



**The Sainsbury Centre**  
for Mental Health

**Removing Barriers. Achieving Change.**

# **A Report on the Administrative Workload for Mental Health Workers**

**Revised version 2006**

**Ines Garcia**

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## **About the Sainsbury Centre for Mental Health (SCMH)**

SCMH is a charity that works to improve the quality of life for people with severe mental health problems. It carries out research, development and training work to influence policy and practice in health and social care. SCMH was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which it receives core funding. SCMH is affiliated to the Institute of Psychiatry at King's College, London.

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## Terms and abbreviations

### Mental Health Workers

The terms 'mental health workers' and 'clinicians' have been used interchangeably in the report. Both include all qualified and unqualified staff working in the three types of mental health teams, regardless of whether they are employed by the NHS or social services. This does not include staff whose role is purely administrative.

**To avoid interviewees being identified by their job title, the following generic terms have been used:**

<b>CPN</b>	= all qualified community psychiatric nurses or community mental health nurses working in assertive outreach and community mental health teams
<b>HCA</b>	= ward based health care assistants
<b>OT</b>	= all qualified occupational therapists
<b>OT assistant</b>	= all unqualified occupational therapist workers
<b>Psychiatrist</b>	= consultant psychiatrist, clinical assistant, senior house officer (SHO)
<b>Psychologist</b>	= all qualified clinical psychologists
<b>Social worker</b>	= all qualified social workers including approved social workers
<b>Staff nurse</b>	= all qualified nurses on the wards
<b>Support worker</b>	= support workers and unqualified social workers
<b>Team manager</b>	= assertive outreach and CMHT team leaders/managers plus ward managers. These can be nurses or social workers by profession.
<b>AOT</b>	= assertive outreach team
<b>CMHT</b>	= community mental health team

### Team codes

To ensure anonymity, the three sites in the study have been given a location code number at random:

ASS01 = Administrative Study Site 01

ASS02 = Administrative Study Site 02

ASS03 = Administrative Study Site 03

Each team will be notified of their own location code only. Location codes will not otherwise be made available.

# 1 Introduction

***“At one time the words ‘administration’ and ‘management’ were more or less interchangeable ... Nowadays ‘administration’ tends to be understood as the narrower task of developing and maintaining procedures. That is to say it is seen as an aspect of organising.”***

Cole (1990)

In 2002, the Audit Commission report *Recruitment and Retention: A public service workforce for the 21<sup>st</sup> century* revealed that “the sense of being overwhelmed by bureaucracy, paperwork and targets” was one of the main reasons for people leaving their posts in the public sector (Audit Commission, 2002). Other research has also shown that mental health workers often state that they spend too long doing paperwork and that this can be a significant cause of occupational stress, dissatisfaction or burnout (Dallender & Nolan, 2002; The Sainsbury Centre for Mental Health, 2000; Edwards *et al.*, 2000; Harper & Minghella, 1997; Sullivan, 1993) and that paperwork can impact on the amount of time that can be spent on direct care (Tingle, 2001; Whittington, 2000, Higgins *et al.*, 1999; Ryrie *et al.*, 1998; Robinson, 1996).

Defining administrative work is not straightforward, particularly when we explore this in the context of mental health services. There are the aspects of administrative work undertaken by mental health workers which are closely linked to service user care such as assessments, care planning and other forms of record-keeping, phone calls to housing departments, reports for tribunals and many others. A second set of administrative tasks relates more directly to the mental health workers themselves and their teams such as recruitment paperwork, telephoning to obtain agency staff and locums, travel claims and appraisal documents. A third set of administrative tasks relates to the collection of data that can inform at local and national levels how services are organised. These tasks often serve a performance monitoring function and include recording of caseloads and contact with service users, audits and the compilation of statistical information.

One of the most difficult dilemmas for services is how to develop and maintain procedures that are effective and informative but not overly bureaucratic. How can we ensure that what we are monitoring is telling us what we need to know? For example, can recording the number of service user contacts or the completeness of the paperwork tell us anything about the quality of the actual care given? Do we need to ask additional or different questions? Getting the right information without making monitoring processes too onerous is a real challenge for all performance monitoring bodies.

If as the Audit Commission and others have found, people are finding administrative work a source of stress, then this needs to be explored. To do this we need first to establish a baseline of the amount of time taken on administrative work, what work is carried out and by whom, and the benefits and limitations of the systems in place to

facilitate this work, such as information technology. Secondly we need to understand people's attitudes to and opinions on this part of their work, and distinguish between what people find helpful and rewarding and what is perceived as creating barriers to care provision or affecting morale, and why.

The research undertaken for this project aimed to provide a better understanding of the administrative workload for psychiatrists, nurses, health care assistants, psychologists, social workers, support workers, occupational therapists and occupational therapy assistants in three sites. The completion of time diaries enabled a snapshot to be obtained of time spent on: all written and computerised documentation, both clinical and non-clinical; telephone calls; photocopying; and filing. The diaries did not include conversations, meetings or handovers. Qualitative interviews helped to address the lack of in-depth knowledge of mental health workers' perceptions of their administrative workload and explored some of the more complex topics relating to this such as performance management, time management and communication.

Administrative work is currently and will almost certainly remain an integral part of the role for all mental health workers, so creating a sustainable balance between administrative work and direct service user care is essential. Furthermore, a whole system approach can only be feasible by understanding how each aspect of the mental health worker's role fits into and influences that system. The challenge therefore is not just for performance monitoring bodies but for individuals, teams, Trusts and workforce planners to work together to ensure that all aspects of mental health workers' roles are given their due value and importance and workloads organised accordingly.

## Background

There are drivers, not just in Mental Health Trusts but across the NHS, which have promoted greater vigilance in record keeping. Record keeping is an essential and integral part of the care provided to service users. Professional bodies such as the Nursing and Midwifery Council (NMC), the College of Occupational Therapy and the British Medical Association (BMA) all produce guidelines on quality and standards.

**Good record keeping helps to protect the welfare of patients and clients by promoting:**

- high standards of clinical care
- continuity of care
- better communication and dissemination of information between members of the inter-professional health care team
- an accurate account of treatment and care planning and delivery
- the ability to detect problems, such as changes in the patient's or client's condition, at an early stage

*(Guidelines for records and record keeping, Nursing & Midwifery Council, 2004)*

Another way of looking at record keeping is to understand its importance in reflective practice. Completing clinical records enables the clinician to:

**Think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work and weigh alternative approaches to the care of their patients. The capacity for professional self-reflection and self-appraisal of one's professional work is essential ... to the maintenance of his or her professional skills and to the provision of high quality clinical services.**

(Bodek, H., The New York State Society for Clinical Social Work, Inc., quoted on [www.clinicalsw.org/basic\\_standards.html](http://www.clinicalsw.org/basic_standards.html))

In mental health services one major change has been the instigation of the care programme approach (CPA). It was introduced in 1991 and then reviewed in 1999 in light of, amongst other things, the challenges of implementing the Mental Health National Service Framework (DH, 1999). One of the main aims of the CPA was to ensure that people got to “the right place for the right intervention at the right time” by having an integrated approach to care co-ordination (DH, 1999). The current National Programme for IT (NPfIT) in the NHS aims to bring in computer systems to aid the care and services provided to everyone using the NHS (for further information please see [www.connectingforhealth.nhs.uk](http://www.connectingforhealth.nhs.uk)). Electronic patient records (EPR) will mean changes to the way information is collected, stored and disseminated. Lord Warner stated that “in time, it will allow staff caring for them – wherever they may be in England – to have instant, accurate access to their essential health history, including allergies, current medication, pre-existing conditions and recent treatment” but there are strict new guidelines on who can access the records (2005). Both the CPA and the NPfIT programme have made and are still bringing about changes to the way that information is recorded and accessed and consequently to the administrative work carried out by mental health workers.

On 1<sup>st</sup> March 2000, the Data Protection Act 1998 became effective thus giving people the right to request to see their notes, and this has led to increased awareness of how notes are written. The BMA advises that “records must be legible and factual, and personal views about the patient’s behaviour or temperament should not be included unless these have a potential bearing on treatment” ([www.bma.org.uk](http://www.bma.org.uk)).

In 2001, the National Audit Office published its report on clinical negligence and stated that “there is a trend towards increased litigiousness on the part of patients, as evidenced by a research finding that the rate of clinical negligence claims increased by 72 per cent in one region between 1990 and 1998” (National Audit Office, 2001). We can see from our own findings in this study that record keeping in case of complaints or litigation is perceived as one of the purposes of administrative work by clinicians.

Increased performance management has also been a driver for better collection and analysis of data on health services. In 2003 the Commission for Health Improvement (now The Healthcare Commission) published its first set of star ratings for Mental Health Trusts in England. Trusts are required to submit information on their services and these are measured against a set of criteria and Trusts are rated accordingly. CPA systems

implementation is just one example of one of the performance indicators for the ratings ([http://ratings.healthcarecommission.org.uk/Indicators\\_2005/](http://ratings.healthcarecommission.org.uk/Indicators_2005/)).

On a very regular basis, many clinicians provide information both for monitoring systems as well as documenting the care service users receive. The ongoing changes in the way the NHS operates will continue to redefine administrative processes and workload.

## Methodology

### Data collection

Two methods of data collection were used in this study: 1) time diaries; 2) in-depth semi-structured interviews. In total mental health workers from nine teams participated. There were three sites involved and these were selected to ensure diverse geographical locations. At each site, one assertive outreach team (AOT), one community mental health team (CMHT) and one inpatient ward participated.

#### Time diary

The time diaries provided recordings of types of administrative tasks that were undertaken and the number of minutes spent on those tasks. This provides a snapshot of administrative workload. The main advantage of this method is that it enables a full week's record of all administrative work to be made across professions and teams. This scale of recording would not have been feasible if it had involved the observation of individual clinicians undertaking administrative work (direct observation method). The diary method is also far less intrusive for both clinicians and service users than using a direct observation method. The limitations of the time diary are that it slightly increases the workload of staff and can be subject to inaccuracies especially if recordings are not made immediately.

The diary template was created in discussion with one of the participating teams at Oxleas NHS Trust. It was reviewed externally by two CMHTs as well as ward staff not taking part in the study and finally reviewed by the steering group. Please see Appendix I for a sample sheet of the time diary.

At each site, a week was set for the diary completion and the aim was to gain a census (total) sample of staff that were on duty during the diary week. All three teams at each site completed the diary in the same week. The week of completion varied at each site as the data collection was staggered over the period of one year. Night staff, agency and bank staff were not included in the diary exercise. In a very small number of cases, staff divided their time between more than one team. Where possible, recordings were made in the diary for just the work a person completed for the team involved in the study and best estimations of average time spent working in the team made. In the case of many psychiatrists, work was spread over several locations such as the ward, CMHT or AOT, outpatients etc. In this instance it was not feasible to divide the diary and therefore all medical staff are shown separately on the diary findings as 'combined medical' in each location.

