



Learning for the future: Service User Inpatient and Crisis team experiences during Covid-19

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Executive Summary

Aims and Methods

The report was commissioned by NHS England/NHS Improvement South East Mental Health Board and conducted within Sussex Partnership NHS Foundation Trust (SPFT), a specialist mental health and learning disability provider in the South East of England which is part of the Sussex Health and Care Partnership IntegratedCare System.

The work followed from the Learning for the Future Project, which aimed to understand: (i) what had changed during COVID-19, (ii) how changes were experienced by staff and service users, and (iii) the organisational learning from and sustainability of these changes.

The current commission specifically aimed to:

- (i) Understand the experiences of service users who had received crisis team or inpatient admissions during COVID-19, through in-depth qualitative interviews,
- (ii) Place the findings in context through a review of evidence of previous inpatient experiences
- (iii) Provide high level recommendations and learning for future service provision
- (iv) Provide a set of resources as a 'blueprint' for other Trusts that want to follow a similar approach in the future.

First, we incorporated a question about crisis and inpatient contacts into our initial 'Learning for the Future' service user survey of harder to reach service users.

Second, we undertook a rapid review of the literature, in terms of previous research that explored service user experiences of inpatient services and recent publications following the onset of the COVID-19 pandemic.

Finally, 14 of the Learning for the Future sample of harder to reach service users were working age adults with an inpatient/crisis team experience, of whom 7 took part in in-depth qualitative interviews. Data was analysed thematically to produce key findings and recommendations.

Findings

- The literature review highlighted, how early societal impacts of the pandemic such as employment, youth, isolation, home-schooling, bereavement, anxiety, fear of covid and long-covid had the potential to exacerbate inequalities, mental ill-health and inpatient experiences. Front-line health staff, women, people with underlying mental health issues and lower educational level may be at greater risk for poor mental health.
- Overall, service users experienced a drop in their wellbeing and sense of safety during the pandemic. Those who received crisis team or inpatient admissions were female/non-binary, and BAME service users.

There were:

- Multiple COVID-19 related triggers to poor mental health; Normal coping mechanisms were removed



due to lockdown.

- Big changes in service delivery which were a challenge, especially for service users with Autism Spectrum Conditions (ASC); Virtual/phone consultations were acceptable at least for routine catch-ups and for some people, but not for everyone.
- Exacerbated barriers to personal support, including limitations to personal freedom and care, limited or non-existent social contact and additional barriers as a result of PPE use.
- Enormous challenges for staff and services: Crisis services sometimes inadvertently exacerbated mental health service use; some staff went to enormous efforts to support their services users, but decisions made regarding physical health and safety were sometimes at significant cost to mental health and wellbeing; and it was clear that staff need support too.

Recommendations

As a region, we should:

- Consider how to identify and prevent future mental health issues related to inequalities
- Provide training
 - For crisis and inpatient staff to enable them to support bereavement and other COVID-related issues
 - For crisis and inpatient staff in how to enhance service user experiences in inpatient/crisis team settings in the context of change.
 - For all staff in how service inconsistency can reinforce and exacerbate crises
 - For all staff in how to engage therapeutically on-line
- Consider creative ways to actively personalize and socialize care and PPE use and create opportunities for activity and engagement in inpatient services.
- Provide scenario-based training and guidelines to aid all staff in providing care that is personalized, and that balances physical and mental health care and risk
- Consider how best to support staff well-being.



Context and commission

The report was commissioned by NHS England/NHS Improvement South East mental health board and conducted within Sussex Partnership NHS Foundation Trust (SPFT), a specialist mental health and learning disability provider in the South East of England which is part of the Sussex Health and Care Partnership IntegratedCare System.

SPFT has an active and productive clinical research community, aiming to design, deliver and disseminate evidence-based mental health practice both regionally and nationally. Research and Quality Improvement approaches aim both to interrogate the current evidence base through systematic reviews and analyses, and through specific evaluations of novel service delivery, as well as to develop and evaluate cutting-edge interventions and approaches.

Projects are informed by: (i) clinically important research questions, (ii) robust research design and delivery, and (iii) strong, collaborative patient and public involvement (PPI). These approaches ensure that projects and findings are not only important to clinicians and services but are also meaningful to service users and place them at the centre of service delivery.

At the onset of the COVID-19 pandemic it became clear that a number of changes and novel approaches to service delivery were being rapidly implemented in our services. In response, the Chief Executive Office (CEO) of SPFT commissioned a specific evaluation of experiences and changes in service delivery during the pandemic. This 'Learning for the future' project was run by members of the research team, in collaboration with clinical and corporate staff and the People Participation ('expert by experience' or 'PPI') team.

Key aims of the Learning for the future project were to understand: (i) what had changed, (ii) how changes were experienced by staff and service users, and (iii) the organisational learning and sustainability of these changes in terms of what should stop and what should continue.

The Learning for the future project used a mixed methods approach, combining quantitative (numerical) and qualitative (descriptive) surveys completed by clinicians and service users, to explore core changes including home working, remote (digital) service delivery, the rapid introduction of virtual consultations, and the mental wellbeing of our staff and service users. The reports from the Learning for the future project can be found at the following webpage: [Learning for the Future: Our response to Covid-19 | Sussex Partnership NHS Foundation Trust](#)

One survey was dedicated to understanding the experiences of service users. This survey was developed and designed in collaboration with the People Participation team. Members of the People Participation team were also invited to collect the survey data from service users and 10 'Experts by Experience' who had used services themselves (50% female, 12.5% BAME) agreed to collect the data. They received training, and further refined the survey following role play practice in using the questionnaire.

The service user survey aimed to hear from hard-to-reach service users, including children and young people, those with psychosis, autistic spectrum conditions and learning disabilities, emotionally unstable personality disorders, and dementia. The survey asked about volume, types and satisfaction with contacts; mental health, wellbeing and safety; helpful and unhelpful service changes since the first lockdown; experiences of contacts including privacy, safety and preferences around remote and video contacts; impacts on mental health; and a comprehensive section on



demographics, protected characteristics and disability.

During this time, new challenges were emerging. It became apparent that greater numbers of people were requiring mental health inpatient admissions during the pandemic. Inpatient staff wondered whether these service users were different from their usual service users. These staff also wanted specific advice regarding how best to support particular types of service users such as those with mental health issues and autistic spectrum conditions.

In light of the Learning for the Future project and the challenges for inpatients, NHSE&I commissioned a new piece of work. The current commission specifically aimed to:

- (i) Understand the experiences of service users who had received crisis team or inpatient admissions during COVID-19, through in-depth qualitative interviews,
- (ii) Place the findings in context through a review of evidence of previous inpatient experiences
- (iii) Provide high level recommendations and learning for future service provision
- (iv) Provide a set of resources as a 'blueprint' for other Trusts that want to follow a similar approach in the future.

What we did

First, we incorporated a question about crisis and inpatient contacts in our initial 'Learning for the Future' service user survey. See Appendix 1 for a copy of the survey. This allowed us to understand more about who had received crisis team and inpatient services during the pandemic. It allowed us to explore key differences between those who had used inpatient services and those who had not, and it also allowed us to recruit some of our service users who had used these services to take part in the in-depth qualitative interviews.

Second, we undertook a rapid review of the literature, both in terms of previous research that explored service user experiences of inpatient services but also in terms of any recent publications following the onset of the COVID-19 pandemic.

Finally, we commenced the development of the new inpatient project. We reconvened members of our 'Expert by Experience' People Participation Team and invited them to help us develop the topic guide for the Qualitative Interviews (see Appendix 2 for a final version). We contacted our team who were responsible for recent quality and safety assurance reviews of inpatient services and asked for their thoughts about appropriate questions, and we shared a draft of the topic guide with the Acute Adult Inpatient Improvement Learning Collaborative and asked for feedback.

