

A Picture of Health?

A review of the quality of physical healthcare provided to adult patients admitted to a mental health inpatient setting



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A review of the quality of physical healthcare provided to working age and older adult patients admitted to a mental health inpatient setting

A report published by the National Confidential Enquiry into Patient Outcome and Death (2022)

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Foreword

Firstly, I would like to thank our staff, the study advisory group and case reviewers, together with all the clinicians who have participated in this study, as well as the local reporters who have facilitated data collection. In doing so they have gone above and beyond during these unprecedented times of pandemic. It is a testament to the resilience, dedication and determination of all involved that we've been able to produce this report.

Some of the case studies presented here took me back to my days as a very junior doctor armed with only eight weeks' experience as a medical student in psychiatry. I can still recall how stressful and scary it was to be faced with patients with complex acute medical and mental health conditions. I can only imagine therefore, that it must be even more stressful for mental health professionals to be faced with complex medical problems which they have likely not encountered for years. The core training curricular for psychiatry does not focus heavily on the assessment of physical health conditions and the report clearly shows that staff working in mental health inpatient settings can rapidly become deskilled in basic medical tasks and physical healthcare. This theme came through strongly from the survey data and applied to consultants as well as junior and nursing staff.

There is a highly complex relationship between deterioration in mental health and physical health, which means that many patients will require considerable expertise to be managed appropriately. It appears that there is currently no consistent way of ensuring that patients or mental healthcare professionals can access that expertise. Whether the solution, as suggested by many participants is to have regular GP presence on inpatient mental health wards, or to strengthen the relationship, infrastructure and communication between mental and physical health organisations, may well depend upon the existing local set up and geography.

Methods of identifying acute deterioration such as NEWS2 and basic measurement of vital signs, could be done sufficiently frequently by all mental health ward staff, so that they can feel confident in knowing when to escalate and seek care from physical healthcare colleagues. However, issues were identified all too often at this most basic level. Surely, all staff should receive regular refresher training in these basics as part of their mandatory training requirements?

The lack of consistent organisational protocols, IT infrastructure such as electronic records and e-prescribing, compounds the issues. I find it remarkable that patients' physical health records cannot be accessed from mental health inpatient settings, in a time when anyone can access their own lifetime medical record through the NHS App.

This report paints an honest view of the physical healthcare available to many patients in mental health inpatient settings. While there are clearly pockets of excellence, all too often there was an obvious need for improvement in the care provided as well as the systems that support and underpin the provision of care. I hope therefore that this report will shine a spotlight on this issue and prompt a radical change in the way in which the physical healthcare needs of patients in mental health inpatient settings are met.



Ian C Martin, Chair

Key messages aimed to improve the care of people admitted to a mental health inpatient setting who are also physically unwell

MESSAGE 1. ASSESS PATIENTS FOR ACUTE PHYSICAL HEALTH CONDITIONS ON ARRIVAL AT A MENTAL HEALTH INPATIENT SETTING AND THEN UNDERTAKE A DETAILED PHYSICAL HEALTH ASSESSMENT ONCE THE PATIENT IS ADMITTED



Patients admitted for mental healthcare but who are also physically unwell need complex care. Patients may need a transfer to a physical health hospital for an acute condition, and/or they may have at least one long-term physical health condition that needs monitoring

A detailed physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients

Physical health conditions were not included in the initial clerking for 29/150 (19.3%) patients

MESSAGE 2. DEVELOP A PHYSICAL HEALTHCARE PLAN FOR PATIENTS ADMITTED TO A MENTAL HEALTH INPATIENT SETTING



The ongoing physical healthcare of patients should be monitored to prevent deterioration

A plan for physical health observations was not documented for 48/217 (22.1%) patients

No advice was given about who should be notified in the event of physical health concerns for 47/169 (27.8%) patients

Physical healthcare plans were formulated for only 155/291 (53.3%) patients

MESSAGE 3. FORMALISE CLINICAL NETWORKS/PATHWAYS BETWEEN MENTAL HEALTH & PHYSICAL HEALTHCARE



Mental healthcare staff need support in providing effective physical healthcare

127/268 (47.4%) mental healthcare professionals surveyed who reported feeling 'fairly'/'less than fairly' confident or competent in caring for patients with long-term conditions

Local care pathways or pre-existing arrangements with physical healthcare providers were used as part of the care plan for 71/291 (24.4%) patients

MESSAGE 4. INVOLVE PATIENTS AND THEIR CARERS/FRIENDS/FAMILY IN THEIR PHYSICAL HEALTHCARE AND USE THE ADMISSION AS AN OPPORTUNITY TO ASSESS, AND INVOLVE PATIENTS IN THEIR GENERAL HEALTH



Hospital admissions are an excellent opportunity to assess and help improve a patient's general physical health and including family/carers can be a great form of support

15/29 (51.7%) organisations with a physical health strategy had a specific commitment to improve communication about physical health with patients and carers

No record that the physical health review had been discussed with the patient's family/ carers in 100/188 (53.2%) sets of notes reviewed

MESSAGE 5. INCLUDE MENTAL HEALTH AND PHYSICAL HEALTH CONDITIONS ON ELECTRONIC PATIENT RECORDS



Effective electronic patient records for physical as well as mental health, that could be shared across providers, would improve patient safety and make communication easier

20/56 (35.7%) organisations reported that all elements of the clinical record were available in the electronic patient record

244/405 (60.2%) clinicians using the systems thought the electronic patient record allowed easy viewing/input of the patient's physical health needs

Executive summary

Method

Data from clinical and organisational questionnaires, case notes and surveys were reviewed to assess the care provided to patients aged 18 years and older who were admitted to a mental health inpatient setting for at least one week during 01/11/18 to 31/10/2019, and who:

- Had existing chronic obstructive pulmonary disease/asthma/cardiovascular disease/diabetes
- Had experienced a transfer to a physical health hospital
- Died in the mental health inpatient setting or within 30 days of discharge

Key messages

1. Assess patients for acute physical health conditions on arrival at a mental health inpatient setting and then undertake a detailed physical health assessment once the patient is admitted

Patients admitted for mental healthcare but who are also physically unwell need complex care. Patients may need a transfer to a physical health hospital for an acute condition, and/or they may have at least one long-term physical health condition that needs monitoring. Physical health conditions were not included in the initial clerking for 29/150 (19.3%) patients and a detailed physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients.

2. Develop a physical healthcare plan for patients admitted to a mental health inpatient setting

The ongoing physical healthcare of patients should be monitored to prevent deterioration. A plan for physical health observations was not documented for 48/217 (22.1%) patients and no advice was given about who should be notified in the event of physical health concerns for 47/169 (27.8%) patients. Physical healthcare plans were formulated for only 155/291 (53.3%) patients.

3. Formalise clinical networks/pathways between mental healthcare and physical healthcare

Mental healthcare staff need support in providing physical healthcare. There were 127/268 (47.4%) mental healthcare professionals surveyed who reported feeling 'fairly'/'less than fairly' confident or competent in caring for patients with long-term conditions and 216/317 (68.1%) thought there was scope for improvements in the hospital's networks with local physical healthcare providers. Local care pathways or pre-existing arrangements with physical healthcare providers were used as part of the care plan for 71/291 (24.4%) patients in this study.

4. Involve patients and their carers/friends/family in their physical healthcare and use the admission as an opportunity to assess, and involve patients in their general health

Hospital admissions are an excellent opportunity to assess and help improve a patient's general physical health and including family/carers can be a great form of support. There were 15/29 organisations with a physical health strategy that had a specific commitment to improve communication about physical health with patients and carers. However, there was no record that the findings of the physical health review had been discussed with the patient's family/carers in 100/188 (53.2%) sets of notes reviewed.

5. Include mental health and physical health conditions on electronic patient records and allow sharing across healthcare providers

Effective electronic patient records (EPR) for physical as well as mental health, should be shared across providers, to improve patient safety and make communication easier. While all organisations apart from one had some form of EPR system, only 20/56 reported that all elements of the clinical record were available on it and only 244/405 (60.2%) clinicians using the systems thought the EPR allowed easy viewing/input of the patient's physical health needs.

Recommendations

These recommendations have been formed by a consensus exercise involving all those listed in the acknowledgements. The recommendations have been independently edited by medical editors experienced in developing recommendations for healthcare audiences to act on.

The recommendations highlight areas that are suitable for regular local clinical audit and quality improvement initiatives by those providing care to this group of patients. The results of such work should be presented at quality or governance meetings and action plans to improve care should be shared with executive boards.

Executive boards are ultimately responsible for supporting the implementation of these recommendations. Suggested target audiences to action recommendations are listed in italics under each recommendation.

The term 'healthcare professionals' encompasses all those involved in the patient's care

1	<p>On arrival at a mental health inpatient setting, check if the patient faces any acute risks to their physical health, including physical health risks associated with rapid tranquilisation and take appropriate action.</p> <p>Target audience: <i>Mental healthcare professionals and receiving mental health ward medical and nursing staff</i></p>
2	<p>On admission to a mental health inpatient setting, carry out and record an initial physical health assessment on all patients. If the patient has the mental capacity to consent to undergo a physical health assessment but refuses, document this then and try again as soon as practicable.</p> <p>This should start within 4 hours* and include, but not limited to:</p> <ol style="list-style-type: none"> a. Baseline observations including blood pressure, heart rate and respiratory rate and temperature and oxygen saturation b. Details of existing physical health conditions and any acute changes since the last clinical review c. Current medication (physical and mental health) including side effects and adherence d. Whether the patient is at risk of withdrawal from drugs/alcohol e. Height, weight, relevant blood tests (use recent blood tests if appropriate) and an ECG f. Hydration status and a fluid balance plan g. Dietary status, with input from the nutrition team as necessary h. Review of physical health risks associated with rapid tranquilisation i. The frequency of repeat physical health observations, relevant to the patient's condition, using the National Early Warning Score (NEWS2) where appropriate <p><small>*This is in line with the Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2022)</small></p> <p>Target audience: <i>Mental healthcare professionals with support from allied health professionals</i></p>

RECOMMENDATIONS

3	<p>Within 24 hours of admission to a mental health inpatient setting, collaboratively develop and document a physical healthcare plan with every patient, based on their initial physical health assessment. Where applicable include:</p> <ol style="list-style-type: none"> a. The most appropriate healthcare location to treat the patient’s physical healthcare needs (e.g. mental health or physical health hospital) b. Monitoring and treatment plans, including: <ul style="list-style-type: none"> - how frequently to review the physical health risk assessment, recognising acute or chronic health conditions - how often to repeat physical health observations and whether to use early warning tools (National Early Warning Score (NEWS2)) - a nutrition plan c. The physical health support needed d. Escalation plans in the event of deterioration (linked to the NEWS2 score) or patient not consenting to be assessed, that include who to contact and when e. Identification of gaps in clinical history and a plan to address them <p>Target audience: <i>Mental healthcare professionals supported by physical healthcare professionals</i></p>
4	<p>Within 24 hours of admission to a mental health inpatient setting, pharmacy staff (in the mental health inpatient setting, and where involved, in the physical health hospital) should undertake a full medicines reconciliation, including all medications for physical as well as mental health.</p> <p><i>This is in line with NICE Quality Standard 120 (Medicines optimisation 2016) https://www.nice.org.uk/guidance/qs120</i></p> <p>Target audience: <i>Pharmacy staff in mental health inpatient settings and physical health hospitals</i></p>
5	<p>Develop and implement an organisational policy and protocol to ensure that patients in a mental health inpatient setting are properly assessed, and treated, for physical health conditions in a considerate and collaborative manner. This could be done by:</p> <ol style="list-style-type: none"> a. Formalising existing clinical networks or pathways for diagnosing or treating common acute conditions for example, infection or existing long-term conditions b. Training registered mental health nurses, healthcare assistants, or any other staff as appropriate to monitor and support the management of common long-term physical conditions, while ensuring their competencies are well defined and are kept up to date c. Collaborating with local physical health hospitals to develop a physical health liaison service <p>Target audience: <i>Mental health executive boards and physical health executive boards supported by commissioners</i></p>
6	<p>Develop and implement an organisational policy and protocol for the transfer to, and readmission from, a physical health hospital to a mental health inpatient setting. This should include:</p> <ol style="list-style-type: none"> a. A comprehensive clinical summary which includes, but is not limited to: <ul style="list-style-type: none"> - Physical and mental health condition(s) - Current physical and mental health care plans - Physical and mental health medications - Monitoring and escalation plans - A mental health capacity assessment and the status of mental health legislation (if applicable) <p style="text-align: right;">continued over</p>

RECOMMENDATIONS

	<p>b. Prompt treatment in the physical health hospital</p> <p>c. A plan for readmission to the mental health inpatient setting developed by the physical and mental healthcare teams working together. Include:</p> <ul style="list-style-type: none"> - The estimated date of discharge and return to the original mental health ward - The planning for physical healthcare provision that goes beyond what is available in the mental health inpatient setting <p>d. A record of transfers to a physical health hospital due to a deterioration in the physical health of a patient – this should be regularly audited for unexpected transfers</p> <p>Target audience: <i>Mental health executive boards and physical health executive boards supported by commissioners and all healthcare professionals</i></p>
7	<p>Develop and implement an organisational policy and protocol to involve patients, carers/friends/family in the patient’s physical healthcare. This could include:</p> <p>a. Enabling carers/family/friends to provide staff on the ward with information about the patient’s physical health</p> <p>b. Access to clear information on what general physical health assessments are carried out when a patient is admitted to the ward</p> <p>c. Access to:</p> <ul style="list-style-type: none"> - Healthy lifestyle advice - How family/friends/carers can support good physical health <p>d. Ensuring that with patient consent, patients and their carers/family/friends can:</p> <ul style="list-style-type: none"> - Receive updates on the patient’s physical health including transfers to physical healthcare settings - Ask questions about the patient’s physical health needs - Contribute to the development of and/or receive a copy of the patient’s physical healthcare plan - Receive clear information about any post-discharge follow-up physical health plans <p>Target audience: <i>Mental health executive boards and mental healthcare professionals, associated patient involvement groups</i></p>
8	<p>Use admissions to a mental health inpatient setting as an opportunity to assess and involve patients in their general health. A hospital policy, supporting training in a range of health improvement topics for staff who work directly with patients, could include:</p> <ol style="list-style-type: none"> a. Exercise b. Diet c. Smoking cessation d. Alcohol use e. Substance use f. Sexual and reproductive health g. Immunisation h. Routine NHS screening programmes <p>Target audience: <i>Mental health executive boards and physical health executive boards supported by commissioners</i></p>

RECOMMENDATIONS

9	<p>Offer support to patients admitted to a mental health inpatient setting who smoke tobacco, drink alcohol at harmful or dependent levels, or use other drugs. Use defined substance misuse pathways and where needed, include:</p> <ol style="list-style-type: none"> Assessment and screening tools Specialist advice Interventions and prescribed treatment (especially for dependence) Follow-up after discharge, supported by the local alcohol or drugs recovery services (local health authority commissioned services) <p><i>This is in line with Making Every Contact Count: https://www.makeeverycontactcount.co.uk/</i></p> <p>Target audience: <i>Mental healthcare professionals, local authorities and commissioners</i></p>
10	<p>Record the correct physical health diagnosis, ICD-10/SNOMED CT codes (or equivalent) in mental health clinical records and discharge summaries.</p> <p>Target audience: <i>Mental healthcare professionals, hospital coders</i></p>
11	<p>Ensure that electronic patient records in mental health inpatient settings:</p> <ul style="list-style-type: none"> - Have the functionality to record physical health conditions - Have the facility for tasks to be set to aid disease and treatment monitoring - Are accessible, to allow handover between clinical teams and across healthcare providers <p>Target audience: <i>Mental health executive boards, IT departments and providers of electronic patient record systems supported by NHS Digital, NHS Wales Informatics Service, Northern Ireland Statistics and Research Agency</i></p>
12	<p>Provide a discharge summary to the patient, their carer/s, GP and community mental health team within 24 hours of discharge. This should include:</p> <ul style="list-style-type: none"> - Mental and physical health diagnoses - All medications for mental and physical health, including who will provide them and the reason for any prescription changes - Follow-up arrangements with the community mental health team/GP - Mental health and physical health care plans - Any support needed to carry out the care plans <p>Target audience: <i>Mental healthcare professionals</i></p>

Introduction

The physical health disparities facing people living with mental health conditions are extremely well known. Records of this disparity for people living with schizophrenia date back to the 17th century.¹ Estimates of premature mortality range from 10 to 20 years in developed countries.² Despite both awareness of and efforts to close this gap, it continues to widen, illustrating the inequity facing people living with mental health conditions who have not benefitted equally from improvements in population health.^{3,4,5}

Over a decade ago this issue of inequality was described as, “a scandal that contravenes international conventions for the ‘right to health’”.⁶ An extensive body of literature, guidance, advocacy and policy recommendations have been made available to try and guide health service efforts to close this gap.^{7,8,9} However, policy focus has put particular emphasis on the delivery of screening and interventions across care settings to try and reduce the burden of cardiometabolic risks and disease in people living with conditions such as schizophrenia and bipolar affective disorder.^{4,5,10,11} Less attention has been paid to the premature mortality associated with substance use disorder, other mental health conditions (including personality disorder) and the synergistic risks of substance use on mental and physical health outcomes.^{12,13}

The majority of preventable deaths are due to chronic physical health conditions such as cardiometabolic and respiratory disease. Individuals living with mental health conditions are less likely to receive preventative care, a diagnosis of a long-term disease or, to receive treatment for an identified condition.¹⁴ These treatment inequities have been demonstrated across a wide range of physical health conditions, including: cancer, diabetes, arthritis and stroke, as well as for several surgical procedures.^{14,15,16} Together, this evidence suggests there are significant missed opportunities to identify and treat coexisting physical health conditions.

The focus of this report is the quality of physical healthcare delivered in mental health inpatient settings. Only a small percentage of patients experiencing mental health conditions receive inpatient care, however, those who do require it tend to have the most severe or complex of conditions. Furthermore, deterioration in mental health that precipitates admission to an inpatient unit is frequently accompanied by a deterioration in physical health.^{7,8}

The mental health inpatient setting provides an opportunity to serve as a valuable safety net to intervene in the physical health of a group of people who may otherwise be hard to reach and whom are not engaged with primary care.¹⁶ Patients admitted to a mental health inpatient setting tend to fall into three broad groups as far as physical health is concerned:

- Patients with a coexistent long-term physical health condition that has acutely deteriorated (for example due to missed medications) or an acute physical illness concurrent with a deterioration in their mental health. This group may need early diagnosis and treatment in an acute hospital
- Patients with known pre-existing long-term medical condition(s) that are currently well controlled. This group would benefit from review, monitoring, and optimisation of their physical healthcare
- Patients who have no known physical healthcare needs. For this group, admission to the mental health inpatient setting would be an opportunity for a physical health check to optimise primary prevention, close any diagnosis gaps and support improved knowledge about, and engagement in, physical healthcare

INTRODUCTION

Despite clear arguments to ensure that mental health inpatient units are resourced to provide safe, effective holistic mental and physical healthcare, the quality and comprehensiveness of physical health provision remains variable. Barriers to improvements are multifold: mental health nurse training does not provide them with the opportunity to develop and sustain core physical health competencies; clinical separation of psychiatry from other medical specialties can lead to rapid de-skilling of the medical workforce in psychiatry and structural barriers, including physical separation of mental health inpatient units from physical healthcare settings and a lack of access to basic equipment to assess and monitor physical health.

Understanding the current quality of provision and how it can be improved is critical to making a change in this area. This study was developed to try and address some of these issues and recommendations have been made to drive quality improvement initiatives for the care provided to future patients.

WHAT THE PATIENTS AND CARERS SAID

Data were collected using two surveys with parallel questions to seek the experiences of patients and carers on the quality of physical healthcare provided in the mental health inpatient setting.

The majority of people who had been a patient had a long-term health condition 54/64 (84.4%) and the quality of physical healthcare was rated as good by just 25% of both groups.

WHERE CARE WAS DESCRIBED AS GOOD

Care was described as holistic.

Regular and robust monitoring of physical health was undertaken.

There was good attention to health promotion.

Patients' physical healthcare needs had been taken seriously.

Patients had received prompt physical healthcare.

Patients were listened to.

Follow-up appointments were arranged when physical health needs had been identified.

Effort was made to treat pain and monitor the patient's response to treatment.

WHERE CARE WAS DESCRIBED AS LESS THAN GOOD

Patients and carers reported concerns about the well-being of staff. Some responses described features of 'burn out' in staff which seemed to leave them disconnected, disinterested, stressed and lacking in compassion.

There was too little patient and carer involvement in care planning and during ward rounds. Many patients were unclear on their rights to be included in discussions.

Patients noted having to repeatedly ask for help.

There was a lack of access to physical health medication or medical devices.

"Even after I was told a physical health nurse would assess me there was confusion from mental health nurses about whether I'd actually been referred to physical nurses, leading to further delay."

There were reported delays in assessment, diagnosis and treatment and a perceived lack of access to 'gold standard' treatments and expertise.

"I had chest infection, increasing breathlessness and feeling unwell but they just checked blood pressure daily nothing else relating to my problem."

SUGGESTED AREAS FOR IMPROVEMENT IN THE VIEW OF THE SURVEYED PATIENTS AND CARERS

ACCESS TO STAFF WITH RELEVANT EXPERTISE

"I think a physical health nurse in the hospital for all the wards or to work across the inpatient sites would be helpful"

"Mental health staff need to know how to recognise when someone is in pain, not faking it."

"In older admissions...years ago...there was a more holistic approach."

REDUCE VARIATION IN ATTITUDE AND KNOWLEDGE

"I am a person with feelings and just because I have some problems, it doesn't mean I can't understand what's going on in my body."

"Some staff were kind and tried their best but many of them made me feel like I was being difficult by asking for help".

"Staff were mostly too busy so mental not physical health was prioritised."

STRATEGIES TO PROMOTE AND SUPPORT HEALTHY EATING

"I received no advice on diet and this would have been very helpful as I find you over-eat all the wrong things when you are very unwell, which is made worse by the medication making you hungry. It is far too easy to eat lots of white toast & jam for instance - why not supply wholemeal bread instead."

"Provide healthy eating prompts on easy-to-read pictorial posters in the canteen? In normal life I eat a balanced diet but when I am mentally ill, I am governed by my impulses instead."

MORE ACCESS TO EXERCISE AND ACTIVITIES

"They had a personal trainer who was amazing. As someone who was kept on the ward for most of my admission due to risk, he brought boxing gloves and yoga mats to the ward. It was through that I found my love of exercise and realised the impact it had on both my physical and mental health."

"I enjoyed the fitness classes on the ward and, when I was well enough to go out, the yoga classes and walking group. They had the added benefit of being good for my mental health."

SUGGESTED AREAS FOR IMPROVEMENT IN THE VIEW OF THE SURVEYED MENTAL HEALTHCARE PROFESSIONALS

1 IMPROVE ACCESS TO TRAINING FOR NURSES TO BUILD AND SUSTAIN SKILLS IN PHYSICAL HEALTHCARE

"Mental health staff, like myself are provided with very little training relating to physical health. Working within an inpatient setting, I would find additional training very useful."

"General nursing training differs within each university when completing a Registered Mental Nursing degree and some universities offer no exposure to general nursing. I personally would undertake RGN training as a top up alongside my work as an RMN if this was available to me."

2 SUPPORT JUNIOR DOCTORS - MANY FELT THAT THEY HAD INADEQUATE TRAINING, EXPERIENCE AND/OR SUPPORT OF SENIOR STAFF OR A TRAINED NURSING WORKFORCE TO CARRY OUT MONITORING AND OTHER GENERAL TASKS

"Often as a junior doctor you can be relatively isolated, with limited support from the GP or hospital specialists for the management of chronic conditions"

"Most of my time as a trainee on the wards was spent caring for physical health issues with no senior supervision as the consultants did not have the knowledge to provide the support."

3 TO IMPROVE SERVICES, RELATIONSHIPS, COMMUNICATION AND CARE PATHWAYS THAT CROSS THE CARE SETTINGS, HELP ACUTE SECONDARY CARE STAFF UNDERSTAND THE LIMITATIONS OF PSYCHIATRIC INPATIENT CARE IN PROVIDING PHYSICAL HEALTHCARE.

"It is a struggle to obtain the appropriate advice and intervention for patients on the ward. The physical health services appear overwhelmed and simply don't want to agree to take on anymore."

"There need to be stronger structures in place to ensure physical health needs are identified, appropriately treated, and that this is done in the correct setting; there is poor awareness amongst our colleagues in medicine of the limitations of physical healthcare delivery on mental health wards. There needs to be better collaboration and cooperation between acute, community, primary and mental healthcare."

4 TRAINED AND QUALIFIED MEDICAL STAFF (NOT JUST UPSKILLED MENTAL HEALTH STAFF) ARE NEEDED TO PROVIDE SAFE CARE TO INPATIENTS WITH COMPLEX COMORBIDITIES.