A database of time diary data was set up and the data explored by team and by profession in order to ascertain average percentages of time spent on administrative tasks.

Evaluating the accuracy of self-completed data is difficult and this is true of the time diaries. In order to improve accuracy each team received telephone contact and personal visits to ensure that there were no problems and to check diaries were being completed. Team managers and local leads had an important role in assisting with this process.

In total nine teams took part in the time diary recording. Most of the diaries were completed to a very high standard of clarity and comprehension. However, two out of the three wards appeared to have insufficient time diary data and/or incomplete data recording. The findings of those two wards did not correspond to the data from the ward where time diary completion was high (and included high participation of both qualified and unqualified nurses). This should be borne in mind when considering the findings from the inpatient wards.

### **Qualitative interviews**

The aim of the interviews was to obtain more in-depth data by exploring the opinions and attitudes of staff concerning their administrative work.

The interviews were semi-structured to allow staff freedom to talk about any issues relating to the subject they felt pertinent and/or important. Interview questions were devised to pick up on some of the key activities included in the time diaries as well as other important topics relating to administrative workload such as information technology and time management. The steering group reviewed the interview questions and modifications were made. Following this a pre-study interview was conducted to test the questions. Please see Appendix II for the list of interview questions.

At each site, a random sample of staff was selected for interview and this sample was stratified by profession. Interviews lasted an average of 45 minutes. Most were face-to-face and taped and transcribed. There were two telephone interviews and three other interviews where notes were taken due to recording difficulties.

Thematic analysis was carried out using Maxqda software.

### **Steering group**

A steering group was set up to continually review the study process and to advise on the findings. The steering group had representation from: The Royal College of Psychiatrists, The Royal College of Nursing, the British Association of Social Workers, the College of Occupational Therapists and the British Psychological Society.

## **Confidentiality and anonymity**

Confidentiality and anonymity are important in research such as this. In many instances only one person from a profession completed the diary per team or even per site so individuals could be easily identified. To avoid this happening there are considerable restrictions on the reporting of time diary data. As three sites are involved, each site has been given a code and individual sites will be informed of their own code. Interview data does show the profession of the interviewee but not the team or location to avoid identification.

## **Ethical approval**

Approval was gained from the Multi-centre Research Ethics Committee (now Central Office for Research Ethics Committees or COREC) and then subsequently from each Trust research and development (R&D) department. Local research ethics committees were given notification of the study in accordance with the central research ethics approval.

Information sheets were given to staff providing detail of the study and signed consent obtained for taped interviews.

## 2 Findings

### Response rates

In total we received back 78 diaries and this is an average of 26 diaries per site. Response rates were at 80% or higher for seven out of the nine teams. The two exceptions were inpatient wards where response rates dropped down to 46% and 50%.

A total of 56 in-depth interviews were completed. Participation in interviews was very high in all teams with the exception of one inpatient ward where only the ward manager agreed to be interviewed. Only two other people selected in the remaining eight teams were not interviewed. In order to ensure that representation was gained from all staff groups in each of the teams, the overall number of interviews conducted exceeded the 36-40 anticipated.

### What did people do?

Mental health workers are faced with an enormous variety of work. Both the time diaries and interviews show this to be the case.

Examples of administrative work include:

- Writing up notes and the CPA paperwork
- Correspondence including referrals and discharges
- Gathering/inputting data for audits or for Trust management
- Human resources paperwork such as compiling job descriptions and obtaining agency, locum and bank staff
- Complaints and associated paperwork
- Supervision, appraisal and student related paperwork
- Reports such as those required for tribunals or management hearings
- Form filling such as mileage claims, funding requests, prescription charts and disability living allowance
- A wide range of administration relating to housing, benefits and utilities including forms, letters, faxes, phone calls and e-mails
- Phone calls including those directly with service users and carers; those to outside organisations such as voluntary sector and residential care; those to other staff within the Trust such as other clinicians, catering or management
- Filing and photocopying.

To gain an understanding of volume and percentage of time spent on administrative work the time diaries provided a valuable snapshot. As mentioned in the methodology, there are considerable limitations on what can be shown due to issues of confidentiality. The charts relate directly to the main categories of administrative work shown in the diaries and these are:

- Phone calls
- Reports
- Correspondence
- Client notes
- Referrals/discharge
- Statistics/audit
- All other form filling
- Worker to worker admin (paperwork for appraisals, supervision, student etc.)
- Filing and photocopying
- Other (e.g. preparation for seminar)
- Completing the time diary.

The time diaries show an overall average (mean) percentage of time spent on administration across all professions, in all our three sites, which equates to 31.5% (ranging from 3.7% at lowest (an HCA) to 93% at highest (a team manager), with a median of 27.8%) or just under one third of the mental health workers' total time.

Figures 1 to 3 in Appendix III show the percentage of overall time spent by each team on the main administrative tasks. These charts reveal that in each location the highest percentages of time are spent on phone calls, correspondence and client notes. There is variation both across and within the locations for each activity. For example, the highest amount of time spent on phone calls was not consistently found in one type of team or in one location. The highest number of phone calls was found in the CMHT in location ASS01, the AOT in ASS02 and the inpatient ward in ASS03. These results may be helpful to teams in identifying time-consuming administrative tasks and to act as a starting point for undertaking further work to explore specific administrative tasks and work practices.

Figures 4 to 6 in Appendix IV show the total amount of time in hours spent on administrative tasks in each location. These hours are for all professions combined and confirm that the highest amount of actual time in each location is spent on client notes, phone calls and correspondence. The particularly high number of hours spent on client notes in ASS03 relates to the high percentage of time spent on client notes by the AOT and inpatient wards in ASS03. In location ASS02 the lower number of hours spent on phone calls in comparison with the other two sites can be cross referenced with the lower percentages of time spent on phone calls at this location during the time diary week.

Figures 7 to 9 in Appendix V show the percentage of time spent on administration by profession by site. There is a case for arguing that directly client related phone calls constitute part of the direct care and are therefore not administrative. However, this is not always simple to decide so they have been kept in with the administrative tasks throughout the study. To show the difference in administrative workload when taking these calls out, the charts in this Appendix and the following Appendix show two percentages: one including directly client related phone calls and one excluding directly client related phone calls. It should be noted that where there was only one person in a profession who had completed a time diary their percentage has not been included for

reasons of confidentiality and anonymity. Although this data cannot claim to represent usual working patterns as it is only a snapshot, it does show the variation in administrative workload for the professions.

Figures 10 to 13 in Appendix VI show the average percentage of time spent on administration by team in each location. These findings are only for the period of one week but give an insight into the types of percentages of time being spent on administrative work. Direct comparisons are difficult because of the number of variables that could impact on these percentages. It is perhaps noteworthy though that the percentages of time spent on administration are particularly similar for assertive outreach teams at each site. Conversely the inpatient wards show marked differences and this is in part accounted for by the issues of data collection on the wards referred to in the methodology section. Another factor is the variation in the role of the health care assistant that is illustrated by interview findings presented in the later section 'The role of healthcare assistants'.

## The purpose of administration

### Information provision

The response from the majority of interviewees was that clinically related administration provided information for other team members and professionals. This information was necessary to ensure both continuity of care and high quality care. Records also served the function of acting as an aide mémoire to the person who wrote them.

Examples of information provision being the main purpose of administrative work

*"I think it's all just really centred round ensuring the patient's getting all the input from us that they can."* (HCA)

*"If [the service user has] actually forgotten quite a lot of what has happened, you can say 'well hang on, look, last time you were ... this helped' "* (CPN)

### Defensive

Although the provision of information was the most frequent answer across all professions and teams, a number of people did also mention that paperwork was a means of defence against potential complaints or litigation.

*"It feels as though a lot of stuff is precious ... in case something happens."*  
(staff nurse)

There was a call from one psychiatrist for people to be braver about their work and not feel the need to document every single thing.

## Managing the administrative workload

The interviews clarified that for many, administration is something that often has to be tagged on to the working day and fitted in as and when possible rather than being allocated to specific days or times during the day. The interviews also revealed that undertaking administrative work is a value-laden process with staff being happier to undertake paperwork and calls relating to service users but less happy with non-client related administrative work such as recording contacts and other form-filling.

Some interviewees could see specific benefits arising from the administrative work they carried out and this enhanced job satisfaction:

*“when you’re doing these things [housing, benefits etc.] and seeing an outcome, that then gives you pleasure in the job and that satisfaction in the job, so to just be doing purely visits and none of the admin, you wouldn’t get that.” (support worker)*

Some reported that they could see purpose in all the administrative they carried out:

*“There isn’t anything that I’ve been doing that I’ve thought ‘Why am I doing this?’ or ‘How pointless this is’ or ‘Didn’t I just do this somewhere else.’ (CPN)*

Others believed that paperwork had increased without any benefits and this was the case for some people who had been longer in service:

*“If it [increased administration] made improvements to patient care I would say fine but I don’t think it has, I think it’s just statistics and written stuff. It doesn’t make any difference to your patient care, none at all.” (CPN)*

Unlike many other jobs, clinical staff have two distinct categories of work: a) direct work with service users or carers; b) all other work including paperwork. A dichotomy arises as staff try to ensure both good quality paperwork and high standards of care. This dichotomy is exacerbated by having an unpredictable daily workload (emergencies, incidents, admissions etc.), by the use of agency and bank staff who are unlikely to be able to undertake the full range of administrative duties, and by a lack of administrative support. People reported different ways of managing their time. Some spoke of their individual preference whilst others spoke of a team culture. One psychiatrist spoke of having to get up each day of the previous week at 4.30 am in order to do paperwork. Others such as health care assistants on the wards had very little administrative work. The interviews revealed that people often felt the need to prioritise their workload and this made completing administrative tasks difficult at times. Some did paperwork in their own time, some always prioritised service user care, others ensured paperwork was kept up to date. Finding a way to balance workloads was not always easy and there was the sense from a number of interviewees that one thing could only be done at the expense of another:

#### Examples of trying to balance workload

*“I tend to ... try to get the notes done as soon as it [care] has happened ... unfortunately sometimes it does mean to say that I haven't spent enough time with the patient.” (staff nurse)*

*“If somebody's struggling, then the visits and the actual clinical contact ... would take preference over, 'Well, I've got some care plans to update' ... definitely admin takes a back seat. And that's not a good thing.” (CPN)*

There is also a difficult issue of immediate versus long-term value. Staff were torn between the immediate needs of service users and the longer-term value of paperwork in providing information to ensure good care. The internal dilemma is recognised in this example:

*“What I would like to change is how I feel about doing admin – that I could put time aside ... to actually do it.” (CPN)*

Some mentioned that just the thought of the administrative work piling up became a source of stress in itself.

