A PICTURE OF HEALTH?

Bridging the gap between physical and mental healthcare in adult mental health inpatient settings

NCEPOD

Improving the quality of healthcare

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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The Medical and Surgical Clinical Outcome Review Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.

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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 data 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. 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

EXECUTIVE SUMMARY

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.

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 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 physical health conditions* recorded on discharge from the mental health facility:

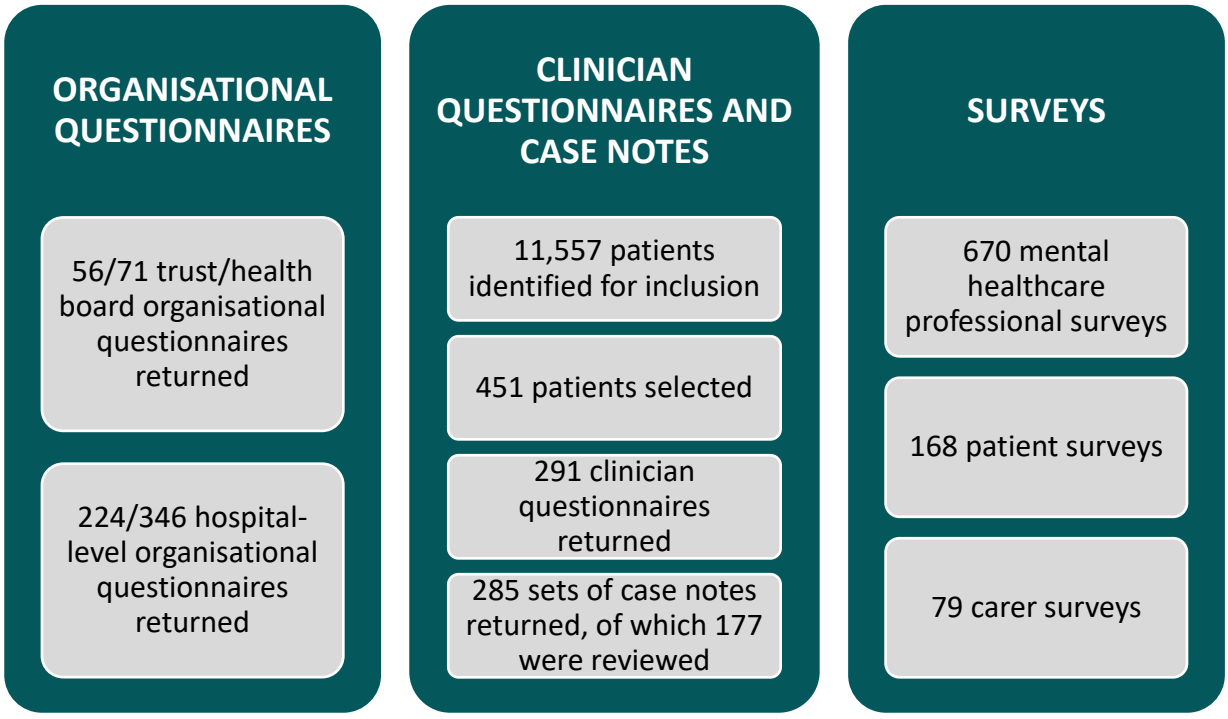
- Chronic obstructive pulmonary disease/asthma
- Cardiovascular disease
- Diabetes

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.*

Data returned



Key messages

The five key messages shown in the infographic have been agreed as the primary focus for action.

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	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. ***Target audience:*** *Mental healthcare professionals and receiving mental health ward medical and nursing staff*
2	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. This should start within 4 hours* and include, but is not limited to: 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 **This is in line with the Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2022)*

	Target audience: *Mental healthcare professionals with support from allied health professionals*
3	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: 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: - 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 ***Target audience:*** *Mental healthcare professionals supported by physical healthcare professionals*
4	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. *This is in line with NICE Quality Standard 120 (Medicines optimisation 2016)* https://www.nice.org.uk/guidance/qs120 ***Target audience:*** *Pharmacy staff in mental health inpatient settings and physical health hospitals*
5	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: 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 ***Target audience:*** *Mental health executive boards and physical health executive boards supported by commissioners*
6	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:

	a. A comprehensive clinical summary which includes, but is not limited to: - 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) 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: - 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 ***Target audience:*** *Mental health executive boards and physical health executive boards supported by commissioners and all healthcare professionals*
7	Develop and implement an organisational policy and protocol to involve patients, carers/friends/family in the patient's physical healthcare. This could include: 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: - 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: - 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 ***Target audience:*** *Mental health executive boards and mental healthcare professionals, associated patient involvement groups*
8	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: 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 ***Target audience:*** *Mental healthcare professionals and executive boards supported by commissioners*
9	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: 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) *This is in line with Making Every Contact Count:* *https://www.makingeverycontactcount.co.uk/* ***Target audience:*** *Mental healthcare professionals, local authorities and commissioners*
10	Record the correct physical health diagnosis, ICD-10/SNOMED CT codes (or equivalent) in mental health clinical records and discharge summaries. ***Target audience:*** *Mental healthcare professionals, hospital coders*
11	Ensure that electronic patient records in mental health inpatient settings: - 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 ***Target audience:*** *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*
12	Provide a discharge summary to the patient, their carer/s, GP and community mental health team within 24 hours of discharge. This should include: - 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 ***Target audience:*** *Mental healthcare professionals*

INTRODUCTION

THE FULL INTRODUCTION CAN BE FOUND IN THE APPENDICES

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.

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. 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

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 a 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 for asking for help".

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

"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."

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."

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"

CHAPTER 1: METHOD

FULL DETAILS CAN BE FOUND IN APPENDIX 1

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.

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.

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.*

Data collection and analysis

Data from clinical and organisational questionnaires, case notes and surveys were reviewed to assess the care provided. Data have been presented throughout this report from different data sources coded for ease of reference as:

CQ – clinician questionnaire
CR – case reviewers
OQ – organisational questionnaire
HPS – health professional survey
PCS – patient carer survey

NB: For all data presented, percentages are calculated only where the denominator is greater than 100.