Our first challenge was to obtain Trust approval to interview the service users. Our Quality Improvement team were keen to ensure that this externally commissioned project had appropriate governance and safety in place. We registered the project with the Quality Improvement team, provided information and consent sheets for the participants (see Appendix 3), completed data management plans (see Appendix 4), and a data protection impact assessment for the use of an audio-recorder for the interviews (see Appendix 5).

Following our previous experiences, we felt that the most critical contribution for the People Participation team was the development of the interview topic guide. On this occasion, and in the interests of time, the



interview data would be collected by a research assistant.

The final topic guide combined the suggestions derived from consultation with our People Participation team, the feedback from our NHS-Improvement Learning Collaborative group and proposed questions from our inpatient quality and safety assurance reviews. The topic guide questions focused on experiences of inpatient or crisis team contact, links between these experiences and COVID-19 experiences, impacts of COVID-19 and lockdown on experiences and sense of safety, quality of care received, crisis team or inpatient experience, extent to which community, crisis and inpatient care met needs and preferences (including for those with ASC/neurodiversity), impact of COVID-19 and lockdown on discharge from inpatient or crisis team, where people received most support, and their perspectives on how we can best support people who are vulnerable in a crisis in the future. In addition, as the plan was to re-contact people who had already taken part in the previous service users survey, the People Participation team felt it was important to acknowledge their previous participation, and include bespoke follow-up questions for each individual that built on what they fed back in their previous questionnaire.

The aim was to collect 10 in-depth qualitative interviews with service users who had received either crisis team or inpatient services or both during the pandemic and analyse this data thematically to produce key findings and recommendations.

What we learnt from the published research

Prior to the pandemic, recent studies identified that societal factors such as economic recession and austerity lead to increased mental health inpatient admissions (Smith et al. 2020). These societal factors may interact with and exacerbate common personal and interpersonal factors such as psychosis experiences, aggression, reduced insight, disengagement from medication regimes and from mental health care professionals (Jong 2017). The same increase in admissions may therefore be expected from the pandemic.

Previous narrative reviews of inpatient experiences (e.g. Glasby & Lester) revealed that this was often a negative experience for service users with concerns over lack of freedom, cleanliness and access to staff and facilities such as food, water, bathing, telephone or outside space, combined with a sense of low staff morale. A more recent narrative synthesis also identified that service users experienced boredom, reduced mood and slower recovery due to a lack of activities (Foye et al. 2020). It is anticipated that many of these concerns may be further exacerbated by the pandemic.

Since the onset of COVID-19, Davies (2020) on behalf of the Nuffield trust, identified spikes in population anxiety and depression that were maintained beyond lockdown, with exacerbations likely linked to initial delayed access to services, mental health exacerbations and new mental health problems caused by the impact of the pandemic. Societal impacts of the pandemic such as employment and isolation were expected to continue to impact mental health in the long term, with additional impacts of bereavement, anxiety and acceptance of long-covid also identified (Davies 2020; BABCP 2020). Young people, those living alone, and those both young and living alone may be particularly vulnerable to depression, stress, loneliness and fatigue (Field et al. 2020). Fear of catching the virus, home-schooling and childcare are additional demands and Agrawal (2020) warned against overuse of anxiolytic medications.

A number of studies have also reviewed the mental health of healthcare workers (e.g., Lai et al 2020; Liberati et al 2021). Lai and colleagues reviewed early impacts of the pandemic on the mental health of healthcare workers in China, finding rates of anxiety, depression and stress in the region of 45-71% of people, linked to many of the issues outlined above. Liberati and colleagues undertook a qualitative study with 35 mental healthcare workers in the NHS during the pandemic which included crisis team and inpatient staff. They found that staff had experienced pausing of services, redeployment to new roles and remote working, and



were trying to provide care in constrained and challenging circumstances with limited access to informal support. They faced dilemmas regarding prioritization of support, working therapeutically, and balancing risks of covid infection with need for contact. Staff reported feeling guilt and helplessness and compensating by taking on more tasks or making exceptions, but this led to further distress, isolation and burnout. Staff felt unsupported, unable to take time off and that organizational support and communication was poor.

Some of these risk factors are summarized in a rapid review last year by Public Health Scotland which concluded that front-line health staff, women, people with underlying mental health issues and lower educational level and therefore disadvantage, may be at greater risk for poor mental health following the pandemic. The review also found that social and family support, hygiene and physical activity were protective (PHScotland 2020). There are clearly challenges arising from COVID-19 for both current and future mental health service users but also for staff which are likely to continue in the medium to long term, and have particular impacts in crisis and inpatient settings.

Who took part

Thirty-five participants were interviewed as part of the original service user survey of 'remote working' experiences, of whom 8 (23%) identified as male and 3 (9%) as non-binary, and the remaining 24 were female (68%); 4 were BAME (11%).

Of this sample, 19/35 (54%) had either a crisis team contact, inpatient admission or both. Five admissions were for older adults with dementia and were excluded from the inpatient study, leaving 14 service users who could be contacted to take part.

What we learnt from our own research

All service users who received crisis team or inpatient admissions during the pandemic were female/non-binary, and included all BAME service users

Of the 14 working age adult service users who had a crisis team contact or admission since the onset of the pandemic, 12 identified as female and 2 as non-binary (one female sex and one male sex). All 4 of those who identified as BAME had either a crisis team contact (n=1) or both crisis team contact and admission (n=3) and 3 of those who identified as non-binary had both crisis team contact and inpatient admission.

Attempts were made to contact all 14 service users to complete an in-depth interview about their crisis team and/or inpatient experiences. Three participants were not contactable/did not respond, and 1 was too physically unwell with breathing problems. Ten participants initially consented, but of these 2 then became unwell and did not respond further (one was readmitted as an inpatient), and 1 denied receiving either crisis team contact or inpatient admission. This left 7 service users who completed the in-depth interview.

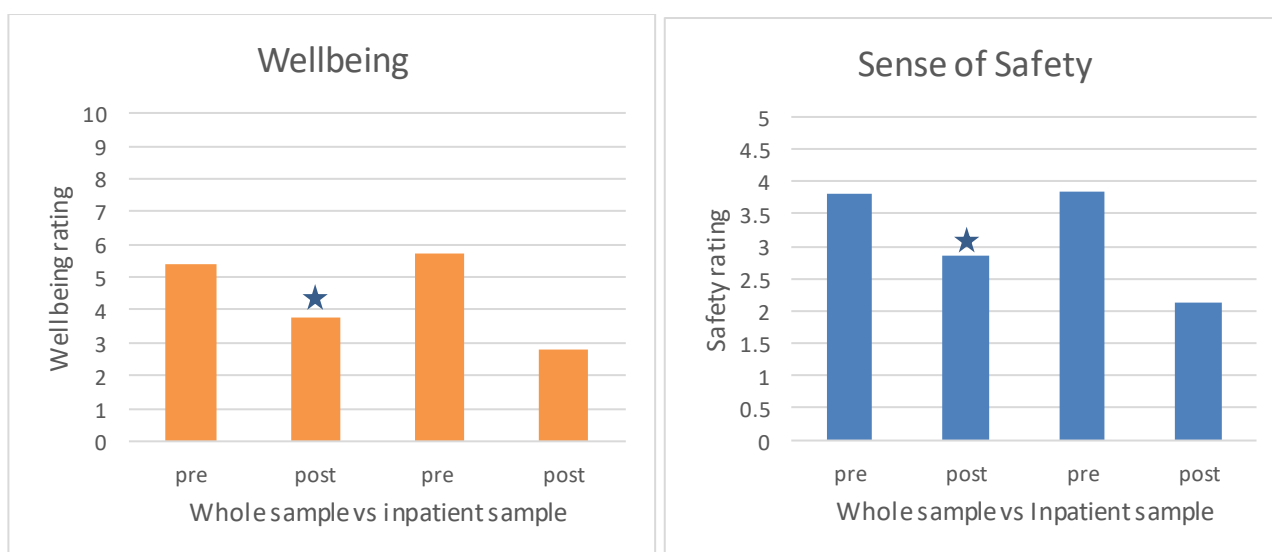
Seven participants provided an in-depth qualitative interview. Their demographics are provided below.