The concerns with balancing workload are compounded by a lack of predictability not only of clinical workload but also administrative workload. These manifest in not knowing how much workload there will be and when it will occur. For example, preparing reports for tribunals can take several hours but may not happen frequently. Slotting in time for this preparation is not easy:

*“The tribunal reports that I've done take me a good two and a half, three hours ... sometimes they're not advised that they're needed until a week before, and then you've got to find the time in that week to actually put it together.” (OT)*

There were other administrative duties like this including telephone calls:

#### Examples of unpredictability of phone calls

*“If you've got a member of staff goes off sick, the policy is to go through the bank list first and that can take ages [ringing] each person individually to cover that shift ... then you go onto X agency and that fails as well” (staff nurse)*

*“You can sit there and the phone doesn't ring all morning. You can sit there and you'll never be off the bloody thing. It's totally unpredictable.” (CPN)*

It was not only unpredictability but the volume of administrative workload related to certain administrative tasks and processes that some interviewees were concerned about. Human resources (HR) related administration could be particularly problematic for team managers. One manager spoke of not having HR people on site which exacerbated difficulties with tackling disciplinary action and long term sickness. The administrative processes involved were reported as taking up substantial chunks of the day. Another spoke of rigid and slow recruitment practices which had meant that the onus on paperwork and maintaining contact with applicants fell to them as team manager. Team managers were also more likely to report being involved in protracted complaints processes including lengthy redrafts of responses.

## Information technology

Information Technology (IT) was the topic talked about at greatest length during the interviews. The interviews revealed some valuable and in-depth information about change management, culture and skills.

### Polarised views on IT

Across all the teams and sites, views on IT seemed to be polarised. Interviewees were either optimistic about the use of IT and its future relating to their work or they declared themselves 'technophobes'. There did not seem to be a pattern by profession but there did appear to be some connection between people's views on IT and the following factors: the lengths of time in the service; whether they had the use of computers at home; whether they had used computers during a degree course; or whether they had previously had a non-clinical post that required computer use.

#### Examples of polarised views on IT

*"I'm one of these very, very awkward old people who is completely IT illiterate ... I suppose I'm technophobic if you like."* (social worker)

*"I'm self taught ... but I love technology..so for me it's just been fiddling and getting it and just enjoying."* (CPN)

Other people labelled their colleagues 'technophobes'. However, one senior person who said people who did not read their e-mails were 'technophobes' seemed unaware of the huge difficulty of computer access for some staff who struggled to find a free terminal between clinical visits.

### Benefits

For many that expressed views on the benefits of IT, they related to their own day-to-day work such as making it easier to access a range of information.

*"It's better than pulling out lots of different files."* (social worker)

Others spoke of the future and the way that technology would change working practice and reliance on work stations.

*“People are talking about the new tablets and IPAC-like hand-held things where our nurses may have a trolley-like thing with a laptop in it, with wireless access, so that they can roll it down the ward, down the corridor without having to depend on the physical space where a workstation is available to them.”*  
(psychiatrist)

Team managers and performance leads were more likely to take a whole system view point:

*“Our approach to performance is ensuring that this information is being collected and ... that it’s being monitored on a regular basis by the people who are delivering the services on the ground. So you’ve got real ownership and people can see how we’re performing and they can understand the reasons for the shortfalls. They can come up with solutions about how we improve and how we get there.”* (performance lead)

## Staff involvement in designing systems

Interviewees were asked whether they had been consulted on IT developments and requirements. There seemed to be a general acceptance that a change to the IT system is something staff will have to adapt to rather than having active participation in its development. This perception seems to be a combination of either not having been consulted, lack of any definite feedback on consultations that had taken place or not seeing taking part in a consultation as a priority.

### Examples of views on staff involvement

*“I think there has been consultation and I think clinicians and people who use the systems’ views have been taken into account.”* (team manager)

*“There’s a to do list that’s this long and ... you do the urgent stuff when it gets too bad, so things like, “Do you want to contribute to designing X system?”, whatever that is, no way.”* (social worker)

Several interviewees spoke of mismatches between the system and the requirements of the clinician. This could, for example, take the form of entry boxes being inflexible, causing duplication by having to enter the same information in more than one place, or the inability to cut and paste information. For some, such problems were an inevitability of a new system but for others there were concerns about how such modifications could be made even when fault-reporting mechanisms had been in place.

## Replacing like with like?

One of the most fundamental questions raised was whether IT systems were offering a new way of providing information or simply replicating paper systems. This move from written documentation to computerised records has largely been seen to date in the development of electronic CPA systems.

*“Trust X has been developing ... the ECPA, where many paper based documents have been converted into electronic format, but it is very much like reading a paper document ... does not give me the additional advantage which other electronic systems would give you, like creating reports on a particular diagnosis or a particular treatment or a particular intervention or getting a very quick report on a key worker and their caseload. These privileges are not there.” (psychiatrist)*

Trying to adapt a paper system to an electronic one has given rise in some instances to duplication of workload. Notes may be written on paper, such as during CPA meetings, which then have to be typed up on the computer. A mixture of part-written and part-electronic systems means that information that is input into computers may not be accessible to other team members.

Another psychiatrist spoke of how moving to electronic patient records would necessitate a re-think of confidentiality issues. In this instance the implementation of a new system could be the catalyst for new ways of record keeping.

*“There’s all sorts of data security things around electronic patient records but there wouldn’t be much point in just duplicating all the old paper problems, by saying that the psychologists could only read the psychology entries and the agency nurse could only read the agency nurse entries because you wouldn’t get a holistic picture.” (psychiatrist)*

## Computer access

Across the sites the access to computers was variable. In some instances the access to computers was good with most team members having their own computer, whilst in others computer access was very limited. Difficulties in access were often linked to the expansion of a team with office space and facilities not matching their new requirements. It was not always clear how decisions had been made on who would have computers on their desks; for example, in one team with insufficient computers, psychologists had computers even though they were not care co-ordinators. There were obvious frustrations expressed by people who found it difficult to gain regular computer access:

*“We’ve got so few computers, it’s waiting to get on and ... it’s really difficult. I do have to do some e-mails and I do try and get on a computer every day to check them.” (support worker)*

There was recognition by some interviewees that access to computers is fundamental and that no progress towards electronic records can be made until ready access is there for everyone:

*“You type up a document and it’s on the computer, but because there’s not enough PCs then everything has to be printed off, so you’re not saving any paper because you’ve got have a hard copy of it.” (team manager)*

The exception to this was on the wards where computer access was seen as less of a problem and this perhaps relates to the fact that wards were not using them so frequently. One ward manager spoke of resistance by staff to any form of administration let alone computers and an example was provided by a CPN who spoke of having to reiterate information that had been input into the ECPA because ward staff had not accessed or could not access it.

Most of the wards had a limited number of computers and given current usage, it is hard to gauge whether computer access will be a future problem on wards once more electronic systems are utilised.

*“It is quite annoying really that we spend all this time putting on our contacts, doing core assessments, doing this and that and people can’t even access the system.” (CPN)*

## **E-mail**

Encouragingly, most people had access to e-mail albeit limited at times by the computer access problems discussed previously in this chapter. Views on e-mail were quite mixed with some finding it an asset and others finding it caused other problems. A few interviewees appreciated the role that e-mail could take in patient care, particularly with regard to the speed with which other professionals could be contacted for information or advice. The e-mail facility seemed to assist communication in teams where all members were regularly accessing their e-mail accounts. Some interviewees were also thinking ahead to when it could be a way of keeping in touch with service users.

In other locations there were complaints that some people did not know how to use e-mail or did not have regular access. There were also assumptions that because someone in the Trust had an e-mail address that it was active but this was not always the case.

There were also difficulties with ‘e-mail overload’. One of the problems was with the practice of copying everyone into Trust e-mails instead of using a noticeboard on a Trust intranet. This caused large volume of e-mails not all of which were relevant.

### Examples of e-mail overload

*“People, they press ‘send’ and it goes round the whole hospital saying ‘do you want to come to a party?’ from people you don’t know.” (OT assistant)*

*“When you think of the 50 e-mails I get now, I wasn’t getting 50 phone messages a day before e-mail came in, nothing like.” (psychiatrist)*

## Skills and training

A lack of skills in typing and use of computers was frequently mentioned in the interviews. There seemed to be an assumption within Trusts that staff would be able to type even though for many, their experience of computers was minimal. Without keyboarding skills, administrative tasks can become more time intensive.

*“For some curious reason when computers have come on the scene and they are on everybody’s desk, people assume that people have got keyboard skills.” (psychiatrist)*

Others were less sympathetic to their colleagues:

*“Sometimes they can be lazy, you know, they don’t just want to go onto the computer and type these things. When they know there’s a secretary there, admin staff, they give it to them to type.” (social worker)*

For some who had taken part in training and using a new system, the process had been extremely difficult. The emotional strain this had caused some people is evident in the quote below:

*“I mean going over to the computer was a bit of a nightmare for some of us ... learning to use it and then losing it all and then starting again was terrible, terribly traumatic.” (OT)*

At all sites staff generally spoke highly of the quality of the IT training they had received. However in two sites the problem with the training was that it was often out of step with need. This was either because people had started a job or needed to use the system before training could be provided or the training was too far in advance of a new system being implemented. IT training was not always taken up when offered because of annual leave, emergency calls etc.

Lack of training was a particular issue at one site:

Examples of lack of training from one site

*"We've had no training and we've just been surveyed for our views on training, we've yet to know what they are going to offer us ... there's nothing in the Trust and I've been told we're certainly welcome to go off and get ourselves some training."* (psychiatrist)

*"I'm waiting for this computer training we should have had ages ago ... they were talking probably at least 4-5 years ago about us having training and it never happened."* (OT)

One CPN reported the difficulties for wards where they were running with high levels of agency staff that were not given training.

The concern with not providing training or providing training at the wrong times is that it can potentially disengage staff from the IT agenda. Given that some staff have scant IT knowledge before attending training on local systems, the provision of training too soon before implementation of systems will mean that training is forgotten. Staff will either be left to struggle or will need refresher courses meaning further release from their clinical work.

## Social services and health systems integration

By interviewing both health workers and social workers it has become apparent that there were concerns about systems integration. The first of these concerns was about having two systems running at the same time and the second was about lack of access for healthcare professionals to social services' notes:

Examples of lack of integration from two sites:

*"[We] still sort of have to log on to two systems – like the council system and the trust system."* (social worker)

*"That is my understanding, that eventually both things will be merged but I don't know whether that is two years or 20 years away."* (psychiatrist)

The interviews revealed that the integration of systems and notes is a complex area. Where social workers and support workers were based within Trust teams some reported feeling distanced from social services and were not able to gain access to information they needed:

*"We haven't got a social services system here which is really poor, so I am very very isolated now from social services, I don't know what is going on."*  
(support worker)

## Face to face contact recording (daily contacts, K rner returns)

One of the most frequently stated complaints from teams in the community was that of having to record numbers of contacts with service users. There was a large-scale lack of clarity about the purpose of completing statistics even at team manager level. Interviewees told of having to go through diaries to collate the information and talked of backlogs of entries to record and inaccuracies largely due to non-recording.