CHAPTER 2: DATA RETURNED AND DEMOGRAPHICS

FULL DETAILS CAN BE FOUND IN APPENDIX 2

Data returned

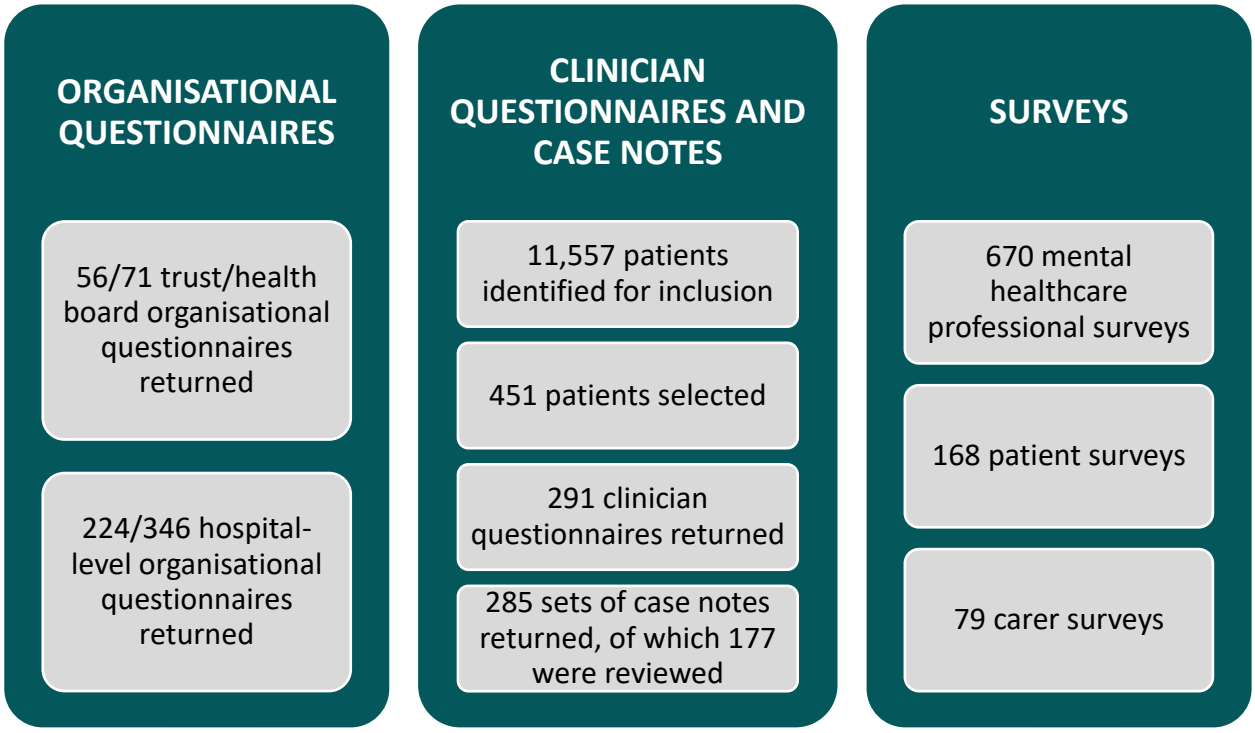


Figure 2.1 Participation and data returned

Demographics of the study sample population

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. The sample 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).

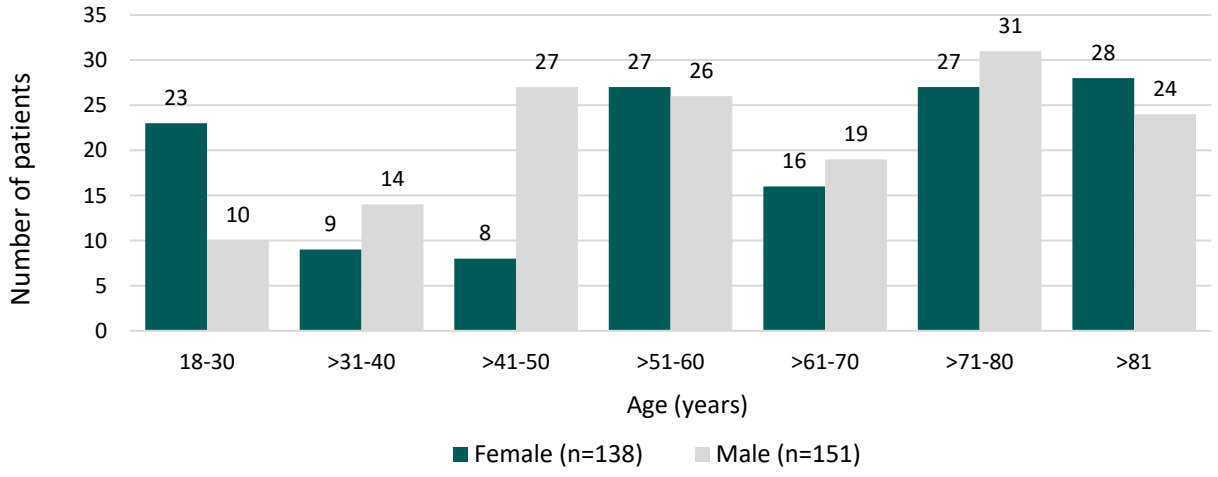


Figure 2.2 Age and gender of the study sample population
Clinician questionnaire data

CHAPTER 3: ADMISSION

FULL DETAILS CAN BE FOUND IN APPENDIX 3

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.[1]

	KEY FINDINGS	Data source	Position in Appendix 3
1	191/291 (65.6%) patients were detained under the Mental Health Act (1983) (or equivalent)	CQ	Table 3.1 Page 11
2	103/291 (35.4%) patients were transferred from the emergency department or general wards of a physical health hospital	CQ	Table 3.2 Page 12
3	169/268 (63.1%) patients were admitted outside 'normal working hours'	CQ	Table 3.3 Page 12
4	Physical health conditions were not included in the initial medical clerking for 29/150 (19.3%) patients	CR	Table 3.4 Page 12/13
5	201/291 (69.1%) patients had two or more physical health conditions	CQ	Figure 3.2 Page 13
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	Narrative Page 14 Paragraph 2
7	39/223 (17.5%) patients did not have their capacity to consent assessed at admission	CQ	Narrative Page 14 Paragraph 2
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	Narrative Page 14 Paragraph 3

CHAPTER 4: INITIAL ASSESSMENT

FULL DETAILS CAN BE FOUND IN APPENDIX 4

	KEY FINDINGS	Data source	Position in Appendix 4
9	33/291 (11.3%) patients did not have an initial physical health assessment at the time of admission to hospital	CQ	Narrative Page 15 Paragraph 1
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	Table 4.1 Page 15
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	Figure 4.1 Below and Page16

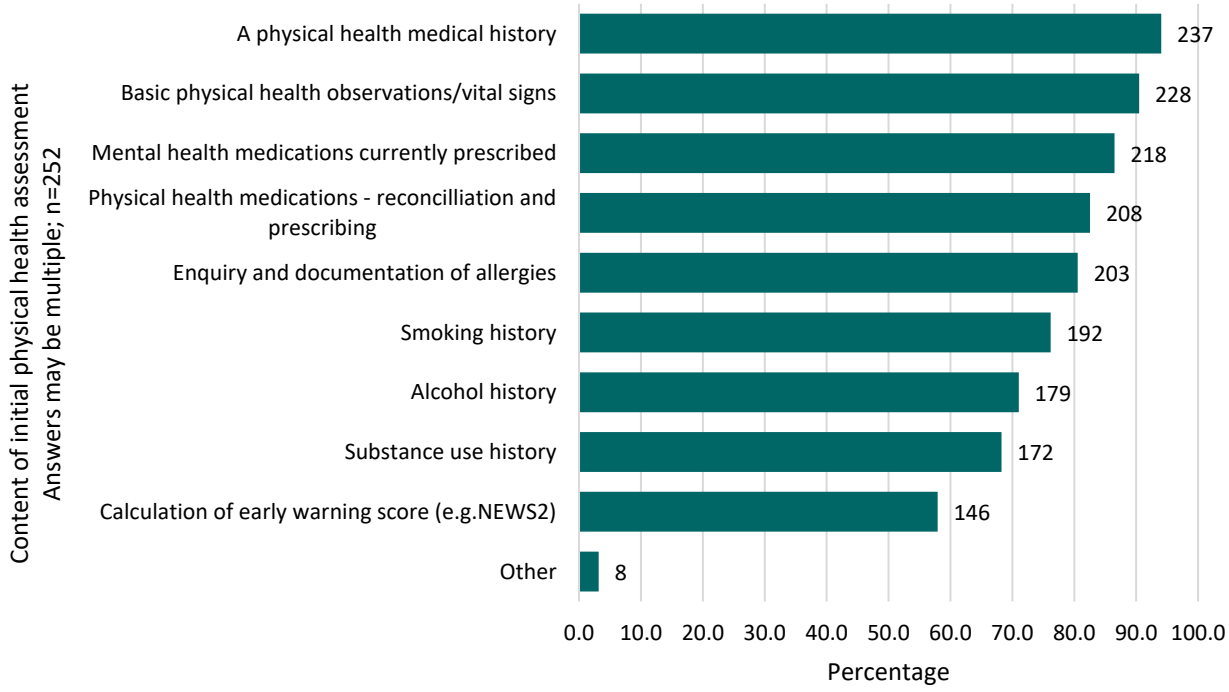


Figure 4.1 Content of initial physical health assessment

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	Figure 4.2 Page 16/17

13	Physical health and mental health medications were documented for 208/252 (82.5%) and 218/252 (86.5%) patients respectively	CQ	Narrative Page 16 Paragraph 2
14	An initial physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients	CR	Narrative Page 17 Paragraph 1
15	A plan for physical health observations was not recorded for 48/217 (22.1%) patients (assess in 217/252)	CQ	Table 4.3 Page 17/18
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	Narrative Page 18 Paragraph 3
17	14/56 organisations did not have a protocol for responding to patients who refuse physical health observations	OQ	Narrative Page 18 Paragraph 4
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	Narrative Page 19 Paragraph 3
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	Table 4.6 Page 19/20
20	19/56 organisations had no policy for reviewing physical health at each clinical review	OQ	Narrative Page 20 Paragraph 1

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.