"No MDT approach to physical care - all falls on junior doctors - expected to take on a level of responsibility for physical healthcare that is inappropriate and would usually be informed by GPs/district nurses etc. in any other community setting."

"There should be a GP contracted to run a clinic for every mental health ward. Telephone advice is not sufficient and there is a large cohort of long-term mental health patients who have been completely excluded from the primary care system by long hospitalisation with no provision for GP review i.e., GP actually attending the ward. SHO grade doctors are no substitute for a fully qualified GP, a fact readily observable in GP practices which cannot use them as such. Although I am competent to manage acutely unwell patients, I lack, and cannot obtain the level of expertise needed."

5 NEW PATHWAYS UNDERPINNED BY TRAINING, SECONDMENTS, SUPERVISION OR SHADOWING WOULD IMPROVE THE CARE DELIVERED

"More training is needed around wound care, venous thromboembolism, cardiometabolic issues, sexual and oral health. I have also suggested that cardiac arrest drills may be helpful, as in previous jobs this has highlighted any areas where staff needed extra support or training."

"I suggest the Trust support a 3-day face to face/virtual for theory parts physical health training for mental health nurses at band 5 and above. This could include medical devices training, diabetes, basic wound care, stroke, COVID-19, falls, cancer and catheter care to build confidence and make the role of physical health champions more meaningful."

6 INITIATIVES TO IMPROVE PHYSICAL HEALTHCARE PROVISION IN MENTAL HEALTH INPATIENT SETTINGS SHOULD BE IMPLEMENTED WITH ORGANISATIONAL COMMITMENT, INFRASTRUCTURE AND INVESTMENT

"It is incredibly difficult to be a specialist in psychiatry and keep up to date with psychiatry practice AND to keep up to date with physical healthcare. We need appropriate input for our inpatient and community teams for physical health, as we are failing our patients without this."

"Very poor communication and no systems in place that I am aware of that link us to a physical health hospital. Schemes have been started in the past to improve this, but then phase out"

Method

Study Advisory Group

A multidisciplinary group of clinicians specialising in mental and physical health was convened to define the objectives of the study and advise on the key questions. The Study Advisory Group (SAG) comprised healthcare professionals in psychiatry, older adult psychiatry, mental health nursing, emergency medicine, acute/general medicine, general nursing, surgery, alongside lay, patient/service user and carer representatives. This group steered the study from design to completion and commented on the report recommendations.

Study aim

To identify and explore remediable factors in the clinical and organisation of the physical healthcare provided to adult patients admitted to a mental health inpatient setting.

Objectives

The SAG identified specific objectives that would address the aim of the study:

- Access to physical healthcare within the inpatient mental health setting
- Identification, assessment, treatment and monitoring of patients with (or at risk of developing) physical health conditions, including withdrawal from substance use
- Evidence of inappropriate or delayed interventions and/or escalation of care to another specialty or physical healthcare setting
- Prescribing and monitoring of medication including reconciliation in the event of transfers between care settings and at point of discharge
- Care planning with community, primary and secondary care for safe discharge and arrangement of follow-up for identified physical health needs
- Support for patient and carer involvement in care-planning, health education and self-management

- Communication and sharing of relevant information, including physical health history, care plans and medication records
- Evidence of any missed opportunities to intervene in patients at risk of developing a long-term physical health condition
- Training, competencies and the confidence of healthcare professionals in the delivery of physical healthcare for those who are at risk of or have a known physical health condition/s
- Appropriate application of the Mental Capacity Act (2005) in decisions and actions taken in relation to the physical healthcare, needs or risks of the patient
- Assessment of the provision of organisational structures, services and the policies in place to facilitate the delivery of physical healthcare to meet the needs of this group of patients

Study population and sampling criteria

Inclusion criteria

Adults aged 18 years and older who were admitted to a mental health inpatient setting for a period of more than one week during the study period of 1st November 2018 to 31st October 2019, and who had one or more of the following concomitant physical health conditions* recorded on discharge from the mental health facility:

- Chronic obstructive pulmonary disease/asthma
- Cardiovascular disease
- Diabetes

OR: The physical health condition of the patient necessitated an acute transfer to a physical health hospital for assessment/treatment/stabilisation

OR: The patient died in the mental health inpatient setting or within 30 days of discharge from the mental health inpatient setting

*Physical health condition refers to pre-existing or newly identified health conditions requiring ongoing assessment/treatment.

Exclusion criteria

- Suicides, homicides and self-harm related deaths as this group of patients is covered by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
- Patients in hospitals who were part of tertiary commissioned services – these encompassed patients with dementia, other organic brain injury or learning disability not in conjunction with any other mental health condition

Sampling criteria

A maximum of four patients were selected from each participating hospital based on predefined groups of age, whether or not a transfer to a physical health hospital had occurred and outcome (discharged alive/or died).

Hospital participation

All NHS, independent or not-for-profit inpatient mental health inpatient settings in the UK, where patients received healthcare for a time limited period for a primary mental health disorder with expectation of discharge to an alternative setting were invited to provide data for the study. This excluded:

- Specialist services but not secure/forensic settings or inpatient services for deaf people
- Other tertiary mental health commissioned services including eating disorders, neuropsychiatry, brain injury rehabilitation units, dedicated learning disability, mother and baby units and tier 4 personality disorder inpatient settings
- Long-term care facilities including residential care homes and nursing homes
- Home-treatment periods of care that did not involve an admission to an inpatient setting over the episode of care
- Crisis houses

In addition, local contacts in secondary acute physical health NHS hospitals were asked to identify patients who had been transferred from a mental health inpatient setting to a physical health ward during the study period and these were matched with the patients identified in mental health inpatient settings.

Data collection – peer review**Spreadsheet**

A pre-set spreadsheet was provided to every local reporter to identify all patients meeting the study criteria during the study time period. From this initial cohort the sampling for inclusion in the study took place.

Questionnaires

Three questionnaires were used to collect data for this study.

Clinician questionnaire

This questionnaire was sent electronically to the named consultant psychiatrist responsible for the care of the patient throughout the hospital admission.

Organisational questionnaire – trust/health board level

This questionnaire was disseminated to each mental health trust/local health board, health and social care trust and independent mental healthcare provider identified as meeting the criteria to participate.

Organisational questionnaire – hospital level

This questionnaire was disseminated to each inpatient unit with patients in the study to focus questions on aspects of service provision that may have varied within the organisation.

Case notes

Copies of case note extracts were requested for each case in the study sample for peer review. These included:

- Clinical annotations of the general mental health record including all medical, nursing and allied health professional notes and specific physical health sections such as physical health assessments, physical health risk assessments, proformas and care plans
- Test results such as bloods/echocardiogram/imaging
- Drug/fluid charts
- Physical health observations such as the National Early Warning Score (NEWS2)
- Transfer documentation/readmission notes
- Discharge summary from physical health and mental health inpatient settings

Peer review of the case notes and questionnaires

A multidisciplinary group of case reviewers was recruited to peer review the case notes. The group of case reviewers comprised consultants and healthcare professionals in psychiatry, older adult psychiatry, mental health nursing, emergency medicine, acute/general medicine, general nursing and surgery.

Case notes were anonymised by the non-clinical staff at NCEPOD. All patient identifiers were removed. Neither the clinical co-ordinators at NCEPOD, nor the case reviewers had access to patient identifiable information.

After being anonymised, each case was reviewed by at least one reviewer within a multidisciplinary Microsoft Teams® meeting. Cases were reviewed in the first 13 meetings by a 'buddy-pair' comprising one mental health and physical health clinician. For the remaining meetings the reviewers were content to review cases individually, seeking advice if needed.

At regular intervals throughout the meeting the meeting chair allowed a period for each case to be summarised and discussed and opinions sought from other reviewers present at the meeting. This process identified themes and highlighted potential case studies to be included in this report.

Case reviewers were also asked to grade the overall care each patient received according to the following scale:

Good practice: A standard that you would accept from yourself, your trainees and your institution

Room for improvement: Aspects of **clinical** care that could have been better

Room for improvement: Aspects of **organisational** care that could have been better

Room for improvement: Aspects of both **clinical and organisational** care that could have been better

Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution

Insufficient data: Insufficient information submitted to NCEPOD to assess the quality of care

Data collection – mental healthcare professional survey

This open-access anonymous survey was used to collect data on the views of healthcare professionals working in mental health regarding their own confidence and competencies in delivering physical healthcare in an inpatient mental health setting. It was developed with input from relevant groups to reflect the target audience and the survey link was sent to a wide group of stakeholders to disseminate via local and national professional networks.

Data collection – patient and carer surveys

Two open-access anonymous surveys designed with input from the study advisory group and a patient and carer advisory group to provide data on the care patients and their carers/families received during an inpatient admission to a mental health inpatient setting. Links to these surveys were disseminated to a wide group of stakeholders via local patient and public involvement groups, and national service user and carer networks and promoted via social media.

Information governance

All data received and handled by NCEPOD comply with all relevant national requirements, including the General Data Protection Regulation 2016 (Z5442652), Section 251 of the NHS Act 2006 (PIAG 4-08(b)/2003, App No 007) and the Code of Practice on Confidential Information.

Each patient was given a unique NCEPOD number. All electronic questionnaires were submitted through a dedicated online application. Prior to any analysis taking place, the data were cleaned to ensure that there were no duplicate records and that erroneous data had not been entered. Any fields that contained data that could not be validated were removed.

Data analysis

Following cleaning of the quantitative data, descriptive data summaries were produced. Qualitative data collected from the case reviewers' opinions and free text answers in the clinician questionnaires were coded, where applicable, according to content to allow quantitative analysis.

Data analysis rules

- Small numbers have been suppressed if they risked identifying an individual
- Any percentage under 1% has been presented in the report as <1%
- Percentages were not calculated if the denominator was less than 100 except for occasional comparison of percentage across a group, where it helped clarify the findings

- Anonymised case studies have been used to illustrate particular themes
- There is variation in the denominator for different data sources and for each individual question within the mental healthcare profession and patient/carer surveys
- All trusts/health boards have been referred to throughout the report as organisations

The findings of the report were reviewed by the SAG, case reviewers, NCEPOD Steering Group including clinical co-ordinators, trustees and lay representatives prior to publication. In addition, the recommendations were independently edited, and the report proofread, by two external proof readers.

Data returned and demographics

Figure 2.1 shows the organisational participation and the clinical, as well as survey data returned.

An organisational questionnaire was received from 56 mental health organisations. Hospital level questionnaires were returned from 224 hospitals which were part of 56 organisations, the majority (182/224; 81.3%) were NHS mental health inpatient settings with or without specialised commissioned units. Thirteen were NHS physical health hospitals with specialist mental health wards.

The impact of the COVID-19 pandemic on the data collection must be acknowledged. However, while the pandemic impacted on the process of returning data to NCEPOD (data collection was delayed by approximately eight months) it did not impact on the quality of data

received. While the sample included was slightly smaller than originally planned, it was large enough to make this a viable report. For this reason, an active decision was made to minimise any risk of additional burden on the clinical community, or to delay publication of the report any longer than necessary by repeatedly chasing additional data to be returned.

Demographics

The total study population of 11,557 patients had a mean age of 57.4 years and mode of 72 years. The older age group reflected in this population and the sample selected for review highlights the importance of providing a collaborative approach to physical healthcare for those likely to have the most comorbidities.

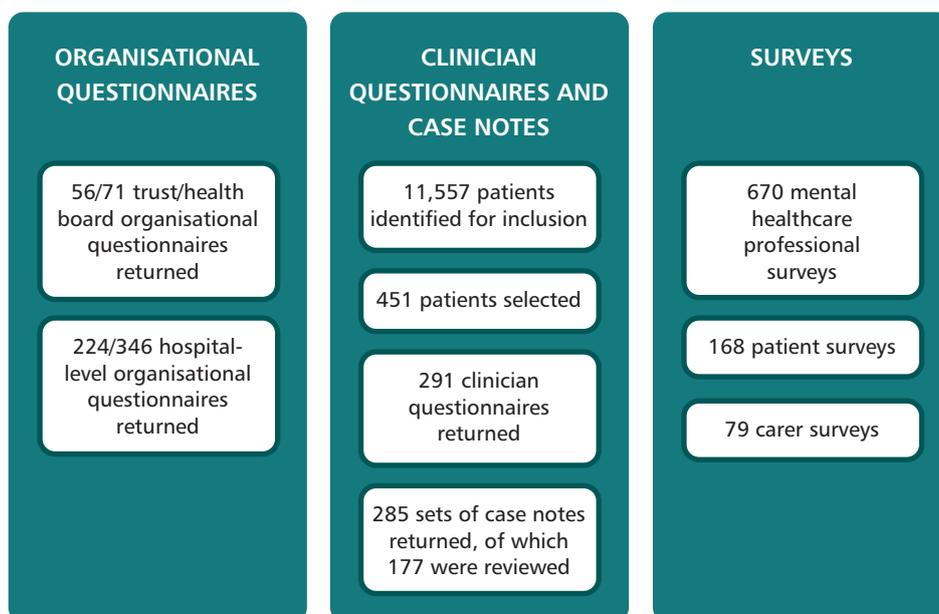


Figure 2.1 Participation and data returned

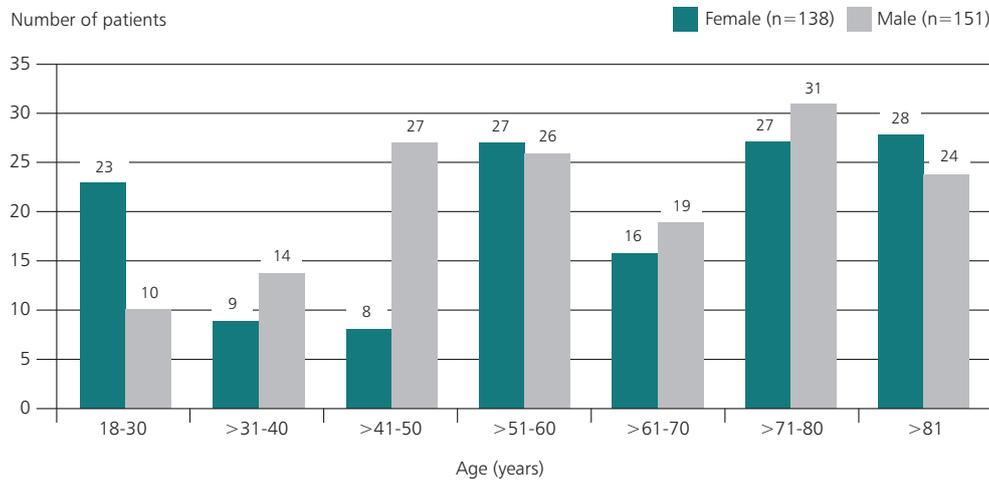


Figure 2.2 Age and gender of the study sample population
Clinician questionnaire data

The sample selected for detailed review comprised 138/291 (47.4%) female and 151/291 (51.9%) male patients whose age ranged from 19 to 96 years with a mean age of 61.6 years (Figure 2.2).

Details of patient ethnicity were available for 284/291 (97.6%) patients, with the majority 255/284 (89.8%) identifying as ‘White British’ or ‘White other’ (Table 2.1). This proportion is the same as in the initial dataset of 11,557 patients and also reflected in the UK population as a whole.¹⁷

Table 2.1 Ethnicity of patients in the study sample

	Number of patients	%
White British/White other	255	89.8
Asian/Asian British	13	4.6
Black/African/Caribbean/Black British	9	3.2
Mixed/multiple ethnic groups	7	2.5
Subtotal	284	
Not answered	7	
Total	291	

Clinician questionnaire data

Admission

Figure 3.1 shows the reason for the mental health admission. While some admissions were for more than one reason, the most common reason for admission was an increased risk to self or others (194/291; 66.7%)

followed by an acute deterioration of a known affective or psychotic condition. Other reasons for admission included optimisation of and suspected side effects of medications.

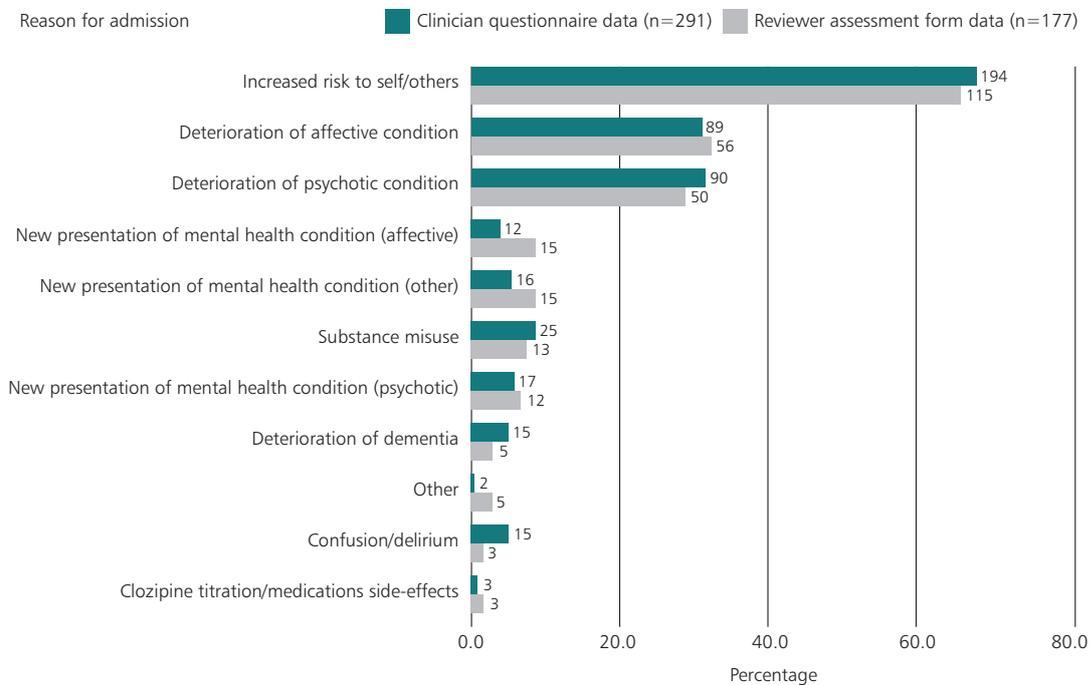


Figure 3.1 Primary reason for admission
Case reviewer data and clinician questionnaire data

Table 3.1 The patient was detained under the Mental Health Act (1983) (or equivalent) or subject to recall under a community treatment order for this admission

	Number of patients	%
Yes	191	65.6
No	100	34.4
Total	291	

Clinician questionnaire data

While some mental health patients voluntarily agree for admission to hospital others may require detention under the Mental Health Act (1983) (or its equivalent) or recall under a community treatment order. Detention under the Mental Health Act (1983) (or equivalent) was made in 191/291 (65.6%) admissions (Table 3.1). This included 22 admissions under Section 136, the hospital being the initial place of safety.

A recent public health survey found that people with a physical health and mental health condition were up to four times more likely to attend an emergency department than the general population.¹⁸ Table 3.2 shows that transfers from the emergency department or general wards of a physical health hospital formed 103/291 (35.4%) admissions while the patient's usual place of residence was the location prior to admission for 111/291 (38.1%) patients. It should be noted that the selection criteria for this study were biased towards selecting those with associated physical health conditions, which is reflected in the number of patients who were either in an acute hospital or an assisted living facility.

Table 3.2 Location the patient was admitted from

	Number of patients	%
Usual place of residence	111	38.1
Other NHS hospital	103	35.4
Residential home/continuing care home/nursing home	34	11.7
Mental health inpatient unit	16	5.5
Prison/court/police station	10	3.4
Temporary place of residence	8	2.1
Other	6	1.7
Place of safety	3	1.0
Total	291	

Clinician questionnaire data

Table 3.3 shows that of the 268/291 patients in this study with complete data on the time and date of admission, 169/268 (63.1%) were admitted outside 'normal working hours'.

Table 3.3 Time and day of admission

	Number of patients	%
Monday-Friday: working hours (08:00-17:59)	99	36.9
Weekend/out of hours (18:00-07:59)	169	63.1
Subtotal	268	
Missing data	23	
Total	291	

Clinician questionnaire data

The initial assessment at the time of admission to any hospital should involve a detailed physical and mental health history and clinical examination. This assessment also establishes a baseline for future comparison and helps in gauging the patient's response to treatment. Case reviewers found that for the 150/177 cases where there was sufficient data to answer, physical health conditions were not included in the initial medical clerking for 29/150 (19.3%) patients (Table 3.4).

Table 3.4 All physical health conditions for this patient were recorded on admission

	Number of patients	%
Yes	121	80.7
No	29	19.3
Subtotal	150	
Insufficient data to answer	27	
Total	177	

Case reviewer data

Figure 3.2 overleaf shows the physical health conditions recorded in this study at the time of admission to hospital. In total, two or more physical health conditions were recorded in 201/291 (69.1%) patients, with cardiovascular (111/291; 38.1%), respiratory (96/291; 33.0%), diabetes mellitus (Type 1 or 2; 100/291; 34.4%), hypertension (82/291; 28.2%) and neurological conditions (30/291; 10.3%) being the top five physical health conditions. These common and comorbid conditions were in line with the most recent 'Health Survey for England' (2018) report.¹⁹ It was also reported that 36% of the general population were overweight, having a body mass index (BMI) of 25-30 and 28% were obese with a BMI of 30 or over.¹⁹

Cardiovascular conditions were more frequently seen in patients older than 65 years (>65 years: 89/111; 80.2%; ≤65 years: 22/111; 19.8%). The early occurrence of lung disease (≤65 years: 55/96; 57.3%) and diabetes (type 1 or 2; ≤65 years: 54/100; 54%) would correlate with prevalence of smoking and metabolic derangements reported in other studies.

Physical health condition – Answers may be multiple; n=291

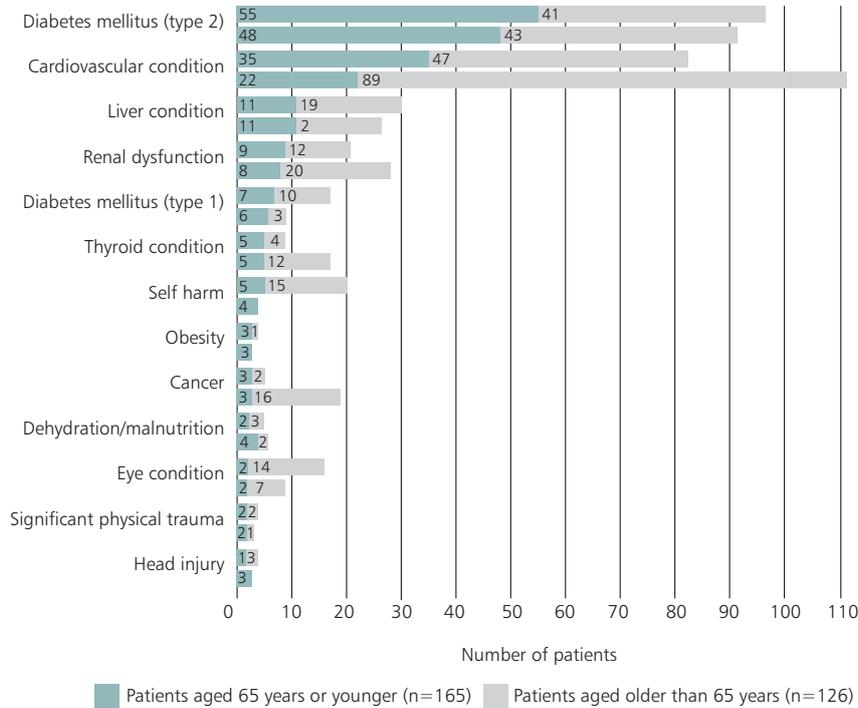


Figure 3.2 Physical health conditions by age (≤ and > than 65 years)
Clinician questionnaire data

Mental capacity

An important principle of mental capacity assessment is that a person must be assumed to have mental capacity unless it is established that they do not. Assessment of mental capacity to consent for care and treatment in hospital should be performed in line with current local legislation and as set out in the Royal College of Psychiatrists’ *Standards for Inpatient Mental Health Services* (2019).²⁰

In this study, 43/56 organisations had a policy that all patients should be assessed for their capacity to consent to physical examination and physical healthcare on admission. Clinician

questionnaire data reported that for 223/291 patients where it was possible to answer, 184/223 (82.5%) patients had their mental capacity to consent assessed at the time of admission. It was not assessed at this time for 39/223 (17.5%) patients.

Where mental capacity was assessed, 104/184 (56.5%) patients were found to have mental capacity and 74/184 (40.2%) were assessed not to have capacity. Case reviewers found that 158/177 (89.3%) patients underwent an assessment of their capacity to consent and were of the opinion that mental capacity was not appropriately assessed for 52/158 (32.9%) patients and the assessment was not timely for 28/158 (17.7%) patients.