### Examples of not knowing the value or purpose of contact recording

*“Not really understanding what it’s all about makes me less rigorous than I might be ... it’s not high on my list of priorities often. I don’t know the value of it.”*  
(psychologist)

*“I know I missed two months earlier in the year because I got so far behind, it was January and February. I think I got to six months behind on putting that information in so I just let it go.”* (CPN)

It was not unusual during the interviews to encounter strong feelings about this recording process.

*“Everything we do is recorded and we still have to enter on that thing what we’ve been doing ... it feels like, ‘Oh, you know, we’ve got to keep an eye on them’ ... it feels like – nannyish.”* (social worker)

Some interviewees did guess at what the purpose might be, but these were presumptions rather than actual knowledge:

### Examples of presumed purpose of face to face contacts

*“I presume that what Trust X would use it for is to look at their services in detail and work out have we got enough provision, is one team overloaded, is another team working a lot less face to face contact?”* (CPN)

*“I presume it’s ... for the PCTs to check that we are actually fulfilling our side of the bargain in looking after their clients.”* (CPN)

The lack of clarity about contact recording and its purpose makes it difficult to know exactly what interviewees were referring to. It seemed in some instances that they were talking about the obsolete K rner return. K rner returns used to be carried out by Trusts but are no longer required as the Mental Health Minimum Data Set has replaced this requirement. In addition, individual Trusts or Trust departments may decide to gather further statistical information.

## Administrative support and role

All teams had support from administrative staff with psychiatrists and psychologists sometimes having separate support. The way that administrative staff worked varied with some covering a whole range of activities whilst others had more specific functions such as answering the phone. Many interviewees spoke of the importance of administrative support.

### Examples of praise for administrative staff

*“You just say ‘oh, can you sort this out?’... and she’ll give it back to you on a piece of paper that looks really smart and all professional.” (OT)*

*“I don’t think I’ve ever been as pleased in my professional working life with the admin as I am here.” (psychologist)*

A psychiatrist mentioned the difficulties when administrative staff were on leave. Although provided with a temporary secretary, the psychiatrist had not been around to explain what needed doing so was not sure what work was getting done. Cover for ward clerks and team administrative staff was reported as patchy.

There were concerns expressed by a number of interviewees that secretaries and administrative staff were overloaded with work and there was therefore reluctance to give them any further work. However, the role of the secretary/administrator did seem somewhat unclear with some team members getting secretaries to type up their letters whilst others were keen or at least able and willing to type their own. As such it was difficult to be clear how much regular and consistent involvement administrative staff had in care co-ordination administration.

*“I see X sitting alongside some of the secretaries sometimes and dictating to them while they do a letter, but I suspect that they’re quite stressed because they’re really secretaries for the whole team” (support worker)*

This blurring of boundaries between administrative and clinical work is an important finding from this study. Several health care assistants expressed concerns about their nurse colleagues who had to spend large amounts of time being office based rather than ward based. Some interviewees were philosophical about the change whilst others were more scathing:

### Examples of attitudes to change in role

*"I feel like a glorified secretary." (staff nurse)*

*"The role of the CPN has changed ... since we started doing the CPA and the ECPA ... we've become partially admin workers." (CPN)*

*"Even if we don't want changes, society changes ... so we have to move along, at least with the tide." (social worker)*

## Communication

### Communication with other agencies

Communication with other agencies such as housing, benefits, and utilities forms a substantial part of the administrative workload for many mental health workers. This communication can take the form of phone calls, e-mails, faxes, letters, reports, forms and referrals. There was considerable variation in views on this communication and this in part depended on how much contact a person had with other agencies as part of their role. For support workers, this contact made up a large part of their day-to-day work and was evidenced in the time diaries and interviews.

The experiences of support workers from each site of the precise concerns including attitudes make for quite lengthy but highly valuable reading, shown in the examples below. The proposed solution from one site compares well with what happens in practice for another site and with a specific example in the third site where an employee from a housing association visits a service user. These examples also highlight the impact that outside agencies can have on the workload of support workers but also the possible stigma that still remains for those with mental health problems:

### Information from support workers from the three different sites on dealing with housing and/or benefits

*"I've written several sort of requests, if you will, with ideas ... I suggested that something which would save a lot of time is having a dedicated person in each department because people don't take account of people's mental health problems ... we could solve a lot of problems if there was somebody who you could meet face to face." (support worker)*

*"It's a bit of a learning curve really but we've got identified people for each area and they're pretty good ... they usually come here or we meet with those at the client's house or something, if they want to exchange or something ... but then they do tend to cancel quite a bit as well." (support worker)*

*"One housing association recently went to X which is a secure unit to visit a client about sorting out some housing stuff, and she rang me up and said 'I'd never go anywhere like that again' ... she said it really upset and disturbed her and played on her mind, because the chap was so poorly, so they probably don't realise, and I think a lot of people when they hear the words 'mental health', I think some of the agencies think 'skiver'. I do really feel that." (support worker)*

A fundamental lack of understanding of the service user's problems can lead to inappropriate responses and situations that can cause anxiety and upset for service users. One OT assistant spoke of their time intensive method of dealing with other agencies. The example illustrates this:

*"I was with a client, who had some water rates arrears, and I got a woman on the phone and she was saying 'we want this paid now ... we want it all at once'. And she was being really, really obstructive and really quite rude to be honest with you. And so I said, 'Okay, fine I'll talk to him about it.' He [service user] just went 'booh, well I can't pay it now' ... so I rang back, got a completely different person, 'fine we'll make an instalment arrangement'. Absolutely totally and utterly different reaction within the space of two minutes. ... Then he [service user] calmed down. So that's what I usually do." (OT assistant)*

In contrast, other teams and other professionals had positive comments, and having a named person seemed to be very definite help and was mentioned by many professional groups. Much appears to be down to local arrangements and possibly individuals within those organisations who have varying degrees of mental health knowledge:

*"I think setting up this with X Housing, having this person that's specifically there ... it's brilliant. I can't tell you how wonderful it's been because he's very, very accessible, absolutely brilliant, he will meet with the client, keep you informed, that's been really, really good." (OT)*

The stress placed on service users by not having effective systems to manage housing and benefits was discussed. One interviewee spoke of the way that this can exacerbate illness and by doing so create yet more paperwork:

*"If somebody becomes unwell because they worry about the bills and the rent and everything else, that triggers people and the situation or condition becomes worse, which then means you've got to start filling out increased risk forms ... so it's like perpetual motion." (support worker)*

The solution to these difficulties is, on the one hand, simple – it seems that having a named person with some knowledge of mental health issues who will also meet the service user is what works well. On the other hand, the ability to influence organisations outside the NHS is variable and may need senior Trust management input into negotiations. From the information gathered in the interviews, some staff struggle to get their voices heard, particularly those that are unqualified.

## Communication within the team

Interviewees were asked about the flow of information within their teams. This was to explore what were blocks or aids to communication. Although this does not directly

relate to administrative work it can have an impact. The ease with which multi-disciplinary team members can find all relevant notes, the effectiveness of the methods for sharing information that will assist with the completion of administrative work, and the way workload is shared are just three examples of this. Generally, communication was thought to be good in all teams. Verbal handover meetings assisted with this as did good access to notes and many positive comments were made about team communication. In community teams (both assertive outreach and CMHTs), a reduction in professional role boundaries seemed to be one way in which information flow was facilitated:

Examples of good communication within a CMHT, AO team and ward

*“We haven’t got problems with communication and we don’t distinguish that ‘you’re a social worker, I am a nurse’, we are a community mental health team and we work as such.” (CPN)*

*“Everybody talks about things, everybody knows what’s happening. If a phone call comes in, it doesn’t have to necessarily go to a particular person because everybody would hopefully be able to know what our plans were for that person and where we were going with that person.” (CPN)*

*“We have access obviously to the notes on the ward and we do get a lot of relevant feedback to their care.” (HCA)*

## Communication within the Trust

Information flow between teams in a Trust was more problematic. Some community teams spoke of problems with wards such as receiving conflicting information, or talking to “three or four different bank staff for example who have part of the story” or decisions being made in ward rounds that are then changed and the community teams not notified. Similarly there were problems the other way round for wards.

Conversely, there was understanding about work pressures for colleagues in other teams.

*“There are ... big, big lapses sometimes with receiving core assessments through, when the person’s being admitted. Now that’s not all the time and its obviously understandable if they’re very busy in the community.” (ward manager)*

One team manager explained their thoughts on how the perceived fluctuating status of teams due to changes in service configuration impacted on the flow of information:

*“I know at the moment we’re suffering from ... well, you can only call it jealousy really from others. It’s because we’ve had money. They’ve not. That’s affected not so much communication, but the relationship. So I suppose when you have a poor relationship with somebody, the communication isn’t as open and honest as perhaps it could be.” (team manager)*

Information from Trust management and other groups within the Trust such as policy documents were generally felt to be available often via the internet or via feedback from team managers. It was then felt to be down to individuals to ensure they read the information but some confessed that it was not always a priority with competing demands on time.

*“I’m on some sort of forum and one of the documents that on there is 246 pages long ... there’s no chance I’m going to sit there and read through that – I haven’t got time to do that.” (CPN)*

## Star ratings and performance management

### Star ratings

Mental Health Trusts are monitored in a number of ways including service user and staff surveys. The 2003/4 targets and indicators (relevant for time of interviews) included:

- the implementation and model fidelity of assertive outreach teams;

- CMHT integration which measured the degree to which teams had integrated health and social care staff;
- CPA systems implementation;
- hospital cleanliness;
- readmissions;
- suicide rates;
- patients with copies of their own care plans;
- Consultant appraisals;
- physical environment;
- Mental Health Minimum Dataset implementation which includes valid returns on such indicators as ethnic category and date patient last seen (by care co-ordinator).

(Healthcare Commission, 2004)

*“They reckon it’s a [X star] Trust or something isn’t it? I’m not sure what that means because, well it hasn’t really interested me to be honest ... I’m not a manager with that kind of ethos to look at organisational things, I leave that to other people.” (CPN)*

The interviews revealed that mental health workers had little understanding of how teams were monitored. Very few interviewees knew anything about star ratings and many had never heard of them. Those that had heard of them often did not know what they were or what they measured.

Although the team and ward managers were largely aware of star ratings, there was often uncertainty in how their particular team fitted in to the ratings:

*“I don’t think star ratings have much, much connection with actually what goes on in practice actually at all ... I’ve not been approached in terms of looking at our team in terms of the star rating.” (team manager)*

Consultant psychiatrists, as a professional group, were able to comment more on some of the specifics of the ratings such as electronic CPA and waiting times. In contrast, performance leads felt that the information on rating and performance monitoring was transparent. One lead emphasised that information on star ratings was sent out by internal e-mail so the information was available. Some interviewees confirmed they had received information by Trust e-mail but had not read it thoroughly as it did not seem directly relevant to them.