	Age	Main problem which trust supports	Gender	Marital Status	First Language	Ethnicity	Disability
P1	18-29	Depression	Female	Single	English	White (British)	Yes a lot

P2	18-29	Complex PTSD	Non-binary	Single	English	White (British)	Yes a lot
P3	45-59	EUPD	Female	Married/civil partnership	English	White British	Yes a little
P4	45-59	ASC/EUPD	Female	Separated/Divorced	English	White (British)	Yes a little
P5	18-29	Dissociative Identity	Female	long-term relationship	English	Mixed Ethnicity	Yes a little
P6	18-29	ASC and LD	Female	Single	English	White (British)	Yes a lot
P7	18-29	Mental health	Female	single	English	White (British)	Yes a little

General wellbeing and safety have decreased since the pandemic

Forty percent (n=14) of the service users initially interviewed within the Learning for the future project had an adult crisis team contact or inpatient admission during the pandemic between March 23rd -Dec 2020. All were female or non-binary, and this sample included all of those from a BAME background. In addition, the whole sample had a significant drop in their reported well-being and sense of safety from pre to post onset of the pandemic [Wellbeing df(33) t=3.03, p<.005; Safety df(32) t=2.996, p<.005], but this drop in wellbeing and sense of safety was greater for the 14 who received crisis team or inpatient contact, and even greater for the 7 people who were the focus of the in-depth interviews.



While some of these 7 service users described their experiences as ‘hit and miss’, others described positive experiences, for example, of a transition from CAMHS to adult services during the lockdown. All identified that increased contact and support was the most helpful change that could be made to support their wellbeing and safety, whether that be more regular phone contact, groups or therapy.

Qualitative findings



COVID-19 triggers to mental ill-health

1. Multiple COVID related triggers to poor mental health

Triggers included poor home or family environment, isolation, unemployment and changes in job role, as well as bereavement. Of note, 2 of our 7 service users reported a bereavement which precipitated their admission. Several service users described low mood and suicidality prior to admission.

2. Normal coping mechanisms removed due to lockdown

Service users also talked about their normal coping mechanisms being removed due to lockdown, such as being unable to swim and one person talked about there being no distractions from self-harming due to not having a phone on the ward.

COVID-related service change challenges

3. Big changes in service delivery were a challenge, especially for ASC service users

Understandably, service users talked about everything changing in service delivery, including reliance on virtual consultations and phone calls, care being inconsistent, services stopping suddenly and timings not being met. Routine was also disrupted in in-patient settings. This was particularly problematic for service users with Autistic Spectrum Conditions who struggled to cope with change.

4. Virtual/phone consultations are acceptable for routine catch-ups and for some people, but not for others

Service users identified that virtual/phone consultations were good for general catch ups and for some people, but not for lengthier discussions about personal issues. These particular service users were likely to end a phone or virtual consultation sooner than they would a face-to-face meeting.

Exacerbated barriers to personal support

5. Exacerbated loss of personal freedom and care

Some service users talked of exacerbated loss of freedom and inconsistent rules in in-patient settings. Smoking was a particular challenge due to people needing to go outside to smoke. In some wards, people were not allowed out and were provided Champix to reduce cravings, while in other wards only people who smoked were allowed out. Others talked of feeling trapped and losing personal belongings for fear they were a COVID risk.

6. PPE as barriers to personal support

This loss of personalized care was further exacerbated at various points by staff wearing PPE. Masks, visors and scrubs were seen as barriers and made it harder, especially for service users with ASC or other disabilities, to process information

7. Social contact limited or non-existent

Service users talked about the exacerbation of social isolation within in-patient settings due to communal



areas being closed, social contact and visits being stopped, and inconsistent opportunities for remote contact with family. Service users described being isolated in their rooms, leading to worsening of mental health and panic attacks.

Enormous challenges for staff and services

8. Crisis services may inadvertently exacerbate service use

Several service users talked about inconsistencies in crisis service responses, in some cases dependent on demand. Whilst it could be seen as a positive sign that someone is not so unwell that they need crisis support, several service users experienced this as a rejection which exacerbated their mental health problems and led to avoidance of subsequent help-seeking.

9. Enormous support efforts of staff balancing physical and mental wellbeing support

Service users talked about the enormous efforts made by some staff to support them despite the challenges of the pandemic. Others described that decisions made regarding physical health and safety sometimes came at significant cost to mental health and wellbeing. Staff found it hard to maintain physical health and safety and support mental health and wellbeing at the same time. This challenge contributed to inconsistencies in approaches where care was personalized and went above and beyond expectations for some, but not others.

10. Staff need support too

Some service users mentioned that staff may have been impacted, may have been having a bad day and that staff need to support each other. There is much evidence in the literature for the impact of COVID-19 on staff mental health. Stress and burnout may impact on interactions with service users which can then exacerbate service users' mental health and crises. It will be critical to continue to provide good staff well-being support. The Learning for the Future project, has developed specific tools and guidance to support staff wellbeing, which can be found here: [phase 3 staff wellbeing.pdf \(sussexpartnership.nhs.uk\)](https://www.sussexpartnership.nhs.uk/phase-3-staff-wellbeing.pdf)

Meaning and Recommendations for crisis and inpatient services

This report reflects the perspectives and experiences of a small sample of service users who received inpatient and/or crisis team support between March and December 2020. The project was designed to capture the perspectives from harder to reach service users whose voices we do not ordinarily hear. They do not necessarily reflect broader experiences of using inpatient services, but they do lead to a number of recommendations that arise out of these perspectives.

1. COVID-19 exacerbates societal inequalities in mental health: marginalized, disadvantaged and isolated groups including women, LGBTQ and BAME populations are most at risk

The mental health of the population is impacted by societal factors such as the COVID-19 pandemic. Of note from our current sample, even within mental health services, marginalized groups such as female, non-binary and BAME service users fared worst, and required crisis support or admission. This is consistent with many previous studies which show poorer mental health and less positive service experiences in people from LGBTQ and BAME groups (e.g. Das Munchi et al. 2018), and with the rapid review by NHS Scotland which identified risks also for women, and those with lower educational backgrounds. The findings are consistent with the predictions of Davies (2020) that existing inequalities are likely to be exacerbated by COVID-10 and last for a long time.



Recommendation: As a region, we should consider how to identify and prevent future mental health issues related to inequalities.

2. Mental ill-health is exacerbated by COVID-related factors including bereavement.

There are likely to continue to be exacerbations in mental health, and inpatient admissions linked to bereavement.

Recommendation: Consider crisis and inpatient staff training to enable them to support bereavement and other COVID-related issues

3. Some service users find it harder to engage therapeutically and discuss personal issues and mental health exacerbations by phone or video-consultation.

This challenge has also been identified by staff in terms of accessing their own personal/informal support remotely, which they found to be harder by phone or video consultation.

Recommendation: consider regional training in how to engage therapeutically on -line. We have already delivered training within SPFT in response to this issue.

4. Extreme service changes, inconsistent service responses and staff stress can exacerbate mental ill-health in those at greatest risk.

Recommendation: Consider training staff in how service inconsistency can reinforce and exacerbate crises, and in how to enhance service user experiences in inpatient and crisis team settings in the context of change.

Recommendation: Continue to work to support staff well-being.

5. There are challenges for inpatient services in personalizing care and ensuring opportunities for social contact in the context of a pandemic, which are further exacerbated by the need to wear PPE, limit social contact and socially isolate.

Recommendation: consider creative ways to actively personalize and socialize care and PPE use and create opportunities for activity and engagement in inpatient services.

6. Staff are struggling to balance physical and mental health risks and support.

Recommendation: provide scenario-based training and guidelines to aid all staff in providing care that is personalized, and that balances physical and mental health care and risks.