	KEY FINDINGS	Data source
1	191/291 (65.6%) patients were detained under the Mental Health Act (1983) (or equivalent)	CQ
2	103/291 (35.4%) patients were transferred from the emergency department or general wards of a physical health hospital	CQ
3	169/268 (63.1%) patients were admitted outside 'normal working hours'	CQ
4	Physical health conditions were not included in the initial medical clerking for 29/150 (19.3%) patients	CR
5	201/291 (69.1%) patients had two or more physical health conditions	CQ
6	43/56 organisations had a policy that all patients should be assessed for their capacity to consent to physical examination and physical healthcare on admission	OQ
7	39/223 (17.5%) patients did not have their capacity to consent assessed at admission	CQ
8	Mental capacity was not appropriately assessed for 52/158 (32.9%) patients and the assessment was not timely for 28/158 (17.7%) patients	CR

Initial assessment

The Royal College of Psychiatrists' *'Standards for Inpatient Mental Health Services'* (2019) requires a physical health review to be started within four hours of admission, or as soon as is practicably possible, and completed within one week, or prior to discharge.²⁰ In this study, 33/291 (11.3%) patients did not have an initial physical health assessment at the time of admission to hospital. The reasons were either because the patient was not co-operative (27/33) or unable to give consent (4/33). In 7/33 of patients, a decision not to examine was made either because they were recently transferred from a physical health hospital or an imminent transfer to an acute hospital was planned.

Of the 252 patients who did undergo an initial assessment of physical health, this was completed in the first four hours for 147/252 (58.3%) patients and over 24 hours for 14/252 (5.6%) patients (Table 4.1).

Table 4.1 Timing of the physical health assessment following admission

	Number of patients	%
≤1 hour	39	15.5
>1 hour and ≤4 hours	108	42.9
>4 hours and ≤6 hours	29	11.5
>6 hours and ≤12 hours	24	9.5
>12 hours and ≤24 hours	38	15.1
>24 hours	14	5.6
Total	252	

Clinician questionnaire data

As mentioned in Chapter 3, 169/268 (missing data in 23; 63.1%) patients were admitted outside 'normal working hours'. Table 4.2 shows that the clinician undertaking the initial examination was the out of hours doctor in 123/252 (48.8%) cases. A mental health nurse was involved in the initial examination of 76/252 (30.2%) patients and was the only clinician examining the patient for 10/252 (4.0%) patients.

Table 4.2 Healthcare professional who carried out the initial physical health assessment

	Number of patients	%
Out of hours (on-call) doctor	123	48.8
Other doctor	119	47.2
Mental health nurse	76	30.2
Consultant psychiatrist (or other equivalent doctor)	6	2.4
Pharmacist	3	1.2
Healthcare assistant	2	<1
Allied health professional	2	<1
Out of hours (on-call) nurse	2	<1

Answers may be multiple; n=252

Clinician questionnaire data

CASE STUDY 1 –

Delay in undertaking a physical health assessment

A 54-year-old patient was admitted late in the evening with a history of bipolar affective disorder, diabetes mellitus and hypertension. An initial assessment was not completed until the next morning by the junior doctor on-call. Until that point, neither blood pressure nor blood glucose levels were checked, and diabetes medications were not given. By the time the patient was assessed they were drowsy and dehydrated, requiring transfer to the local physical health hospital.

Case reviewers were of the opinion that timely assessment and administration of medications would have prevented the complications occurring and the need for a hospital transfer.

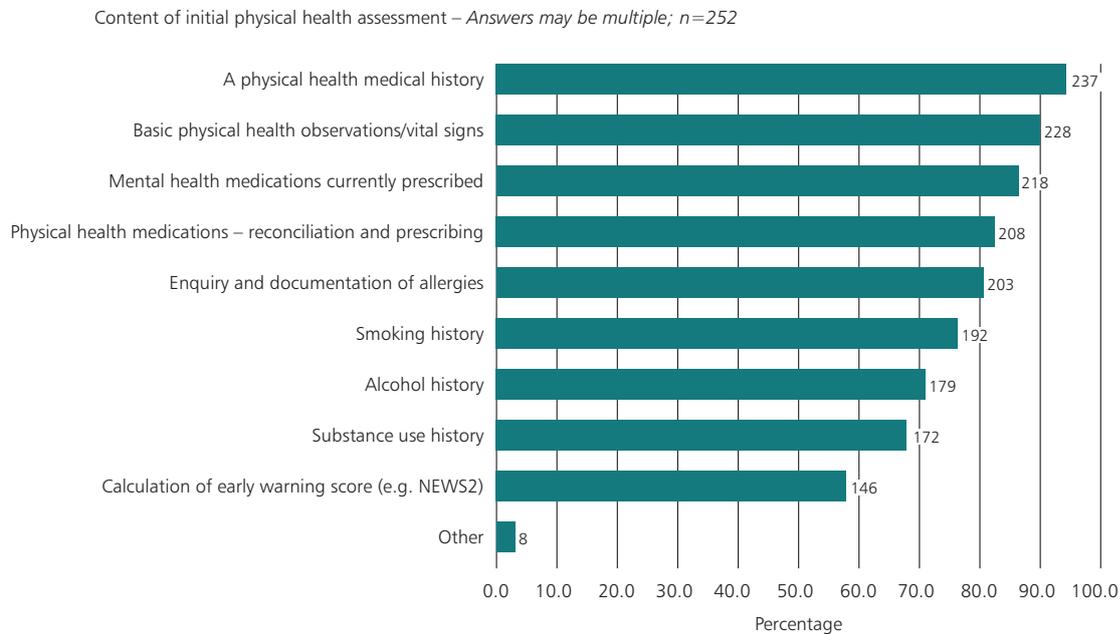


Figure 4.1 Content of initial physical health assessment

Clinician questionnaire data

The higher prevalence of smoking, alcohol and substance use in this group of patients means it is important that details of these form part of the initial assessment. History of smoking was taken for 192/252 (76.2%) patients, alcohol for 179/252 (71.0%) and substance use for 172/252 (68.3%) patients.

A basic set of observations were noted for 228/252 (90.5%) patients and an early warning score (or equivalent) documented for 146/252 (57.9%) patients (Figure 4.2). Case reviewers found the most common reason for not recording observations was refusal by the patient. Physical health and mental health medications were documented for 208/252 (82.5%) and 218/252 (86.5%) patients respectively.

Figure 4.2 overleaf highlights the physical health observations undertaken. Blood pressure and heart rate were recorded for 220/228 (96.5%) patients, respiratory rate for 204/228 (89.5%) and oxygen saturation for 202/228 (88.6%) patients.

Blood glucose was tested in only 111/228 (48.7%) patients, yet it is known that people with serious mental illness, such as schizophrenia and bipolar disorder, are twice as likely to develop diabetes mellitus and have poorer outcomes due to it and a larger group have hyperglycaemia, insulin resistance and other features of metabolic syndrome. A baseline blood glucose measurement at the time of admission is therefore very useful.

Case reviewers found that an initial assessment was undertaken for 126/177 (71.2%) patients. They believed that the initial physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients. The main reasons for rating the assessment as 'inappropriate', were delays in assessment (8/28), incomplete physical health observations and incomplete or inappropriate documentation of them (15/28). Case reviewers were of the opinion that clinical outcome was adversely affected for four patients.

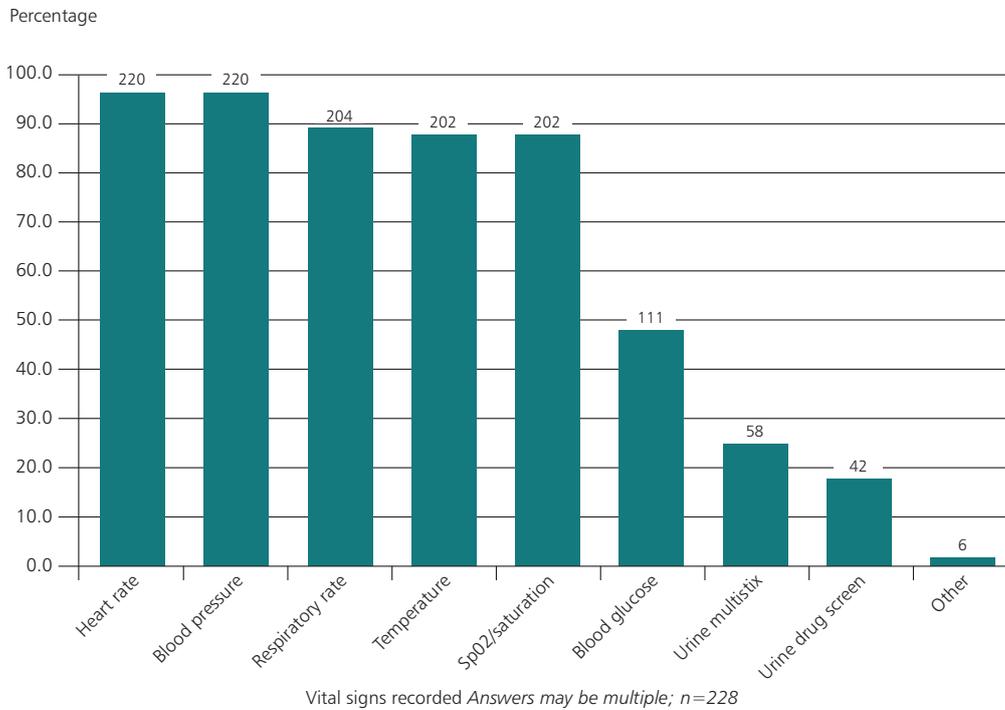


Figure 4.2 Physical health observations undertaken
Clinician questionnaire data

The Royal College of Psychiatrists' *'Standards for Inpatient Mental Health Services'* (2019) recommend that in the first 12 hours of admission, patients should have a risk assessment considering the risk to themselves, risk to others and risk from others.²⁰ However, there is no similar recommendations on the assessment of short-term physical health risks, which may guide plans for physical health monitoring and escalation of care for mental health inpatients. Resources include the QRISK²¹ and Lester tools¹⁰ for the assessment of long-term physical health risk, and early warning scoring systems such as the National Early Warning Score (NEWS2)²² are used in acute hospitals to identify physical health deterioration and trigger escalation of care. Some mental health inpatient settings have also started using such tools (see Chapter 9).

The NEWS2, and similar tools also provide guidance on the frequency of clinical observations. However, not all patients in a mental health ward require regular physical

health observations making it difficult to decide how often they should be made. Therefore, deteriorating physical health could be missed or identified too late even when NEWS2 scoring was available but was not being monitored with appropriate regularity. Table 4.3 shows that where it could be determined (217/252) a plan for physical health observations was not recorded for 48/217 (22.1%) patients.

Table 4.3 A plan for monitoring physical health observations was put in place at the time of the initial physical health assessment

	Number of patients	%
Yes	169	77.9
No	48	22.1
Subtotal	217	
Unknown	35	
Total	252	

Clinician questionnaire data

Case reviewers found that plans for monitoring physical health observations were documented at the time of the physical health assessment in 104/153 (68.0%) patients with insufficient data to answer in 24. They found that these plans were timely in 96/104 (92.3%) cases reviewed, and of appropriate frequency for 83/104 (79.8%) patients.

Clinician questionnaire data showed that for the 169/252 patients for whom a monitoring plan was made, observations were planned for every 1-6 hours for 41/169 (24.3%) patients, suggesting acute physical health concerns. A further 32/169 (18.9%) patients required 6-12 hourly observations, and the remaining patients required less frequent observations.

Every plan for physical health monitoring should also document the triggers for escalation and to whom to escalate concerns. Data from the clinician questionnaires showed that no advice was given about who should be notified in the event of physical health concerns for 47/169 (27.8%) patients.

Case reviewers reported that clinical outcome was adversely affected for six patients due to lack of clearly documented advice on escalation of concerns. Furthermore, the organisational data showed that 14/56 organisations did not have a protocol for responding to patients who refuse physical health observations. A specific template or care plan to manage such a situation was also not available in 22/56 organisations.

Rapid tranquilisation

Effective management of patient-related violence and aggression requires early identification, prevention, and de-escalation. If these measures fail, patients require seclusion, physical restraint, or rapid tranquilisation. Rapid tranquilisation can be achieved by the use of medications given intramuscularly or intravenously. Each of these interventions carries a risk of complications, especially if the patient has an underlying physical health condition, for example some drugs can cause cardiac arrhythmias in someone with heart disease. NICE guideline NG10 '*Violence and aggression: short-term management in mental health, health and community settings*' recommends that each

patient requiring rapid tranquilisation should have a personalised plan and pharmaceutical strategy.²³

Table 4.4 shows that physical health conditions that could impact patient safety in the case of rapid tranquilisation were documented for 134/270 (49.6%) patients (not answered in 21). This included evidence of respiratory disorders in 60/134 (44.8%) patients and cardiac conditions in 71/134 (53.0%).

Table 4.4 Documented physical health conditions that could have impacted patient safety in the case of rapid tranquilisation

	Number of patients	%
Yes	134	49.6
No	136	50.4
Subtotal	270	
Not answered	21	
Total	291	

Clinician questionnaire data

Clinician questionnaire data highlighted that such information was not shared for 66/134 (49.3%) patients, often because they considered that rapid tranquilisation was not anticipated for that patient or in that situation (Table 4.5). Where concerns were considered, they were communicated verbally to nursing staff in 31/134 (23.1%) cases and documented in clinical notes in 27/134 (20.1%).

Table 4.5 Method of sharing concerns about rapid tranquilisation

	Number of patients	%
No method	66	49.3
Verbally communicated to the nursing team	31	23.1
Documented clearly in the patient's care plan	27	20.1
Placed as an alert	5	3.7
Correspondence was sent to the patient's GP	4	3.0
Other	18	13.4

*Answers may be multiple; n=134
Clinician questionnaire data*

Case reviewers were able to determine that 110/177 (62.1%) patients had a condition that could have impacted the safety of rapid tranquilisation and found that this information was not properly documented nor communicated to the relevant staff in 61/110 (55.5%) cases reviewed.

A physical health risk assessment was not undertaken for 68/252 (27.0%) patients who had a physical health assessment. This was unknown for a large number of patients (67/252 (26.6%); Table 4.6). Where it could be determined (in 156/177; 88.1%) the case reviewers found that it was documented in the case notes of 81/156 (51.9%) patients and adequately communicated to the nursing staff on 71/81 occasions.

Table 4.6 A physical health risk assessment was formulated on admission

	Number of patients	%
Yes	117	46.4
No	68	27.0
Unknown	67	26.6
Total	252	

Clinician questionnaire data

Organisational data showed that in 19/56 organisations there was no policy for reviewing physical health at each clinical review. While 51/56 organisations had a policy for the physical care/monitoring of patients who received rapid tranquilisation, 17 of them did not have a policy requiring documentation of physical health conditions that could increase risk of collapse/complications during restraint.

	KEY FINDINGS	Data source
9	33/291 (11.3%) patients did not have an initial physical health assessment at the time of admission to hospital	CQ
10	Of the 252 patients who did undergo an initial assessment of physical health, this was completed in the first four hours for 147/252 (58.3%) patients and over 24 hours for 14/252 (5.6%) patients	CQ
11	History of smoking was taken for 192/252 (76.2%) patients, alcohol for 179/252 (71.0%) and substance use for 172/252 (68.3%) patients	CQ
12	228/252 (90.5%) patients had a basic set of observations were documented for and 146/252 (57.9%) patients had an early warning score (or equivalent) calculated	CQ
13	Physical health and mental health medications were documented for 208/252 (82.5%) and 218/252 (86.5%) patients respectively	CQ
14	An initial physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients	CR
15	A plan for physical health observations was not recorded for 48/217 (22.1%) patients (assess in 217/252)	CQ
16	No advice was given to staff about who should be notified in the event of physical health concerns for 47/169 (27.8%) patients	CQ
17	14/56 organisations did not have a protocol for responding to patients who refuse physical health observations	OQ
18	110/177 (62.1%) patients had a condition that could have impacted the safety of rapid tranquilisation and found that this information was not properly documented nor communicated to the relevant staff in 61/110 (55.5%) cases reviewed	CR
19	68/252 (27.0%) patients did not have a physical health risk assessment. Where it could be determined (in 156/177; 88.1%) the case reviewers found that it was documented in the case notes of 81/156 (51.9%) patients and adequately communicated to the nursing staff on 71/81 occasions	CR
20	19/56 organisations had no policy for reviewing physical health at each clinical review	OQ

Comprehensive physical health review

The Royal College of Psychiatrists' *'Standards for Inpatient Mental Health Services'* (2019) require that patients have a comprehensive physical health review completed within one week, or prior to discharge.²⁰ Patients should be informed of the outcome of this assessment and follow-up investigations, or treatments acted upon promptly.

The comprehensive physical health review builds upon the initial assessment discussed in Chapter 4. The objective is to identify opportunities to intervene in primary, secondary, and tertiary prevention of disease. Although there is a range of guidance available from the National Institute for Health and Care Excellence (NICE),²⁵ Royal College of Psychiatrists,²⁰ the Academy of Medical Royal Colleges,^{8,9} and NHS England/Improvement,^{11,24} there is no single standardised approach on what should be included in the comprehensive physical health review.

This study explored several aspects of the physical health review, including the assessments (history, examination and investigations) carried out, the timeframe in which they were undertaken, the actions taken, and any follow-up arranged for patients with identified health needs. Data from the organisational questionnaire and mental healthcare professional survey provided information on the policies, infrastructure and training in place across organisations for staff to carry out the comprehensive physical health review.

Organisational policies on comprehensive physical health review

Most organisations (50/56) had a policy specifying a comprehensive health review should be conducted, but there was variation in the physical health history, clinical examination and investigations that were required in these policies (Figure 5.1).

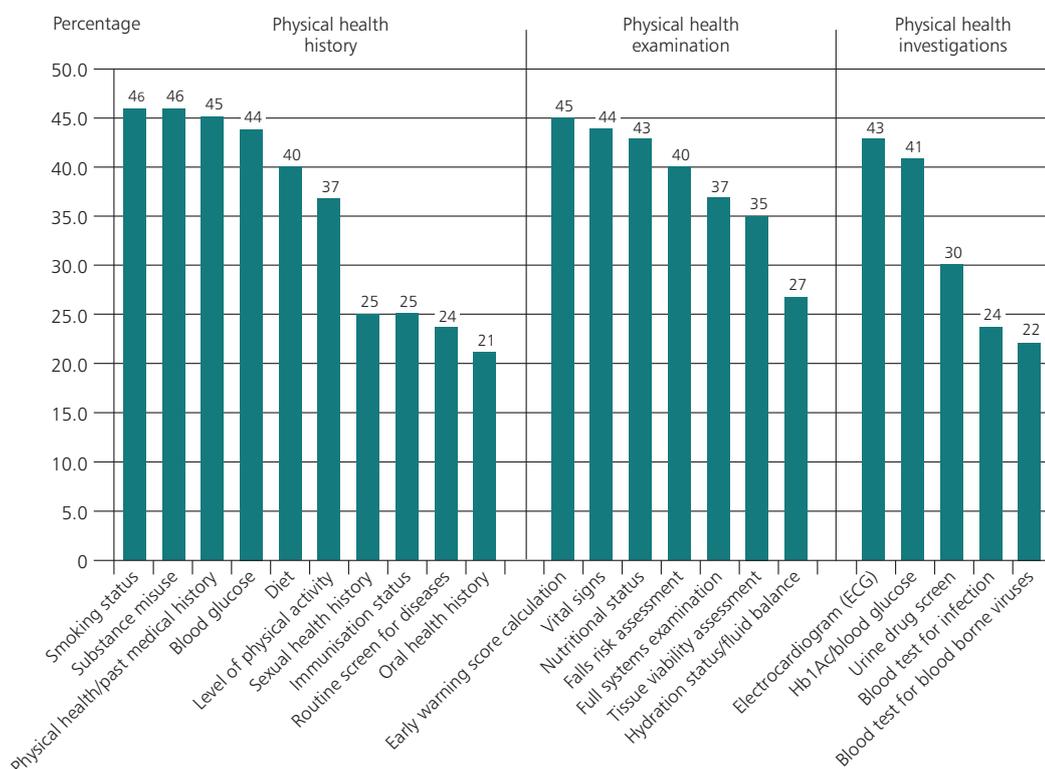


Figure 5.1 Components of the organisational policy for a comprehensive physical health review

Organisational questionnaire data

Components of the comprehensive physical health review; n=50

Infrastructure in place to carry out the comprehensive physical health review

Access to an appropriate clinical space is a basic requirement for carrying out a physical health review. There were 150/224 (67.0%) hospitals from which it was reported that staff had access to a clinic/room for physical examination with an examination couch and curtain on all mental health inpatient wards in the hospital (Table 5.1).

Completed components of a comprehensive physical health review

Figure 5.2 indicates the different components of a comprehensive physical health review that were completed during the overall inpatient admission, including those that had been carried out during the initial assessment.

Table 5.1 Access to a clinic room for a physical examination was available

	Number of hospitals	%
Available on ALL inpatient wards	150	67.0
Available on some wards but not ALL inpatient wards	36	16.1
Not available on any inpatient wards	20	8.9
Examination rooms available, but without curtains	4	1.8
Other	4	1.8
Unknown	10	4.5
Total	224	

Organisational data (hospital-level)

Components of comprehensive physical health review; n=291

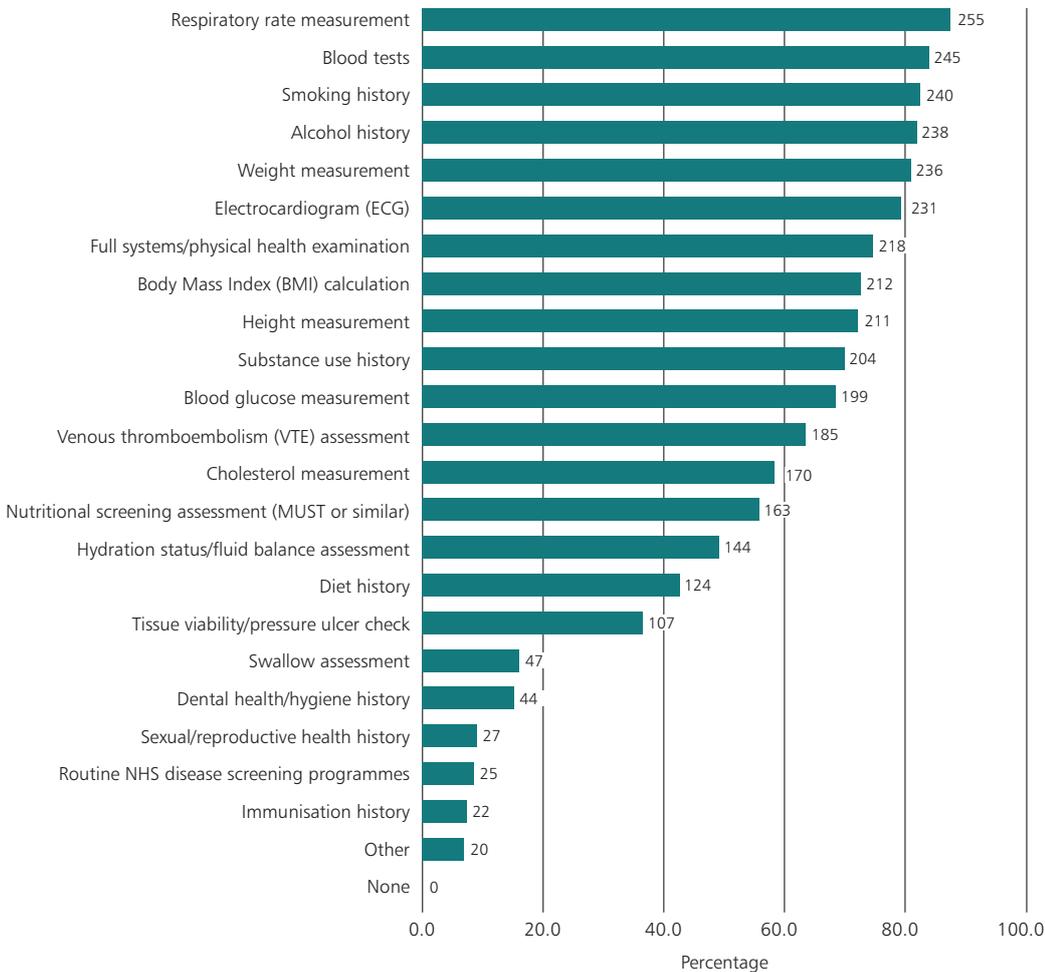


Figure 5.2 Comprehensive physical health review components
Clinician questionnaire data

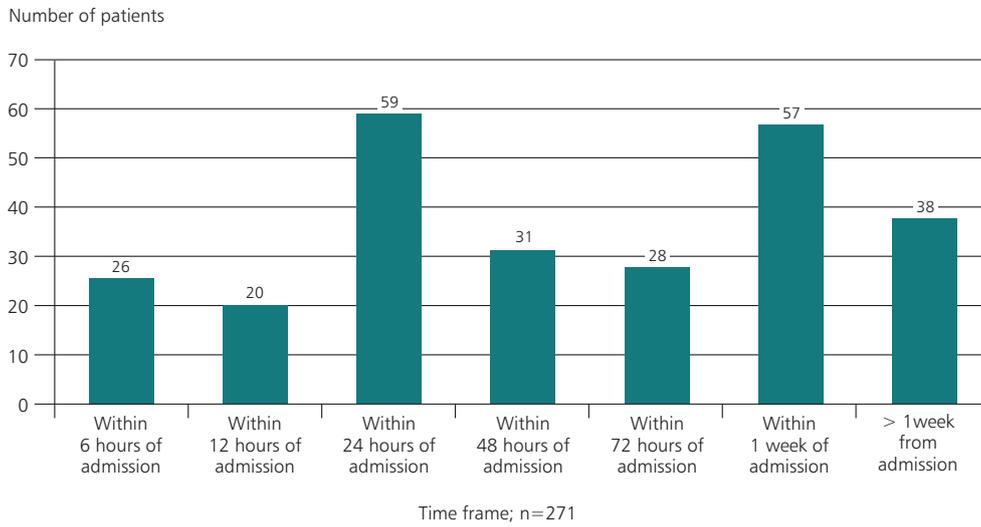


Figure 5.3 Time frame for completion of a comprehensive physical health review
Clinician questionnaire data

In keeping with the variation in organisational policies there was variation in the different elements of care performed. In general, the variation in clinical activity observed in the clinician questionnaire data did appear to correlate with the variation in organisational policies. The exception to this was assessment of diet and nutritional status which despite being frequently required in policies was infrequently carried out.