A way to explore this seeming difference in viewpoint was expressed by one clinician.

*“Sometimes it’s difficult in the NHS to ... integrate the ... political agenda I suppose which, inevitably there’s going to be in any service delivery, with the clinical agenda, and that’s where I think things sometimes get bogged down.” (psychologist)*

The perceived gap between a 'political agenda' and a 'clinical agenda' came across in a couple of interviews where interviewees had some understanding of star ratings. One CPN said that the impact of star ratings was that they had to now work on Christmas Day in order to fulfil the team's fidelity to the model criteria but the CPN argued that there was a lack of evidence base for those sorts of decisions. The interviews as a whole indicate that teams are not engaged in the ratings process.

## Performance management

Interviewees often saw this in terms of individual performance and related this to supervision. One team manager explained that they always reviewed and discussed clinical documentation during clinical supervision. There was also positive feedback in terms of service monitoring from service user evaluations and this was felt to be part of the process of service improvement. Reflections on other audit such as CPA audit were often couched in negative terms although a couple of CMHT members talked about a group ownership to making improvements with a 'hands on deck and work together' approach following audits.

There were concerns expressed about what was being monitored. One psychiatrist spoke of the information being asked for not meaning anything:

*"Sending round forms for us to fill in to say 'are you adhering to the NICE guidelines on schizophrenia?'. There's a million and one things in the NICE guidance on schizophrenia ... it's a nonsense question" (psychiatrist)*

It was also felt that the information gathered did not show the quality of care or in-depth work. Another psychiatrist gave their thoughts on performance management could be best used:

*"Many medical colleagues may not automatically think of patient outcomes first as performance management, they may insist on ... whatever clinical activity they're doing to be the marker and not necessarily the outcome" (psychiatrist)*

Lack of feedback and involvement was mentioned by several interviewees.

*"I know that there was talk about us possibly having to do a presentation at the end of September/beginning of October on the team and some of our outcomes – whether we'd achieved them – but that never came off. I don't know whether it happened and we weren't there or whatever, but I certainly didn't have to prepare anything." (team manager)*

## Quality and standardisation of notes

It was beyond the remit of this study to examine notes to assess for quality although some interviewees did discuss the quality and standardisation of notes. Interviewees described the amount being written in notes as variable with some writing a few points and others writing too much. There did not seem from those who discussed this, that there was any standard approach to writing in notes. Different Trusts, teams or wards had different approaches to writing in client notes but different styles of writing were also occurring within the same team or ward.

*“All the research shows that if you standardise processes then overall quality rises because consistency rises.” (psychiatrist)*

Shared notes were not used in all sites thus meaning that separate notes for nurses, doctors and other professions were still common practice. The practice of shared notes in rural areas with many different locations to cover was not without practical difficulties.

The interviews revealed that there are potential risks entailed when what is written in the notes is unclear. In this example a nurse explains she was unable to identify whether one or more incidents had taken place:

*“You’re supposed to have a front sheet that gives you all the major incidences ... I was trying to create one on one occasion ... but it was so hard trying to do it in the first place because all these doctors had written it ... I really got confused as to how many incidences had arisen.” (CPN)*

Two psychiatrists reported that there was variability in the quality of note writing which sometimes necessitated them spending time rewriting records. Two also spoke of lengthy processes in writing up case note summaries for service users who had long histories but no clear, up to date chronology of events and treatment planning.

*“Sometimes people are very green and I daresay on record rather sloppy, and they don’t bother to do a proper summary ... it has happened in one or two cases where a diagnosis has been wrongly changed from a mood disorder to schizophrenia for example” (psychiatrist)*

Solutions were not always straightforward but nurses from two different sites talked of practices they had seen elsewhere that had seemed better. Both were talking about easy access to relevant and important information.

### Examples of other practice

*"I came across a system that seemed much better to me which was they wrote the notes to do with the care plan with pointers so you knew exactly how the care plan was going. Whereas most notes are written in a diary form ... so would mean a lot of reading through – there's a lot nonsense or irrelevant information."* (CPN)

*"It was just one single form – tick boxes, but also space to highlight, you know, sort of identify risks as well – and it was just that one thing. Everybody knew to look at that one form."* (staff nurse)

## The role of healthcare assistants (HCAs)

The healthcare assistants interviewed all spoke of taking a lesser role in administration than all the other staff groups. Time diary information showed that on one ward HCAs were hardly involved in paperwork (5% of overall time) and this was confirmed by interviewees saying they were able to spend time out on the ward with service users. On another ward HCAs were spending considerable amounts of time on paperwork (34%) and the time diaries indicated that they may have been undertaking the types of paperwork more expected of qualified nurses. In the third site there was more balance with HCAs spending 18% of their time on paperwork.

This data suggests that the role of healthcare assistants is far from consistent across Trusts and their role and how it fits in with other staff would be a useful area of exploration in workforce planning.

## Mental health workers and their wishes

Interviewees were asked if they could make one change to the NHS what this would be. Although many put this in context with administration, the question was open for all comments. This question aimed to explore any burning issues for staff and to give the opportunity to raise issues beyond interviewees own roles and teams. The answers have been loosely grouped in communication-related, administration-related and other although there is overlap. Here are some of the responses:

### Communication-related

- Integration of the political agenda with the clinical agenda.
- Having seamless provision of care with enhanced communication between teams. This includes adopting practice that works for the service user and taking advice from other teams who know the service user.
- Breaking down the 'tribal' culture in the NHS where people want to defend their own work and resist sharing information.
- Improvement in communication in our systems such as housing benefit.
- Clarity about communication: who to contact, how and where.

- Not having so many different types of community teams as it makes information sharing more difficult.
- Ensuring an equal say for all staff on how the ward is run i.e. not just doctors having power.
- Knowing that statistics are used positively.

#### **Administration-related**

- Integrated fully electronic notes that provide up-to-the-moment information.
- Not slavishly documenting everything but having courage in what you do.
- Training on how to complete paperwork so you are not experimenting on what to do or relying on other people.
- Being able to give work to secretaries and more administrative staff.

#### **Other**

- Recruiting the right people, not just people with academic ability but those with other life skills – those that can be caring yet assertive.
- Looking at job profiles, particularly those of team/ward managers, to see how administration and meetings fit in with clinical work.
- Have smaller geographical areas to cover (community teams).
- Higher pay for nursing staff.
- Provision of more psychiatric intensive care unit (PICU) beds.

Interviewees were also asked to name the one administrative task or one aspect of administration that they would change. A number of interviewees said they found it difficult to think of anything 'off the top of their head' and some were happy with the processes as they were.

Below are some responses:

- Getting rid of face to face contact reporting.
- Everyone to have a computer.
- Having a reliable clinical record that does not involve staff in duplicating effort.
- Improving mileage claim procedures that are very onerous for staff who do frequent short distances.
- Getting rid of CPA forms and carers' assessments (as they do not go anywhere as there is no money for carers).

## 3 Key Findings

### Managing workload

- Balancing the competing time demands of direct care provision and administrative work is difficult for many mental health workers.
- The administrative workload for mental health workers is often unpredictable in terms of when and how much work there will be.

### Values

- Undertaking administrative work can be a value-laden process with mental health workers happier to undertake what they can see as being of benefit to service user care.

### Standards

- Standards of record keeping appear to be variable and this relates not only to service user related documentation but also non-service user related record keeping.
- Key information is not always easy to access.

### Administrative support

- Administrative staff roles are varied. Expectations of clinical staff upon their time may differ between individuals in teams leading to ad hoc practices within teams.

### Trust information on data/performance management

- Teams have insufficient information on why information is required, making provision of such information liable to inaccuracies or missed data.
- Clinical staff knowledge, involvement and engagement in performance management such as star ratings is very limited.

### Information technology

- There is a lack of involvement with mental health workers in the development of IT systems.
- There are concerns that new systems could replicate paperwork rather than developing new ways of working
- Computer access is patchy with some staff struggling to find computers to use whilst others have easy access.
- There is a considerable number of clinical staff who lack basic IT skills creating resistance to using new systems or difficulties in doing so.
- IT training for the use of new systems is not always in time with a system 'going live' or for when a clinician needs to start using a system
- Whether computers are used or not can be due to personal preference or a team culture.

### **Communication**

- Although communication within a given team is usually very good, there are communication problems and 'silo' working found within Trusts making the provision of seamless care hard to deliver.
- Communication with outside agencies such as housing, benefits and utilities needs improvement. Poor communication leads to additional workload for clinical staff as well as stress and anxiety for service users. There are examples of positive inter-agency working which show this is achievable.

### **Human Resources**

- Team managers would benefit from greater support from human resources particularly around issues of disciplinary action, long term sickness, absence without leave, and recruitment processes.

## 4 Conclusion

The amount of time spent on administrative work has never been nationally measured to provide a baseline across all types of teams. It is therefore only possible to know anecdotally about an increased volume in paperwork during the past few years. One exception to this lack of data is the work of Dr Keith Hurst at the University of Leeds who has studied how nurses spend their time on psychiatric inpatient wards since 1985. He has found that from 1996, nurses started spending less time on direct care and more time on other duties such as administration (Hurst, 2003). This finding in itself does not mean that there is too much administrative work but it does suggest that the role of the clinician is shifting.

This study has been a first step to understanding the administrative workload across a range of professions and teams. Apart from providing some useful percentages of time it has begun to shed some light on the more complex questions about administrative processes and shown where smaller changes to make processes more effective could be explored. Encouragingly most of the interviewees did clearly understand and see the importance of the administrative tasks that they perform and how these relate to and impact on service user care. Concerns were not so much with the need to undertake administrative work as with the design of systems, poor communication and balancing workload. Understanding why forms need completing and why certain data is required to be gathered was highlighted as being vital to ensure both quality and completeness.

The interviews have shown that paperwork and administrative processes are part of the wider picture of communication and co-operation that comes into play with a whole system approach. Both the social inclusion agenda and the recent green paper on *Independence, Well-being and Choice: a vision for adult social care in England* (DH, 2005) make improving those connections between social care, health care, the voluntary sector, housing and whole range of other agencies even more crucial. Whilst a national drive to promote inter-team and inter-agency working is valuable, smaller local steps are equally as valuable.

Another important finding was the polarisation in views on information technology (IT). With the development of IT systems comes the real prospect of improving communication and reducing bureaucratic processes. Engagement with clinical staff is essential in this process, as is encompassing new ways of thinking about documentation. Simply converting paperwork into electronic work without having the facilities in the system that could provide the types of data needed to inform local practice would be a missed opportunity. Similarly electronic systems need to be designed and implemented so as to cut back, not replicate, unnecessary administrative workload.

The roles of clinicians and the boundaries between roles are in a state of flux. More change is on the horizon with the new Mental Health Bill and changes to workforce

planning such as the introduction of support time recovery workers and ward housekeepers. It not yet apparent what impact such changes will have on existing roles and the changes need careful monitoring.