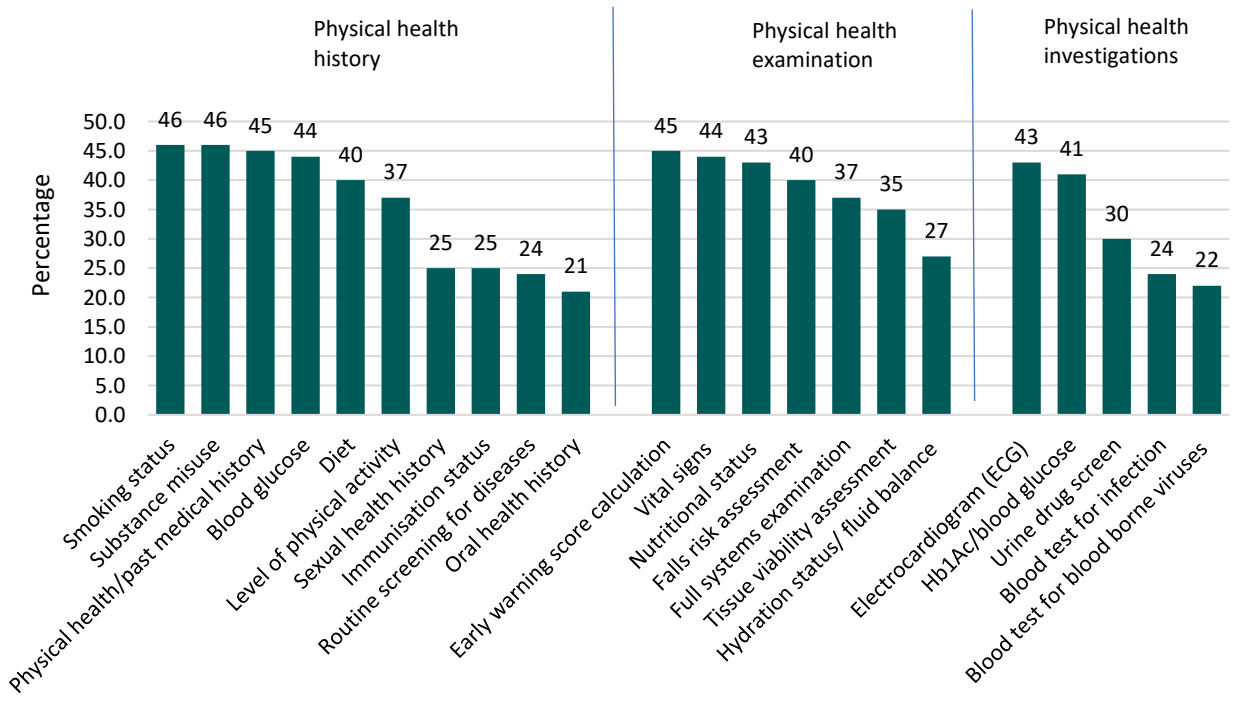
Case reviewers were of the opinion that timely assessment and administration of medications would have prevented the complications occurring and the need for a hospital transfer.

CHAPTER 5: COMPREHENSIVE PHYSICAL HEALTH REVIEW

FULL DETAILS CAN BE FOUND IN APPENDIX 5

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.[1] Patients should be informed of the outcome of this assessment and follow-up investigations, or treatments acted upon promptly.

	KEY FINDINGS	Data source	Position in Appendix 5
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	Figure 5.1 and Figure 5.2 Below and Pages 22/23



Components of the comprehensive physical health review; n=50

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

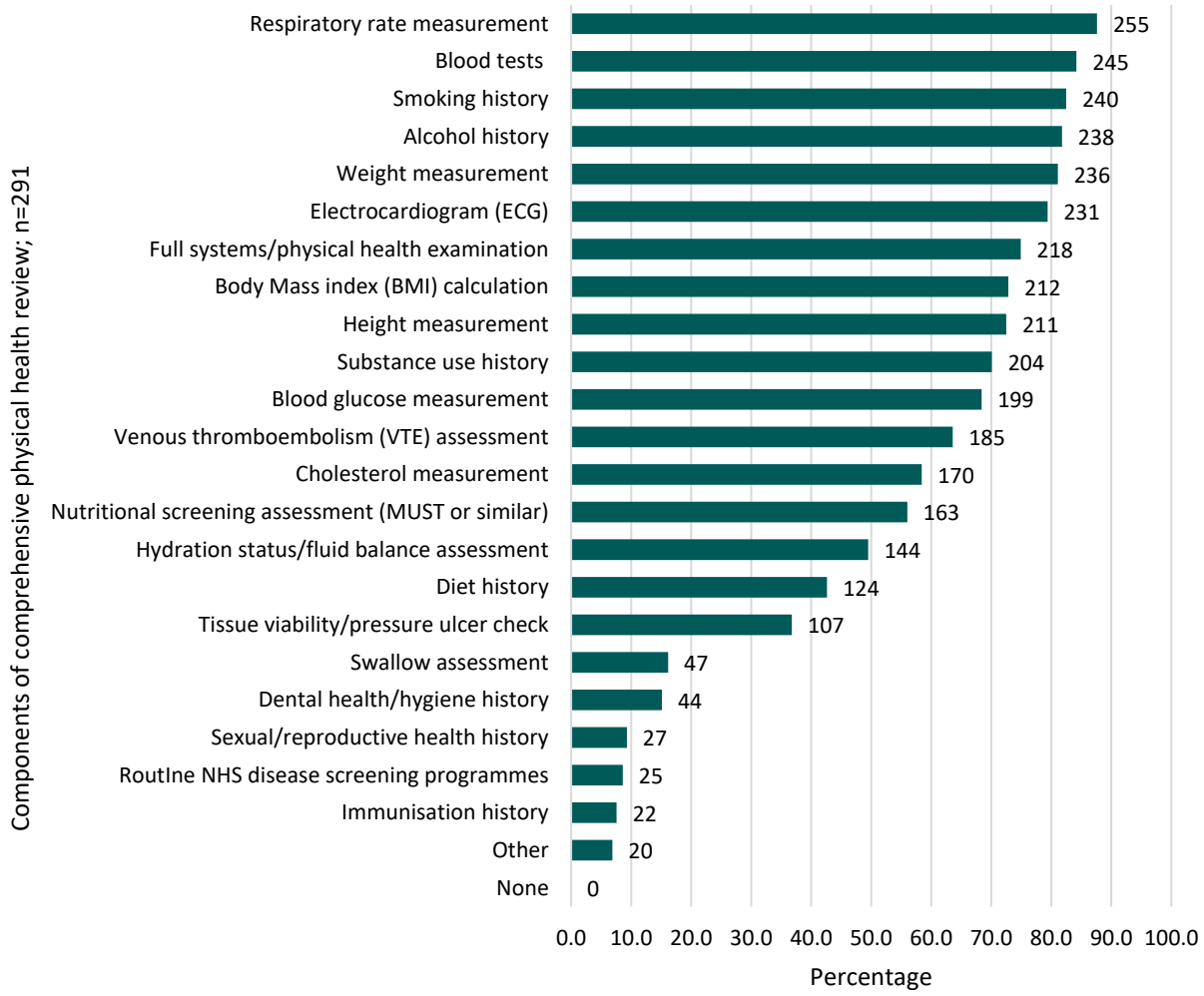


Figure 5.2 Comprehensive physical health review components

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	Table 5.1 Page 22
23	38/271 (14.0%) patients did not have a comprehensive physical health review carried out until a week after admission	CQ	Figure 5.3 Page 23/24
24	For 43/136 (31.6%) patients the comprehensive physical review was not carried out within the appropriate time frame	CR	Table 5.2 Page 24
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	Narrative Page 24 Paragraph 2
26	50/56 organisations had a policy requiring that a cardiometabolic risk assessment is performed on all patients during their inpatient stay	OQ	Narrative Page 25 Paragraph 3