Appendices

Appendix 1. Original Learning for the Future Service User Questionnaire with inpatient and crisis team questions included.

Preparations before the interview starts

- 1) You might want to practice interviewing and writing down the responses, with [Service user EBE member] or someone else before your first interview.
- 2) Our administrator will be allocating service users to you for interviews. You can let her know about any relevant information e.g. days you are busy, whether you can do interviews on zoom, phone or both? Sue will also send you the questionnaire by email and will send paper copies in the post. You can choose whether you fill these in electronically or on paper.
- 3) Our administrator will contact you by telephone shortly after 1st Oct with the firstperson for you to interview – please note down the person’s name and phone number, but destroy this once you have completed the interview.
- 4) When you have the first person’s name and phone number – you can call the person directly to make an appointment for the interview. You should put 141 in front of your number so it is confidential – and then delete your call history after the call.
- 5) When you speak to the service user
 - a. Explain to them about the project – see information below
 - b. Explain that they will receive a £10 Love to Shop Voucher by email or post when they take part – which can be used in lots of shops on-line or in person
 - c. Explain that you are a service user researcher
 - d. Ask the service user (or family member) when they would like the interview to happen
 - e. Ask whether they would like this to be by zoom (if you can offer this) or by phone.
 - f. If someone asks for a copy of the questionnaire in advance – check whether by email or post – take their email/postal address and ask Sue to send this to them
 - g. If someone asks to complete this on their own in writing – ask Sue to send this to them with a stamped addressed envelope.
 - h. If someone is self-harming/at risk or you’re concerned about their own or someone else’s safety – contact your supervisor who can advise on next step
 - i. Either complete the interview then or contact the person at the agreed time
 - j. Make sure you write your own initials, the patients initials and the date on



the first page.

- k. Fill in the questionnaire either electronically or on paper.
- l. Email the questionnaire or photograph of the questionnaire pages to Sue
- m. Sue will send a Love to Shop voucher worth £10 to each service user.
- n. Try out to complete at least one interview before the 1 October.



Date _____ EBE interviewer initials _____ Participant initials _____

Participant location ...*[Please circle the response given]*

East Sussex/West Sussex/Brighton and Hove/Hampshire

MAKING THE PHONE CONTACT

- Ensure you call from a withheld number by dialling 141 before adding the phone number
- If calling from a mobile phone, ensure you delete the phone number you rang from your call history
- Doing both of these things will help to protect everybody's confidentiality

INTRODUCING THE PROJECT

- Use the information below to introduce the project – you can read it or say it in your own words




'Experiences of People using [Mental Health] Services During Covid-19'

INITIAL INFORMATION TO SHARE

**Thank you for taking part in this project! We appreciate your involvement.
Everything you tell us today will be anonymous and confidential.**

Who are WE?

My name is [add name] and I am an expert by experience. This means I have used [Mental Health] services myself in the past. All the interviewers on this project have used [Mental Health] service in the past, and have received training to conduct the interviews – so you can be as honest as you like 

Why are we doing this project?

When the Covid-19 lockdown was announced in March, the way [Mental Health] delivered services had to change quickly. One of the main changes was that most health-related appointments were offered remotely by phone or videocall (not in-person). We would like to hear what your experience of receiving [Mental Health] services has been since March. This is because:

- This will help us to provide better services if Covid-19 lockdown measures are increased in future
- Some of the recent changes may have had a negative impact on you, in which case we would like to hear what they are so we can try to reduce or stop those changes.
- Alternatively, some of the changes might have benefitted you, in which case we would like to continue with those

Taking part in this project is very important because it will help [Mental Health Services] to learn and plan for the future.

What does this project involve?

You are invited to take part in a telephone interview lasting about 30 minutes.

Do I have to take part?

Someone from your clinical team has said that you might be interested, but you don't have to take part if you don't want to.

What will we do with the findings?

We are asking 100 people to take part. We will make a summary of what we find out. If you would like, we will share the findings with you, and let you know what changes we are making to services as a result of the findings. We will share the findings with staff working in the Trust. We may publicise the findings in the future because this may help other NHS Trusts learn and plan for the future themselves.

Importantly, remember whatever we share, we will make sure everything is



anonymous so that no person can be identified.



SETTING UP THE INTERVIEW

[Use 5 minutes at the start to cover the below points]

1. Confidentiality

- Please do not identify yourself or other people in your answers
- We will ensure that when we report the results, they are anonymous

2. Distress

- If you become distressed during the interview:
 - a) Please let me know
 - b) We can end at any time
 - c) You can choose to withdraw your data at any time. We will use your initials to find your anonymised answers and delete them.
 - d) We have put together a leaflet containing resources that might be helpful

3. Structure

The interview will start and end with an open question so that you can talk freely and share what is important to you. The questions in the middle will be more structured. We have done this so that the interview style will hopefully appeal to both people who like to talk openly and those who prefer more structure. This will also make it easier to analyse the data.

4. Interruptions

From interviewer: I would like to hear your thoughts on all the questions. To make sure you have this opportunity, I might need to interrupt you occasionally to keep us on track to cover everything, so please don't be offended if it feels like I am moving us on.

From others in the household: What will we do if we are interrupted by someone else in your household?

CONSENT

Are you happy to begin the interview?

[Please circle/highlight the response given]

- Yes I am happy to begin the interview
- No I am not happy to begin the interview [If the person is not happy then do not continue]



PART 1: CONTACT WITH [MENTAL HEALTH SERVICES] SINCE MARCH

- 1) If you're happy to – you could start by spending a few minutes sharing what your experience of receiving [MENTAL HEALTH] services has been like since March? Or if you'd rather we can come back to this question at the end...

[Allow the participant up to 4 minutes to talk. If they are still talking at 4 minutes, politely interrupt – write the 3 main points below]

If you could summarise your experience in 3 main points, what would they be?

Point 1:.....

Point 2:

Point 3:.....

- 2) Overall, how did the AMOUNT of contact you had with [MENTAL HEALTH SERVICES] change from before March, to since March (lockdown)?

[Please circle the best response]

1	2	3	4	5
Decreased a lot	Decreased a bit	Did not change	Increased a bit	Increased a lot

- 3) Between March and now, have there been any BIG CHANGES IN THE SERVICES YOU'RE IN CONTACT WITH?

[Circle all that apply]

contact stopped with a service	contact continued with a service	contact started with a new service
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- 4) How satisfied are you with the AMOUNT of contact you've had with [MENTAL HEALTH SERVICES] since March (lockdown) to now?

[Please circle the best response]

1	2	3	4	5
Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied



Write any important comments about amount of contact here



5) Have you had any of these **TYPES OF MEETINGS** with **[MENTAL HEALTH SERVICES]** Since **March (lockdown)** to now? Can you rank the top 3 from: 1 (most often meeting type with **[MENTAL HEALTH SERVICES]**), to 2 (next most often) and 3 (third most often).

Type of meeting	Ranking
New Assessment	
Appointment with psychiatrist	
Appointment with psychologist	
Therapy	
Routine support	
Review of care plan	
Other .. please specify	

6) Have you received any **SUPPORT FROM THE CRISIS TEAM** since March?

Yes / No

7) Have you had a **MENTAL HEALTH INPATIENT ADMISSION** since March?

Yes / No

8) Have you had any **CONTACT WITH OTHER PEOPLE WHO USE [MENTAL HEALTH SERVICES]** since March (lockdown)?

[Please circle the response given]

Yes/No

If Yes – 8.1. Did the amount of CONTACT YOU HAD WITH OTHER SERVICE USERS in [MENTAL HEALTH SERVICES] change from before March compared with since March (lockdown)?

[Please circle the response given]

1	2	3	4	5
Decreased a lot	Decreased a bit	Did not change	Increased a bit	Increased a lot

8.2. How much have you valued/would you have valued having contact with other [MENTAL HEALTH SERVICES] service-users in the period from March (lockdown) to now?