Where it could be determined (271/291; 93.1%), the majority of reviews were completed within one week of admission (221/271; 81.5%). For 38/271 (14.0%) patients the comprehensive physical health review was not carried out until a week after admission (Figure 5.3).

For 43/136 (31.6%) patients where it could be determined (there was insufficient data to answer in 41), the comprehensive physical review was not carried out within the appropriate time frame (Table 5.2) and for 12 patients this was because the patient was too unwell or agitated to engage with the assessment, in the opinion of the case reviewers.

Table 5.2 Physical health examination was performed within an appropriate time frame

	Number of patients	%
Yes	93	68.4
No	43	31.6
Subtotal	136	
Insufficient data to answer	41	
Total	177	

Case reviewer data

Case reviewer data

Case reviewers were of the opinion that for 89/177 (50.3%) patients some aspect of the comprehensive review was missed and that in 80/89 of those patients, it could have had an impact on the patient’s care.

CASE STUDY 2 – Missed opportunity for intervention

A 39-year-old patient was admitted with worsening self-harm and suicidal thoughts. They had no fixed abode and had been staying with different friends. The patient was not registered with a GP and they had had multiple crisis admissions in the previous year. The admitting doctor who took a history was told that the patient had noticed a lump on her breast but declined physical examination as they did not want to be examined by a man. The doctor made a brief entry in the case notes for the day team to arrange for a female clinician to examine the patient. The next day during the ward round the patient terminated the review early because they were distressed that discharge was being discussed. There was no subsequent record in the patient's notes of activity to arrange physical examination and the patient self-discharged four days later.

Case reviewers were of the opinion that this patient would have benefited from proactive efforts to engage them in physical examination and with primary care. For example,

A member of the breast clinic could have been contacted in an effort to persuade the patient to attend for assessment. They observed that the brief entry about concern of a breast lump was easily missed amongst extensive documentation of their interactions on the ward. They stated that systems to improve handover between out of hours and day teams, and to flag if basic aspects of care such as physical examination had been missed, would be helpful.

Health promotion and disease prevention

One area of focus for the comprehensive physical health review is to provide health promotion advice and, where indicated, interventions. Specifically, the Royal College of Psychiatrists' 'Standards for Inpatient Mental Health Services' (2019) require that patients should be offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services and that this should be documented in the patient's care plan.²⁰

Current clinical guidance does not delineate between the different clinical needs of inpatients. How and when health promotion interventions are best delivered will vary. For example, those who are generally physically healthy with a sufficiently improved mental state are more likely to engage with opportunistic health promotion advice than those who have complex physical health needs and/or remain mentally very unwell. This study showed that there was notable variability in organisational policies on health promotion (primary and secondary prevention), which interventions were delivered and the organisational infrastructure (staffing/environment) in place to deliver them.

Cardiometabolic disease screening and management

Cardiometabolic disease is one of the primary drivers of excess premature mortality in people living with serious mental illness. In recent years, mental health inpatient settings in England have been incentivised through CQUINS to establish systems to complete a comprehensive cardiometabolic check.²⁴

A total of 50/56 organisations had a policy requiring that a cardiometabolic risk assessment is performed on all patients during their inpatient stay. Nearly all patients did have some form of cardiometabolic risk assessment, but this was not comprehensive, with three or more elements of this assessment not being carried out in over 96/291 (33.0%) patients (Figure 5.2).

Data on staff training and confidence and competence in carrying out these assessments were provided through the organisational questionnaire and mental healthcare professional survey. It was reported from 15/56 organisations that training was provided for psychiatrists and 18/56 that registered mental health nurses (RMNs) had access to training in the comprehensive clinical review. A total of 72/190 (37.9%) staff responding to the mental healthcare professional survey rated themselves as having only some or low confidence and competence in carrying out this assessment. There were 48/66 RMNs who rated themselves as being only 'fairly' or 'less than fairly' confident and competent in carrying out a comprehensive cardiometabolic review and 98 respondents stated that

cardiometabolic risk assessment was not part of their job description (Table 5.3). This correlated with free text data where many respondents indicated the majority of this type of physical healthcare was carried out by junior doctors alone.

Table 5.3 Staff opinion on their confidence to carry out a cardiometabolic risk assessment

	Number of clinicians	%
I can perform the required tasks with complete confidence and a high degree of competence	42	22.1
I am mostly confident and feel that I am mostly competent	49	25.8
I am fairly confident/competent	27	14.2
I have some confidence/competence in performing the required tasks but am aware of some shortfall	33	17.4
I have low confidence in this area and do not feel that I have the required competence to perform this task	39	20.5
Subtotal	190	
Not applicable – these tasks are never part of my job description	98	
Total	288	

Mental healthcare professional survey data

One important aspect of the cardiometabolic risk assessment is the provision of opportunistic advice about healthy diet and exercise. Despite this, based on the organisational responses received, just 16/56 organisations had a policy stipulating that exercise should be available daily. Furthermore, only 9/56 organisations described their provision for exercise as excellent and accessible in all hospitals (Table 5.4). In 12/56 organisations there was only some provision and in 6/56 there was limited provision.

Table 5.4 Organisational provision for exercise

	Number of organisations	%
Excellent provision for exercise at ALL hospitals in the organisation with mental health inpatients	9	68.4
Certain hospitals in the organisation have excellent provision for exercise others do not	24	31.6
Some provision for exercise at ALL hospitals in the organisation with mental health inpatients	12	
There is very limited provision for exercise at this organisation	6	
Unknown	5	
Total	56	

Organisational data

This lack of opportunity to exercise was also reflected in patient and carer experience. In the patient survey, 29/60 patients reported that they were given the opportunity to do exercise such as walking, gym or yoga while on the ward. Several free text comments by patients noted the value they placed on access to this type of activity and the benefits of exercise for their mental health and recovery.

In total, 20/60 patients said that they were given at least some degree of clear advice and information about how to look after their physical health including information about smoking cessation support, exercise and maintaining a healthy diet, while 32/60 reported that they were not given any information.

In addition, 21/60 patients reported that there was someone available to talk to them about looking after their physical health if they wanted to discuss this, a further 33/60 reported that they were not offered this. Carers were asked the same question about the person they cared for and 8/31 agreed that there was someone to talk to while 19/31 disagreed.

**CASE STUDY 3 –
Positive practice using admission as an opportunity
for primary prevention**

A 23-year-old patient was admitted to the ward with their second episode of psychosis. Prior to admission the patient had stopped taking their medication because of weight gain. During the first two days of admission the patient was extremely distressed and became involved in many physical altercations with other patients. A multidisciplinary team review was held with the patient, their family, the ward psychologist and an activities co-ordinator. A plan was made to support the patient to attend daily exercise sessions with a nurse and gym instructor. The patient engaged with this plan, preventing the need for restrictive practice. As the patient’s mental state improved, the patient discussed with the team the role of exercise in improving their mental health, confidence and physical health. A plan was put in place for this to be supported after discharge.

Case reviewers noted this positive practice. They stated the case showed the multiple benefits of having this type of intervention available in an inpatient setting, including opportunities for therapeutic relationships, improvements in mental and physical health and overall experience of care.

Smoking assessment and interventions

The prevalence of smoking in people living with serious mental illness is approximately double that of the general population.^{26,27} Since 2013 NICE public health guidance (PH 48) ‘Smoking: acute, maternity and mental health services’ has stipulated that mental healthcare settings should be smoke-free and services have increasingly been required by commissioners to implement comprehensive smoke-free policies and tobacco dependency treatment pathways.²⁸ These include smoke free mental health settings, routine assessment of dependence on admission to and discharge from an inpatient setting and provision of evidence-based support to stop smoking delivered by trained specialist tobacco dependence practitioners, as specified in the 2016 by the Academy of Medical Royal Colleges.⁸

In this study the majority of organisations reported that a comprehensive smoking policy requiring routine assessment of smoking status on admission to the ward (50/56) and 24-hour availability of nicotine replacement therapy (53/56) had been implemented. However, only 11/56 organisations reported having access to smoking cessation workers in all hospitals and 9/56 reported having no access at all to inpatient smoking cessation officers (Table 5.5).

Table 5.5 Smoking cessation officers are employed at the organisation

	Number of organisations
Employed at each hospital in the organisation	11
Employed by the organisation to circulate between different hospitals as required	15
Some hospitals in the organisation do not have access to dedicated smoking cessation workers	8
None of the hospitals in the organisation have access to dedicated smoking cessation workers	9
Unknown	13
Total	56

Organisational data

Assessment of smoking status was carried out in 240/291 (82.5%) patients. Of these, 101/240 (42.1%) were current smokers and 21/101 (20.8%) of these were heavily tobacco dependent smoking more than 20 cigarettes a day. There were 54/101 (53.5%) patients offered nicotine replacement therapy, but only 27/101 (26.7%) of current smokers were referred for smoking cessation support. There was no documented evidence that a plan was put in place to support smoking cessation after discharge for 54/101 (53.5%) patients.

It was reported from the organisational questionnaire that there was access to training in tobacco dependence and smoking cessation for psychiatrists in 22/56 organisations, and for RMNs in 34/56 organisations. This suggested that there were discrepancies between the presence of smoke-free policies and availability of staff, training and after care pathways to effectively implement them.

Alcohol and substance use assessment and management

There are higher rates of substance use and alcohol dependency in people with mental health conditions than in the general population.²⁹ Assessment and intervention in an inpatient setting is important to address the risk of withdrawal, to enable treatment and to identify and treat any physical condition associated with drug and alcohol problems. The Royal College of Psychiatrists’ ‘Standards for Inpatient Mental Health Services’ (2019) require that patients with drug and alcohol problems should have access to specialist help, e.g. substance use interventions.²⁰

In this study, 46/56 organisations had a policy that a substance use history should be taken. However, only 30/46 policies specified a urine drug screen should be performed and 22/46 required blood-borne virus screening (Figure 5.1). The clinician questionnaire data showed that a history was taken for alcohol use for 238/291 (81.8%) patients and 204/291 (70.1%) for substance use. Of the 37 patients who needed a plan in place to support ongoing alcohol or substance use interventions post-discharge, 17 patients did not have one (Table 5.6).

Table 5.6 A post-discharge plan for alcohol use support was in place

	Number of patients
Yes	20
No	17
Subtotal	37
Not applicable – not required for this patient	185
Not answered	16
Total	238

Clinician questionnaire data

Hydration, fluid balance and nutritional assessment

People living with mental health conditions are at high risk of nutritional deficiencies and/or obesity. Assessment of diet and nutrition in mental health inpatient settings is important both as part of a cardiometabolic risk assessment and because self-neglect (reduced food and fluid intake) is a frequent consequence of a deterioration in mental health and precipitant to a mental health admission.

CASE STUDY 4 –

Missed opportunities for secondary prevention

A 48-year-old patient with schizophrenia was admitted with a relapse of psychosis. There was a long-standing history of cannabis use and relatives had also been concerned that the patient was drinking too much alcohol. Primary care notes were accessed and repeatedly showed ‘did not attend’ for annual physical health checks.

Physical assessment and investigations were conducted and revealed high blood pressure and raised cholesterol. The patient declined an ECG and was too unwell to engage with questions about alcohol use. The admitting doctor noted the ward staff should ‘observe for signs of alcohol withdrawal’ but no formal tool was suggested to assess this.

Throughout the admission raised blood pressure was consistently noted but no treatment was initiated. The discharge plan recommended community team support to reduce alcohol intake and that the patient should see their GP about their blood pressure and cholesterol.

Case reviewers noted that despite regular physical health monitoring there were multiple missed opportunities over the four-week admission to intervene in the patient’s cardiometabolic risks, cannabis and alcohol use. They stated, given the evidence, that this patient found it hard to engage with primary care and the ward staff would have benefited from access to physical health expertise to treat the cardiometabolic risks and more proactively engage the patient in dual diagnosis care.

In total 40/56 organisational policies included taking a history of diet and 43/56 included carrying out nutritional screening. However, a history of diet was taken for only 124/291 (42.6%) patients and a nutritional screening assessment was carried out for only 163/291 (56.0%).

CASE STUDY 5 – Positive practice in substance use management

A 48-year-old patient was admitted with psychotic symptoms. They reported an increase in the use of cocaine, methamphetamine, cannabis and MDMA over the previous two-months following a relationship breakdown. The ward team conducted a comprehensive assessment including blood-borne virus screening and full physical examination. The patient's psychiatric symptoms resolved quickly. Before discharge the ward team spent time providing psychoeducation about the physical and mental health impact of recreational drugs and developed a care plan with the patient that included strategies to manage their mood and support them to attend a sexual health clinic. An appointment was booked with a drug clinic counsellor for the day after discharge.

Case reviewers commented on the excellent holistic and patient-centred approach taken by the team and preventative efforts used to ensure active support at the point of discharge.

Similarly, low rates of assessment of diet and nutritional health were seen by the case reviewers, who were of the opinion that of the 108/177 (61.0%) patients who had some form of nutritional screening assessment, 25/108 (23.1%) patients should have been referred to a dietitian but were not. Reasons why a referral was indicated included complex needs such as obesity, poorly controlled diabetes, antipsychotic drug use and poor nutritional and fluid intake associated with self-neglect related to a mental health condition. Case reviewers also found that 23/108 (21.3%) patients who were assessed, did not have a nutrition plan in place covering their hospital stay and beyond.

While the majority of policies required vital signs to be completed, hydration status appeared to be poorly completed. Only 27/56 organisational policies included assessing hydration/fluid balance and only 144/291 (49.5%) patients had an assessment of hydration status/fluid balance. In the context of the study sample, many of whom had infections, poor oral intake and self-neglect, this was a notable finding.

Oral health, sexual and reproductive health and immunisation status

People living with serious mental illness are known to have lower access to and uptake of population-level public health interventions, including vaccination programmes.³⁰ In view of this, opportunistic interventions in inpatient settings have been recommended as one potential way to increase access to health promotion advice and interventions. However, history and assessment of sexual health, immunisation status and oral health were the least frequently required in organisational policies and were rarely carried out.

Despite substantial evidence that individuals with serious mental illness have higher rates of tooth loss, decay, poorer oral hygiene and gum disease than the general population,³¹ a history of oral health was required in only 21/56 organisational policies and carried out in only 44/291 (15.1%) patients.

Sexual and reproductive history and immunisation history were required in only 25/56 organisational policies and sexual and reproductive history was assessed in just 27/291 (9.3%) patients. In view of how common sexual side effects are with psychotropic medications and the wider impact of mental illness on psychosexual health this was a notable finding.³²

The relatively infrequent inclusion of immunisation history in clinical policies was notable given that people living with serious mental illness are at higher risk of respiratory viruses and poorer consequences from them.¹⁴ Engagement with vaccination programmes also has particular salience for the COVID-19 pandemic where there is evidence of excess deaths in those living with serious mental illness.³⁰ Immunisation history was the least commonly performed clinical activity across all elements of the health check and was carried out for only 22/291 (7.6%) patients.

Identification, assessment and management of new conditions

Another rationale behind the recommendation that all mental health inpatients receive a comprehensive physical health check is that this can serve as an opportunistic intervention to close known diagnosis and treatment gaps

**CASE STUDY 6 –
Substance use, and sexual health**

A 26-year-old patient with a diagnosis of emotionally unstable personality disorder was admitted with an increase in suicidal thoughts, self-harm and substance use. The patient had a past history of suffering sexual abuse and reported a recent history of injecting heroin. Access to the GP records showed a past diagnosis of chlamydia. The patient had been prescribed antipsychotic medication by the community mental health team to treat auditory and visual hallucinations. On discharge from the ward, the patient was advised to self-present to substance use services.

Case reviewers noted that despite a complex history suggestive of many areas of concern for psychosexual and reproductive health, including blood-borne viruses, there was no documentation that any clinician had taken a sexual or reproductive history or discussed this aspect of health with the patient. In addition, case reviewers highlighted that despite a clear history of trauma and drug use, there was no evidence that proactive and supportive efforts were made to try and engage the patient in treatment for substance use. They noted that there was no evidence that a trauma-informed approach had been used to formulate a needs or care plan for how the patient’s mental health impacted their ability to look after their physical health.

for long-term conditions or cardiometabolic risk factors in people living with serious mental illness (secondary and tertiary prevention).^{7,8} This rationale appeared to be borne out within the study cohort. For 82/291 (28.2%) patients a new condition was identified following physical health assessment and investigation. There were 63/177 (35.6%) patients with new physical health conditions identified by case reviewers. For 14/63 cases it was the case reviewers’ opinion that there was a delay in identifying and managing the new condition. Reasons for these included delays in identifying the issue, accessing clinical advice or investigations and in initiating treatment. In 8/14 cases it was the case reviewers’ opinion that the delay negatively impacted patient outcomes.

Type of new condition identified

Newly identified conditions fell broadly into two groups: infections (n=30) and other reversible conditions (n=22)

and newly identified long-term conditions (cardiovascular n=22). In addition there was a high incidence of the potential consequences of self-neglect including constipation, metabolic disturbance, nutritional deficiencies and acute kidney injury.

The majority of these conditions required further clinical intervention or activity. A specialist referral was indicated in 40/82 patients. In 60/82 patients a treatment was initiated and 26/60 patients required treatment for infection and received antibiotics. This was notable in view of the finding that only 144/291 (49.5%) patients were assessed for fluid status and hydration on admission to the ward. Further investigations were indicated in 244/291 (83.8%) and carried out in 105/244 (43.0%) patients.

Use of physical healthcare pathways

For 71/291 (24.4%) patients, local care pathways or pre-existing arrangements with physical healthcare providers were used as part of the care plan for the patient, most commonly in diabetes, geriatric medicine and cardiac care (Table 5.7).

Table 5.7 Local care pathways were used as part of the patient’s care plan

	Number of patients
Diabetes care pathway	23
Older adults/geriatric care pathway	10
Cardiac care pathway	7
Service level agreement	7
Palliative care pathway	6
Chronic obstructive pulmonary disease care pathway	5
General practitioner care pathway	5
Emergency care pathway	3
Neurology care pathway	3
Obstetrics and gynaecology care pathway	2
Gastroenterology care pathway	2
Ambulatory care pathway	1
Other	5
Total	71

*Answers may be multiple; n=71
Clinician questionnaire data*

	KEY FINDINGS	Data source
21	50/56 organisations had a policy specifying a comprehensive health review should be conducted, but there was variation in the physical health history, clinical examination and investigations that were required in these policies. There was also variation in the different elements of care performed	OQ
22	150/224 (67.0%) hospitals reported that staff had access to a clinic/room for physical examination with an examination couch and curtain on all mental health inpatient wards	OQ
23	38/271 (14.0%) patients did not have a comprehensive physical health review carried out until a week after admission	CQ
24	For 43/136 (31.6%) patients the comprehensive physical review was not carried out within the appropriate time frame	CR
25	89/177 (50.3%) patients had some aspect of the comprehensive review missed and that in 80/89 of those patients, it could have had an impact on the patient's care	CR
26	50/56 organisations had a policy requiring that a cardiometabolic risk assessment is performed on all patients during their inpatient stay	OQ
27	15/56 organisations reported that training was provided for psychiatrists in the comprehensive clinical review and 18/56 for registered mental health nurses (RMNs)	OQ
28	48/66 RMNs who rated themselves as being only 'fairly' or 'less than fairly' confident and competent in carrying out a comprehensive cardiometabolic review	HPS
29	16/56 organisations had a policy stipulating that exercise should be available daily	OQ
30	29/60 patients reported that they were given the opportunity to do exercise such as walking, gym or yoga while on the ward	PCS
31	50/56 organisations reported that a comprehensive smoking policy requiring routine assessment of smoking status on admission to the ward was in place and 24-hour availability of nicotine replacement therapy (53/56) had been implemented	OQ

32	11/56 organisations reported having access to smoking cessation workers in all hospitals and 9/56 reported having no access at all to inpatient smoking cessation officers	OQ
33	54/101 (53.5%) patients had no documented evidence that a plan was put in place to support smoking cessation after discharge	CR
34	238/291 (81.8%) patients had a history taken for alcohol use for 204/291 (70.1%) patients for substance use	CQ
35	124/291 (42.6%) patients had a diet history taken and 163/291 (56.0%) a nutritional screening assessment	CQ
36	Of the 108/177 (61.0%) patients who had some form of nutritional screening assessment, 25/108 (23.1%) patients should have been referred to a dietitian but were not	CR
37	144/291 (49.5%) patients had an assessment of hydration status/fluid balance	CQ
38	27/291 (9.3%) patients had their sexual and reproductive history assessed	CQ
39	22/291 (7.6%) patients had their immunisation history checked. This was the least commonly performed clinical activity across all elements of the health check	CQ
40	82/291 (28.2%) patients had a new physical health condition identified following their physical health assessment	CQ
41	40/82 patients required a specialist referral and for 60/82 patients a treatment was initiated	CQ
42	68/252 (27.0%) patients did not have a physical health risk assessment. Where it could be determined (in 156/177; 88.1%) the case reviewers found that it was documented in the case notes of 81/156 (51.9%) patients and adequately communicated to the nursing staff on 71/81 occasions	CR

Physical health monitoring and care planning

The Royal College of Psychiatrists' *'Standards for Inpatient Mental Health Services'* (2019) requires that every patient should have a written care plan, reflecting their individual needs.²⁰ The standards recommend that staff members should actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan and that they should be offered a copy. Guidance for this standard states that the plan should clearly outline agreed intervention strategies for physical and mental health.

In the study sample, 240/291 (82.5%) patients had at least one long-term condition and 82/291 (28.2%) had a newly identified condition that required care planning. Appropriate care planning requires, as a minimum, consideration of frequency of physical health observations to safely monitor any pre-existing or new conditions and an escalation plan in the event of patient refusal.

This study reviewed whether a care plan for physical health monitoring had been made, the types of ongoing monitoring specified, whether the care plan had been shared with the patient and an appropriate carer, and details for escalation and involvement of the multidisciplinary team (MDT). Case reviewers considered the appropriateness of the overall care planning.

Physical health monitoring and care planning

The clinician questionnaire data showed that of the 122/291 (41.9%) patients who did not have evidence of a monitoring plan for physical health observations put in place on admission, 42/122 (34.4%) still did not plan put in place during the first seven days of their hospital stay. Similarly, case reviewers found that 29/94 patients who did not have a physical health monitoring plan made on admission did not have one in place within seven days (Table 6.1).

Table 6.1 An ad hoc physical health monitoring plan was put in place

	Number of patients	%
Yes	65	69.1
No	29	30.9
Subtotal	94	
Not applicable – a plan was made on admission	62	
Insufficient data to answer	21	
Total	177	

Case reviewer data

For those who did have a plan documented either on admission (n=169) or during the first 7 days (n=80), a range of ongoing monitoring requirements were stipulated (Figure 6.1 overleaf)

Escalation plans in the event of patient refusal or abnormal results were only recorded for 46/80 patients with a documented plan and 19/80 did not document who should be notified in the event of a clinical concern.