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	Narrative Page 25 Paragraph 4
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	Table 5.3 Page 25
29	16/56 organisations had a policy stipulating that exercise should be available daily	OQ	Table 5.4 Page 26
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	Narrative Page 26 Paragraph 2
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	Narrative Page 27 Paragraph 2
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	Table 5.5 Page 27
33	54/101 (53.5%) patients had no documented evidence that a plan was put in place to support smoking cessation after discharge	CR	Narrative Page 27 Paragraph 3
34	238/291 (81.8%) patients had a history taken for alcohol use for 204/291 (70.1%) patients for substance use	CQ	Narrative Page 28 Paragraph 2
35	124/291 (42.6%) patients had a diet history taken and 163/291 (56.0%) a nutritional screening assessment	CQ	Narrative Page 28 Paragraph 4
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	Narrative Page 28 Paragraph 5
37	144/291 (49.5%) patients had an assessment of hydration status/fluid balance	CQ	Narrative Page 28 Paragraph 6
38	27/291 (9.3%) patients had their sexual and reproductive history assessed	CQ	Narrative Page 29 Paragraph 4

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	Narrative Page 29 Paragraph 5
40	82/291 (28.2%) patients had a new physical health condition identified following their physical health assessment	CQ	Narrative Page 26 Paragraph 6
41	40/82 patients required a specialist referral and for 60/82 patients a treatment was initiated	CQ	Narrative Page 30 Paragraph 2
42	71/291 (24.4%) patients had local care pathways or pre-existing arrangements with physical healthcare providers used as part of their care plan	CQ	Table 5.7 Page 30

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.

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.

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.

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.

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.

CHAPTER 6: PHYSICAL HEALTH MONITORING AND CARE PLANNING

FULL DETAILS CAN BE FOUND IN APPENDIX 6

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.[1] 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.

	KEY FINDINGS	Data source	Position in Appendix 6
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	Narrative Page 31 Paragraph 4
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	Narrative Page 32 Paragraph 1
45	39/56 organisations reported there was a policy stating that a physical healthcare plan should be recorded for all patients	OQ	Narrative Page 32 Paragraph 2
46	Physical healthcare plans were formulated for 155/291 (53.3%) patients	CQ	Narrative Page 32 Paragraph 2
47	Where a physical healthcare plan had been developed, and could be reviewed, 123/155 (79.4%) specified multidisciplinary team roles	CR	Narrative Page 32 Paragraph 2
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	Narrative Page 32 Paragraph 2
49	83/177 (46.9%) physical healthcare plans were appropriate. Reasons for them not being appropriate included lack of	CR	Narrative Page 33 Paragraph 2

	consistent and clear proactive planning about what to do in the event of refusing assessment and interventions		
50	127/205 (62.0%) patients had documentation as to whether the outcomes of the physical health review had been discussed with them	CQ	Narrative Page 33 Paragraph 3
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	Narrative Page 33 Paragraph 3
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	Narrative Page 33 Paragraph 4
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	Narrative Page 33 Paragraph 5
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	Narrative Page 34 Paragraph 3
55	164/291 (56.4%) clinician questionnaires provided detail of efforts and strategies to engage the patient in the physical health assessment process	CQ	Narrative Page 35 Paragraph 1

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.

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.

CHAPTER 7: PHYSICAL HEALTH MEDICATIONS

FULL DETAILS CAN BE FOUND IN APPENDIX 7

The Royal College of Psychiatrists' '*Standards for Inpatient Mental Health Services'* (2019) require that medicines reconciliation is carried out to ensure accurate and appropriate treatment is maintained when patients move across boundaries of care and that patients have their medications reviewed at least weekly.[1] As part of National Institute of Clinical Excellence (NICE) Quality Standard 120, mental health providers should ensure that systems are in place for people who are inpatients in an acute setting, to have a reconciled list of their medicines within 24 hours of admission.[2]

The 2016 Academy of Medical Royal Colleges report on improving the care of people with serious mental illness recommends that health professionals receive sufficient training to be aware of all medicines prescribed for the patient, are able to work closely with the pharmacist to optimise the use of the medicines and are able to monitor the physical side effects of psychotropic and other medicines prescribed for physical and mental conditions.[3]

	KEY FINDINGS	Data source	Position in Appendix 7
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	Table 7.1 Page 37
57	20/56 organisations had implemented e-prescribing and medicines administration	OQ	Table 7.2 Page 38
58	16/20 organisations had an e-prescribing system that could warn the prescriber of contraindications/drug interactions	OQ	Narrative Page 38 Paragraph 3
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	Table 7.4 Page 38/39
60	237/291 (81.4%) patients were prescribed physical health medications	CQ	Narrative Page 39 Paragraph 1
61	A total of 184/237 (77.6%) patients were prescribed more than three medications for their physical health	CQ	Figure 7.1 Below and Page 39
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	CQ CR	Narrative Page 40 Paragraph 1

	were prescribed physical health medications during their hospital stay		
63	213/291 (73.2%) patients had a full medicines reconciliation (including receiving indicated current prescription of medication) within 24 hours of admission	CQ	Narrative Page 40 Paragraph 5
64	36/66 patients did not have all contraindications or interactions with psychotropic medication documented that should have been	CR	Narrative Page 41 Paragraph 3