[Please circle the response given]

0 1 2 3 4 5 6 7 8 9 10

No value

Hugely valued



Write any important comments about types and methods of contact here



END OF PART 1: CONTACT

PART 2: MENTAL HEALTH, WELLBEING AND SAFETY

9) What is the main reason that [MENTAL HEALTH SERVICES] support you?

.....
.....

10) Has the main reason that [MENTAL HEALTH SERVICES] support you changed since March?

[Please circle the best response]

1	2	3
Reason stayed the same	Reason changed a bit	Reason changed a lot

11) Has your mental health changed since March?

[Please circle the best response]

My mental health has...

1	2	3	4	5
got a lot worse	got a bit worse	stayed the same	got a bit better	got a lot better

12) How would you rate your overall wellbeing during February, before the lockdown measures were introduced?

Please think about your sleep, diet, exercise, mood, and mental health.

[Please circle the response given]

0 1 2 3 4 5 6 7 8 9 10

Worst it's ever been

Typical
for me

Best it's ever been

13) How would you rate your overall wellbeing during the period from March (lockdown) to now?

Please think about your sleep, diet, exercise, mood and mental health.

[Please circle the response given]

0 1 2 3 4 5 6 7 8 9 10

Worst it's ever been

Typical

Best it's ever been



for me



14.1) How safe did you feel during February, before the lockdown measures were introduced?

1	2	3	4	5
Really unsafe	Pretty unsafe	Neither safe nor unsafe	Pretty safe	Really safe

14.2) How safe have you felt during the period from March (lockdown) to now?

1	2	3	4	5
Really unsafe	Pretty unsafe	Neither safe nor unsafe	Pretty safe	Really safe

14.3) What, if anything, have [MENTAL HEALTH SERVICES] done to help you feel safe or improve your wellbeing since March (lockdown)? Please summarise in up to 3 main points

Point 1:.....

Point 2:

Point 3:.....

14.4) What, if anything, could [MENTAL HEALTH SERVICES] have done to help you feel more safe or improve your wellbeing since March? Please summarise in up to 3 main points

Point 1:.....

Point 2:

Point 3:.....



Write any important comments about your well-being and safety since March (lockdown) here

END OF PART 2: MENTAL HEALTH, WELLBEING AND SAFETY



PART 3: SERVICE CHANGES

15) Since March, have you experienced any changes to [MENTAL HEALTH SERVICES] which were HELPFUL?

[Please list up to 3 points below]

Point 1:.....

Point 2:

Point 3:.....



16) Since March, have you experienced any changes to [MENTAL HEALTH SERVICES] which were UNHELPFUL?

[Please list up to 3 points below]

Point 1:.....

Point 2:

Point 3:.....



Write any important comments about service changes since March here

END OF PART 3: SERVICE CHANGES

PART 4: EXPERIENCES OF CONTACT

17) Have you spoken with anyone from [MENTAL HEALTH SERVICES] since March by phone or videocall while you were at home?

[Please circle the best response]

Yes mostly by phone/ Yes mostly by videocall /Yes by both phone and videocall/ No neither

If yes – then please also answer the following for phone/videocalls since March

17.1) I had privacy when speaking to someone **by phone/video** from my home

1	2	3	4	5
Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

17.2) I felt safe whilst speaking to someone **by phone/video** from my home

1	2	3	4	5
Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

17.3) What effect has speaking to someone **by phone/video** had on your mentalhealth?

1	2	3	4	5
Very unhelpful	Slightly unhelpful	No impact	Slightly helpful	Very helpful

17.4) Did speaking to someone **by phone/video** trigger or worsen any mentalhealth difficulty for you? *[Please circle the response]*

Yes /Not Sure/ No

18) Have you attended an appointment within [MENTAL HEALTH SERVICES] in-person (face-to-face) since March? *[Please circle the response]*

Yes /No

If yes – then please also answer the following for in-person/face to face appointments since March

18.1) I had privacy when meeting someone **in-person**

1	2	3	4	5
Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

18.2) I felt safe whilst meeting someone **in-person**

1	2	3	4	5
Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree



18.3) What effect has meeting someone **in-person** had on your mental health?

1	2	3	4	5
Very unhelpful	Slightly unhelpful	No impact	Slightly helpful	Very helpful

18.4) Did speaking to someone **in person** trigger or worsen any mental health difficulty for you? *[Please circle the response]*

Yes /Not Sure/ No

19) How many staff have you seen from **[MENTAL HEALTH SERVICES]** since March?

[Please circle the response given]

Nobody	One main person	a few people	Lots of different people
--------	-----------------	--------------	--------------------------

20) Do you have usually have:

a) access to a phone that you can use *[Please circle the response given]*

Yes/No

b) what you need at home (e.g. computer/i-pad/smartphone/internet connection) to join videocalls? *[Please circle the response given]*

Yes/No

21) How confident are you using online websites?

1	2	3	4	5
Very low confidence	Quite low confidence	Neither low nor high confidence	Quite high confidence	Very high confidence

22) Do you feel that you need some extra support in accessing on-line resources (like websites/ zoom meetings)? *[Please circle the response given]*

Yes/Not Sure/No

23) How likely would you be to agree to speak to someone by phone in future?

1	2	3	4	5
Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely



24) How likely would you be to agree to speak to someone by Videocall in future?

1	2	3	4	5
Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely

25) How likely would you be to agree to attend an appointment with someone in-person in future?

1	2	3	4	5
Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely

26) How would you prefer to speak to someone from [MENTAL HEALTH SERVICES]. Please number these in order 1= 1st choice, 2 = 2nd choice, 3 = 3rd choice

Face to face in person	videocall	Phonecall

Write any important comments about experiences of contact since March here

END OF PART 4: REMOTE CONTACT



PART 5: QUESTIONS ABOUT YOU

27) What is your age group?

Under 18

30-44

60 and over

18-29

45-59

Prefer not to say

28) How would you describe your gender identity?

Male

Female

Non binary

I identify as another term

Prefer not to say

29) Do you identify as Transgender?

Yes

No

Prefer not to say

30) What is your marital status?

Single

Married/Civil Partnership

Cohabiting

Separated/divorced

Widowed

In a long-term relationship

Prefer not to say

31) How would you describe your sexual orientation?

Heterosexual

Lesbian

Gay

Prefer not to say

Bisexual

I identify as another term

32) What is your first language?

.....

33) Which of these ethnic groups best describes you?

White (British)

White Other

Asian/Asian British

Black/African/Caribbean/Black British

Chinese/Chinese British

Mixed Ethnicity

Other

Prefer not to say



34) Are your day-to-day activities limited due to identifying as having a disability?

- Yes - a little
- Yes – a lot
- No
- Prefer not to say

35) Do you have a visual/hearing impairment? *[Please circle visual/hearing impairment]*

- Yes - a little
- Yes – a lot
- No
- Prefer not to say

36) Which category best describes your religion or belief?

- Agnostic
- Buddist
- Hindu
- Jewish
- Rastafarian
- Do not wish to disclose
- Atheist
- Chinese (Confucian or Taoist)
- Humanist
- Muslim
- Sikh
- Other
- Baha'i
- Christian
- Japanese (Shinto)
- Pagan
- Spiritualist

37) Do you believe that you or your background (e.g. your gender, age, ethnicity, sexuality etc) have impacted on the care you have received from [MENTAL HEALTH SERVICES]?

[Please circle the response given]

Yes/No

38) There is a second phase of this project that is particularly looking at the experiences of people who have had a mental health inpatient admission or crisis team contact. Would you be like to be contacted to contribute to the next phase of this project?

