

A Picture of Health?

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

SUMMARY



A Picture of Health?

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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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.

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.

SUMMARY

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

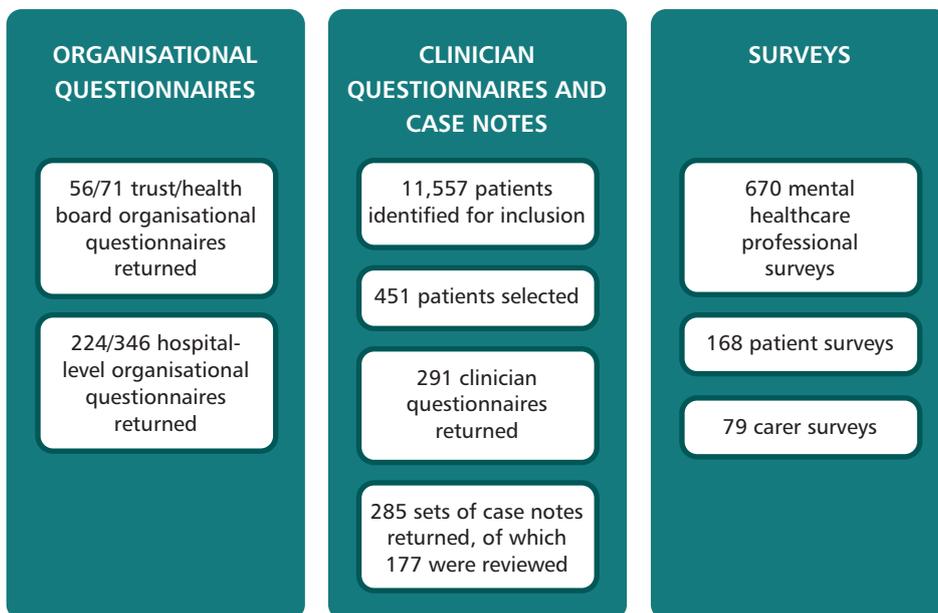
An organisational questionnaire was received from 56 mental health organisations. Hospital level questionnaires were returned from 224 hospitals which were part of 56 organisations, the majority (182/224; 81.3%) were NHS mental health inpatient settings with or without specialised commissioned units.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



Participation and data returned

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

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

	<ul style="list-style-type: none"> b. Prompt treatment in the physical health hospital c. A plan for readmission to the mental health inpatient setting developed by the physical and mental healthcare teams working together. Include: <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 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>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> <ul style="list-style-type: none"> a. Enabling carers/family/friends to provide staff on the ward with information about the patient’s physical health b. Access to clear information on what general physical health assessments are carried out when a patient is admitted to the ward c. Access to: <ul style="list-style-type: none"> - Healthy lifestyle advice - How family/friends/carers can support good physical health d. Ensuring that with patient consent, patients and their carers/family/friends can: <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> <ul 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"> a. Assessment and screening tools b. Specialist advice c. Interventions and prescribed treatment (especially for dependence) d. 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>

Method and data returns

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.

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