring

Equality, Diversity, and Inclusion statement: We have integrated ethnicity data monitoring into our platform to form the start of a data set containing thousands of cases which can then be analysed to detect differences in care quality along sex, race, and age lines. We have representation from the EDI committee at our programme development meetings and attend theirs to update this body of work.

Without accurate data, establishing care disparities is more challenging, hampering efforts to target resources and find solutions in priority areas. We have nested these questions to establish the interhospital variability of ethnicity data recording and better understand the barriers to this data set. This exercise will take 15-20 minutes but provides a significant insight into this issue. Please encourage your team locally to input this data and show them how to find it to improve the collection process.

This data is only going to be used nationally however we do encourage local systems to better capture this data so insights and research can be undertaken in this important space.

Standard 1 - Percentage of patients who had a mental health triage.

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	113	76.11%	23.89%
Any Other Asian Background	171	78.36%	21.64%
Any Other Black Background	111	88.29%	11.71%
Any Other Ethnic Group	457	80.31%	19.69%
Any Other Mixed Background	110	67.27%	32.73%
Any Other White Background	620	76.13%	23.87%
Bangladeshi	50	94.00%	6.00%
Caribbean	87	75.86%	24.14%
Chinese	27	74.07%	25.93%
Indian	158	74.05%	25.95%
Mixed White and Asian	50	62.00%	38.00%
Mixed White and Black African	32	62.50%	37.50%
Mixed White and Black Caribbean	70	77.14%	22.86%
Not Known	3911	71.98%	28.02%
Pakistani	161	80.12%	19.88%

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Prefer Not to Say	138	68.12%	31.88%
White British	12293	75.02%	24.98%
White Irish	125	73.60%	26.40%

Standard 2 - Proportion of medium or high-risk patients who had an appropriate level of observation (Good evidence of continuous or intermittent observation, interaction, or care) during the period that they were considered to be high-risk/medium-risk.

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	36	16.67%	83.33%
Any Other Asian Background	53	32.08%	67.92%
Any Other Black Background	46	26.09%	73.91%
Any Other Ethnic Group	153	28.10%	71.90%
Any Other Mixed Background	36	22.22%	77.78%
Any Other White Background	204	25.98%	74.02%
Bangladeshi	19	31.58%	68.42%
Caribbean	20	25.00%	75.00%
Chinese	7	57.14%	42.86%
Indian	54	27.78%	72.22%
Mixed White and Asian	13	53.85%	46.15%
Mixed White and Black African	10	40.00%	60.00%
Mixed White and Black Caribbean	27	22.22%	77.78%
Not Known	1091	26.12%	73.88%
Pakistani	46	30.43%	69.57%
Prefer Not to Say	50	24.00%	76.00%
White British	3906	29.31%	70.69%
White Irish	35	34.29%	65.71%

Standard 3 - Proportion of patients who had a brief risk assessment by an ED clinician of suicide and further self- harm and met the standard (4 out of 4).

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	88	34.09%	65.91%
Any Other Asian Background	143	31.47%	68.53%
Any Other Black Background	95	31.58%	68.42%
Any Other Ethnic Group	369	33.60%	66.40%
Any Other Mixed Background	97	32.99%	67.01%
Any Other White Background	499	41.48%	58.52%
Bangladeshi	42	47.62%	52.38%
Caribbean	60	36.67%	63.33%
Chinese	18	22.22%	77.78%
Indian	136	37.50%	62.50%
Mixed White and Asian	40	35.00%	65.00%
Mixed White and Black African	26	46.15%	53.85%
Mixed White and Black Caribbean	56	39.29%	60.71%
Not Known	3165	41.93%	58.07%
Pakistani	117	30.77%	69.23%
Prefer Not to Say	116	38.79%	61.21%
White British	10134	44.31%	55.69%
White Irish	97	35.05%	64.95%

Appendix 4: Participating Emergency Departments

England

Addenbrooke's Hospital

Alexandra Hospital

Barnet Hospital

Barnsley Hospital

Basildon University Hospital

Bassetlaw Hospital

Bedford Hospital

Birmingham City Hospital

Blackpool Victoria Hospital

Bradford Royal Infirmary

Bristol Royal Infirmary

Broomfield Hospital

Calderdale Royal Hospital

Chorley and South Ribble Hospital

Colchester Hospital

Conquest Hospital

Countess of Chester Hospital

Cumberland Infirmary

Darent Valley Hospital

Diana, Princess of Wales Hospital

Ealing Hospital

Eastbourne District General Hospital

Fairfield General Hospital

Frimley Park Hospital

Furness General Hospital

George Eliot hospital

Good Hope Hospital

Heartlands Hospital

Hillingdon Hospital

Hinchingbrooke Hospital

Homerton University Hospital

Huddersfield Royal Infirmary

Hull Royal Infirmary

Ipswich Hospital

James Cook University Hospital

James Paget Hospital

Kettering General Hospital

King George Hospital

King's College Hospital (Denmark Hill)