Physical healthcare plans

There was an organisational policy stating that a physical healthcare plan should be recorded for all patients in 39/56 organisations. Clinician questionnaire data showed that physical healthcare plans were formulated for 155/291 (53.3%) patients. Where a plan had been developed, and could be reviewed, 123/155 (79.4%) specified multidisciplinary team roles. In 33/155 (21.3%) cases the plan did not formulate how the patient's mental health may impact on their ability to look after their physical health.

Regular physical health monitoring tasks – Answers may be multiple; =249

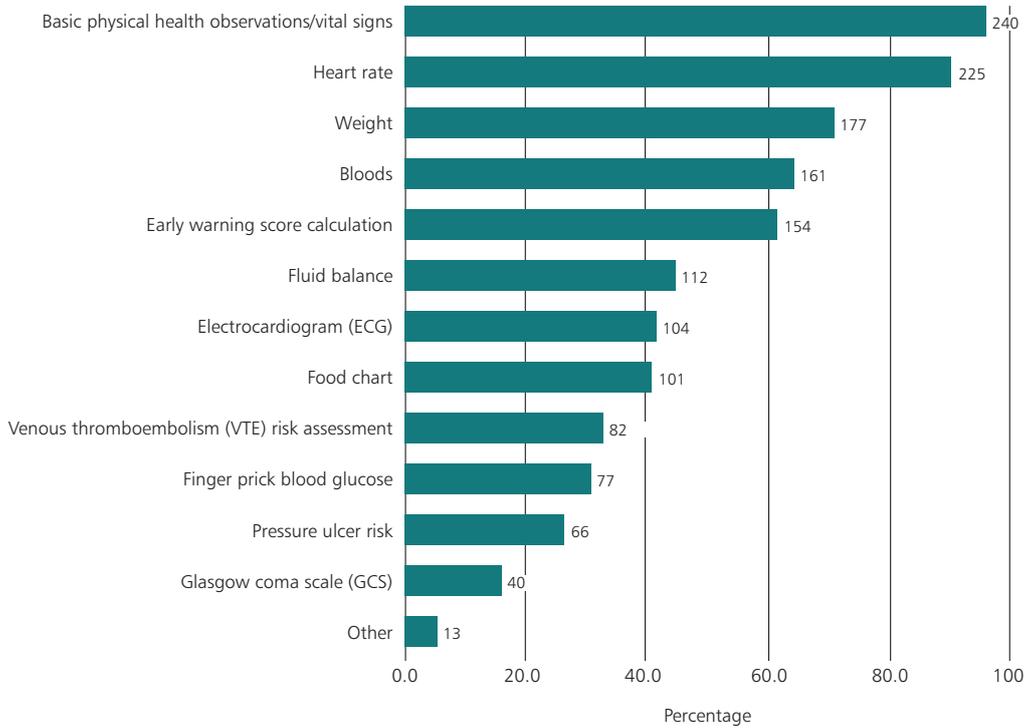


Figure 6.1 Regular physical health monitoring checks
Clinician questionnaire data

However, in the case reviewers’ opinion a much higher figure of 85/150 (56.7%; insufficient data to answer in 27) plans failed to formulate how the patient’s mental health may impact on their ability to look after their physical health (Table 6.2).

Table 6.2 A physical healthcare plan was formulated how the patient’s mental health may impact on their ability to care for their physical health needs

	Number of patients	%
Yes	65	43.3
No	85	56.7
Subtotal	150	
Insufficient data to answer	27	
Total	177	

Case reviewer data

Quality and appropriateness of physical healthcare monitoring and care planning

Case reviewers stated that for 24/62 patients (insufficient data to answer in 3), monitoring plans were not adequate (Table 6.3). Reasons cited included, ‘inappropriate frequency of monitoring’ and ‘lack of detail including details of when and to whom to escalate concerns’.

Table 6.3 The physical health monitoring plan was adequate

	Number of patients
Yes	38
No	24
Subtotal	62
Insufficient data to answer	3
Total	65

Case reviewer data

The case reviewers were of the opinion that physical health care planning was appropriate for only 83/177 (46.9%) patients. Reasons cited included lack of consistent and clear proactive planning about what to do in the event of a patient refusal of assessment and interventions.

CASE STUDY 7 – Strategies to support patient engagement

A 62-year-old patient with cardiovascular disease, COPD and chronic kidney disease was admitted with psychotic depression and severely reduced food and fluid intake. The patient was not fluent in English. Several attempts were made to perform an examination and take bloods, but the patient became hostile and aggressive when approached. The medical plan documented '*continue to try and engage in physical health assessment*'. On the fourth day of admission the patient fell and was transferred to the acute hospital where they were diagnosed with dehydration and worsening kidney failure.

The patient was transferred back two days later to a different ward. Here a ward round review was held with the patient and their family as well as the wider multidisciplinary team to discuss strategies to support engagement with physical healthcare. The junior doctor performed a case note review and identified that during two previous admissions an interpreter and a nurse who were fluent in the patient's language, had been helpful in encouraging them to engage with vital signs and monitoring for refeeding syndrome.

The case reviewers noted the variation in practice across wards on how refusal to engage in physical healthcare was managed. They also noted that the patient's care plan had not included this critical historical information about how best to engage with them when unwell. The reviewers believed that if this had been more visible it may have prevented the deterioration when first admitted. They also stated that better integration of information in an accessible place, and family involvement, would have improved the quality, safety and effectiveness of the patient's care.

Communication and care planning with patients and carers

The Royal College of Psychiatrists' '*Standards for Inpatient Mental Health Services*' (2019) require that patients should be informed of the outcome of their physical health review and that this should be recorded in their notes. They provide guidance that with patient consent, this can be shared with their carer.²⁰ Documentation as to whether the outcomes of the physical health review had been discussed with the patient was identified in the clinician questionnaire for 127/205 (62.0%) patients (not applicable/not answered in 86). Documentation as to whether findings had been discussed with the patient's family/carers was lower, with no record of this for 100/188 (53.2%) patients (not applicable/not answered in 103).

Patient survey data showed that 26/60 patients stated that the clinical team fully involved them in their physical healthcare assessment and explained clearly what assessments and tests were being done, why they were being done, and the results of any tests. However, 28/60 disagreed that this was the case and 20/35 carers reported that they had not felt involved or been communicated with about assessments and tests carried out. This suggested that carers felt less involved and updated than patients on physical healthcare.

Patients were also asked whether the information given to them regarding their physical health was clear, understandable and encouraging. There were 25/60 patients who agreed it was clear and 26/60 who disagreed. Carers were also asked the same question and 15/35 did not feel this was the case.

Physical healthcare strategy

There were 29/56 organisations from which it was reported there was a physical health strategy and nearly all of these (27/29) had someone accountable for its delivery at board level.

Table 6.4 Key policies of a physical health strategy

	Number of organisations
Smoke-free policies coverage and implementation	27
Physical health equipment (e.g. availability and quality of ECG machines)	26
NEWS2 - training coverage and use	26
Identification of the deteriorating patient	26
Policies on preventative screening and assessment - physical health CQUINs including screening and interventions	25
Nurse training and education	25
Use of SBAR technique: Situation, Background, Assessment, Recommendation	23
All clinical staff training and education	23
Information technology and interoperable clinical recording systems	22
Medical staff training and education	20
Substance use identification and treatment	20
Safe prescribing and side effect management	20
Accessibility of medical investigations and diagnostics	14
Staffing policies, e.g. requirement of certain key staff and numbers to support the physical health of patients	14
Patient and carer involvement and education in physical health initiatives	12
Other	2

Answers may be multiple; n=29
Organisational data

The method by which the strategy was being delivered was more variable with 22/29 organisations using a physical health committee to deliver it, while in 16/56 responding organisations this type of improvement activity and approach had not been established at either hospital or organisation level.

Table 6.4 shows the common areas of activity for physical health strategy priorities. It is of note that the assessment and management of substance use, and problems with functional IT to support physical health workflows, were two areas least commonly identified as priorities in organisational strategies.

It was reported by 15/29 organisations, with a physical health strategy, that a specific commitment and plan to improve communication about physical health with patients and carers had been included.

A range of initiatives were being used to advance this work as reported in the organisational data. Development of patient information leaflets were most common but focus groups and patients and carers forums had also been developed in several organisations (Table 6.5).

Table 6.5 Initiatives to involve patients and carers in the physical health strategy

	Number of organisations
Patient information leaflet	40
Carers' forum	21
Patient forum	14
Patient information webpage	10
Patient focus group	8
Patient information app	3
Patient information online platform	3
Other	12

Answers may be multiple; n=56
Organisational data

However, there was a richer documentation of efforts and strategies to engage the patient in the physical health assessment process evidenced in 164/291 (56.4%) completed clinician questionnaires. Free text responses to this question, completed by the case reviewers also demonstrated a range of ways that staff were trying to build rapport, trust and engagement in physical health matters. These included:

- Regularly and repeatedly trying to engage the patient in discussions about their physical health
- Offering elements of assessment, investigation and physical health information in stages
- Using different communication approaches including simplified language to convey information in ways the patient would understand
- Waiting for improvements in mental state or timing approaches with fluctuations when the patient was more settled
- Involving family members or friends to explain and support the process
- Involving other healthcare professionals and staff such as clinical support workers, peer support workers, occupational therapy, physiotherapy and psychology
- Being flexible and sensitive towards the patient’s past experiences and preferences, e.g. considering the gender of the assessing doctor, involving staff from the community or from other wards where the patient had pre-existing and/or more trusted relationships
- Increasing intensity of mental health support (e.g. 1:1 staff or increased frequency of observations) to build rapport and explain why assessment was being requested

Staff training

Access to free physical health training for staff groups other than nurses and doctors is important in view of the principles behind ‘making every contact count’ which emphasises that all healthcare staff have a role in health promotion.³³ Case reviewer data highlighted the positive impact that effective multidisciplinary care can have on improving physical health outcomes. Table 6.6 shows that a wide range of staff, other than nurses and doctors, had access to some physical health training but also that there were potentially missed opportunities to upskill the whole multidisciplinary team, particularly peer support workers, in health promotion.

Table 6.6 Staff members who were able to access free physical health training

	Number of organisations
Doctors (psychiatrists)	51
Registered mental health nurses	51
Support staff – healthcare assistants	48
Social workers	36
Psychologists	41
Occupational therapists	46
Physiotherapists	36
Speech and language therapists	38
Peer workers	23
Employment and benefits advisors	9
Chaplains	8
Other	6

Answers may be multiple; n=56
Organisational data

CASE STUDY 8 – Good practice care planning

A 73-year-old patient with an established diagnosis of bipolar affective disorder was transferred from the acute hospital following treatment for a urinary tract infection and community acquired pneumonia. There were ongoing signs of delirium. A comprehensive plan for monitoring was put in place by the ward team using a delirium management protocol. The plan detailed: frequency of vital signs, when they should be escalated, who to contact, action to be taken in the event of refusal of oral antibiotics, threshold for transfer back to the acute hospital and phone details of who should be contacted in the event of deterioration, including both family and medical teams. Details of personalised strategies to support the patient if they became distressed were noted based on communication with the family. A clear summary of recent antibiotic prescriptions and microbiology were noted.

Case reviewers noted the excellent work to ensure a safe and responsive plan for this patient and the evidence of co-working between the acute trust and mental health inpatient setting and clear involvement of family in all aspects of care.

	KEY FINDINGS	Data source
43	Of the 122/291 (41.9%) patients who did not have evidence of a monitoring plan for physical health observations put in place on admission, 80/122 (65.6%) had a plan put in place during the first seven days of their hospital stay	CQ
44	Escalation plans in the event of patient refusal to have physical health monitoring or abnormal results were only recorded for 46/80 patients with a documented plan and 19/80 did not document who should be notified in the event of a clinical concern	CR
45	39/56 organisations reported there was a policy stating that a physical healthcare plan should be recorded for all patients	OQ
46	Physical healthcare plans were formulated for 155/291 (53.3%) patients	CQ
47	Where a physical healthcare plan had been developed, and could be reviewed, 123/155 (79.4%) specified multidisciplinary team roles	CR
48	In 93/155 (60.0%) cases reviewed the plan formulated how the patient's mental health may impact on their ability to look after their physical health, but this was absent in 33/155 (21.3%) of plans	CR
49	83/177 (46.9%) physical healthcare plans were appropriate. Reasons for them not being appropriate included lack of consistent and clear proactive planning about what to do in the event of refusing assessment and interventions	CR
50	127/205 (62.0%) patients had documentation as to whether the outcomes of the physical health review had been discussed with them	CQ
51	100/188 (53.2%) patients had documentation as to whether the outcomes of the physical health review had been discussed with their family/carers	CQ
52	26/60 patients stated that the clinical team fully involved them in their physical healthcare assessment and explained clearly what assessments and tests were being done, why they were being done, and the results of any tests. However, 28/60 disagreed that this was the case and 20/35 carers reported that they had not felt involved or been communicated with about assessments and tests carried out	PCS

53	25/60 patients agreed that information given to them regarding their physical health was clear, understandable and encouraging and 26/60 who disagreed. Carers were also asked the same question and 15/35 did not feel this was the case	PCS
54	15/29 organisations reported a physical health strategy that had a specific commitment and plan to improve communication about physical health with patients and carers	OQ
55	164/291 (56.4%) clinician questionnaires provided detail of efforts and strategies to engage the patient in the physical health assessment process	CQ
	124/291 (42.6%) patients had a diet history taken and 163/291 (56.0%) a nutritional screening assessment	CQ

Physical health medications

Organisational infrastructure to support medicines management

Access to pharmacists

Nearly all organisations reported that each ward had access to a named pharmacist. In 40/56 there was 24-hour access to a pharmacist in all hospitals and 8/56 there was no out-of-hours provision (Table 7.1). These findings, combined with the study data of delays in medicines reconciliation particularly over weekends, highlight the importance of having systems to support medicines reconciliation seven days a week regardless of the availability of pharmacists to perform this task. Access to electronic drug charts across care settings could significantly improve the safety and efficiency of medicines reconciliation, however, this is still not routinely available.

Table 7.1 Access to 24-hour on-call pharmacists

	Number of organisations
Pharmacists were available on-call 24 hours across ALL hospitals within the organisation	40
Pharmacists were available on-call 24 hours at some but not all hospitals within the organisation	3
No 24-hour access to pharmacists in the organisation	8
Unknown	5
Total	56

Organisational data

Electronic prescribing and medicines administration

One potential solution to address case reviewer findings of frequently undocumented drug interactions is the implementation of an effective system for e-prescribing and administration. However, data from the organisational

questionnaire showed that only 20/56 organisations had implemented using e-prescribing and medicines administration (Table 7.2).

Table 7.2 Electronic prescribing and medicines administration is used within the organisation

	Number of organisations
Yes	20
No	32
Unknown	4
Total	56

Organisational data

Where electronic prescribing had been adopted and rolled out, only 13/20 organisations had achieved full roll out in all their hospitals (Table 7.3). The available functions of e-prescribing in those that had implemented this system were also varied.

Table 7.3 Functions included in the electronic prescribing system

	Number of organisations
Record of the patient's known allergies	19
Warnings to the prescriber of contraindications/drug interactions	16
Record of time critical medications (i.e., those to be administered within two hours)	15
Record of the patient's venous thromboembolism status	14
Record of medicines reconciliation	13
Record of side effects/contraindications	13
Record of the patient's other physical health flags	7
Other	2

Answers may be multiple; n=20

Organisational data

There were 16/20 organisations had an e-prescribing system that could warn the prescriber of contraindications/drug interactions.

In 23/56 organisations there was a policy that required full medicines reconciliation to happen within 24 hours of admission, no matter when the patient was admitted (Table 7.4).

Table 7.4 Organisational policy requiring full medicines reconciliation within 24 hours of admission

	Number of organisations
Yes, if the patient is admitted at any time (including weekends)	23
Yes, if the patient is admitted Monday to Friday (not on weekends)	22
No, the policy regarding medicines reconciliation does not state a timeframe	3
No, the policy regarding medicines reconciliation states a different timeframe	3
No, there is no policy covering this	2
Unknown	3
Total	56

Organisational data

CASE STUDY 9 – Medication reconciliation and long-term condition management

A 67-year-old patient with schizophrenia and diagnoses of HIV, heart failure, diabetes and COPD was admitted with a two-week history of ‘bizarre’ behaviour and paranoid delusions. The patient was already taking haloperidol depot antipsychotic medication and no concerns about concordance had been raised.

On assessment there were signs of fluid overload, peripheral neuropathy, cellulitis and a likely fungal foot infection. The team were concerned that the deterioration in the patient’s mental state was due to infection. They sought phone advice from pharmacy about initiating an antibiotic. The pharmacist communicated concerns about interactions and carried out a comprehensive medication reconciliation which revealed notable discrepancies in the list of medications held by primary care, the HIV team, the cardiology team and the mental health team. Final reconciliation revealed multiple potentially serious interactions between medications which had not been identified. It took the ward team many telephone calls over several days with medical colleagues and pharmacy to alter several medications and initiate a safe treatment plan.

Case reviewers were of the opinion that this patient illustrated the complexity of many inpatients’ needs. They stated that it showed the safety risks presented by multiple prescribers and highlighted the absence of e-prescribing, the absence of systems that alert for drug interactions and an absence of access, in mental healthcare settings, to medical generalists or dedicated care pathways to support with multiple long-term condition management.

**CASE STUDY 10 –
Long-term condition medication**

A 62-year-old patient with a diagnosis of bipolar affective disorder, diabetes, hypertension, COPD and cardiovascular disease was admitted with an episode of mania. The patient had not been eating or drinking for weeks and continued to refuse all investigations and medications for two weeks as an inpatient. On the third week of admission the patient spontaneously agreed to take medications which included oral hypoglycaemics and antihypertensives. Several hours after taking the medications, which had not had any doses adjusted since the admission, the patient collapsed and was transferred to a physical health emergency department with severe hypotension and hypoglycaemia.

Case reviewers noted that regular efforts were made to try and engage this patient with physical healthcare but that there was no plan in the notes about how to manage refusals and who to escalate care to. They stated it was not clear if all the clinical team understood the health risks of the patient’s medical co-morbidities and reduced oral intake. There had not been any care planning around re-titration of the medications in context of physiological changes associated with reduced food and fluid intake.

	KEY FINDINGS	Data source
56	40/56 organisations reported that there was 24-hour access to a pharmacist in all hospitals but in 8/56 there was no out of hours provision	OQ
57	20/56 organisations had implemented e-prescribing and medicines administration	OQ
58	16/20 organisations had an e-prescribing system that could warn the prescriber of contraindications/drug interactions	OQ
59	23/56 organisations reported a policy that required full medicines reconciliation to happen within 24 hours of admission, no matter when the patient was admitted	OQ
60	237/291 (81.4%) patients were prescribed physical health medications	CQ
61	A total of 184/237 (77.6%) patients were prescribed more than three medications for their physical health	CQ
62	31/237 (13.1%) patients had delays in prescription and administration of physical health medications and the case reviewers recorded delays in 26/148 (17.6%) patients who were prescribed physical health medications during their hospital stay	CQ
CR	127/205 (62.0%) patients had documentation as to whether the outcomes of the physical health review had been discussed with them	CQ
63	213/291 (73.2%) patients had a full medicines reconciliation (including receiving indicated current prescription of medication) within 24 hours of admission	CQ
64	36/66 patients did not have all contraindications or interactions with psychotropic medication documented that should have been	CR

Long-term health conditions

Nearly half of those living with serious mental illness have a long-term physical health condition.⁸ Deterioration in a mental illness is frequently accompanied by difficulties in self-care and self-management of long-term conditions. Mental health inpatient settings therefore need to be equipped to identify, safely monitor and manage long-term conditions throughout a patient's admission.

The Academy of Medical Royal Colleges 2016 report recommends that healthcare professionals should be trained in the management of long-term conditions and be able to monitor and provide treatment for long-term conditions in collaboration with specialists.⁸

This study reviewed how long-term conditions were monitored and managed throughout admission and the presence of organisational factors such as staff training, staff roles and pathways for physical health specialties that may impact on the care provided to patients with long-term conditions.

Physical health comorbidities

A total of 240/291 (82.5%) patients included in this study had one or more long-term physical health conditions. The majority, as expected from the sampling criteria had cardiovascular disease, diabetes or a respiratory condition (Figure 8.1).

Physical health conditions – Answers may be multiple; n=240

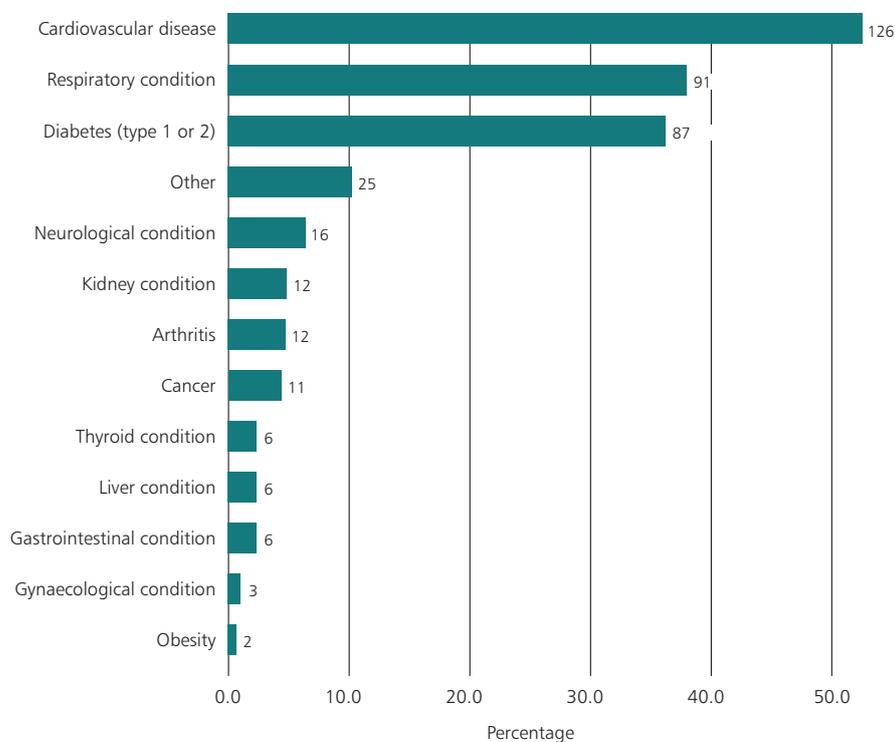


Figure 8.1 Detail of long-term health conditions in the study sample
Clinician questionnaire data

Inpatient monitoring of long-term conditions

In the case reviewer data, 144/177 (81.4%) patients had a long-term physical health condition, of which 122/144 (84.7%) patients were thought to have had appropriate treatment continued for their long-term condition and 48/144 (33.3%) patients with a long-term condition had a new treatment initiated.

Despite these interventions, case reviewers were of the opinion that elements of treatment for a long-term condition had still been missed in 32/144 (22.2%) patients and frequently noted that the patient's poor mental health often challenged their ability to comply with the care for their physical health condition.

Case reviewers were also of the opinion that 45/144 (31.3%) patients did not have an appropriate plan in place for disease management.

Case reviewers found that in 58/144 (40.3%) cases reviewed, there was room for improvement in the management of the condition, including disease monitoring and management, prescribing and, referrals to allied health professionals or physical health specialists and multidisciplinary team involvement (Table 8.1). In five of these cases, it was reported that this impacted on the patient's outcome. Case reviewers described potentially preventable outcomes including deep vein thrombosis, and exacerbation and deterioration in long-term condition control, as well as patient distress due to not being treated in an appropriate environment that could meet their needs.

A total of 38/219 (17.4%) clinicians completing questionnaires stated that there were issues with monitoring of vital signs/physical health observations during the remainder of the inpatient stay (this was unknown for a further 21 patients). The predominant reason cited were challenges in monitoring patients who were unable to comply with physical healthcare interventions.

Table 8.1 Areas where there was room for improvement in the management of long-term conditions

	Number of patients
Room for improvement in monitoring	46
Room for improvement in disease management	39
Room for improvement in multidisciplinary team involvement	31
Room for improvement referral to allied health professionals	25
Room for improvement in prescribing medications	24
Room for improvement in referral to physical health	16

*Answers may be multiple; n=58
Case reviewer data*

Involvement of physical health specialists and allied health professionals

Management of a long-term condition involves responding appropriately to changes noted on monitoring, ensuring appropriate treatment is delivered and input is provided by specialists as needed.

Over the course of the admission a range of health professionals were involved in assessment or examination of 225/291 (77.3%) inpatients with long-term conditions, and none were involved for 66 patients (Figure 8.2 overleaf). These were most commonly occupational therapists (176/225; 78.2%), physiotherapists (93/225; 41.3%) and dietitians (49/225; 21.8%). Specialist physicians at the physical health hospital who were consulted included cardiologists, diabetologists, respiratory physicians, neurologists and palliative care consultants. Despite the high rates of diabetes, cardiovascular disease and respiratory disease in our sample, health professionals from these specialisms were relatively infrequently consulted or involved in care.