This study clearly identifies the difficulties that clinicians are facing in balancing the two very different and important aspects of their role: administrative work and direct service user care. Decisions must be made about whether existing staff need to work differently, what aspects of the clinical role are essential and how the workforce or processes within the NHS and social services could better be configured. Administrative workload has been an unrecognised and unmeasured part of the clinicians' overall workload for too long. If clinicians are to be supported in their role and if good care is to be provided to service users then standing back and doing nothing is not an option.

# 5 Key recommendations

The study findings suggest that there is a number of areas that would benefit from local and national investigation. Below are some of the key recommendations that emerge:

## Managing workload

- Trust management and team leaders should seek to address the difficulties in balancing direct clinical contact and administrative duties. It is not simply individual time management issues but is part of a larger problem of competing priorities which affects almost all clinical staff. Part of this review may need to involve looking at: how work is prioritised; clinical staffing levels that take into account the administrative workload involved in caseloads/bed occupancy; ways of simplifying and streamlining administrative processes and systems.

## Values

- Trusts, teams, professional bodies and higher education departments need to explore how administrative work fits into the changing clinical role.

## Standards

- Higher education departments need to work with professional bodies to develop or enhance training in documentation completion. Any such training needs to be multi-disciplinary.
- Trusts should review the role of agency and bank staff in the completion of administrative documentation. This is particularly pertinent for inpatient wards. Where documentation is computerised, any review needs to look at whether these staff have sufficient training, and access to passwords for computers, and the implications of such staff not having access on service user care/safety and team workload.

## Administrative support

- Trusts should clarify the role of administrative staff in teams and on wards. Levels of support should take into account the hours of operation of teams including wards, the numbers of staff that are being supported as well as different team functions. Administrative staff support for care co-ordination is another area that could be assessed and re-evaluated.

## Trust information on data/performance management

- Performance leads, clinical governance leads and managers should ensure that clinical staff are clearly informed why all data is collected and provided with brief feedback. Part of this review should include checking whether clinical staff are still being asked to collect data in a format which is no longer required such as Korner returns.

- Strategic health authorities and Trusts need to explore how the 'political' agenda and the 'clinical' agenda can be better reconciled to enhance a whole systems approach.

### **Information technology**

- Trusts (and social services) should ensure that clinical staff involvement is proactively gained in the development of IT systems. This should include people from a range of professions. All grades of staff should be involved, not just those in management positions whose needs may be different. This will help to remove unnecessary bureaucracy and duplication and promote 'frontline' involvement in the changes.
- Trusts should review computer access for all clinical staff and ensure that where systems are operational, that they are being used by all staff. This may incorporate the need for clear lines of responsibility in ensuring implementation, training needs assessment, and a range of training that includes basic computer skills training such as keyboard skills.
- IT training needs to be timed to fit in with computer systems going 'live' to promote good IT and documentation practices and to prevent inadequate use of the system which can lead to poor quality clinical and managerial documentation. This would also remove the need to provide refresher training for the system.

### **Communication**

- Trust managers including team leaders should negotiate better means of communication with other agencies such as housing, benefits and utilities. This could include finding a person in each organisation who can act as a point of liaison for mental health service users. It may also involve work shadowing, training and inter-agency workshops on values.
- Trusts and team leaders need to look at ways of enhancing communication within the Trust to promote seamless care provision as well as the sharing of positive practice.

### **Human resources**

- Human resource departments should work with team managers to look at ways that sufficient and timely support can be given over disciplinary matters, long term sickness and recruitment processes.



# Appendix I

**Please see overleaf for example of time diary sheet.**

# Time diary © SCMH 2006

Please tick the box next to the activities you have undertaken during this time period and put the time in minutes you spent on each task

	Task Length in time in minutes						Task Length in time in minutes						
<b>PHONE CALLS</b> (please tick <i>main</i> category of call)						<b>REFERRALS, DISCHARGE</b>							
Directly client related (inc. referrals)	<input type="checkbox"/>	___	___	___	___	___	Written referrals within own team	<input type="checkbox"/>	___	___	___	___	___
Benefits, housing, utilities	<input type="checkbox"/>	___	___	___	___	___	Written referrals other teams in Trust	<input type="checkbox"/>	___	___	___	___	___
Information to / from management	<input type="checkbox"/>	___	___	___	___	___	Written referrals other	<input type="checkbox"/>	___	___	___	___	___
Staffing / HR matters	<input type="checkbox"/>	___	___	___	___	___	Discharge Summaries	<input type="checkbox"/>	___	___	___	___	___
Housekeeping eg. Maintenance, meals	<input type="checkbox"/>	___	___	___	___	___	<b>STATISTICS/AUDIT</b> , Please Specify						
Taking messages for colleagues/clients	<input type="checkbox"/>	___	___	___	___	___	eg. Coded data collection, recording face-to-face						
Retrieving messages from voicemail etc	<input type="checkbox"/>	___	___	___	___	___	contacts (OASIS), bed occupancy stats etc.						
Other, please specify	<input type="checkbox"/>	___	___	___	___	___	.....	<input type="checkbox"/>	___	___	___	___	___
.....	<input type="checkbox"/>	___	___	___	___	___	<b>FORM FILLING OTHER</b>						
<b>REPORTS</b>						Observation recording ('specialling')							
Writing tribunal reports	<input type="checkbox"/>	___	___	___	___	___	Writing prescription charts	<input type="checkbox"/>	___	___	___	___	___
Writing reports for other hearings	<input type="checkbox"/>	___	___	___	___	___	Forms for tests/procedures	<input type="checkbox"/>	___	___	___	___	___
Reading client reports	<input type="checkbox"/>	___	___	___	___	___	Client leave / freedom pass, Sections etc.,	<input type="checkbox"/>	___	___	___	___	___
Reports other, please specify	<input type="checkbox"/>	___	___	___	___	___	Ordering Supplies etc	<input type="checkbox"/>	___	___	___	___	___
.....	<input type="checkbox"/>	___	___	___	___	___	Timesheets, claim forms, Offduty	<input type="checkbox"/>	___	___	___	___	___
<b>CORRESPONDENCE</b>						Funding Requests							
<b>Letter writing / reading / e-mails</b>						Form filling, Other, please specify							
Housing, benefits, DLA, utilities related	<input type="checkbox"/>	___	___	___	___	___	.....	<input type="checkbox"/>	___	___	___	___	___
Client related, all other	<input type="checkbox"/>	___	___	___	___	___	<b>WORKER TO WORKER ADMIN</b> eg						
Non Client related, please specify	<input type="checkbox"/>	___	___	___	___	___	Paperwork for supervision, students,						
.....	<input type="checkbox"/>	___	___	___	___	___	appraisals etc						
<b>Reading policy documents etc.</b>	<input type="checkbox"/>	___	___	___	___	___	.....						
<b>CLIENT NOTES</b>						<b>Filing / photocopying</b>							
Admission details	<input type="checkbox"/>	___	___	___	___	___	<b>Completing this form</b>						
CPA	<input type="checkbox"/>	___	___	___	___	___	.....						
Risk Assessment	<input type="checkbox"/>	___	___	___	___	___	<b>Any other, please specify</b>						
Care / treatment plans	<input type="checkbox"/>	___	___	___	___	___	.....						
Writing up case notes	<input type="checkbox"/>	___	___	___	___	___	.....						
Reading client notes	<input type="checkbox"/>	___	___	___	___	___	<b>Any comments (was anything about your work day unusual):</b>						
Other Please Specify	<input type="checkbox"/>	___	___	___	___	___	.....						
.....	<input type="checkbox"/>	___	___	___	___	___	.....						

# Appendix II

## Semi-structured interview - questions for mental health workers

### Introduction

- Explain the purpose and nature of the study including what we include as 'administration'
- How the interviewee was selected
- Confidentiality
- No right or wrong answers and that they can interrupt, ask for clarification etc.
- About my background
- Ask to tape record and sign consent

### Warm up questions

- Ask something about their job, how long they've been working there etc.

### Interview Questions

- **I'd like to hear about your usual administrative work and thought we could use the time diary as a guide.** (Use the diary to divide up activities and for each section)  
*Probe: on why they personally do that task; who else could do them; how clear it is who should do what.*
- **Could you tell me about the IT system?**  
*Probe: access; training; ease of use; duplication*
- **Your work involves direct client related work, other duties and administration work. Could you tell me something about how you organise your administrative work to fit in with other duties?**  
*Probe: patterns of working; systems in operation (e.g. filing systems); training; competing duties; overtime; breaks; time management.*
- **How does the administration that you do get used?**  
*Probe: who is the administration for; what is its purpose?*
- **I'd like to hear about how information flows within the team.**  
*Probe: shared notes; ease of accessing information; duplication and delays.*
- **I'd also like to hear about how information flows between the team and agencies and other organisations.**  
*Probe: ease of accessing information, knowing where to get information, duplication and delays*
- **Could you tell me something about how the performance of the team is monitored?**  
*Probe: activity data showing number of face to face contacts; managing the team on a day to day basis such as caseload; audits; how the team runs according to the model or benchmarking; star ratings.*
- **Can you tell me how monitoring of performance is fed back to the team?**  
*Probe: team meetings; reports.*
- **Going on from this, how does the team use the data to review practice?**
- **What would you gain, if anything, if you had less administrative work?**
- **What would you lose, if anything, if you had less administrative work?**
- **If you had free run, what is the one admin task that you would change? Why and how?**
- **If you had free run to change admin as a whole or anything about admin, what would you do and why?**

Any other questions that arise from responses given by the interviewee.