[Please circle the response given]

Yes/No

END OF PART 5: ABOUT YOU

DEBRIEFING



Ending

- Thank you for your time
- Your comments and ideas are very valuable to us!
- Would you like further information?
- Talk about EBE experience if the person seems interested
- Provide information about possible future videoconference training
[Offer padlet]
- At the end of the interview, take a minute or two to have a brief chat about how the person found the interview and try to end by talking about something positive or pleasurable. This could be:
 - Plans for the day
 - Plans for meeting up with a family member/friend/someone from the trust
 - How useful the person's contribution has been



Appendix 2 **Inpatient Project - Qualitative questionnaire**

My name is [name]. My supervisor is [name] who is a [role and trust]. This project will be to explore the experiences of service users who received inpatient admission and crisis team support throughout the national lockdown during the pandemic. This information will be used to inform learning and recommendations for our future interventions with service users in crisis.

Therefore, this second questionnaire will be asking more in-depth detail about your experiences of admissions and crisis team use. This will help us to understand from service users who have used inpatient/crisis teams any important learning and changes we should make to improve our services, and to inform the next stage of the project.

We are now contacting all service users from phase 1, who have used these services, and agreed to answer some more questions. Interviews will be conducted by myself, and data will be recorded, typed up, and reviewed to produce some key points, experiences, and top tips for feasible strategies to promote support and reduce admissions. The recorded file will be deleted once what you have said has been typed up.

A report will be produced to help us to improve our services in Sussex and regionally.

Section 1 – open questions

- 1. [X] interviewed you on [x] how have things been since? [question can be deleted if initial survey not undertaken].**
- 2. Can you tell me a bit about how you came to be receiving crisis team support/what led you to come into hospital during the pandemic?**
 - Was this your first/only admission? How was this similar to or different from previous admissions based on first questionnaire?
- 3. To what extent were any of these experiences due to covid19?**
 - Loss of job/financial difficulties/relationships etc
- 4. How did covid19 pandemic or lockdown affect you and your sense of safety personally leading up to the admission/crisis team contact?**
 - What influences whether you feel safe or not?
 - Was there anything new that contributed to the admission, or anything that you normally struggle with that was worse due to covid 19/pandemic?
 - How did the first lockdown affect your mental health compared with the second and third?



- Did you have to self isolate due to symptoms of COVID? If so, how did that impact your mental wellbeing?
- Were there things you were not able to access due to self isolating?
- How did the track and trace system make you feel? Did this affect any part of your mental wellbeing?
- How do you feel about the Covid19 vaccine?
- Can you think of anything which would have helped you feel safer?

5. How did covid19 pandemic or lockdown affect any care that you received before the admission/crisis team contact?

- Were there positive changes due to lockdown which supported your mental health?
- Was there anything you needed but couldn't/didn't get in terms of support?
- Were any staff that were supporting you moved suddenly to other services?
- How did you feel about not being able to access f2f appointments during the first lockdown? Were you offered any f2f appointments?
- How did you feel receiving services through video call? Did this impact on your mental wellbeing?
- How have you felt about seeing staff on video calls or talking to them on the phone instead of face to face? (community)
- What type of activities led you to feel more of less trapped during lockdown? How have you accessed these?
- Can you think of anything about the care you received that could have helped?

6. How did covid19 pandemic or lockdown affect your admission/crisis team experience?

- How was/is your relationship with the staff?
- Did you come across staff wearing Personal Protective Equipment like masks, gloves, aprons or gowns? How did this make you feel? How did affect your relationships with staff?
- How was the cleanliness of the ward/team base? was is as clean as it should be?
- If in hospital– was your stay longer or shorter than previous admissions/contacts due to covid19 (delay/challenges in discharge)?
- Was your leave restricted at all due to lockdown/covid19?
- How did it feel sharing a ward with people who may have covid, or may have to isolate?
- Have restrictions on smoking caused you any issues (even if you don't smoke yourself)?
- Can you think of anything that would have been helpful? Or done differently?



- 7. How well were community/crisis and inpatient teams able to meet your individual needs and preferences or changes in your needs? (are needs or people with ASC/neurodiversity being met)**
- 8. How did covid19 pandemic or lockdown affect your discharge and care after the admission/crisis team contact?**
- did you feel well supported/dropped on discharge? Where were you discharged to? (housing challenges)
 - How consistent was the support you received?
 - Can you think of anything that would have helped?
- 9. Where/from who have you received greatest support during lockdown?**
- Anything that you found helpful to support your mental health outside of the NHS support?
 - Were you involved with any other mental health support services e.g. MIND charity?
 - Any engagement with any peer support online? Any support from Advocates?
 - Can you think of anything that you could have been offered that would have helped/or changes to the support you received?
- 10. What can we learn from lockdown to support those vulnerable to mental health crisis?**
- What important changes would help wellbeing of yourself and other service users whilst we are in lockdown?

Section 2 – own unique experiences [use these prompts to answer any additional questions not already covered by the above]

[A selection of additional bespoke follow-up questions based on a service users' previous responses]



Appendix 3 – Information sheet and consent form for Qualitative Interview Collection

Study Title: What are the experiences of people who have used [Add trust name] services during the Covid-19 pandemic and how can we learn from their experiences to improve wellbeing and service delivery, and reduce the frequency and duration of inpatient admissions?

Information Sheet: Quality Improvement Support Team: Improvement Pathway Registration

Invitation: You are being invited to take part in a Quality Improvement Evaluation interview. It is up to you whether or not you would like to take part. Before you decide, we would like to tell you about the study, answer any questions that you may have and give you time to think about it and discuss it with family, friends, care team or GP if you wish. Information on how to contact us and other independent advice is at the end of this sheet.

What is the Study about? The aim will be to explore in an in-depth evaluation, the experiences of service users in the run up to and discharge from an inpatient admission or crisis contact during the pandemic, and to use this information to inform future service improvements.

Why is the study being done? Since the Covid-19 lockdown in March, the way [add trust name] delivered services had to change quickly. One of the main changes was that most health-related appointments were offered remotely by phone or videocall (not in person). It seems likely that the experiences of people who have used these services will have been impacted. Information from this study will be used to inform learning and recommendations for future NHS interventions with service users in crisis through the inpatient improvement programme and will help to provide better services if Covid-19 lockdown measures are increased in future.

Why me? You have been invited as you are a service user who has had an inpatient or crisis team experience and have already taken part in the previous questionnaire for the broader part of this evaluation.

What would taking part mean? Taking part will involve completing a single short interview (approx. 40 minutes) with a member of the project team either by phone or zoom. We will share what we learn from the project with you if you are interested. The interview will be audio-recorded so that the project team member can listen back and type up what you say. Once we have a typed up copy of what you say the audio-file will be deleted.

Confidentiality: Any information you give will be treated confidentially. This means that we will not tell anyone anything that you tell us as part of the research study.

Would confidentiality ever be broken? If you say something that suggests there is a risk to your own or someone else's safety we are obliged to tell your care team or GP.

Who will know if I decide to take part? Your care-team or care co-ordinator will have initially referred you to the study but they will not know if you take part and will not have any information about what you say in the interview. No-one else will know you are taking part.



Would I receive any reimbursement for taking part?

You will receive a £10 love to shop voucher/or equivalent, for your time

Where would I have to go and when? You will be contacted with a specific date and time that your interview will take place during [add date]. The interviews will be held remotely via a telephone or zoom video call depending on what you prefer.

Do I have to take part? No, it's up to you. If you decide to take part, someone from the research team will contact you. Whether you decide to take part or not will not affect your care through the NHS. If you decide to take part and then change your mind, you are free to withdraw at any time without having to give a reason.

What are the advantages of taking part? Importantly, the findings will help improve future NHS interventions with service users in crisis through the inpatient improvement programme and will help to provide better services if Covid-19 lockdown measures are increased in future. There are no immediate advantages to taking part in the study but some people enjoy taking part in these types of projects, where you can share your views and experiences and help to understand yourself better.