Physical healthcare professional – Answers may be multiple; n=225

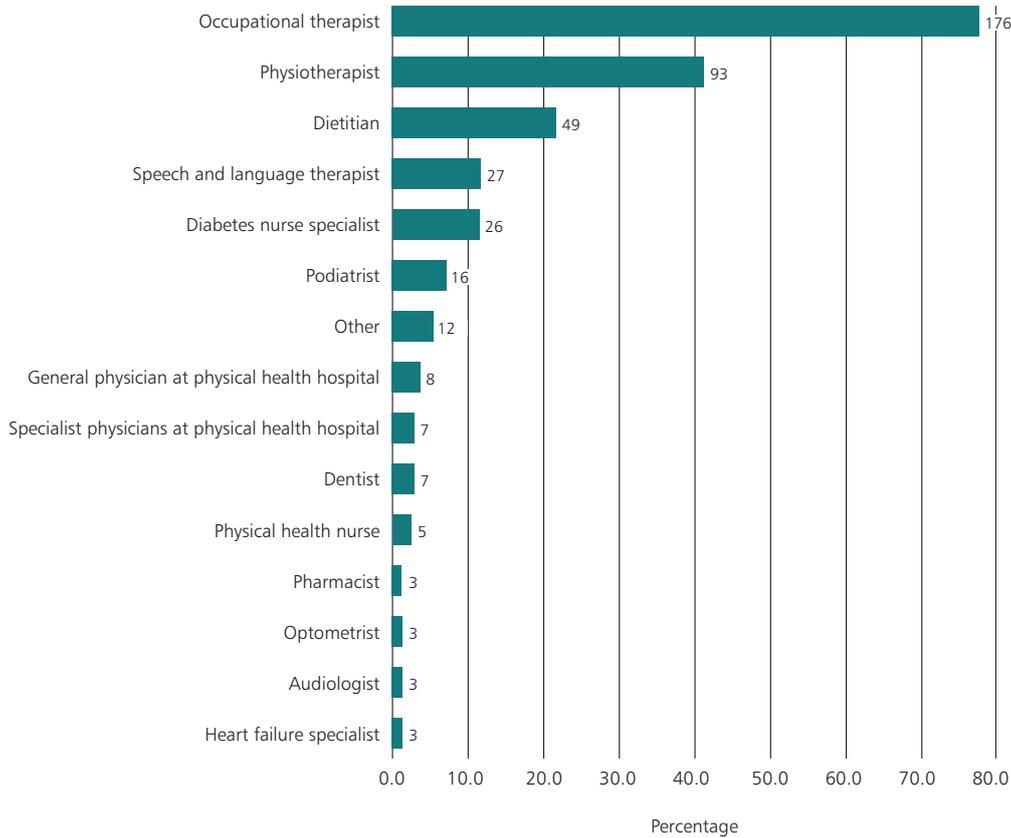


Figure 8.2 Healthcare professionals involved in assessing patients with long-term conditions
Clinician questionnaire data

In addition, for 120/291 (41.2%) patients it was thought that another healthcare professional should have been involved in the patient’s care but was not. Most commonly this was a dietitian (31/120; 25.8%), a diabetes nurse specialist (17/120; 14.2%) or an allied health professional (occupational therapist (15/120; 12.5%), physiotherapist (13/120; 10.8%) or speech and language therapist (7/120; 5.8%).

Staff confidence and training in long-term condition management

Both the Academy of Medical Royal Colleges’ report on improving physical health in serious mental illness⁸ and the Care Quality Commission’s brief guide to physical healthcare in mental health settings³⁶ specify the requirement of

employment of (or suitable arrangements to provide) medical, nursing and pharmacy staff and other healthcare professionals with the necessary skills and knowledge to oversee and deliver aspects of physical healthcare.

One approach to ensuring the availability of these skills is through access to training. The 2016 Academy of Medical Royal Colleges’ report recommended that mental health services should ensure that essential training for clinical staff is provided on recognition and first response to acute physical illness, resuscitation, and management of long-term physical conditions.⁸

It was reported from 53/56 organisations that continuing professional development (CPD) on physical health topics was available, but as shown in Figure 8.3 there was variation in who was able to access training.

Training in common long-term conditions was available in 31/53 organisations for psychiatrists and 42/52 organisations for registered mental health nurses (RMNs). However, training on the safe monitoring and management of long-term conditions was only available in 13/53 organisations for psychiatrists and 25/52 for RMNs. There were 127/268 (47.4%) clinicians who reported in the mental healthcare professional survey that they felt 'fairly' or 'less than fairly' confident and competent in caring for patients with long-term conditions (Table 8.2).

Table 8.2 Staff reported confidence to care for patients with long-term health conditions

	Number of clinicians	%
I can perform the required tasks with complete confidence and a high degree of competence	42	15.7
I am mostly confident and feel that I am mostly competent	99	36.9
I am fairly confident/competent	61	22.8
I have some confidence/competence in performing the required tasks but am aware of some shortfall	66	24.6
Total	268	

Mental healthcare professional survey data

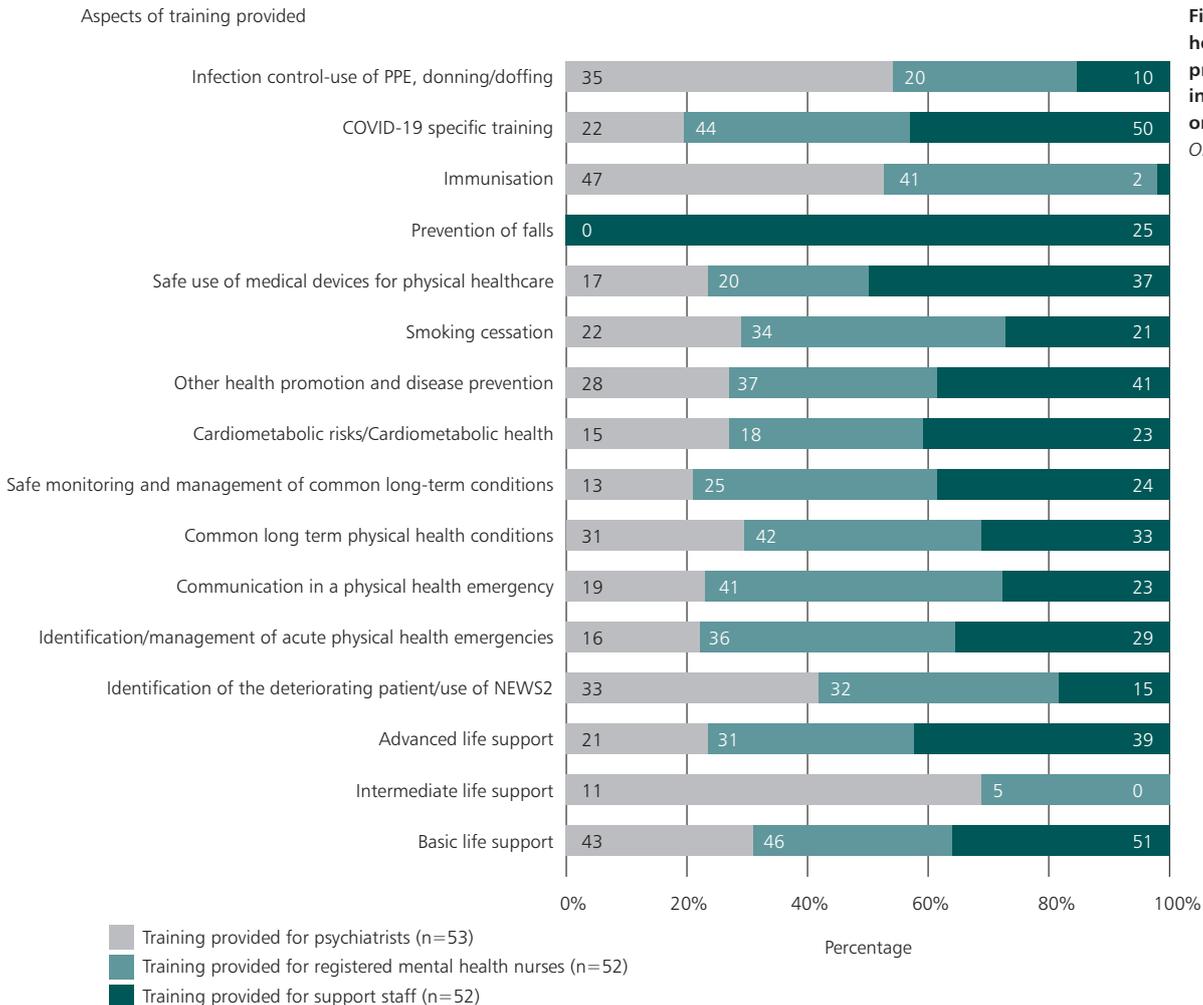


Figure 8.3 Physical health training provided to staff in mental health organisations
Organisational data

Physical health staff roles and care networks

The clinical complexity of the study sample and frequency with which new conditions were identified (see Chapter 5) and deteriorations occurred (see Chapter 9) highlight that simply upskilling mental health staff in physical health knowledge is not likely to be sufficient to meet patients' needs. Organisational strategies to ensure access to professionals with physical health expertise will also be necessary. The 2016 Academy of Medical Royal Colleges report highlighted the need for mental health organisations to employ medical, nursing, pharmacy and other healthcare staff with the necessary skills and knowledge to oversee and deliver appropriate physical healthcare.⁸

There were 17/56 organisations where it was reported that there was access to a medically trained doctor on-site at all times, in all hospitals with acute mental health (inpatient) wards. The minimum grade of doctor out of hours varied but was primarily junior doctors (40/56) (Table 8.3). In 5/56 organisations it was not a requirement that the out of hours doctor had in-date intermediate life support certification.

It was reported from 44/56 organisations that an arrangement was in place for physical health professionals to provide services within the mental health inpatient wards. However, the specialty of healthcare professionals providing services varied. Services from allied health professionals including speech and language therapy (37/44), dietetics (32/44) and occupational therapy (41/44) were most commonly provided. Despite dietetics being commonly provided the study data shown in this chapter suggests that this provision is either not sufficient to meet patient needs or it is not being effectively used by clinical teams (Figure 8.4 overleaf).

Access to medical expertise such as geriatric medicine, primary care, and diabetes specialists were less commonly provided. This is notable in the context of case reviewers' concerns with quality of care in both long-term condition management and as discussed in Chapter 9 on care of deteriorating patients.

Table 8.3 Minimum grade of doctor on-site, out of hours

	Number of organisations
Foundation level (FY1, FY2)	31
Core medical/internal medicine/specialty trainee (years 1-3), junior specialist trainee (CT1-3, ST1-3)	9
Staff grade	2
Associate specialist	2
Unknown	12
Total	56

Organisational data

Network relationships with physical health hospitals

An alternative way to ensure that access to relevant physical healthcare expertise is available is through the development of network relationships with hospitals focusing on physical health. Of the clinicians surveyed 317/412 (76.9%) reported that their workplace had networks, relationships or links with the nearest physical health hospital. However, 216/317 (68.1%) thought there was scope for improvement in these networks.

Healthcare professional views on supports in place to deliver physical healthcare

The thematic analysis of 112 free text responses to the mental healthcare professional survey highlighted several key themes relating to the level of training, confidence or support with regard to physical health of patients they care for (Table 8.4 overleaf).

Physical health professionals providing services within the organisation – Answer may be multiple; n=44

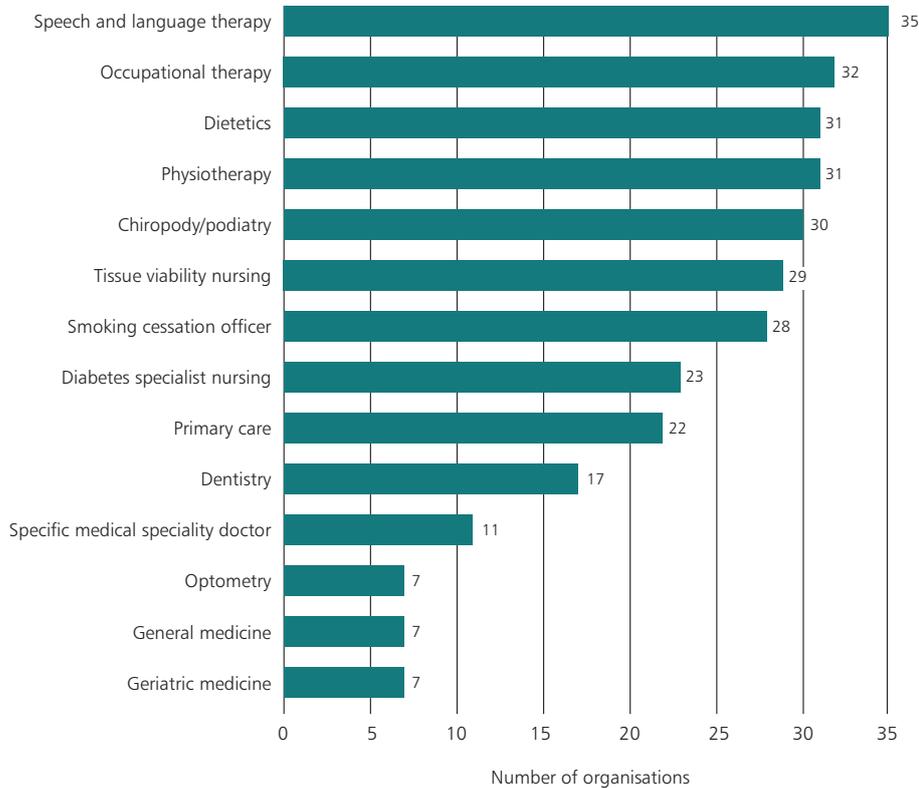


Figure 8.4 Physical health support services provided within mental health inpatient wards
Organisational data

Table 8.4 Themes from the mental healthcare professional survey relating to the level of training, confidence or support with regard to physical health

Theme
A perceived need and desire across nearly all surveyed staff for improved access to training and ongoing opportunities to build and sustain skills in physical health
Junior doctors reported on their experience of feeling accountable to deliver the majority of physical healthcare for inpatients. Many felt that they had inadequate training, experience and/or supervision and lacked the support of a sufficiently trained nursing work force to carry out monitoring and other general tasks needed to provide safe care
Mental healthcare staff stated that secondary care did not always understand the limitations of psychiatric inpatient care in providing physical healthcare. Many respondents noted scope for improvement in relationships, communication, services and care pathways that span these settings
The need for appropriately trained and qualified medical staff (not just upskilled mental health staff) to provide safe care to many inpatients with complex comorbidities and unmet primary care needs.
The role of new staffing models, technology and new pathways alongside training, secondments, supervisory and shadowing arrangements to improve the appropriateness of care delivered
Initiatives to improve physical health provision within psychiatric inpatient care tend to be short-term and transitory and/or implemented without the necessary organisational commitment, infrastructure and investment to support sustained improvements

Mental healthcare professional survey data

CASE STUDY 11 –***Positive practice in end of life care***

A 78-year-old patient with mild vascular dementia and metastatic lung cancer had been admitted with increasing challenging behaviour. Shortly after admission the patient became increasingly withdrawn and confused. An urgent in-reach review was provided by the respiratory and palliative care team who visited the ward and confirmed the patient was in the terminal stages of their illness. The ward team agreed that any transfer to an alternative care setting would be disruptive and distressing. End of life care planning was put in place with the family, mental health team and medical teams. A comprehensive plan was drawn up to provide symptom control. A few weeks later the patient died comfortably in the ward with their family present.

The case reviewers believed excellent care had been provided. They stated the close working relationships between all clinical teams, efforts to ensure the family were involved and supported throughout, the flexibility of the medical teams visiting the ward and exceptionally clear documentation in the patient's care plan which ensured all out of hours staff knew the care plan had contributed to exemplary end of life care.

	KEY FINDINGS	Data source
65	240/291 (82.5%) patients had at least one long-term condition	CQ
66	32/144 (22.2%) patients had elements of treatment for a long-term condition missed	CR
67	38/219 (17.4%) clinicians completing questionnaires stated that there were issues with monitoring of vital signs/ physical health observations during the inpatient stay	CQ
68	Occupational therapists (176/225; 78.2%), physiotherapists (93/225; 41.3%) and dietitians (49/225; 21.8%) were most commonly involved with caring for patients with long-term conditions	CQ
69	120/291 (41.2%) patients should have had another healthcare professional involved in their care but was not	CR
70	31/56 organisations provided training in common long-term conditions for psychiatrists and 42/52 organisations for registered mental health nurses (RMNs)	OQ
71	127/268 (47.4%) mental healthcare professionals reported that felt 'fairly' or 'less than fairly' confident and competent in caring for patients with long-term conditions	HPS
72	44/56 organisations reported that an arrangement was in place for physical health professionals to provide services within the mental health inpatient wards. However, these were variable with not all services being available across all wards	OQ
73	317/412 (76.9%) mental healthcare professionals reported that their workplace had networks, relationships or links with the nearest physical health hospital. However, 216/317 (68.1%) thought there was scope for improvements in these networks	HPS

Deterioration and transfers

A number of mental health patients have additional physical illness that may worsen during hospitalisation. In others an acute illness may occur that is not related to their long-term condition. Data presented in Chapter 6 show that 240/291 (82.5%) patients included in this study had one or more long-term physical health conditions.

In the clinician questionnaire data, there were 147/291 (50.5%) who had an acute episode that led to a transfer to a physical health hospital. Case reviewers identified 116/177 (65.5%) for whom this was the case.

Deterioration

Before an episode of acute physical illness there are often clinical indications that predict deterioration in physical health. Regular and timely clinical observations can track, identify, and predict such deteriorations, and enable early intervention to mitigate catastrophic outcomes. An early warning system commonly used in acute hospitals is the National Early Warning Score (NEWS2).²² In this study, treating clinicians reported that an early warning score was used for 115/131 (87.8%; not answered in 16) patients with acute illness (Table 9.1). Case reviewers found that an early warning score was not used for 29/116 (25.0%) patients and reported that 22/29 of these patients would have benefited from use of one, preventing a delay in treatment for seven patients.

Table 9.1 An early warning score was used in the week prior to transfer to a physical health hospital

	Number of patients	%
Yes	115	87.8
No	16	12.2
Subtotal	131	
Not answered	16	
Total	147	

Clinician questionnaire data

In response to the early warning score, changes were made to monitoring for 44/107 (41.1%; not applicable in 8) patients (Table 9.2). The changes included more frequent monitoring (38/44), escalation of care (8/44) and/or referral to an appropriate specialist (2/44), with more than one of the above steps taken in some cases.

Table 9.2 Changes were made to the patient's monitoring in response to the early warning score

	Number of patients	%
Yes	44	41.1
No	63	58.9
Subtotal	107	
Not applicable – no monitoring plan	8	
Total	115	

Clinician questionnaire data

Case reviewers also stated that other monitoring should have been carried out prior to transfer to an acute hospital for 28/116 (24.1%) patients. These include more frequent clinical observations (13/28), performing an ECG (6/28), relevant blood tests (4/28), checking blood glucose (3/28) and a complete physical examination (2/28). Some patients required more than one intervention.

Treating clinicians noted symptoms of the impending acute deterioration of physical health in 88/147 (59.9%) patients (Figure 9.1). Common symptoms were breathlessness (29/88), fever (20/88), altered consciousness (13/88), cough (13/88) and abdominal pain (10/88). Some patients had multiple symptoms. Case reviewers found that documentation of the above information incomplete in 18/88 cases reviewed.

In addition to symptoms of acute illness, other indicators for transfer were noted for 105/147 (71.4%) patients. These included abnormal blood test results in 33/105 (31.4%) patients, blood glucose in 8/105 (7.6%) and ECG in 12/105

(11.4%) patients. Also noted were changes to the early warning score (or its components), seizures, falls, inability to eat, and other factors, the details of which are provided in Figure 9.2 overleaf. Forty-two patients transferred had no indicators apart from their symptoms.

In the opinion of case reviewers, appropriate investigations were not completed for 22/116 (19.0%) patients, which included checking blood glucose (3 patients), other blood tests (14 patients) and an ECG (6 patients)

Symptoms of deterioration – Answers may be multiple; n=88

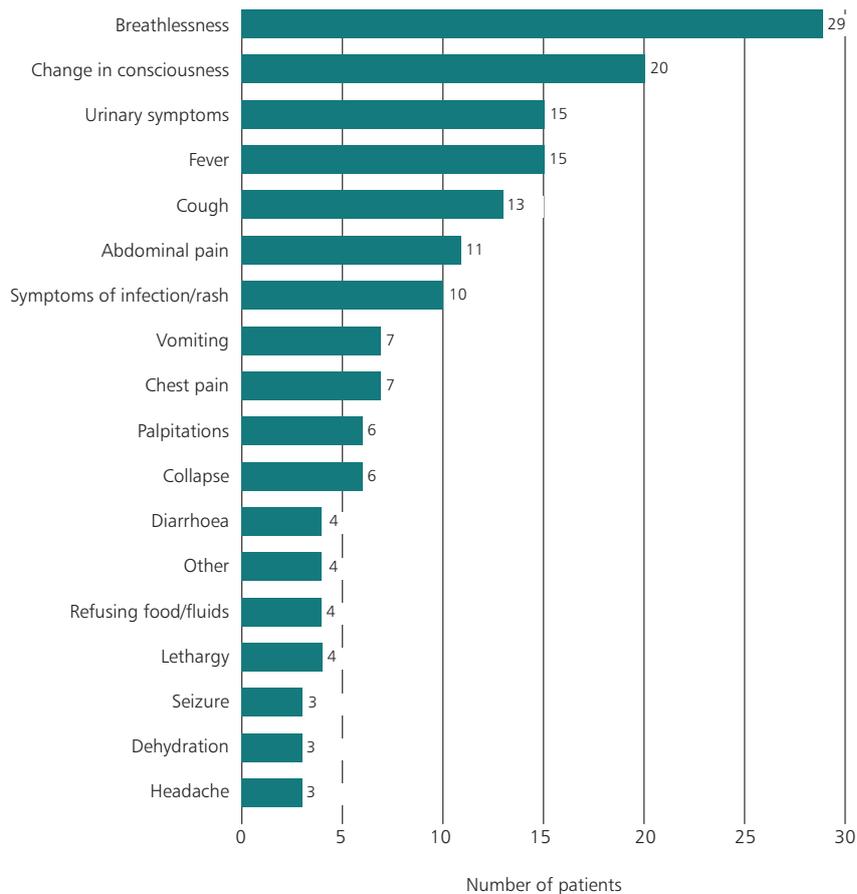


Figure 9.1 Symptoms prior to transfer
Clinician questionnaire data

Indicator of deterioration – Answers may be multiple; n=105

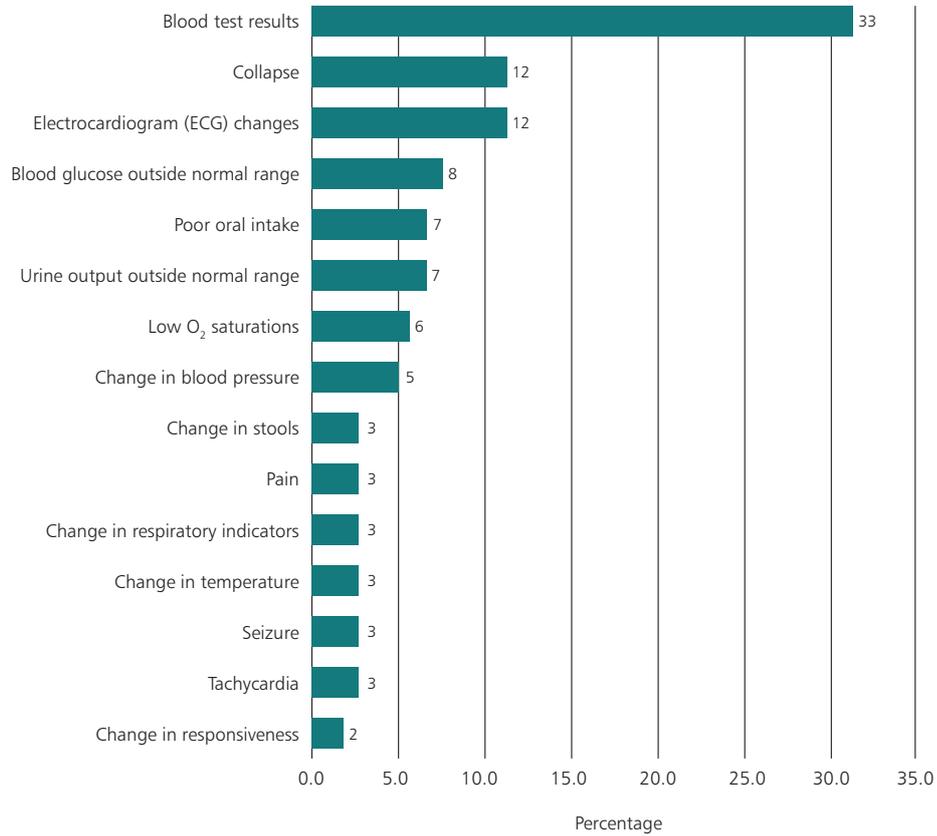


Figure 9.2 Indicators for transfer to a physical health hospital
Clinician questionnaire data

While it is important that early symptoms and signs of deterioration in physical health are identified, it is also important that prompt steps are taken to prevent (and reverse if possible) further deterioration. This can avoid transfer to an acute hospital and prevent a break in continuity of mental healthcare. Case reviewers found that 18/110 (16.4%; insufficient data to answer in 6) patients did not receive appropriate physical healthcare at an early stage (Table 9.3). They noted that timely and appropriate intervention would have prevented admission to acute hospital for eight patients. For example, early detection of elevated blood pressure could be managed by outpatient services or by telephone consultation to avoid an emergency transfer to acute hospital at a later stage.