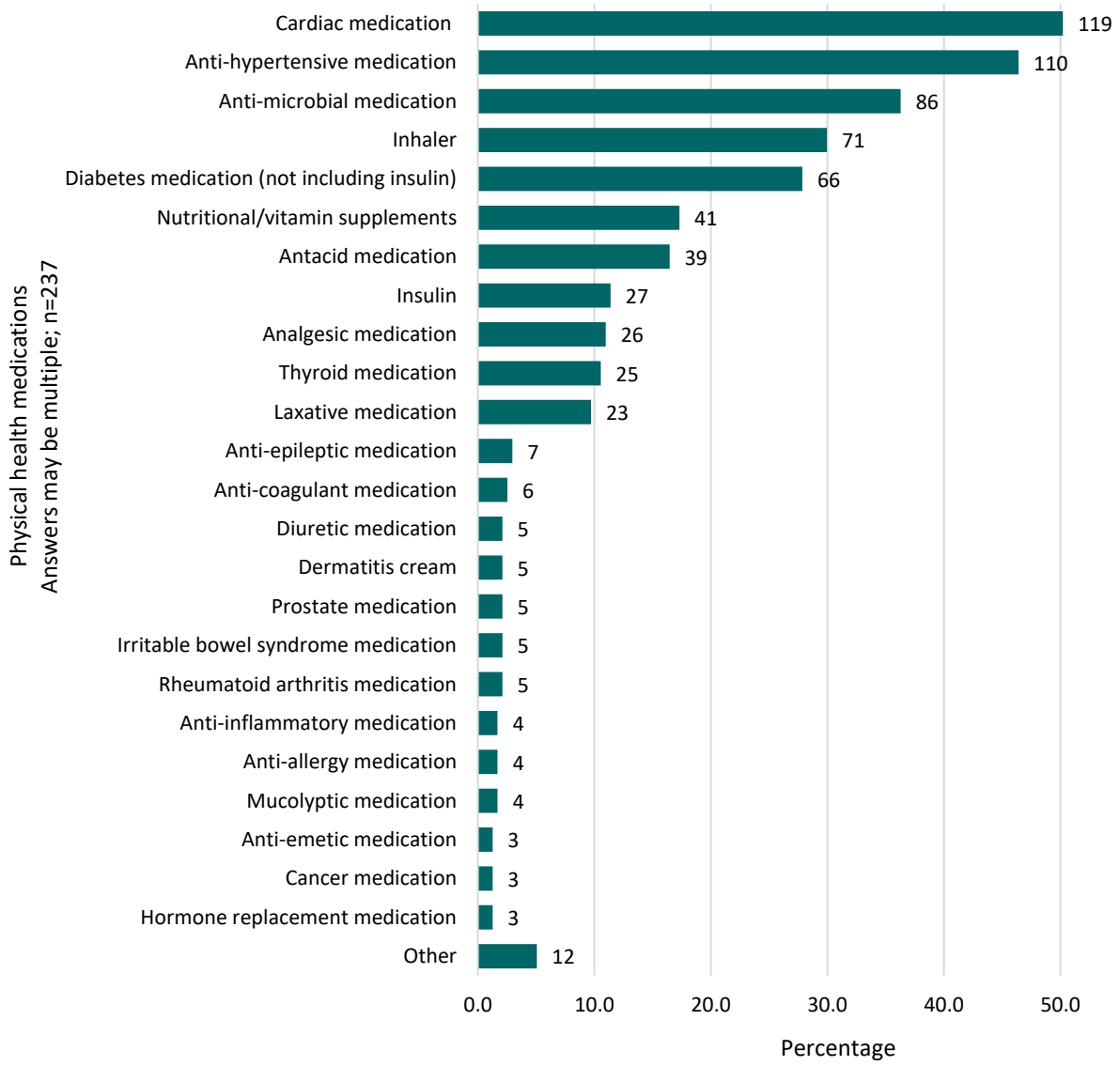


Figure 7.1 Prescribed medications for physical health conditions

CASE STUDY 9: MEDICATION RECONCILIATION AND LONG-TERM CONDITIONS

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.

CHAPTER 8: LONG-TERM HEALTH CONDITIONS

FULL DETAILS CAN BE FOUND IN APPENDIX 8

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.[3]

	KEY FINDINGS	Data source	Position in Appendix 8
65	240/291 (82.5%) patients had at least one long-term condition	CQ	Figure 8.1 Page 42

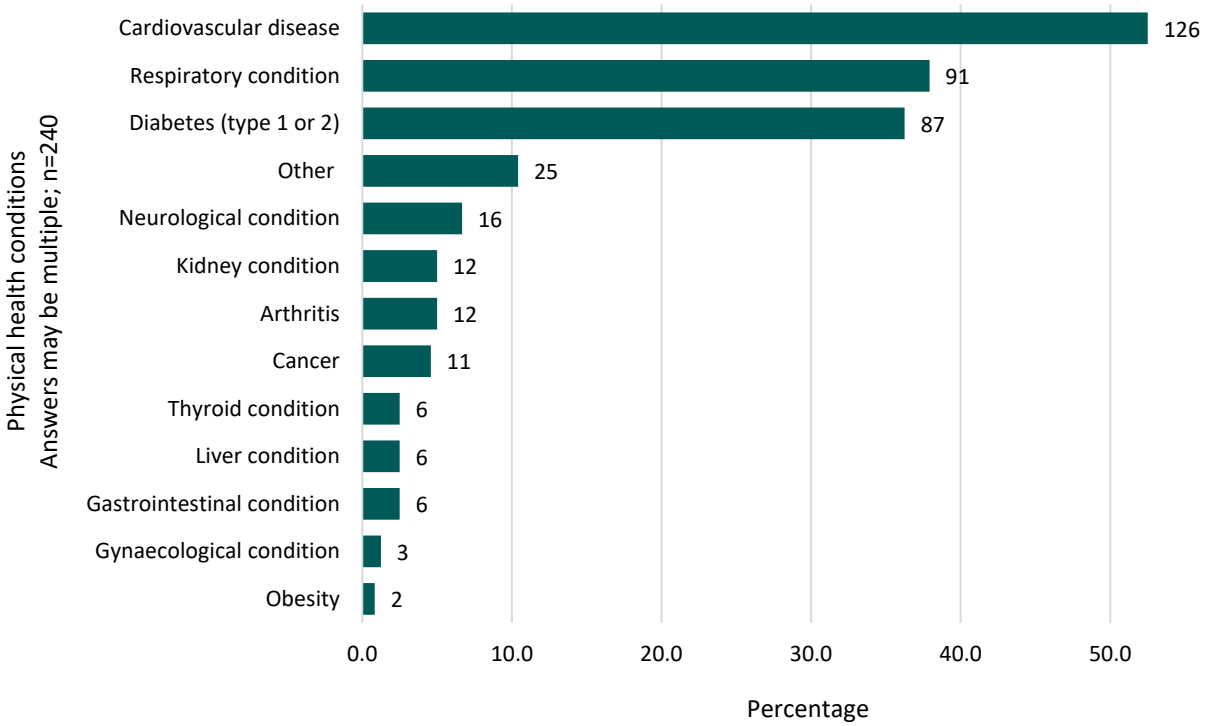


Figure 8.1 Detail of long-term health conditions in the study sample

66	32/144 (22.2%) patients had elements of treatment for a long-term condition missed	CR	Narrative Page 43 Paragraph 2
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	Narrative Page 43 Paragraph 5
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	Figure 8.2 Below and Page 44

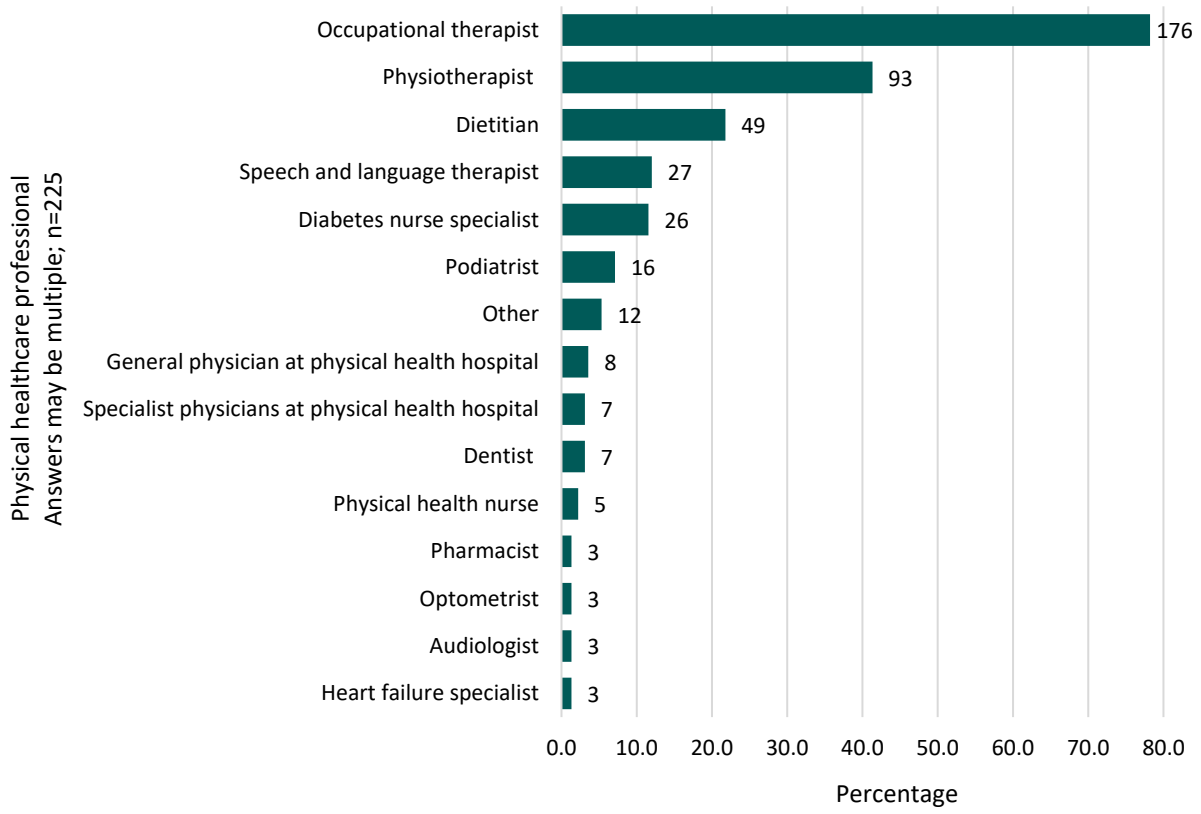


Figure 8.2 Healthcare professionals involved in assessing patients with long-term conditions