# Appendix III

Figure 1

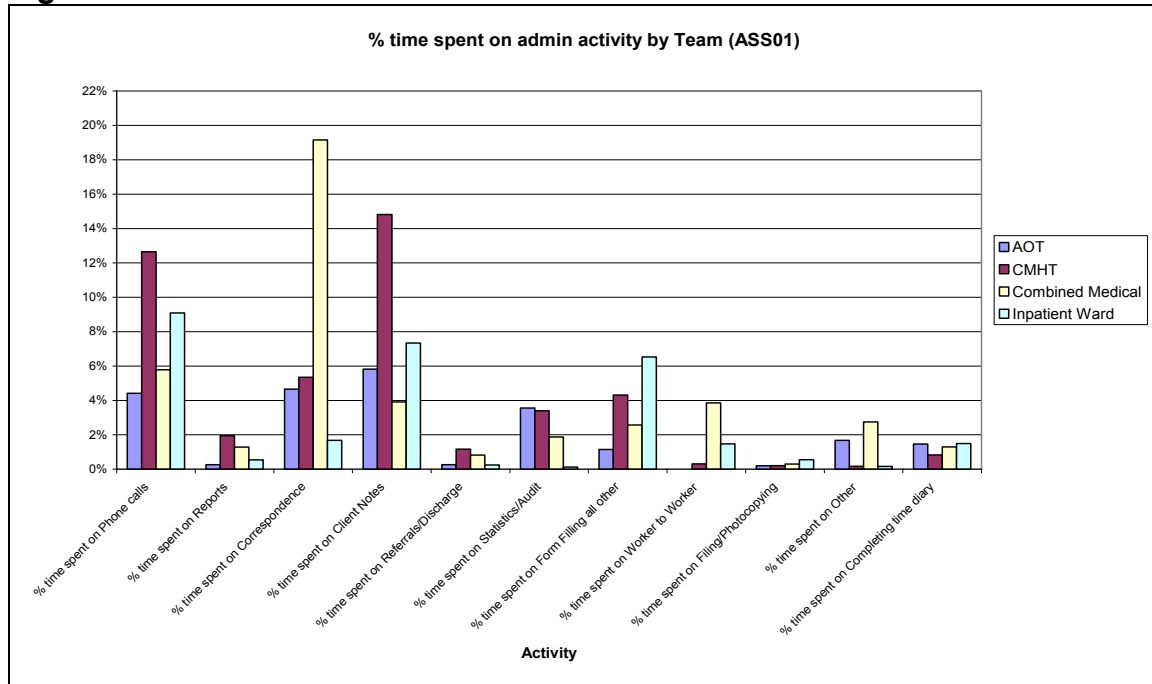
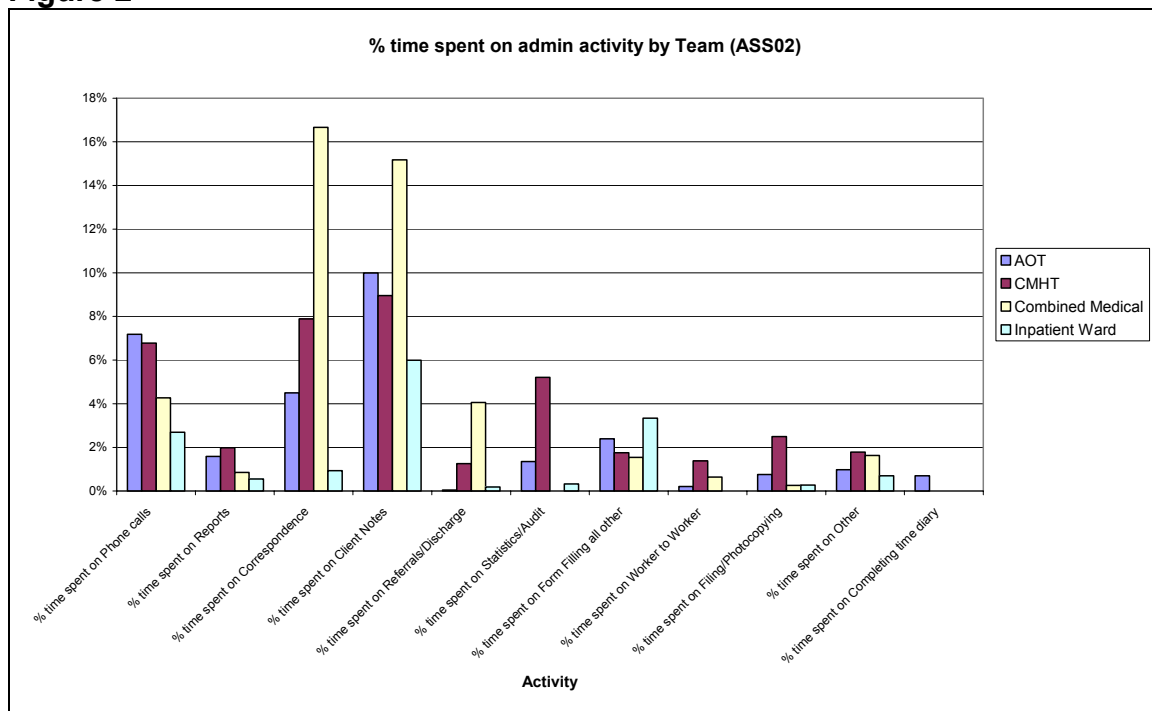


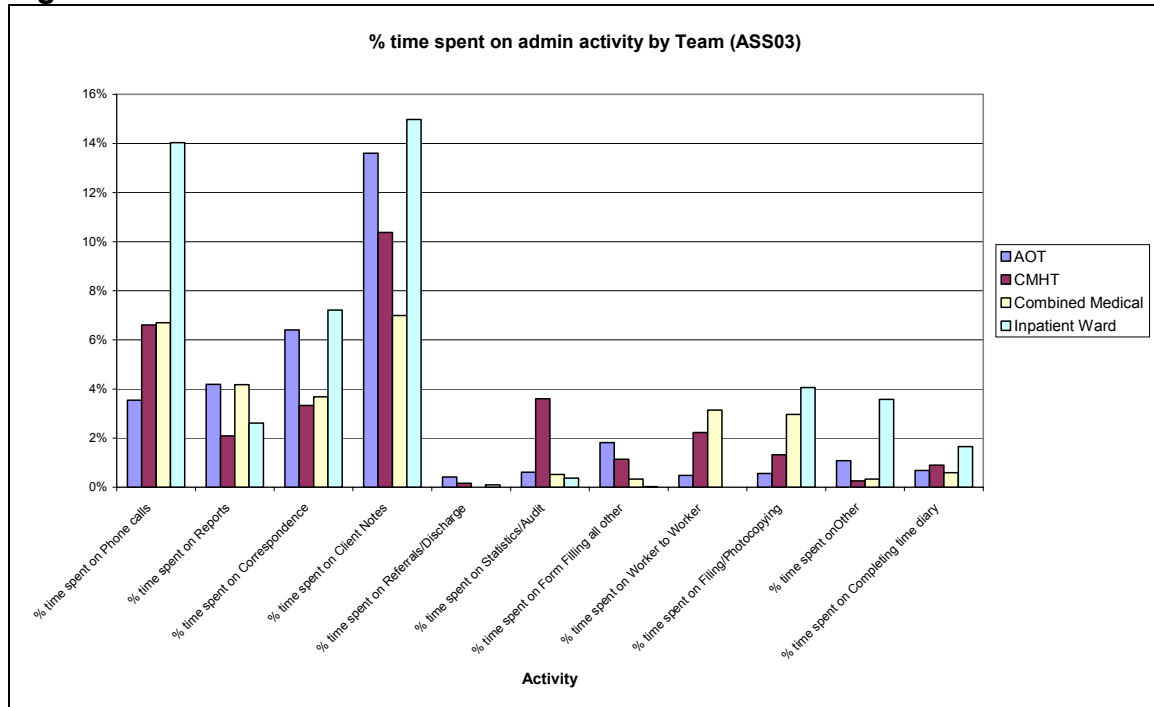
Figure 2



\* Combined medical on the charts = consultant psychiatrists, clinical assistants, SHOs and all other medical staff

## Appendix III continued.

Figure 3



\* Combined medical on the charts = consultant psychiatrists, clinical assistants, SHOs and all other medical staff

# Appendix IV

Figure 4

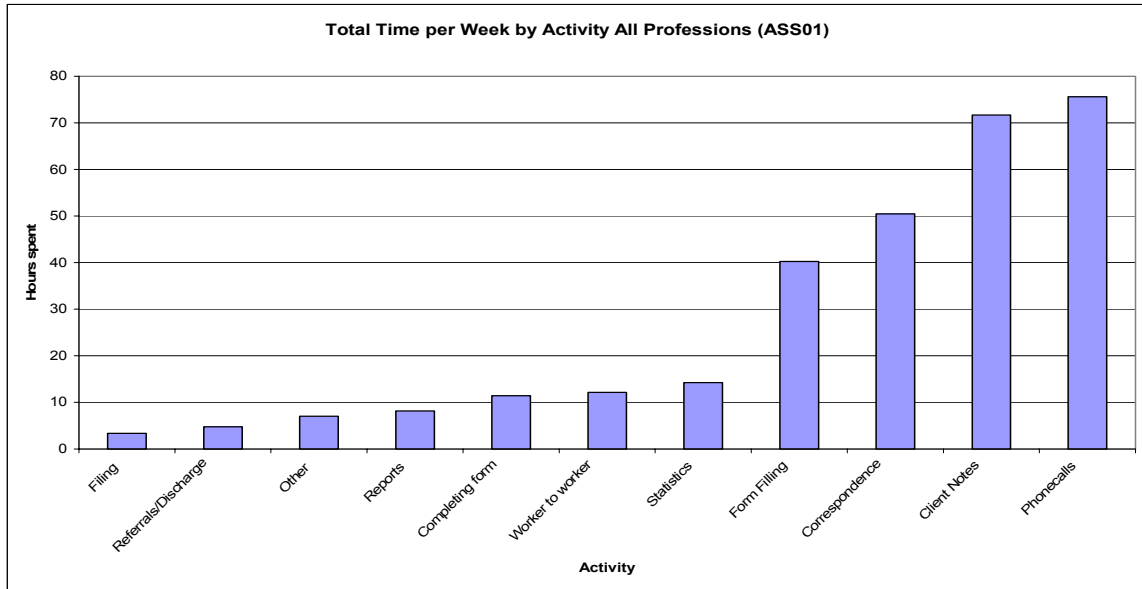
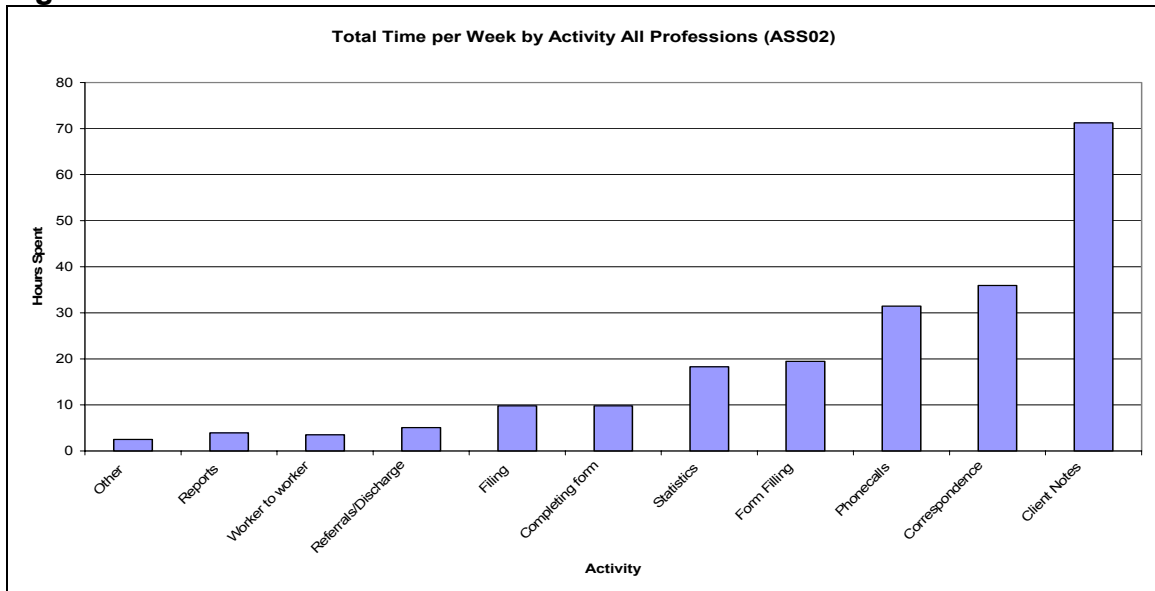
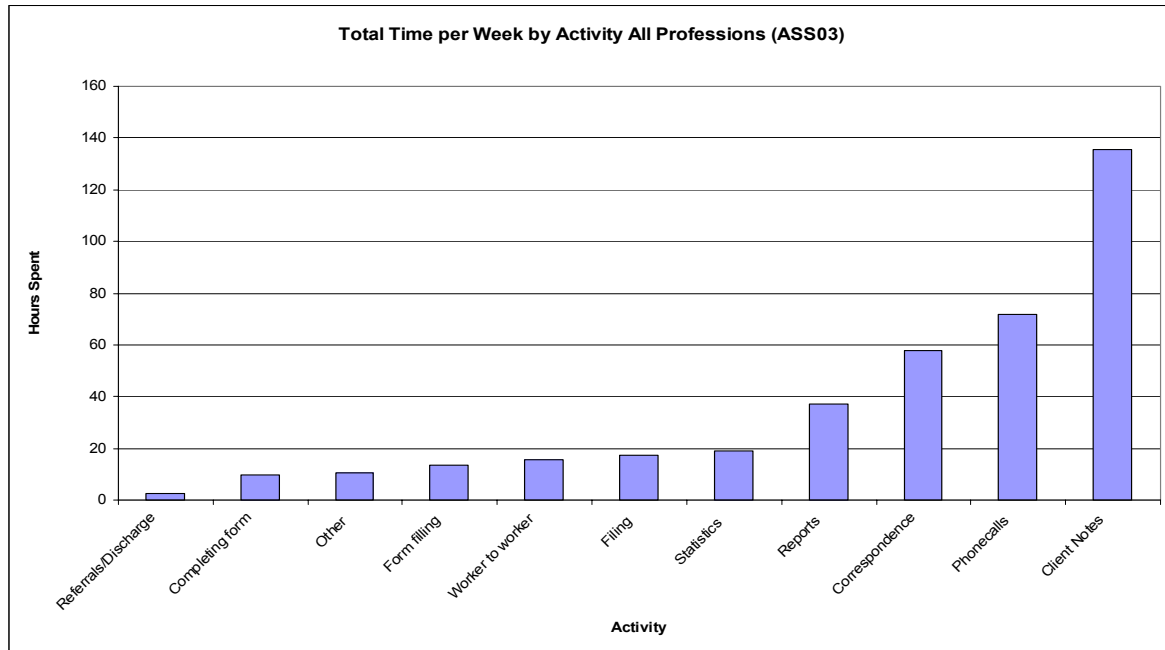