Table 9.3 Deterioration in the patient's physical health was managed appropriately

	Number of patients	%
Yes	92	83.6
No	18	16.4
Subtotal	110	
Insufficient data to answer	6	
Total	116	

Clinician questionnaire data

Advice was sought from the physical health team for acute deterioration for 116/147 (78.9%) patients. Clinicians at the local physical health hospital were consulted in 98/116 (84.5%) instances, a local physical health liaison service was involved for 14/116 (10.3%) patients, with the remainder receiving advice from a GP (4/116; 3.4%) or other provider such as emergency services (10/116; 8.6%) (Table 9.4).

Table 9.4 Healthcare professions who provided advice following acute deterioration

	Number of patients	%
Clinicians at physical health hospital (by telephone or other means of communication)	98	84.5
Physical health liaison in the mental health inpatient setting	14	12.1
Emergency services	10	8.6
Other	8	6.9
GP/GP liaison	4	3.4
Palliative care team	3	2.6

Answers may be multiple; $n=116$
Clinician questionnaire data

Treatment/intervention was started for 68/147 (46.3%) patients by the mental health team based on advice received. The treatment offered included oxygen in 26/68, antibiotics in 26/68, analgesics in 19/68 and rehydration in 7/68 patients. Case reviewers commented that of the 62/116 patients who did not receive early treatment (antibiotics and/or intravenous fluids), it should have been offered to a further 9/62 patients.

Case reviewers also found delays in identifying acute deterioration by the mental health team for 20/107 (18.7%; insufficient data to answer in 9) patients (Table 9.5). One issue identified was diagnostic overshadowing, as the indicators of physical illness were attributed to the underlying mental health condition. Other reasons for delay included, not acting on a rising early warning score or missed signs of dehydration.

Table 9.5 Delays occurred in identifying the acute deterioration in physical health

	Number of patients	%
Yes	20	18.7
No	87	81.3
Subtotal	107	
Insufficient data to answer	9	
Total	116	

Case reviewer data

Transfer to a physical health hospital

A total of 147/283 (51.9%) patients were transferred to a physical health hospital with an acute physical health episode (Table 9.6). In general, no evidence of delay was found in the transfer of 130/147 (88.4%) patients to an acute hospital in the view of clinicians completing questionnaires. Where delays were identified (17 patients), they were attributable to the availability of a suitable ambulance and the logistics of organising transfers, each of which affected the transfer of 5/17 patients. There was a delay on three occasions due to patient refusal.

Table 9.6 Acute episode that led to transfer to a physical health hospital

	Number of patients	%
Yes	147	51.9
No	136	48.1
Subtotal	283	
Not answered	8	
Total	291	

Clinician questionnaire data

There were 85/142 (59.9%; not answered in 5) patients transferred who were detained under the Mental Health Act (1983) (or equivalent) for treatment of the mental health condition (Table 9.7).

Table 9.7 Patient being transferred to a physical health hospital was detained under the Mental Health Act (1983) (or equivalent)

	Number of patients	%
Yes	85	59.9
No	57	40.1
Subtotal	142	
Not answered	5	
Total	147	

Clinician questionnaire data

As mentioned previously, the principles of patient consent apply to all aspects of healthcare, including transfer to another hospital. When transfer to a physical health hospital is due to an acute illness, obtaining consent can be challenging, for example if the patient is drowsy or confused. Of the 147 patients transferred, mental capacity to consent to transfer to a physical health hospital was assessed in 55 and not in 40 patients (it was unknown in 52). Clinicians completing questionnaires reported that 32/55 patients assessed were deemed to have capacity, 20/55 were not. In 14/20 patients deemed not to have mental capacity, there was documented evidence that the transfer was in their best interests. Case reviewers found that appropriate procedures regarding the assessment of capacity were not conducted for 36/68 patients (and there was not sufficient data to answer this question for a further 48 patients).

In addition to the legal requirement for patient consent it is important to involve patients, their carers and family members (as appropriate) in planning treatment and care. Frequent and regular communication is emphasised in the Royal College of Psychiatrists' 'Standards for Inpatient Mental Health Services' (2019).²⁰ In 24/72 cases (insufficient data to answer in 44), case reviewers found

that communication with patients about their condition and management plan was not appropriate. There was no evidence that the carer/ family had been advised of the deterioration in physical health in 15/80 (not applicable in 24, insufficient data to answer in 12) furthermore they were not informed of the transfer to a physical health hospital in 17/79 (not applicable in 27, unknown in 10).

Case reviewers stated that transfer to an acute hospital could have been avoided in 16/116 (13.8%) patients. Early identification of the problem (9/16), early referral (3/16), appropriate advice from the physical health team (7/16) would have helped avoid the transfer. Multiple factors were identified in some cases.

CASE STUDY 12 – Avoidable transfer

A 34-year-old patient with a history of long-term alcohol use and self-neglect was admitted for detoxification therapy. The patient was known to have bronchial asthma, diabetes mellitus and a diabetic foot ulcer. At initial assessment they were noted to be tachycardic and blood tests suggested liver dysfunction. Despite this, and the fact that NEWS2 was routinely used throughout the hospital, the patient was only scheduled to receive a weekly physical health review. On day five of admission, the patient was found collapsed on the floor. Clinical assessment revealed evidence of sepsis with fever, high respiratory rate and heart rate and low blood pressure, requiring emergency transfer to the local physical health hospital.

Case reviewers were of the opinion that timely NEWS2 scoring would have identified physical health deterioration at a much earlier stage, possibly preventing sepsis and the necessary transfer to the physical health hospital.

Physical healthcare pathways

Organisational data showed that 35/56 mental health organisations had physical healthcare pathways for their inpatients that could prevent unnecessary acute physical health hospital admissions. In addition, 18/56 organisations had a specific pathway or protocol for inpatients with specific physical health conditions. These pathways were in the form of dedicated advice on the phone in 10/18, fast track pathway in 2/18, named contact in 3/18 and in-reach teams in 3/18 of organisations. In six other organisations, such arrangements were dependent on specific area or speciality, while one was an integrated organisation with formal arrangements with physical health specialties.

Of the 18 organisations mentioned above, ten also had protocols and policies on standards of management of common long-term health conditions in the hospital setting, such as lipid disorders, diabetes mellitus, COPD and cardiovascular disease including hypertension. These protocols included details of the frequency and type of monitoring offered in 9/18, medications in 5/18 and an escalation of care plan in 9/18 of organisations.

Availability of medical notes during hospital transfer
Timely and comprehensive handovers ensure continuity of care which is particularly important during transfer to another hospital. Organisational data showed that 39/56 organisations used a transfer letter, while 33/56 relied on a printout of case notes and mental health staff accompanying the patient. It was possible to share electronic notes at 20/56 organisations (Table 9.8). In addition, 18/56 organisations maintained a central record of inpatients transferred to a physical health hospital.

Mental health notes were sent with the patient in 52/140 (37.1%) transfers to an acute physical health hospital (not documented in seven cases). For the remaining patients, physical health clinicians had access to notes for 3/140 (2.1%) patients or could request them in 6/140 (4.3%) cases. However, mental health notes did not accompany the patient in 56/140 (40.0%) transfers. Other methods of communication included a referral or transfer letter in 14/140 (10.0%) cases, a printout of extracts of notes in 6/140 (4.3%) and a telephone handover in two cases (Table 9.9).

Table 9.8 Arrangements for the transfer of case notes with a patient to a physical health hospital

	Number of organisations
Notes are printed out/copied and physically transferred with the patient	30
A transfer letter including clinical summary is transferred with the patient	39
The patient is accompanied by mental health staff member who brings a written clinical summary	33
Mental health notes (relevant sections) are available for the physical health hospital on request	20
Mental health notes (relevant sections) are available for the physical health hospital on request	5
There is the possibility of shared electronic access of notes between the physical and mental health inpatient settings	20
Partial electronic access (if the patient opted for this)	2

Answers may be multiple; n=56
Organisational data

Table 9.9 Transmission of mental health notes to the physical health hospital

	Number of patients	%
Mental health notes were not sent	56	40.0
Mental health notes were sent with patient when transferred to physical health hospital	52	37.1
Referral/transfer letter was sent	14	10.0
Treating clinical team from physical health hospital requested patient's mental health notes	6	4.3
Printouts of extracts from the notes were sent with the patient when transferred to physical health hospital	6	4.3
Physical health hospital has complete electronic access to patient's mental health notes	3	2.1
A handover was carried out over the telephone	2	1.4

Answers may be multiple; n=140
Clinician questionnaire data

Record keeping and data management

There were 55/56 organisations that had some form of established electronic patient record (EPR) system. However, there was variation in the comprehensiveness of the electronic system with only 20/55 organisations reporting that all elements of the clinical record were on the electronic system (Table 9.10). The specific electronic record system used also varied across organisations with a total of 14 different systems identified. The most commonly used were RIO™ (n=17) and SystmOne™ (n=7).

Recording of physical and mental health conditions

Information about the prevalence and type of physical health comorbidities of patients with mental health conditions is essential for planning services that can respond to these needs. Despite having electronic note systems there was notable variation in standards for recording both mental and physical health diagnoses.

The majority of organisations (39/56) reported that there was a standardised method of recording physical healthcare plans, although 12/56 did not. Physical healthcare plans were often recorded in a separate tab on the electronic notes system (26/39).

Only 244/405 (60.2%) mental healthcare professionals working in mental health inpatient settings, who responded to the survey, thought the EPR allowed easy viewing/input of the patient’s physical health needs, and 142/143 (99.3%) thought that it could be improved.

Table 9.10 Sections included in the electronically available clinical records

	Number of organisations
Clinical annotations/care record/clinical notes	32
Case summary including discharge/admission summaries	31
Blood results	28
Investigation/test results	26
Hospital transfer documentation	23
Physical health observations/vital signs (heart rate, oxygen saturation, respiratory rate, blood pressure, temperature)	22
The entire clinical record (including all components listed here)	20
Prescriptions and medications	18
Early warning scores	15
None of the case record was available electronically	1

Answers may be multiple, n=56
Organisational data

Only 31/56 organisations reported that mental health conditions were recorded as ICD-10 codes (or equivalent) across the organisation (Table 9.11). There was even greater variation around coding for physical health conditions with only 10/56 organisations reporting that this was conducted as standard practice.

Table 9.11 Mental health diagnosis was recorded as ICD-10 codes

	Mental health diagnosis	Physical health diagnosis
	Number of organisations	Number of organisations
Information was recorded as standard	31	10
Information was recorded sometimes/inconsistently	4	16
Information was not generally recorded	17	26
Unknown	4	4
Total	56	56

Organisational data

There was also variation in practice where physical health diagnoses of comorbidities were recorded. The majority of organisations recorded these in a specific physical health section on the EPR, however, 13/56 indicated that diagnoses were not routinely recorded (Table 9.12).

Table 9.12 Records of known physical health diagnoses of comorbidities were kept

	Number of organisations
A specific free text physical health section on the electronic patient record	23
Physical health diagnoses were not routinely recorded	13
A specific physical health section on the electronic patient record which included ICD-10 (or equivalent) coding	12
Specific section in paper case note record	4
Standard proforma in paper case note record	3
No specific physical health section nor ICD-10 codes used, but documented in free text	2
Other	12

Answers may be multiple, n=56
Organisational data

Table 9.13 provides details of how physical health information was added to medical record systems, as reported by treating clinicians in mental health inpatient settings. An EPR system with a specific section for physical health conditions was available for 167/291 (57.4%) patients. Physical health information was recorded in paper-based case notes with a standard proforma for 26/291 (8.9%) patients, a specific section of the notes for 15/291 (5.2%) patients, or chronologically in the notes for 21/291 (7.2%) patients included in this study.

During the case review process, reviewers frequently noted significant challenges in navigating the available records to understand the patient’s physical health status, care planning and interventions being carried out. They described wide variation in practice of how information was stored (e.g. scanning and uploading physical health observations and ECGs) in the electronic record and reported difficulties in being able to effectively access and use this information.

Table 9.13 Medium used to record physical health information in the mental health notes

	Number of patients	%
A specific physical health section on the EPR - free-text	167	57.4
Chronologically documented with all other mental health information in the EPR	141	48.5
A specific physical health template on the EPR	69	23.7
Standard paper proforma in paper-based case note records	26	8.9
Chronologically documented with all other mental health information in paper-based case notes	21	7.2
Within a specific section for physical health in paper-based case note records	15	5.2

Answers may be multiple; n=291
Clinician questionnaire data

CASE STUDY 13 – Poor documentation

A 45-year-old patient with schizophrenia, diabetes and COPD was admitted with a relapse of psychosis. The admitting on-call doctor carried out an initial physical health assessment. The doctor undertook a medication reconciliation and documented that the day team needed to complete this process and take medical history.

Case reviewers noted that for the next four weeks ward round documentation included a cut and paste summary of this initial incomplete and inaccurate medication list and history. Admission physical health observations were also repeatedly re-entered although they were no longer contemporaneous nor accurate. There was an extensive physical health proforma in the patient’s notes which was incomplete apart from vital signs. Reviewers noted the safety risks presented by cutting and pasting inaccurate information into the clinical record and from the use of cumbersome assessment tools that were inconsistently used.

Access to primary care records

Despite the need for rapid access to a patient’s physical health records, 14/56 responding organisations had immediate electronic access to the patient’s primary care medical record with most relying on requests for this information to be sent (Table 9.14).

Table 9.14 Accessibility of notes from other providers

	Number of organisations
Complete electronic access (if the patient opted for this)	14
Paper records were sent on request	15
Electronic records were made available on request	19
Other	12

Answers may be multiple; n=56
Organisational data

Access to secondary care/acute physical healthcare records

Only 14/56 responding organisations had complete electronic access to secondary care/acute physical healthcare records and 23/56 organisations had no electronic access relying on requests for notes and transfers of that information.

Only 10/56 organisations reported that physical health hospitals had complete electronic access to mental health records and 32/56 had partial access (Table 9.15). In all, 20/56 organisations reported that there was the possibility of shared electronic access to notes between the physical and mental health inpatient settings.

Table 9.15 Accessibility of mental health inpatient setting case notes to clinicians in physical health hospitals

	Number of organisations
Complete electronic access by authorised clinical staff	10
Partial electronic access to clinical authorised clinical staff	32
Electronic records on request	9
Paper records on request	2
Telephone access only	0
Other	14

Answers may be multiple; n=56
Organisational data

DETERIORATION AND TRANSFERS

	KEY FINDINGS	Data source
74	An early warning score was not used for 29/116 (25.0%) patients and 22 of these patients would have benefited from one, preventing a delay in treatment for seven patients	CR
75	In response to the early warning score, changes were made to monitoring for 44/107 (41.1%) patients	CR
76	88/147 (59.9%) patients had symptoms of the impending acute deterioration of physical health	CQ
77	22/116 (19.0%) patients did not have appropriate investigations completed, which included checking baseline blood glucose, other blood tests and an ECG	CR
78	105/147 (71.4%) patients had other indicators for transfer in addition to symptoms of acute illness. These included abnormal blood test results in 33/105 (31.4%) patients, blood glucose in 8/105 (7.6%) and ECG in 12/105 (11.4%) patients	CQ
79	18/110 (16.4%) patients did not receive appropriate physical healthcare at an early stage. Case reviewers noted that timely and appropriate intervention would have prevented admission to acute hospital for eight patients	CR
80	Advice was sought from the physical health team for acute deterioration in 116/147 (78.9%) patients	CQ
81	20/107 (18.7%) patients had delays in identifying their acute physical deterioration by the mental health team	CR
82	147/283 (51.9%) patients were transferred to a physical health hospital with an acute physical health episode	CQ
83	Of the 147 patients transferred, mental capacity to consent to transfer to a physical health hospital was assessed in 55 and not in 40 patients (it was unknown in 52)	CQ
84	32/55 patients assessed for mental capacity to consent were deemed to have capacity, 20/55 were not. In 14/20 of patients deemed not to have mental capacity, there was documented evidence that the transfer was in their best interest	CQ

	KEY FINDINGS	Data source
85	36/68 patients did not have appropriate procedures followed regarding the assessment of capacity (there was not sufficient data to answer this question for a further 48 patients)	CR
86	18/56 organisations reported a specific pathway or protocol for inpatients with specific physical health conditions	OQ
87	18/56 organisations maintained a central record of inpatients transferred to a physical health hospital	OQ
88	16/116 (13.8%) patients could have avoided transfer to an acute hospital	CR
89	35/56 organisations reported having physical healthcare pathways for their inpatients that could prevent unnecessary acute hospital admissions	OQ
90	39/56 organisations used a transfer letter, while 33/56 relied on a printout of case notes and mental health staff accompanying the patient to a physical health hospital	OQ
91	55/56 organisations had some form of established electronic patient record system. However, there was variation in the comprehensiveness of the electronic system with only 20/55 reporting that all elements of the clinical record were on the electronic system	OQ
92	31/56 organisations reported that mental health conditions were recorded as ICD-10 codes across the organisation. There was even greater variation around ICD-10 coding for physical health conditions with only 10/56 organisations reporting that this was conducted as standard practice	OQ
93	244/405 (60.2%) mental healthcare professionals working in mental health inpatient settings, thought the electronic patient record allowed easy viewing/input of the patient's physical health needs, and 142/143 (99.3%) thought that it could be improved	HPS
94	Despite the need for rapid access to a patient's physical health records, 14/56 responding organisations had immediate electronic access to the patient's primary care medical record with most relying on requests for this information to be sent	OQ
95	10/56 organisations reported that physical health hospitals had complete electronic access to mental health records and 32/56 had partial access	OQ

Readmission from a physical health hospital

While a mental health inpatient setting provides secondary care for patients whose mental health condition could not be treated at home, it does not have the equipment, other resources, policies and protocols to provide the level of physical healthcare possible in an acute physical health hospital. This gap between physical healthcare provision in an acute physical health and mental health inpatient settings results in some patients having to return to the acute hospital, usually at short notice. It compromises patient safety and quality of care due to inadequate care planning and communication between the two teams.

There were 83/147 (56.5%) patients transferred to physical health hospitals who returned for readmission to the mental health inpatient setting and 42/83 patients who had multiple readmissions. Clinicians completing questionnaires considered 9/70 (13 unknown) discharges from the physical health hospital to be untimely and 13/83 handovers from the physical health hospital to be inadequate.

It is noteworthy that the physical health of 25 patients deteriorated during the short periods of readmission, resulting in higher intensity of physical healthcare in the acute hospital. Clinicians treating these patients reported that 18 patients required two readmissions and 11 needed even more readmissions.

Case reviewers found that 64/101 (63.4%) patients had been readmitted (unknown in 15) and were of the opinion that the patient was discharged from the acute hospital too soon in 16/64 cases reviewed. They also found that this adversely impacted the physical health/outcome for six patients. Case reviewers noted that there were multiple readmissions in 34 cases.

In the opinion of the case reviewers such multiple readmissions could have been avoided by better discharge planning by physical health hospitals in nine cases and better communication between physical and mental healthcare providers in six cases. Mental healthcare providers could have prevented multiple readmissions by early physical health management in 11 instances, better monitoring of physical health in six, early treatment of physical health conditions in six and improving communication between mental health colleagues in three instances (Table 10.1). More than one of the above improvements were required in some cases.

Table 10.1 Improvements in care that could have prevented multiple readmissions

	Number of patients
Access to medical liaison team/advice in mental health inpatient settings	14
Physical health management prior to admission to mental health inpatient setting	11
None of the above	11
Discharge planning in the physical health hospital	9
Communication/sharing of information between hospital providers	8
Monitoring of physical health conditions in the mental health inpatient setting	6
Treatment of physical health conditions in the mental health inpatient setting	6
Communication/documentation of physical health conditions between mental health inpatient setting staff	3

*Answers may be multiple; n=34
Case reviewer data*

**CASE STUDY 14 –
Multiple readmissions**

A 65-year-old patient with schizophrenia, diabetes, hypertension and heart failure was admitted for increasing aggression. A week after admission the patient was noted to be more breathless and transferred to the local physical health hospital with suspicion of worsening heart failure. They returned after two days of treatment by the heart failure team with advice to double the dose of diuretic medication. Assessment at the mental health inpatient setting at this stage revealed that the patient was lethargic and dehydrated, with a blood glucose of 14mmol/L. It was not clear from the discharge letter whether the patient’s diabetes medications had been changed. After discussion with the medical registrar, the patient was transferred back to the physical health hospital for acute management of their diabetes.

Case reviewers were of the opinion that not all physical healthcare conditions were optimised before transfer back to the mental health inpatient setting. Better communication including a comprehensive discharge summary and verbal handover should have accompanied the transfer. Readmission could have been avoided if decisions to transfer were made jointly by the physical health and mental health teams.

	KEY FINDINGS	Data source
96	83/147 (56.5%) patients transferred to physical health hospitals returned for readmission to the mental health inpatient setting and 42/83 patients who had multiple readmissions	CQ
97	9/70 (13 unknown) patient discharges from the physical health hospital were untimely and 13/83 handovers from the physical health hospital were inadequate	CQ
98	64/101 (63.4%) patients had been readmitted and were discharged from the acute hospital too soon in 16/64 cases reviewed	CR
99	Mental healthcare providers could have prevented multiple readmissions by early physical health management in 11 instances	CQ

Outcome and discharge

As mental healthcare is increasingly provided in the community, the mean length of hospital stays in mental health inpatient settings has fallen over the years and is about 40 days in patients with serious mental illness. In this study, mean length of hospitalisation was 71.3 days, with a median of 33 days and mode of 30 days. As seen in Figure 11.1, 50% of patients were discharged by the 110th day.

Discharge

In all, 249/291 (85.8%) patients included in this study were discharged from hospital during the study period and one remained in hospital. Most patients were discharged back to community care with 110/249 (44.2%) discharges to people's home or temporary residence. Transfer to a nursing or residential home or other care services occurred in 54/249 (21.7%) discharges, along with transfers to another physical health hospital for 53/249 (21.7%) and hospice for 20/249

(8.0%) patients, suggesting a need for ongoing care and support (Table 11.1). These discharge destinations reflect the study sample having one or more physical health conditions.