What are the disadvantages of taking part? You might find it upsetting or tiring to talk about how services did or didn't offer the support you required. You can stop at any time during the interview, without having to give a reason. If you have any concerns, please talk to someone. You can also talk to your friends or family, or an independent person, or a researcher. The names of an independent person and the researchers are given on the next page.

What would happen to the results of the study? The results of the study will be provided as a report for the NHS and may be written up for a mental health journal, but the information will be confidential and anonymous and your name will not be included. If you are interested we can send you a summary of the findings from the study.

Who will see my data, how will it be used and what will happen to it? Your data is your responses to the questions in the interview that are part of this study. Your data will be initially audio-recorded and then typed up and stored on a computer. All your study data will be anonymous so no-one outside of the research team will know it belongs to you. Only the research team will have access to the data that you give as part of the study. Paper data will be stored in locked filing cabinets and audio and computer data will be stored electronically in secure NHS or University files and will be protected by a password known only to the study team. Your data will only be used for this study and closely related studies. Your personal information, like your name and address will be stored in the same secure way but separate from your study data. Your study data will be stored for 10 years, and your personal data for up to one year after the end of the study. After this time data will be deleted or shredded.

What will happen if I am unable, or don't want to carry on with the study? You can withdraw from the study at any time without having to give a reason. Any data that you have provided up until that point will be included in the study.



Who is funding this study?

The project is funded by NHS England and the regional NHS Improvement team for inpatient services.

What if there is a problem? If you have a concern about any aspect of the study, you should ask to speak to the researchers, using the contact information below. They will do their best to answer your questions. If you remain unhappy you can contact the research department, or Patient Advice and Liaison Service using the contact information below.

What if I have a complaint: If you have a complaint about the way you are approached or treated during the course of this research study, you may want to talk to the Patient Advice and Liaison Service (PALS) who will advise you on what to do. Their contact information is below.

Who has reviewed this study? This research has been approved by the NHS Quality Improvement Support Team. The questionnaire that we are using to elicit their responses has been developed by the people participation team who are supporting this project.

Is the study insured? In the unlikely event that something goes wrong and you are harmed during the research, [add trust name] has insurance in place to cover their legal liabilities in the event of injury or damage to you arising from this study. If you experience any distress, you can contact the study team, your care team or your GP.

Who can I contact to talk about taking part in this study?

If you have any questions about the study, please contact me or my supervisor for the research:

[Add names here]

If you want to talk to someone independent about research, you can contact your local Patient Advice and Liaison Service (PALS):

[Add PALS details here]

Thank you for reading this



Study title: What are the experiences of people who have used [add trust name] during the Covid-19 pandemic and how can we learn from their experiences to improve wellbeing and service delivery, and reduce the frequency and duration of inpatient admissions?

Consent Form:

Please read the following points and put your initials in each the box after the point to show that you agree, [this will be completed by the project team member by phone and initialled and data on behalf of the patient] :

1. I have read the information sheet above and taken the time to think about whether or not to take part.
2. I have been given the contact details for people who I can talk about whether or not to take part.
3. I agree to take part in this study.
4. I understand that this involves me talking to a project team member about my views on **[MENTAL HEALTH SERVICES]** services during the Covid-19 pandemic.
5. I understand that taking part will involve an interview with the project team of about 45 minutes which will be audiorecorded for use in the study.
6. I understand that if I tell the project team something which suggests there is a risk to me or someone else, the researcher may need to pass this on to my care team.
7. I understand that data collected during this project may be looked at by the project team.
8. I understand that I can change my mind and withdraw at any time without having to give a reason.
9. I understand that if I decide to stop doing the project, unless I ask otherwise, the



information I have already given will still be used in an anonymised form (without my name).

10. I am willing to be contacted in the future to be asked about taking part in additional related research.

11. I understand that this research is completely confidential and all my data will be used in a confidential manner. My name will not be published in any way.

Study title: What are the experiences of people who have used [add trust name] during the Covid-19 pandemic and how can we learn from their experiences to improve wellbeing and service delivery, and reduce the frequency and duration of inpatient admissions?

Consent Form:

Please sign and print your name to show that you consent to take part in this research study and agree with the points previously asked:

SIGNED:

PRINT NAME:

DATE:

Appendix 4 – Data collection management plan Quality Improvement Hub

Data Collection Plan form (for each measure)

Who will collect data?	The data will be collected by members of the project team, following enrolment on the project, and after ensuring IG training. [Add names of project team here]
What data will they collect? Are these data <u>attributes</u> (yes/no, categories) or <u>variables</u> ? (measured numerical data)	The data will be qualitative narrative and descriptive data (and therefore not attributes or variables) although the data will be analysed to produce themes.
Where will they collect the data?	The majority of staff are working from home. They will be collecting the data via either zoom or telephone depending on the preference of the service user.
When will they collect the data? (frequency (daily, weekly, monthly) and if part of existing process at what step)	They will collect the data from each person at a single time point once the project is ready to start.
How will the data be recorded? Is there an existing source? (be specific)	The data will initially be audiorecorded, and then transcribed into a word document.
Will we count every event or take a sample? <i>If sampling how will we choose the sample?</i>	The sample is all participants who completed a previous survey and agreed to be recontacted, and who have had an inpatient admission since the pandemic.
What are the stratifiers? (if any)	none
What analytical tools do we plan to use?	Thematic analysis
How will data be presented? – types of tables and charts	Data will be presented in tables and theme diagrams and in a final report.
Who will do the analyses and create the charts? (Same person?)	The analysis will be conducted by [add names]



Who will receive the results? How often will they receive them?	[name] will receive audiorecorded interviews as they are collected and as per the Data Protection Impact Assessment.
--	--

(Based on p103-p107 of Lloyd, R. *Quality Health Care: a guide to developing and using indicators*. Jones & Bartlett 2004)

Guidance notes for data collection plan form

Questions	What to consider
<i>Who will collect data?</i>	Someone needs to do it, and they need to know it's them (or when it's them) Good if it's the people who are actually delivering the care but recognise the opportunity costs
<i>What data will they collect?</i> <i>Are these data <u>attributes</u> (yes/no, categories) or <u>variables</u>? (measured numerical data)</i>	Need clarity on what is needed (operational definitions need to be available and understood)
<i>Where will they collect the data?</i>	Need to know where in process data will be gathered and in which locations
<i>When will they collect the data?</i>	Need to agree frequency of data collection. This depends on process throughput and cycle time. In general there needs to be enough data to reduce random variation but frequent enough time points to be able to assess quickly whether changes are in fact improvements
<i>How will the data be recorded?</i> <i>Is there an existing source?</i>	Sometimes existing information systems can be adapted. Don't wait for this to pilot measurement - paper and pencil are very powerful tools at early stages.
<i>Will we count every event or take a sample? If sampling how will we choose the sample?</i>	For improvement we only need limited (just-enough) data so frequent sampling is often useful Need to agree a sampling methodology (if appropriate) Judgement sampling sometimes sufficient but random sampling sometimes required
<i>Are there obvious stratifiers?</i>	Stratifiers are subdivisions of data that reflect known differences in the process (for example by diagnostic group, day v night shift, week-day care and weekend care?) Use subject matter expertise to identify known differences in processes of care.
<i>What analytical tools do we plan to use?</i>	Need to understand how the data will be analysed and presented so we can see if changes are improvements. What statistics (e.g. median, mean, range, standard deviation) will we use?
<i>How will data be presented? – type of chart or table</i>	What tables and graphical tools: histogram, Pareto chart, line graph (run chart, control chart) will be used <ul style="list-style-type: none"> • Descriptive (enumerative) statistics –line and column charts • Analytical (predictive) statistics – run and control charts
<i>Who will do analyses and create charts?</i>	Someone needs to do it, and they need to know it's them. Is it same person for both analysis and chart creation?