King's Mill Hospital

Kingston Hospital

Leeds General Infirmary

Leighton Hospital

Lincoln County Hospital

Lister Hospital

Luton & Dunstable University Hospital

Macclesfield District General Hospital

Manchester Royal Infirmary

Medway Maritime Hospital

Milton Keynes University Hospital

Musgrove Park Hospital

Norfolk and Norwich University Hospital

North Devon District Hospital

North Manchester General Hospital

Northampton General Hospital

Northern General Hospital

Northumbria Specialist Emergency Care Hospital

Northwick Park Hospital

Peterborough City Hospital

Pilgrim Hospital

Princess Alexandra Hospital

Princess Royal Hospital - University Hospitals Sussex NHSFT

Princess Royal University Hospital - King's College Hospital NHSFT

Queen Alexandra Hospital

Queen Elizabeth Hospital - Gateshead Health NHSFT

Queen Elizabeth The Queen Mother Hospital

Queen's Hospital - Barking, Havering, and Redbridge University Hospitals NHS Trust

Queen's Medical Centre

Rotherham District General Hospital

Royal Berkshire Hospital

Royal Bolton Hospital

Royal Cornwall Hospital

Royal Derby Hospital

Royal Liverpool Hospital

Royal Preston Hospital

Royal Shrewsbury Hospital

Royal Surrey County Hospital

Royal Sussex County Hospital

Royal Victoria Infirmary

Russells Hall Hospital

Salford Royal

Salisbury District Hospital

Sandwell General Hospital

Scarborough Hospital

Scunthorpe General Hospital

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South Tyneside District Hospital

Southend University Hospital

Southport and Formby District General Hospital

St George's Hospital

St Helier Hospital

St James's University Hospital

St Mary's Hospital

St Peter's Hospital

Stepping Hill Hospital

Tameside General Hospital

The County Hospital - Wye Valley NHS Trust

The Maidstone Hospital

The Princess Royal Hospital - Shrewsbury and Telford Hospital NHST

The Queen Elizabeth Hospital - The Queen Elizabeth Hospital King's Lynn NHSFT

The Royal Free Hospital

The Royal Lancaster Infirmary

The Royal London Hospital

The Tunbridge Wells Hospital

Torbay Hospital

University Hospital Coventry - UH Coventry and Warwickshire NHST

University Hospital Lewisham

University Hospital of North Tees

Walsall Manor Hospital

Warwick Hospital

Watford General Hospital

West Cumberland Hospital

West Middlesex University Hospital

West Suffolk Hospital

Weston General Hospital

Wexham Park Hospital

Whiston Hospital

Whittington Hospital

William Harvey Hospital

Worcestershire Royal Hospital

Worthing Hospital

Wythenshawe Hospital

Yeovil District Hospital

York Hospital

Northern Ireland

Craigavon Area Hospital

Daisy Hill Hospital

Ulster Hospital

Scotland

Aberdeen Royal Infirmary

Queen Elizabeth University Hospital

Royal Alexandra Hospital

Wishaw General Hospital

Wales

Grange University Hospital

Glan Clwyd Hospital

Morriston Hospital

Prince Charles Hospital

Princess of Wales Hospital

Royal Glamorgan Hospital

Ysbyty Gwynedd

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Appendix 5: Understanding your IQR visualisation.

Inter-Quartile Range Visualisations

Although this report is focussing on the overall national picture, it was felt that it would be useful to show the range of performances for the individual sites involved in this Quality Improvement Programme.

These IQR visualisations provide a benchmarked view of how all sites compare to each other across the full time period. It is coloured to show the quartile range for the sites. The bottom 25% performing sites have been coloured red, the top 25% performing sites are green, with the remaining sites orange, (which means they performed within the inter-quartile range).

It is hoped these new views will help generate discussion within the individual sites QIP Team as it means that they will be able to benchmark their performance against all other sites.

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Appendix 6: Additional Methodology Context and Adaptions

Rationale

The Quality Improvement Programme (QIP) aimed to track the current performance in EDs against clinical standards in individual departments and nationally on a real time basis over a two-year period. The aim was for departments to be able to identify where standards were not being reached so they could do improvement work and monitor change in real time.

Mental Health (Self-Harm): Year 1

During the initial months of the QIP no specific time limits were set on data entry. This included the Statistical process control chart's (SPCC) on ''time to'' and specifically included time to mental health triage, time to ED clinician review after triage, time to Adult Psychiatric Liaison Service review in ED following referral and total time spent in ED before either discharged/admitted/transferred off site. This resulted in some poor-quality data entry that skewed the mean on the ''time to'' SPCC that had been created for the process measures. Individual patients were affecting data entry and included examples like several days / months entered for some of the ''time to'' data points. This defeated the objectives the QIP was designed for as these outliers were adversely affecting the mean on the SPC charts. It was in view of this time limits were subsequently set.

This included setting an upper limit of 24 hours for time to mental health triage, time to ED clinician review after triage and time to Adult Psychiatric Liaison Services review in ED following referral. The upper limit for data entry for total time spent in ED before either discharged/admitted/transferred off site was set at 7 days.

We do understand that there have been cases who have been outliers. This especially included patients who had stayed for more than 7 days in some ED's. We felt to have a meaningful data and SPCC, limits needed setting. Any data points outside these limits should be treated as special cause variation and best investigated locally. Once this was set and the few patients (out of 18,684) omitted, the data entry was more meaningful and reflected what were ground realities.

Note: Adult Psychiatric Liaison Services is the term used for QIP purpose. This term can vary across trust's and include adult psychiatric liaison nurse, mental health services or crisis liaison team. They would be the services within your trust responsible for reviewing the patient for a mental health assessment following ED management of the patient's physical needs (self-harm).

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