Table 11.1 Discharge destination

	Number of patients	%
Home/temporary place of residence	110	44.2
Nursing home/residential home/other care services	54	21.7
Physical health hospital	53	21.3
Other hospital/non-NHS run hospital/hospice	20	8.0
Prison/police station	4	1.6
Other	5	2.0
Unknown	3	1.2
Total	249	

Clinician questionnaire data

Cumulative percentage

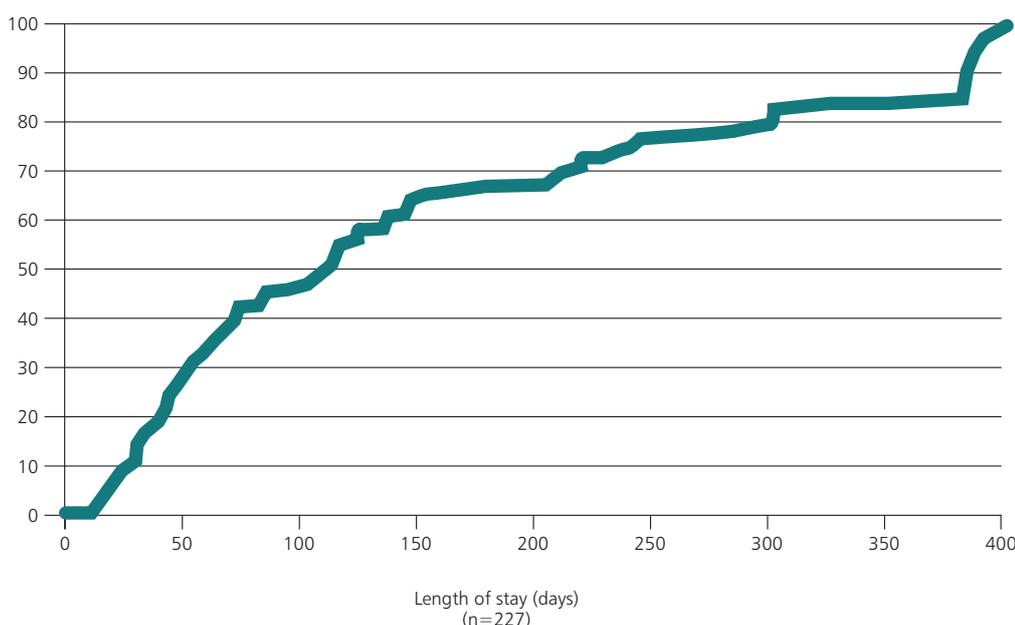


Figure 11.1 Length of hospital stay

Clinician questionnaire data

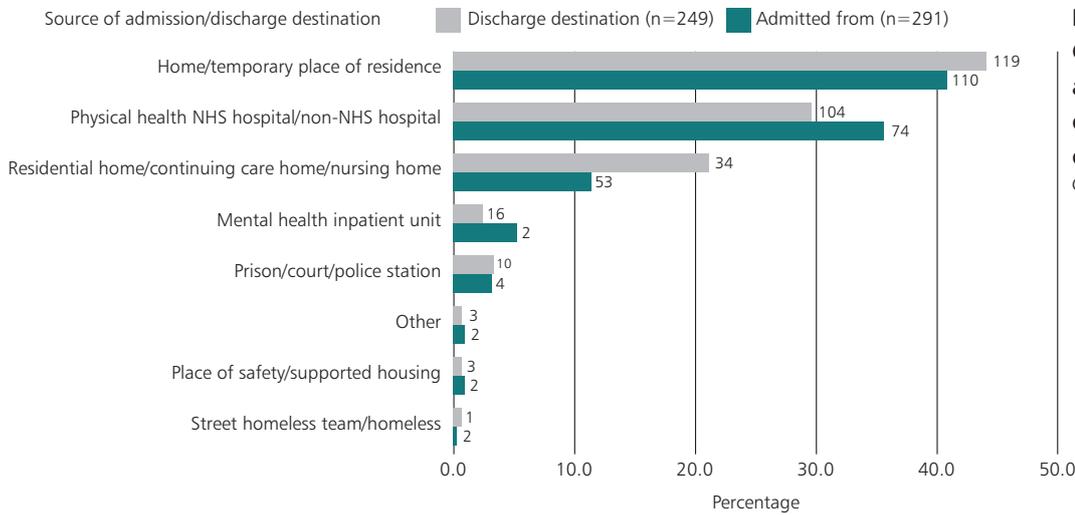


Figure 11.2
Comparison of admission and discharge destinations
Clinician questionnaire data

Clinician questionnaire data

Figure 11.2 compares admission and discharge locations. While 119/291 (41.0%) of all admissions were from patients’ homes, 110/249 (44.2%) discharges were back to their home or a temporary place of residence. Conversely, admissions from a physical health hospital formed 103/291 (35.4%) admissions whereas 53/249 (21.3%) of all discharges were to a physical health hospital. While there were no admissions from a hospice, 20/249 (8.0%) discharges were to a hospice. Finally, nursing, residential homes or other care facilities contributed to 34/291 (11.7%) of all admissions and received 54/249 (21.7%) of all discharges.

Physical frailty, irrespective of age, is known to increase the need for nursing home and other institutional care. Based on the demographics of our study sample, frailty could have been one of the factors for this outcome in some cases but would not account for all discharges. Further research is required to ascertain whether admission/transfer for physical health reasons or admission to physical health hospital are risk factors for residential/nursing/continuing care home care for mental health inpatients.

In 21/249 (8.4%) clinical questionnaires it was reported that the discharge summary was absent. The information included most frequently in discharge summaries was on medications for mental health in 218/228 (95.6%) and for physical health in 171/228 (75.0%) patients. Information on newly diagnosed physical health conditions was included in 70/228

(30.7%) summaries and on previously known conditions in 151/228 (66.2%) summaries (Table 11.2). Other physical health needs were included less consistently.

Table 11.2 Components of the discharge summary

	Number of patients	%
Details of any mental health medication(s) including changes made since admission	218	95.6
Details of any physical health medication(s) including any changes made since admission	171	75.0
Details of any physical health condition(s) including any deterioration or changes during the admission	151	66.2
Details of any newly diagnosed physical health conditions	70	30.7
Assessment of the patient’s capacity to care for their own physical health needs	39	17.1
Assessment of the patient’s ability to self-manage medications	31	13.6
Special requirements regarding nutrition	18	7.9
Special requirements regarding hydration	12	5.3
Details regarding follow-up	5	2.2
Advanced care plans	2	<1
Other	3	1.3

Answers may be multiple; n=228
Clinician questionnaire data

Case reviewers found that a discharge summary was included in 70/177 (39.5%) sets of case notes reviewed. Details of physical health were mentioned in 51/70 discharge summaries, medications in 60/70 and mental health risk in 45/70, while exercise and hydration needs were documented in just one (Figure 11.3). Assessed mental capacity to care for physical health needs was documented in 8/70 discharge summaries. This was notable as impaired mental capacity to care for physical health needs would impact on the ability to adhere to medication plans or look after physical and mental health after discharge, possibly resulting in deterioration and readmission. Case reviewers were of the opinion that appropriate physical health information was not included in 20/70 discharge summaries available to them.

Death

In this study 57 patients died: 40/57 died prior to discharge, 15 died in the mental health inpatient setting and 25 in the physical health hospital, and 17 patients died within 30 days of discharge. The causes of death were most commonly infections (n=17) or worsening long-term conditions (n=12). Aspiration pneumonia as a cause of death in 8/57 was likely to be a complication of swallowing difficulties either due to frailty, neurological disorders like dementia and Parkinson’s disease, or stroke. Other causes of death were other infections/sepsis (3/57), cancer (2/57), frailty (4/57) and cardiovascular disease including heart failure (6/57). The cause of death was unknown or inconclusive in 16/57 patients. Death was linked to the patient’s physical health condition for 25/40 (unknown in 17) patients and was not expected in 20/45 patients (unknown in 12).

Items recorded on the discharge summary – Answers may be multiple; n=70

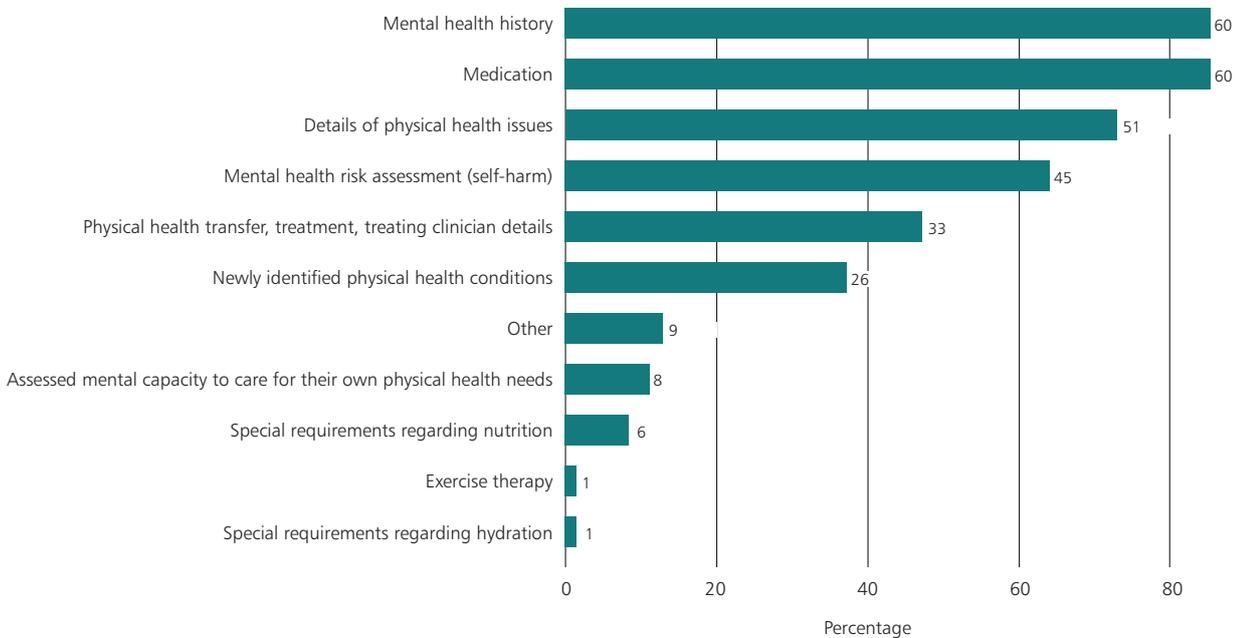


Figure 11.3 Contents of the discharge summary

Case reviewer data

Mortality reviews

Learning from deaths is an essential part of quality improvement work for healthcare organisations. Since September 2017, all trusts in England are required to have a process for mortality reviews. In December 2016, the Care Quality Commission (CQC) published '*Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England*'.³⁷ This was followed in March 2017 by the '*National guidance on learning from deaths*' published by the National Quality Board.³⁸ Furthermore, the Royal College of Psychiatrists has produced a 'Mortality review tool' for mental health trusts.³⁹

It was reported by 49/56 organisations that mortality reviews were undertaken (detail in Table 11.3). No response was received from four organisations, while the remainder said they "did not know" (3/56).

Table 11.3 Deaths routinely considered at mortality reviews

	Number of organisations
Deaths in and inpatient setting	45
Deaths following transfer to physical health hospital	34
Deaths within 30 days of discharge	36
Learning disabilities mortality review (LeDeR)	39
Other	14

Answers may be multiple; n=49
Organisational data

	KEY FINDINGS	Data source
100	For patients in the study, the mean length of hospitalisation was 71.3 days, with a median of 33 days	CQ
101	249/291 (85.6%) patients were discharged from hospital during the study period and one remained in hospital	CQ
102	21/249 (8.4%) patients did not have a discharge summary accessible in their notes	CQ
103	The information included most frequently in discharge summaries was on medications for mental health in 218/228 (95.6%) and for physical health in 171/228 (75.0%) patients	CQ
104	Information on newly diagnosed physical health conditions was included in 70/228 (30.7%) discharge summaries and on previously known conditions in 151/228 (66.2%)	CQ
105	20/70 discharge summaries did not contain all the appropriate physical health information in the case reviewers' opinion	CR
106	51/70 discharge summaries available for review contained details of physical health, medications in 60/70 and mental health risk in 45/70, while exercise and hydration needs were documented in just one	CR
107	8/70 discharge summaries contained information on the assessed mental capacity to care for physical health needs	CR

Overall quality of care

Case reviewers found that there was room for improvement in physical healthcare of 119/163 (73.0%, insufficient data to answer in three) patients (Table 12.1). Key aspects of care requiring improvement were treatment of long-term physical health conditions (62/119; 52.1%), documentation of physical health observations (61/119; 51.3%) and delays in identifying acute deterioration (19/119; 16.0%) patients. Documenting all physical health conditions (44/119; 37.0%) and communicating acute deterioration effectively (25/119; 21.0%) would also improve quality of care (Figure 12.1).

Table 12.1 Room for improvement in the physical healthcare provided in the mental health inpatient setting

	Number of patients	%
Yes	119	73.0
No	44	27.0
Subtotal	163	
Insufficient data to answer	14	
Total	177	

Case reviewer data

Area with room for improvement – Answers may be multiple; n=119

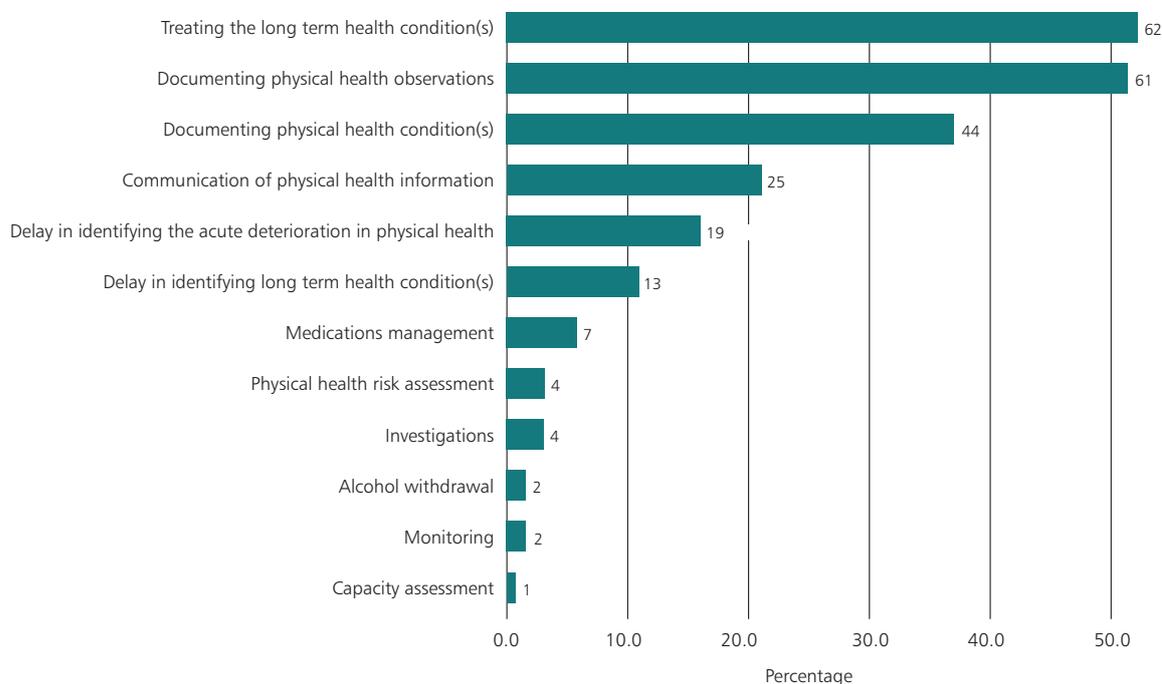


Figure 12.1 Areas with room for improvement

Case reviewer data

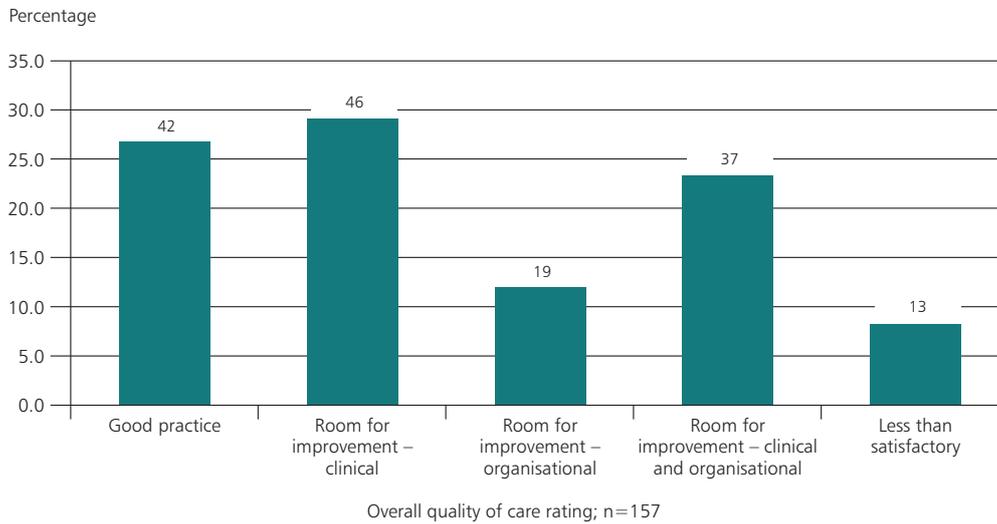


Figure 12.2 Overall quality of care
Case reviewer data

While physical healthcare is impacted in multiple ways, case reviewers found that a mental health condition impacted substantially on the quality of physical healthcare of 78/158 (49.4%; insufficient data to answer in 19) patients (Table 12.2). It also affected the clinical outcome for 25 patients.

Table 12.2 Mental health condition impacted on the quality of physical healthcare

	Number of patients	%
Yes	78	49.4
No	80	50.6
Subtotal	158	
Insufficient data to answer	19	
Total	177	

Case reviewer data

Considering the overall quality of care provided to patients in this study, case reviewers believed that it met standards of good practice for 42/157 (26.8%) patients. There was room for improvement in organisation of care for 19/157 (12.1%) patients, in clinical and organisational care for 37/157 (23.6%) and in clinical care for 46/157 (29.3%) patients. Case reviewers were of the opinion that overall quality of care was less than satisfactory for 13 patients reviewed (Figure 12.2).

	KEY FINDINGS	Data source
108	There was room for improvement in physical healthcare of 119/163 (73.0%) patients	CR
109	Key aspects of care requiring improvement were:	CQ
	- treatment of long-term physical health conditions (62/119; 52.1%)	CQ
	- documentation of physical health observations (61/119; 51.3%)	CQ
	- delays in identifying acute deterioration (19/119; 16.0%) patients	CQ
	- documenting all physical health conditions (44/119; 37.0%)	CR
	- communicating acute deterioration effectively (25/119; 21.0%)	CR
111	A mental health condition impacted substantially on the quality of physical healthcare of 78/158 (49.4%) patients	CR
112	The overall quality of care provided to patients in this study met standards of good practice for 42/157 (26.8%) patients. There was room for improvement in organisation of care for 19/157 (12.1%) patients, in clinical and organisational care for 37/157 (23.6%) and in clinical care for 46/157 (29.3%) patients	CR

Impact of the covid-19 pandemic

The COVID-19 pandemic illuminated and magnified the impact of structural health inequalities in people living with serious mental illness. As the COVID-19 pandemic unfolded, mental health inpatient units were faced with the task of providing care for a population who had higher risk from this disease and worse outcomes in units that had limited skills and facilities to provide physical healthcare for unwell or at-risk patients.

In addition to revealing systemic problems however, the COVID-19 pandemic also contributed to rapid advancements in practice. This study sought to understand what learning, progress and challenges had been faced by mental health inpatient units during this time. Organisations were asked if aspects of care had changed since the pandemic and if so, in what way, what factors contributed to these changes and, what were the biggest barriers to providing care. The types of developments reported by 35/56 organisations are summarised in Table 13.1.

Table 13.1 Areas where changes in practice occurred due to the COVID-19 pandemic

Area of care
Infection prevention and control - increased training, staff awareness, staff skills, policies and systems for testing and acting on outbreaks
Improved systems for infection screening and swabbing
End of life care – advancement of rate of development of policies and procedures and relationships/pathways with palliative care teams
Preventative care, e.g. initiation of routine vitamin D supplementation and smoking cessation support
Venous thromboembolism risk assessment – increased awareness of risk from experience of caring for isolating patients
Management of the deteriorating patient – upskilling through training and increased staff experience
Technology - virtual care reviews including access to acute trust providers
Remote consultations - Accurx and Attend Everywhere
Networks and relationships with respiratory physicians
Networks and relationships with geriatric services
Increased knowledge of respiratory illness and when to escalate
Knowledge and skills in oxygen use
Physical health observations monitoring and use of NEWS2
Availability and use of physical health monitoring equipment
Care planning for patients who are clinically vulnerable
Immunisation assessment and provision – COVID-19 and flu
Infectious disease screening
Admission, transfer and discharge policy/procedures
Staffing policies and relocation of staff to areas with increased physical health need
Increased awareness in staff of risks of smoking
New staffing models, e.g. recruitment of GP and physician associate
Development of physical health screening tool
System level initiatives to reduce unnecessary transfers to acute hospital settings

Organisational data

Organisations cited a range of factors that helped facilitate these developments in 31/56 organisations. Leadership, relationships with acute hospitals, physical health infrastructure and physical health governance were all commonly cited as facilitators (Table 13.2). These facilitators may be relevant more widely to advancing organisation and system-level developments in physical health provision. Other factors thought to have facilitated change included training (COVID-19 specific education), the infection prevention and control team, the development of care pathways, technology and primary care networks.

Table 13.2 Key factors that helped facilitate positive COVID-19 innovations

	Number of organisations
Leadership	27
Relationships with local acute hospitals	22
Physical health infrastructure, e.g. equipment, facilities, diagnostics	20
Physical health quality and governance structures	20
Other	5

Answers may be multiple, n=35
Organisational data

Organisations described a range of barriers to implementing these changes in 43/56 organisations. Patient concordance with infection control procedures and staff skills and confidence in physical healthcare were considered the largest barriers (Table 13.2). Again, these barriers may be relevant more widely to understanding challenges to advancing organisation and system level advancements in physical health provision.

Table 13.2 Biggest barriers in providing physical healthcare to mental health inpatients during COVID-19

	Number of organisations
Patient compliance with infection control protocols and restrictions	37
Staff skills and confidence in physical healthcare	31
Access to advice and input from physical health professionals	20
Staff compliance with infection control protocols	19
Staff confidence/competence in delivering end of life care	14
Carer understanding of infection control protocols and restrictions	11
Challenges in ensuring equal prioritisation of patients for hospital transfer by the local acute hospital staff	10
Lack of access to diagnostics	8
Relationship with acute hospitals	5
Lack of policies and procedures for end of life care	4
Lack of physical health equipment	4
Lack of trust leadership structures to support development and implementation of new physical health policies	3
Other	9

Answers may be multiple; n=43

Organisational data

Additional challenges noted included the build/physical environments of mental health units which were not conducive to infection prevention and control and significant difficulties presented by not having the facilities to treat patients in isolation, e.g. shared toilets/showers/bedrooms on some units.

Staff confidence and competence in delivering COVID-19 care

Clinicians were asked to rate their confidence and competence in monitoring and treating patients with clinically stable COVID-19. In total, 143/223 (64.1%) rated themselves as at least (or more than) mostly confident and competent (Table 13.3). There were 187/249 (75.1%) who rated themselves as at least (or more than) mostly confident and competent in infection prevention and control (Table 13.4). These responses were higher than for management of other long-term conditions perhaps indicating the impact of relentless focus on upskilling staff in disease management.

Table 13.3 Staff reported confidence to provide physical health monitoring and/or treatment for patients with COVID-19 who were clinically stable

	Number of clinicians	%
I am mostly confident and feel that I am mostly competent	75	33.6
I can perform the required tasks with complete confidence and a high degree of competence	68	30.5
I am fairly confident/competent	45	20.2
I have some confidence/competence in performing the required tasks but am aware of some shortfall	21	9.4
I have low confidence in this area and do not feel at all that I have the required competence to perform this task	14	6.3
Subtotal	223	
Not applicable – these tasks are never part of my job description	33	
Total	256	

Mental healthcare professional survey data

Table 13.4 Staff reported confidence in infection prevention and control

	Number of clinicians	%
I can perform the required tasks with complete confidence and a high degree of competence	99	39.8
I am mostly confident and feel that I am mostly competent	88	35.3
I am fairly confident/competent	42	16.9
I have some confidence/competence in performing the required tasks but am aware of some shortfall	15	6.0
I have low confidence in this area and do not feel at all that I have the required competence to perform this task	5	2.0
Subtotal	249	
Not applicable – these tasks are never part of my job description	7	
Total	256	

Mental healthcare professional survey data

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Glossary

Term	Abbreviation	Definition
National Early Warning Score		This involves calculating a set of physical observations including respiratory rate, oxygen saturation (on air or oxygen), systolic blood pressure, pulse rate, consciousness and temperature to provide a total score between 0 and 7. Patients scoring 0 require a minimum of 12 hourly observations, while those scoring 1-4 require observations every 4-6 hours. A score of 3 in a single parameter or total of 5 should trigger hourly observations and escalation to the medical team looking after the patient and a consideration for moving to an appropriate higher care clinical area. A total score of 7 or over should trigger continuous monitoring, review by the medical team and transfer to critical care.
Medicines reconciliation		Medicines reconciliation is the process of identifying an accurate list of a person's current medicines (which can be from a variety of sources) and comparing it with the current list in use. Any discrepancies should be identified and changes documented.
Rapid tranquilisation	RT	This is the use of medication usually intramuscular or exceptionally, intravenous, where oral medication is not possible or appropriate and urgent sedation is needed.
Comprehensive physical health review		This health review focused on physical health problems such as cardiovascular disease, diabetes, obesity and respiratory disease.
Cardiometabolic risk assessment		An assessment of the risk to a patient of having a cardiovascular event such as heart attack or stroke when one or more risk factors are present. Some major risk factors include: obesity, high LDL ("bad") cholesterol, high blood fat (triglycerides), low HDL ("good") cholesterol, high blood pressure, diabetes and smoking tobacco.
		This is a condition in which a person has trouble controlling emotions or behaviours
Blood-borne viruses	BBVs	Hepatitis B, Hepatitis C and HIV are the 3 main blood borne viruses.
CQUIN		The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered.
Polypharmacy		This is when people are regularly taking at least five different medications.
ICD-10 codes		The International Classification of Diseases is a globally used tool for coding healthcare conditions.

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