<p><i>Who (or which group) will receive and review the results?</i></p> <p><i>How often?</i></p>	<p>Important that someone is reviewing outputs and able to take action on them</p>
--	--

| _____



Appendix 5 – Data Protection Impact Assessment

Data Privacy Impact Assessment

A data privacy impact assessment is a due diligence questionnaire that asks information about how personal and special category information is being used. We complete these assessments to support the safe handling and appropriate management our service users and staff's information as set out by policy and law. If we understand what we are doing with peoples data then we are able identify controls that we can put in place to minimise risk and ensure the confidentiality, integrity and availability of data .Once completed sent to: [email]

Use of Digital Dictation Recorders

The use of digital audio recorders is strictly governed by Information Governance. To ensure best practice and appropriate management of devices, the following procedures must be followed:

- Treat recordings as you would a Health Record
- Store recording in a restricted folder with limited access
- Upload recording/s within 2 weeks (gold standard) and delete from device
- It is advisable to transfer any relevant information onto the patient record through transcription or summarisation. Where it is not possible to transfer clinical information from the recording to the record the recording must be considered as part of the record and be retained accordingly
- If not transcribed and uploaded to Carenotes. ensure the location of a recording is logged on Carenotes and follow the same [retention schedule](#) as you would for Health Records
- Ensure you have consent if recording meetings and / or patient sessions
- Be aware that patients can withdraw consent or ask for recordings to be stopped at any time
- Report incidents of data breaches via [Ulysses](#)
- Ensure you track the digital recorder's whereabouts, sign in / out and keep a log
- Ensure recorder is stored in a locked drawer
- Devices should be Trust approved
- The use of *personal* devices e.g. smart phones / tablets are not permitted

Audio recordings may form part of the service user's treatment and care and can be a beneficial way of monitoring care.

Recordings can be made as part of the assessment, investigation or treatment of service user's condition or illness

Recordings are also beneficial to the Trust for teaching, training, assessment of health professionals and students as well as research and development.

For purposes such as teaching, training or assessment of healthcare professionals and students, research or other health-related uses which are not designed to benefit the patient directly – also known as secondary purposes

DPIA Ref:	
Requester	
Name & Job Title	
Contact Details	
Team	R&D
CDS	Corporate
Manager	[name]
Information Asset Owner	[name]
Background Information	

<p>Reason for use</p>	<p>Since the Covid-19 lockdown in March, the way [MENTAL HEALTH SERVICES] delivered services had to change quickly. One of the main changes was that most health-related appointments were offered remotely by phone or videocall (not in person). It seems likely that the experiences of people who have used these services will have been impacted. This is especially important when considering inpatient and crisis team input, as there is the possibility that changes in the nature and frequency of contacts have an impact on mental well-being which in turn impacts on admissions.</p> <p>Our CEO commissioned the Learning for the future project to evaluate both staff and service user experiences of wellbeing and service delivery during the pandemic, and to provide recommendations and learning for the future in terms of how services could adapt in the longer term. This information has already been shared in the form of webinars with staff and is currently being developed into publications with specific guidance for CDSs and professional groups, to be incorporated into future staff support and service delivery planning.</p> <p>As a result of this work, NHS England/NHS Improvement commissioned a report on this work as an example of good practice for how to learn from staff and service user perspectives to implement change regionally and nationally. The regional NHSE/NHSI team have requested a follow-up project to understand more specifically service users' inpatient and crisis team experiences and to determine how this might inform future community, crisis team and inpatient service delivery and staff training. This forms part of the South East Inpatient Improvement Programme work of NHSI. The results of the evaluation will be shared with the NHSI Inpatient Improvement Programme team in order to further develop high impact recommendations for service delivery both regionally and locally. The results will be shared as a report, and a blueprint set of tools and processes for further taking this learning forward into service transformation at a local and regional level.</p> <p>The project itself, which is a service evaluation and QI project will involve interviewing up to 14 service users who have had an inpatient or crisis team experience, have already taken part in the broader learning for the future project and agreed to be recontacted. The questionnaire that we are using to elicit their responses has been developed by the people participation team who are supporting this project.</p> <p>We would like to audio record these interviews in order that we can transcribe them verbatim so that we can analyse and report on the core themes as part of future recommendations</p>
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	<p>for service implementation. We will use the orbs recording system on the staff intranet or a trust compatible recording device, which is regularly used for this purpose in R&D. We will be working with NHSI stakeholders to translate these themes into actionable service strategies for regional implementation.</p> <p>The service users recordings will be anonymized, so no personal information will be recorded. They will be stored and transcribed in an anonymized format for the purposes of future learning and service improvement. The recordings will be stored on NHS and University systems in password protected formats and deleted after the end of the evaluation. We will ensure this data has been permanently removed.</p> <p>We have registered the evaluation and the recommendations and tools arising from it as an evaluation/improvement project within the trust in order for it to be regulated under appropriate guidance and governance.</p>
Will recordings be sent outside of the trust (to another person or organisation)	The recordings will be transferred to a secure University server in anonymised format for transcription purposes as outlined below.
How will you inform people that you are recording?	The patients who are involved in this project will be informed in an initial information and consent form, prior to the start of the interview. They will be reminded not to share any names or other personally identifiable information during the interview.
If the data is being sent externally, how will it be sent?	The data will be zipped and encrypted using 7-zip or equivalent and transferred to the secure University Box/OneDrive system where it will be stored in password protected format. This is as advised by The University Sponsor for ethics and governance as the most secure route.
Who will have access to this data?	Only the team directly involved in this project will have access to this data.
Has everyone with access completed data protection / IG Training?	Yes – although for the research staff member who will transcribe and analyse the anonymised recordings, this will be a training session using the IG information. This has been agreed with the QI team
Content	
What personal data is being collected? (<i>any information that can identify a natural person</i>)	No additional personal data is being collected as part of this project. Personal data was available from a previous project and people had agreed to be recontacted for this purpose.
What special category information is being collected? (<i>More sensitive data requiring additional protection e.g. Racial / ethnic origin, political opinions, beliefs, diagnosis, sexual orientation</i>)	The data being collected is about inpatient and crisis team service delivery experiences – no additional sensitive data will be collected.

How long with the recording/s be held for?	We have read the above information. This data is for service evaluation and not part of or relevant to clinical case management. As per standard in R&D projects, the audio-recording will be deleted following transcription into a word document, and the word document will be held on record for 10 years.
How will the data be deleted?	Data will be deleted and the deleted files also removed permanently from deleted folders.
Can the data be anonymised?	Yes the audio-recording and the transcribed data will be anonymized and no personal information will be recorded or shared.
Will individuals be able to request this data as part of a Subject Access Request?	The individual will be able to request a copy of their own transcribed data and will also be routinely provided with the overall themes from the group as a whole and asked to provide feedback on their validity.
If you collect information based on explicit consent, how can consent be withdrawn?	Service users can request to be withdrawn by contacting any of the study team up to the point at which the final report is produced.
Have you informed the information asset owner for your area of this intention to process data by this method	Yes, [name] is the asset holder and is also involved in this project.
Additional comments	We have been guided by advise from the QIST team, Research Governance Team and University Ethics Sponsor in completing these responses and the processes agreed are the most secure available in compliance with GDPR.

Information Governance Assessment

Legal Basis

What is the legal basis for processing personal data? (<i>any information that can identify a natural person</i>)	Explicit Consent		
	Performance of a Contract		
	Legal Obligation		
	Vital Interests		
	Public Interest / Task		
	Legitimate Interests		
What is your legal basis for processing special category data? (<i>More sensitive data requiring additional protection e.g. Racial / ethnic origin, political opinions, beliefs, diagnosis, sexual orientation</i>)	Explicit Consent		
	Employment / Social Law		
	Vital Interests		
	Legitimate Interests (not for profit / foundation)		
	Made public by data subject		
	Legal Proceedings		
	Substantial Public Interest		
	Management of Health Services		
Archive purposes in the public interest			

Authorisation

Comments from DPM:

Data Protection Manager		Date	
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Comments from Head of IG:			
Head of Information Governance		Date	
Device Approved:			