69	120/291 (41.2%) patients should have had another healthcare professional involved in their care but was not	CR	Narrative Page 44 Paragraph 2
70	31/56 organisations provided training in common long-term conditions for psychiatrists and 42/52 organisations for registered mental health nurses (RMNs)	OQ	Narrative Page 45 Paragraph 3
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	Table 8.2 Page 45/46
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	Figure 8.4 Below and Page 47

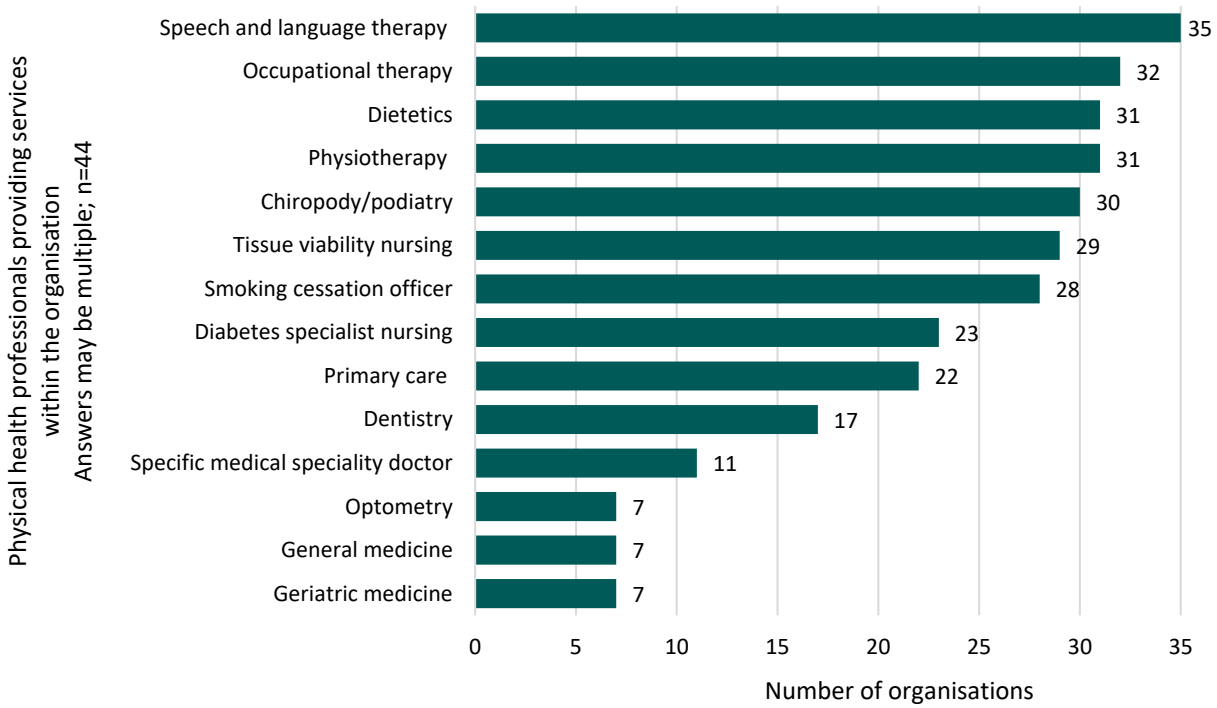


Figure 8.4 Physical health support services provided within mental health inpatient wards

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	Narrative Page 47 Paragraph 3

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.

CHAPTER 9: DETERIORATION AND TRANSFERS

FULL DETAILS CAN BE FOUND IN APPENDIX 9

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.

	KEY FINDINGS	Data source	Position in Appendix 9
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	Narrative Page 49 Paragraph 3
75	In response to the early warning score, changes were made to monitoring for 44/107 (41.1%) patients	CR	Table 9.2 Page 49/50
76	88/147 (59.9%) patients had symptoms of the impending acute deterioration of physical health	CQ	Figure 9.1 Page50

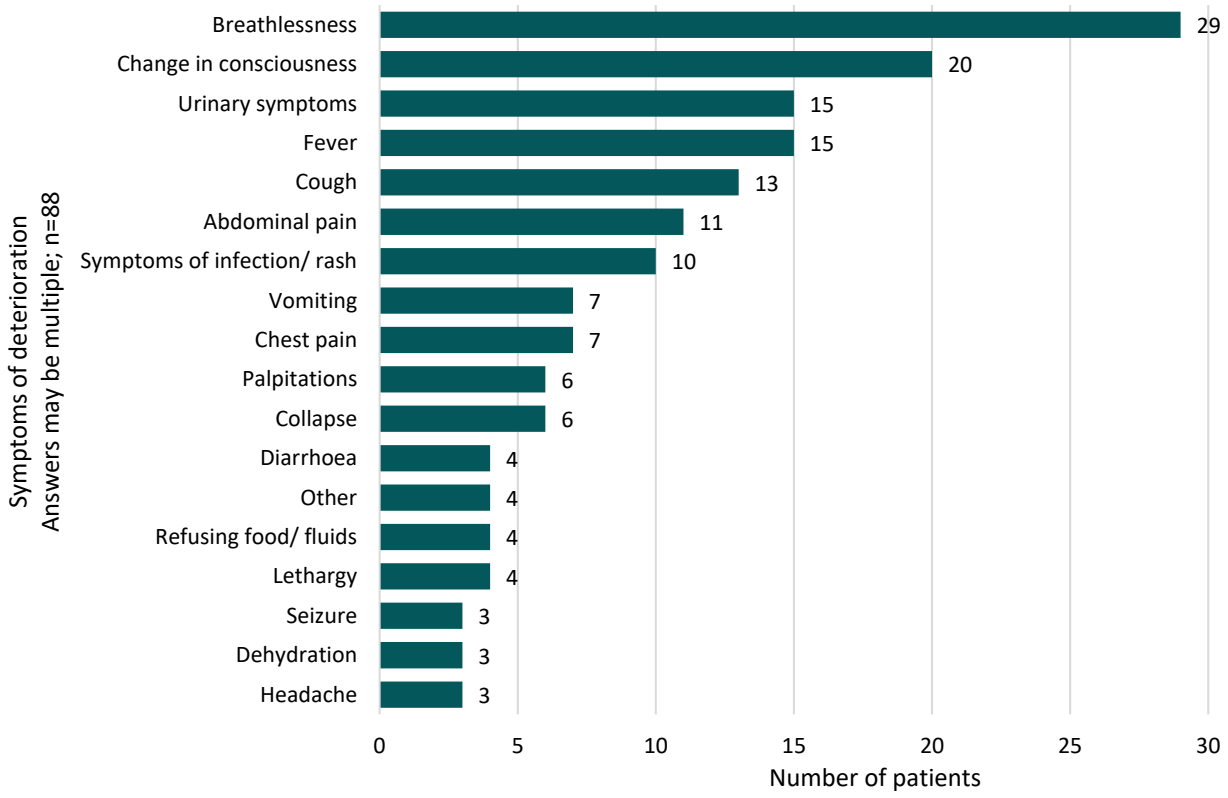


Figure 9.1 Symptoms prior to transfer

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	Narrative Page 51 Paragraph 2

