DATA BURDEN REDUCTION STRATEGY
Mental Health Clinical Outcome Review Programme

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) strives to limit the data collection burden on healthcare professionals and support staff, and aims to collect data, which is proportionate, with a clear business purpose and does not duplicate other data collections.

Our core database consists of clinical and social variables and details of care. In some studies, we also record patient and professional views on safer care.

Core database

Our core data collection is based on the successful model that has provided us with comprehensive national data for 25 years and has led to improvements in patient safety and suicide prevention in mental health care. Data provision burden by service providers is limited: first, for any individual Trust/Health Board the number of patient suicides each year is very small and for many in a year will be zero; second, we have a tightly defined data set, reviewed and refined recently, that contains only those variables essential for analysis and reporting. We have introduced an electronic portal for receipt of questionnaires which has reduced the burden on clinicians by automating some responses; we continue to keep this under review to make improvements where possible.

Our data collection follows three stages:

- We receive information on all suicide (and undetermined) deaths from official national sources,
- We identify mental health contact with the help of NHS provider organisations,
- We receive questionnaire responses from the clinical team who provided care.

Our close relationship with clinicians is essential to maintaining our response rate (consistent response rate of 95%). Clinicians have told us via our stakeholder survey that they value NCISH being clinician-led, and that our findings have an important influence on their practice. We will continue to survey clinicians and respond to any concerns raised. We welcome clinician suggestions for emerging concerns, and prioritise dissemination to front-line professionals. We value clinician input and have recently amended the tone of our letters in response to suggestions. We have an established four-stage reminder protocol that rigorously follows up questionnaire completion, and offers help to those finding it hard to meet our timelines because of workforce pressures or other difficulties.

Services have demonstrated support for our work by being responsive to our requests (e.g., we received risk assessment tools from all services for our recent study, though risk is a sensitive area). The primary reason for our high level of participation is our emphasis on the benefits to services via:

- Translation of evidence-based recommendations into measurable statements against which organisations can assess their suicide prevention plans (our "Safer Services" toolkit),
- Providing an annual safety scorecard (in England),
- Working directly with local areas in England to support Quality Improvement,
- Feeding evidence into policy and guidance in all UK countries,
- Direct invitations to attend our annual conference,
- Prioritising NHS requests for speaking engagements,

- Providing slide sets for use in local training sessions,
- Responding to concerns raised, e.g., we have established a relationship with the Regulation and Quality Improvement Authority in Northern Ireland.

Estimated workload

Our estimate for questionnaire completion by a clinician who was familiar with the patient is around 30 minutes. It is unusual for a clinician to have more than one questionnaire per year. Taking part in our data collection can contribute to Continual Professional Development, reflective practice, audit requirements and appraisal for individual clinicians. We estimate that for administrators to complete a datasheet to identify service contact takes 2-3 hours quarterly.

Topic Specific studies

We also conduct studies to include the general population, to collect data on related outcomes (such as self-harm), and conduct controlled and linkage studies.

- We invite suggestions for topics via our stakeholder network, stakeholder survey and social media (X, BlueSky, LinkedIn); topics are selected by our advisory group (including funder representation) to ensure relevance,
- We reduce burden where we can by extraction of data from sources (e.g., coroners reports, serious incident reviews, routine data) wherever possible.

Further plans to minimise data collection requirements

- We will continue to work to minimise local burden, though our feedback suggests it is viewed as acceptable. Information from our questionnaires can also be of direct benefit locally, for audit and safety improvement.
- There is little risk of duplicate data entry by clinicians, with one questionnaire sent per patient, and careful cross-checking by our research team.
- We have moved from paper questionnaires to collecting pseudonymised data via a secure electronic portal, including auto-completion of sections that are dependent on previous responses. We have recently made improvements to the electronic data collection portal to improve the experience for the user.
- We will now investigate the possibility of introducing a portal for our datasheet (i.e., patient identification) returns.
- We continue to liaise with organisations holding relevant datasets, including NHS Digital, to explore opportunities to reduce participant burden by supporting and supplementing our data collection:
    (1) Earlier identification of deaths by suicide,
    (2) Identification of mental health service contact, avoiding the need for service datasheet completion,
    (3) Clinical data that could supplement the NCISH questionnaire, allowing us to shorten our questionnaires.
- We remove questions from our questionnaire that are no longer reported.