

Commissioner’s Guide to the NCEPOD Report- “A Picture of Health”

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

Introduction

The physical health disparities facing people living with mental health conditions are well documented. Estimates of premature mortality range from 10 to 20 years in developed countries. 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.

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. 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. 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.

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

Patient population

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.*

In the period 1st November 2018 to 31st October 2019 there were 11,557 inpatient admissions to a mental health ward for patients with a physical health condition or who were transferred to a physical health hospital or who died within 30 days of admission.

Clinical issues

Initial medical clerking and initial physical health assessment

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

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

39/223 (17.5%) patients did not have their capacity to consent assessed at admission

Mental capacity was not appropriately assessed for 52/158 (32.9%) patients and the assessment was not timely for 28/158 (17.7%) patients

33/291 (11.3%) patients did not have an initial physical health assessment at the time of admission to hospital

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

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

Comprehensive physical health review, cardiometabolic health interventions

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

For 43/136 (31.6%) patients the comprehensive physical review was not carried out within the appropriate time frame

124/291 (42.6%) patients had a diet history taken and 163/291 (56.0%) a nutritional screening assessment

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

144/291 (49.5%) patients had an assessment of hydration status/fluid balance

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

Medications management

Physical health and mental health medications were documented for 208/252 (82.5%) and 218/252 (86.5%) patients respectively

213/291 (73.2%) patients had a full medicines reconciliation (including receiving indicated current prescription of medication) within 24 hours of admission

#64. 36/66 patients did not have all contraindications or interactions with psychotropic medication documented that should have been

Physical health care planning

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

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

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

Deteriorating patients

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

In response to the early warning score, changes were made to monitoring for 44/107 (41.1%) patients

22/116 (19.0%) patients did not have appropriate investigations completed, which included checking baseline blood glucose, other blood tests and an ECG

Patient communication, engagement, involvement

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.

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 .

Organisational issues

Assessing physical health in mental health wards

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

19/56 organisations had no policy for reviewing physical health at each clinical review

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

18/56 organisations reported a specific pathway or protocol for inpatients with specific physical health conditions

31/56 organisations provided training in common long-term conditions for psychiatrists and 42/52 organisations for registered mental health nurses (RMNs)

15/56 organisations reported that training was provided for psychiatrists in the comprehensive clinical review and 18/56 for registered mental health nurses (RMNs)

Deteriorating patients and transfer to a physical health hospital

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.

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

18/56 organisations maintained a central record of inpatients transferred to a physical health hospital

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

Record keeping and data on physical health conditions

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

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

Regarding the sharing of patient records with physical healthcare providers: 10/56 organisations reported that physical health hospitals had complete electronic access to mental health records and 32/56 had partial access

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

Key features of a service

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.

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

The ongoing physical healthcare of patients should be regularly monitored to prevent deterioration, particularly for patients with ongoing physical health concerns.

Formalise clinical networks/pathways between mental healthcare and physical healthcare

Mental healthcare staff need support in providing physical healthcare. Formalising pre-existing links between physical and mental healthcare providers will support this.

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.

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.

National guidance and reports

Royal College of Psychiatrists CCQI Standards for Inpatient Mental Health Services. 2019

https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/rcpsych_standards_in_2019_lr.pdf?sfvrsn=edd5f8d5_2

Improving the Physical Health of adults with Severe Mental Illness: essential actions
RCPsych/RCN/AOMRC. 2016

<https://www.aomrc.org.uk/reports-guidance/improving-physical-health-adults-severe-mental-illness-essential-actions/>

Royal College of Psychiatrists CCQI Quality networks AIMS

https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/aims/standards-for-acute-inpatient-services-for-working-age-adults---7th-edition.pdf?sfvrsn=66d6904f_7

NICE guideline [NG10] Violence and aggression: short-term management in mental health, health and community settings. Recommendation 1.2.15

<https://www.nice.org.uk/guidance/ng10>

NICE Quality standard [QS154] Violent and aggressive behaviours in people with mental health problems. Published 29 June 2017

<https://www.nice.org.uk/guidance/qs154>

NICE Quality standard [QS11] Alcohol-use disorders: diagnosis and management

Published:24 August 2011

<https://www.nice.org.uk/guidance/qs11>

NICE Quality standard [QS23] Drug use disorders in adults

Published:19 November 2012

<https://www.nice.org.uk/guidance/qs23>

NHSE CQUIN Guidance 2019/2020

<https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf>

NHSE CQUIN guidance 2016/2017 Personalised care and support planning

<https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf>

NHSE CQUIN guidance 2016/2017

Cardio metabolic assessment and treatment for patients with psychoses/ Serious Mental illness (PSMI)

<https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf>

NHSE CQUIN guidance 2020/2021 Adult secure healthy weight

<https://www.england.nhs.uk/wp-content/uploads/2020/02/pss-indicator-specifications-202021.pdf>

NHSE CQUIN Guidance 2019/2020 Improving the quality and breadth of data submitted to the Mental Health Services Dataset

<https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf>

Health Education England – Make Every Contact Count

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769486/Making_Every_Contact_Count_Consensus_Statement.pdf

Health Education England – Better Training Better Care

<https://www.hee.nhs.uk/sites/default/files/documents/Broadening%20the%20Foundation%20Programme%20-%20Recommendations%20and%20implementation%20guidance.pdf>

Improving the Physical Health of Adults with Severe Mental Illness: essential actions
RCPsych/RCN/AOMRC. 2016

<https://www.aomrc.org.uk/reports-guidance/improving-physical-health-adults-severe-mental-illness-essential-actions/>

NHSE Guidance on the NHS Standard Contract- requirements on interoperability of clinical IT systems. 2018

<https://www.england.nhs.uk/wp-content/uploads/2018/09/interoperability-standard-contract-guidance.pdf>

NHSE Guidance on the NHS Standard Contract- requirements on interoperability of clinical IT systems. 2018

<https://www.england.nhs.uk/wp-content/uploads/2018/09/interoperability-standard-contract-guidance.pdf>

NHSE Guidance on the NHS Standard Contract-requirements on discharge summaries and clinic letters and on interoperability of clinical IT systems. 2018

<https://www.england.nhs.uk/wp-content/uploads/2018/09/interoperability-standard-contract-guidance.pdf>