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	Figure 9.2 Page 51

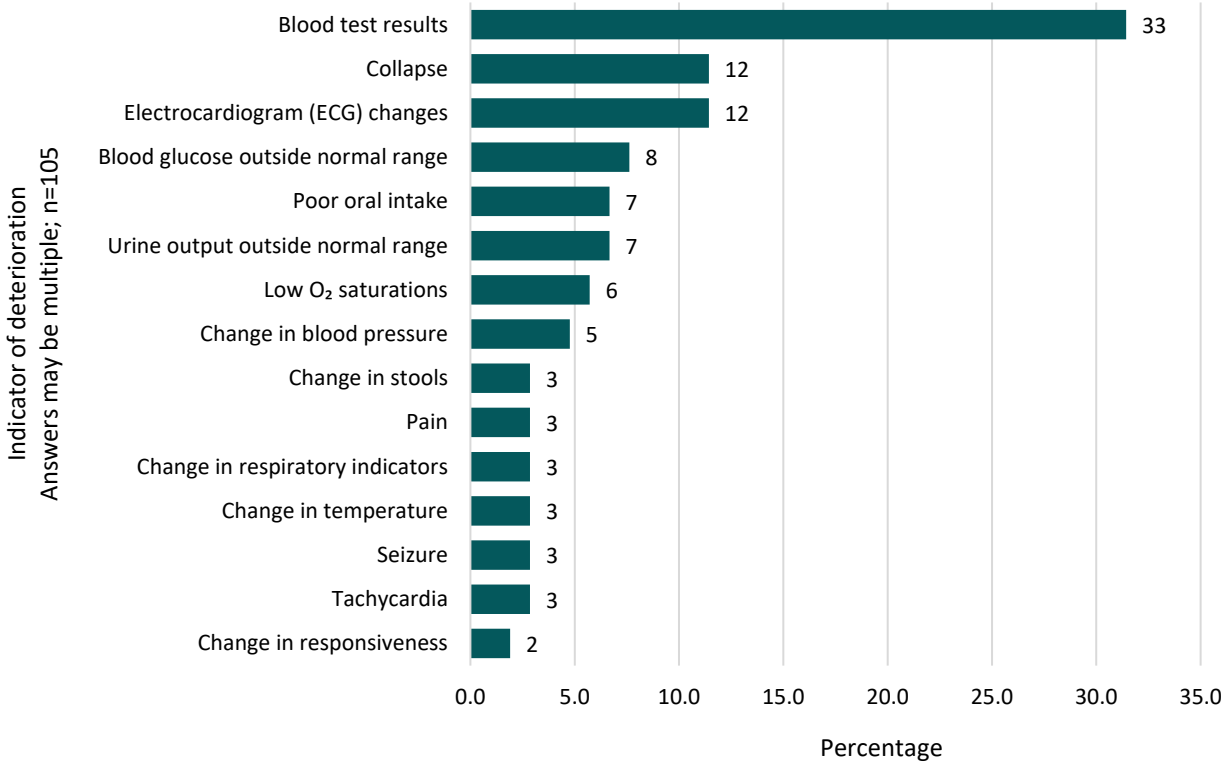


Figure 9.2 Indicators for transfer to a physical health hospital

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	Table 9.3 Page 51/52
80	Advice was sought from the physical health team for acute deterioration in 116/147 (78.9%) patients	CQ	Table 9.4 Page 52
81	20/107 (18.7%) patients had delays in identifying their acute physical deterioration by the mental health team	CR	Table 9.5 Page 52
82	147/283 (51.9%) patients were transferred to a physical health hospital with an acute physical health episode	CQ	Table 9.6 Page 53
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	Narrative Page 53 Paragraph 3

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	Narrative Page 53 Paragraph 3
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	Narrative Page 53 Paragraph 3
86	18/56 organisations reported a specific pathway or protocol for inpatients with specific physical health conditions	OQ	Narrative Page 54 Paragraph 3
87	18/56 organisations maintained a central record of inpatients transferred to a physical health hospital	OQ	Narrative Page 54 Paragraph 5
88	16/116 (13.8%) patients could have avoided transfer to an acute hospital	CR	Narrative Page 54 Paragraph 2
89	35/56 organisations reported having physical healthcare pathways for their inpatients that could prevent unnecessary acute hospital admissions	OQ	Narrative Page 54 Paragraph 3
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	Table 9.8 Page 54/55
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	Table 9.10 Page 55/56
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	Table 9.11 Page 56/57
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	Narrative Page 56 Paragraph 4

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	Table 9.14 Page 58
95	10/56 organisations reported that physical health hospitals had complete electronic access to mental health records and 32/56 had partial access	OQ	Table 9.15 Page 58/59

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.

CHAPTER 10: READMISSION FROM A PHYSICAL HEALTH HOSPITAL

FULL DETAILS CAN BE FOUND IN APPENDIX 10

	KEY FINDINGS	Data source	Position in Appendix 10
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	Narrative Page 60 Paragraph 2
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	Narrative Page 60 Paragraph 2
98	64/101 (63.4%) patients had been readmitted and were discharged from the acute hospital too soon in 16/64 cases reviewed	CR	Narrative Page 60 Paragraph 4
99	Mental healthcare providers could have prevented multiple readmissions by early physical health management in 11 instances	CQ	Table 10.1 Page 60/61

CASE STUDY 14: UNNECESSARY READMISSION

A 65-year-old patient with schizophrenia, diabetes, hypertension and heart failure was admitted. 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.

CHAPTER 11: OUTCOME AND DISCHARGE

FULL DETAILS CAN BE FOUND IN APPENDIX 11

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. I

	KEY FINDINGS	Data source	Position in Appendix 11
100	For patients in the study, the mean length of hospitalisation was 71.3 days, with a median of 33 days	CQ	Figure 11.1 Below and Page 62

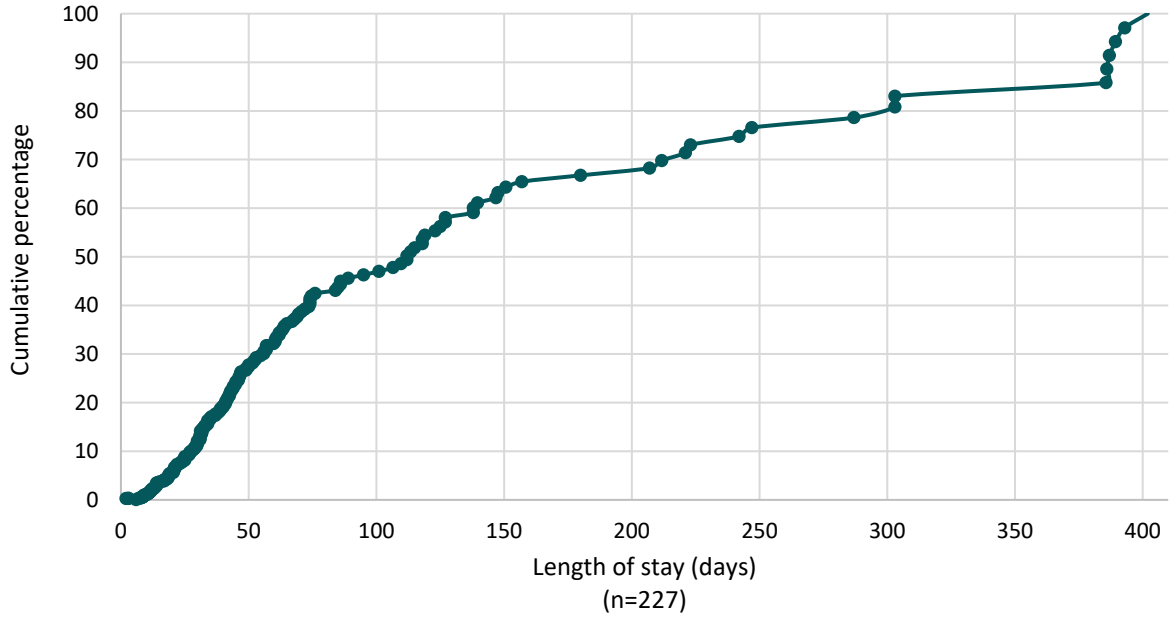


Figure 11.1 Length of hospital stay

101	249/291 (85.6%) patients were discharged from hospital during the study period and one remained in hospital	CQ	Table 11.1 Page 62/63
102	21/249 (8.4%) patients did not have a discharge summary accessible in their notes	CQ	Narrative Page 64 Paragraph 1
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	Table 11.2 Page 64

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	Table 11.2 Page 64
105	20/70 discharge summaries did not contain all the appropriate physical health information in the case reviewers' opinion	CR	Narrative Page 64 Paragraph 2
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	Figure 11.3 Below and Page 64/65

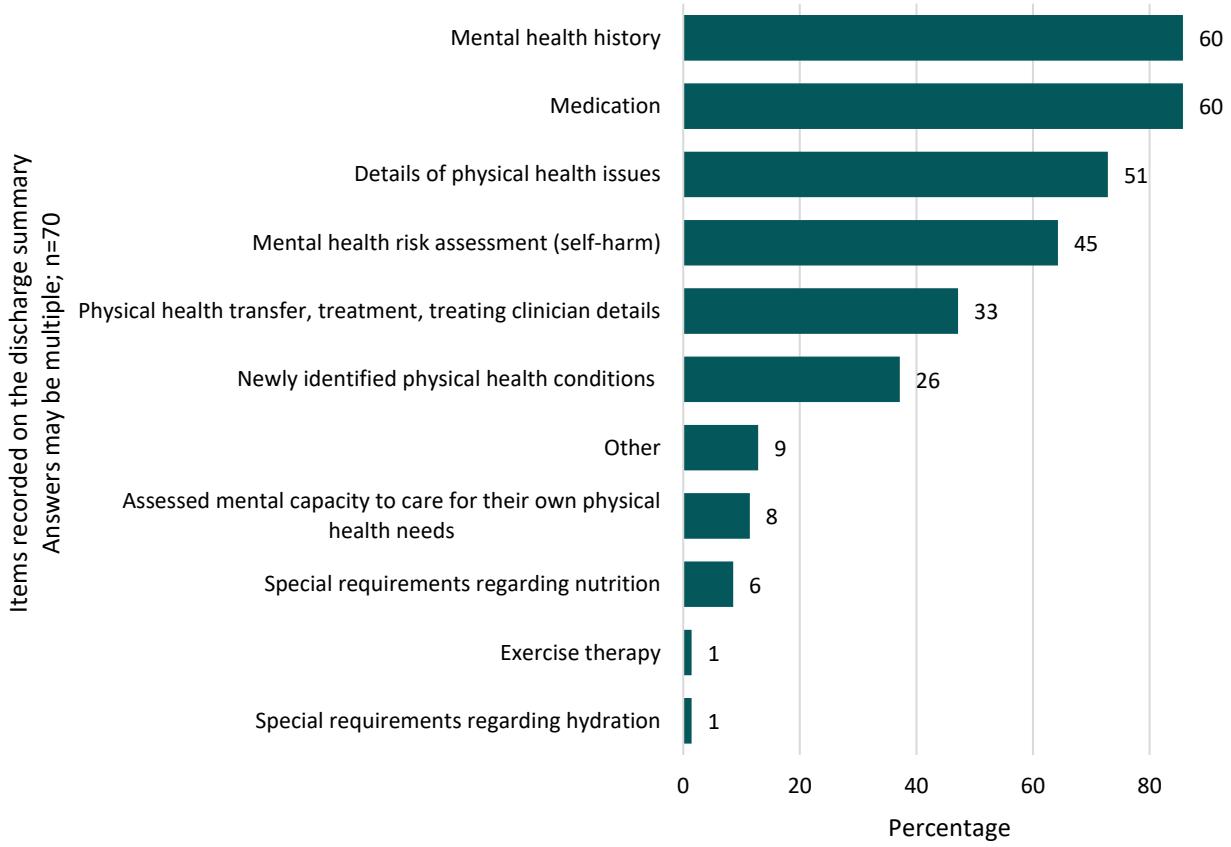


Figure 11.3 Contents of the discharge summary

107	8/70 discharge summaries contained information on the assessed mental capacity to care for physical health needs	CR	Narrative Page 64 Paragraph 2

CHAPTER 12: OVERALL QUALITY OF CARE

FULL DETAILS CAN BE FOUND IN APPENDIX 12

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

	KEY FINDINGS	Data source	Position in Appendix 12
108	There was room for improvement in physical healthcare of 119/163 (73.0%) patients	CR	Table 12.1 Page 67
109	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%) - delays in identifying acute deterioration (19/119; 16.0%) patients - documenting all physical health conditions (44/119; 37.0%) - communicating acute deterioration effectively (25/119; 21.0%)	CR	Figure 12.1 Below and Page 67

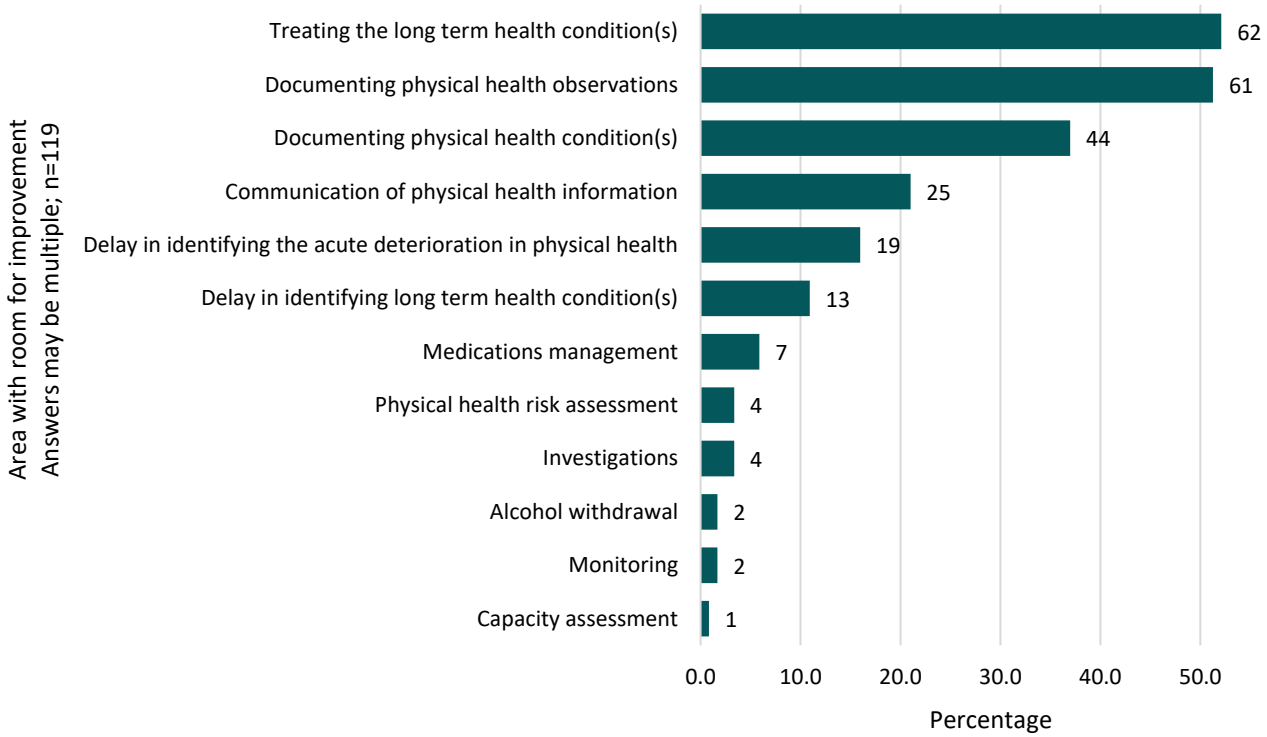


Figure 12.1 Areas with room for improvement

111	A mental health condition impacted substantially on the quality of physical healthcare of 78/158 (49.4%) patients	CR	Table 12.2 Page 67/68
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	Figure 12.2 Page 68

REFERENCES

THE FULL REFERENCE LIST CAN BE FOUND IN THE APPENDICES

1. Royal College of Psychiatrists. Standards for Inpatient Mental Health Services 3rd Edition , 2019 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/rcpsych_standards_in_2019_lr.pdf?sfvrsn=edd5f8d5_2
   [NB This is reference 20 in the APPENDICES]
2. NICE Quality Standard [QS120] Medicines optimisation Published: 24 March 2016 https://www.nice.org.uk/guidance/qs120
   [NB This is reference 35 in the APPENDICES]
3. Academy of Medical Royal Colleges. Improving the physical health of adults with severe mental illness: essential actions, 2016 https://www.aomrc.org.uk/reports-guidance/improving-physical-health-adults-severe-mental-illness-essential-actions/
   NB This is reference 8 in the APPENDICES]

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