Figure 5



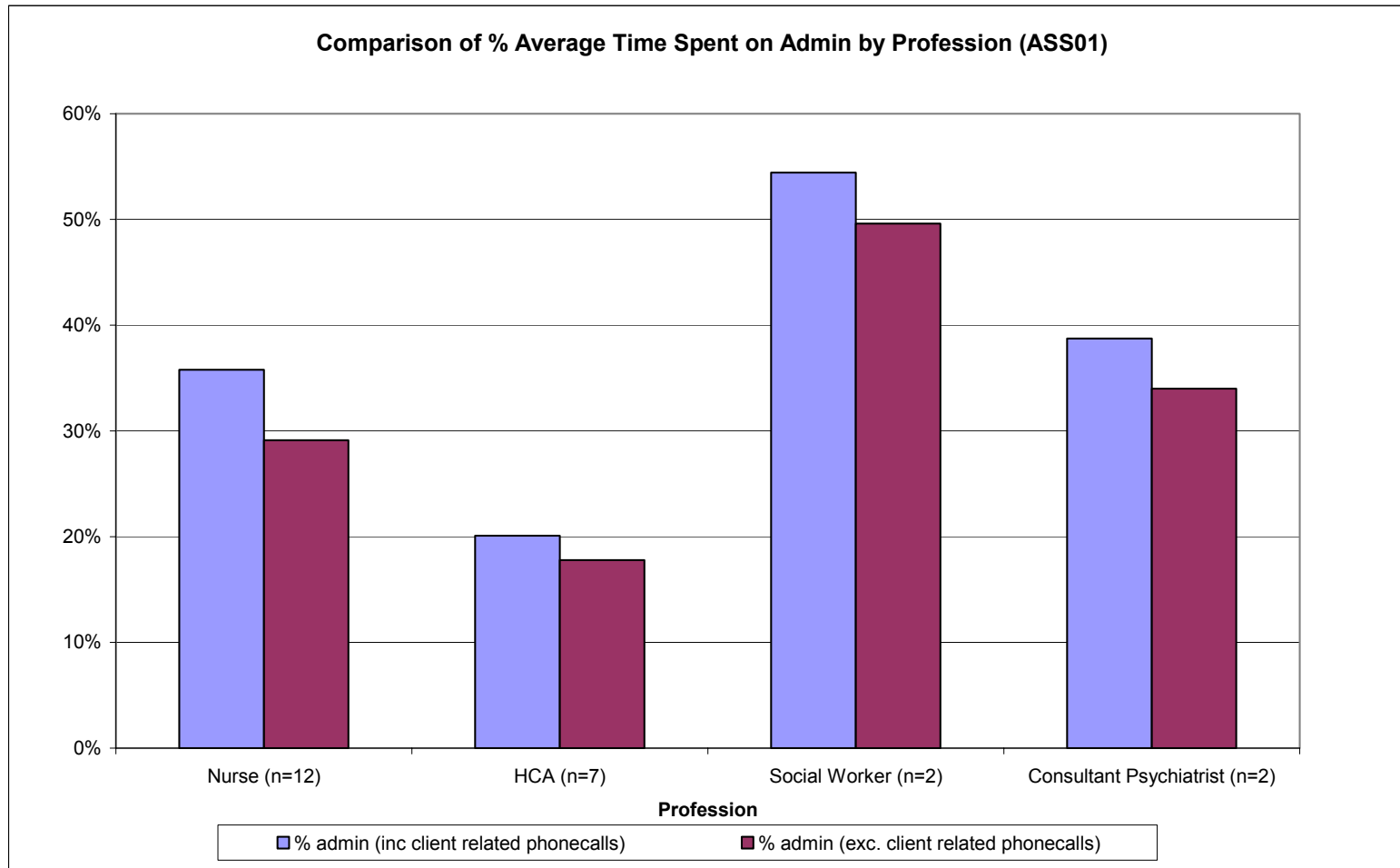
## Appendix IV continued.

Figure 6



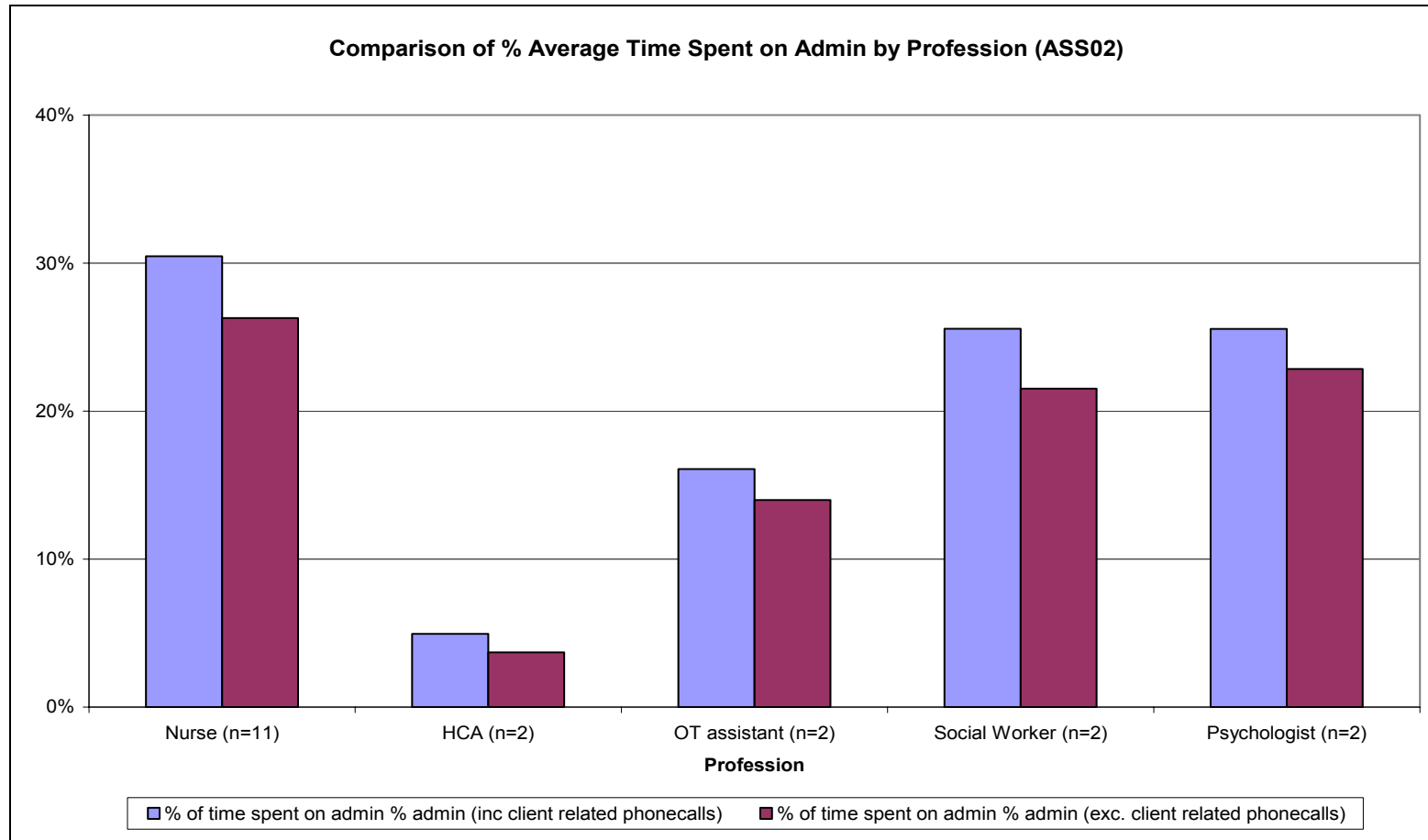
# Appendix V

Figure 7



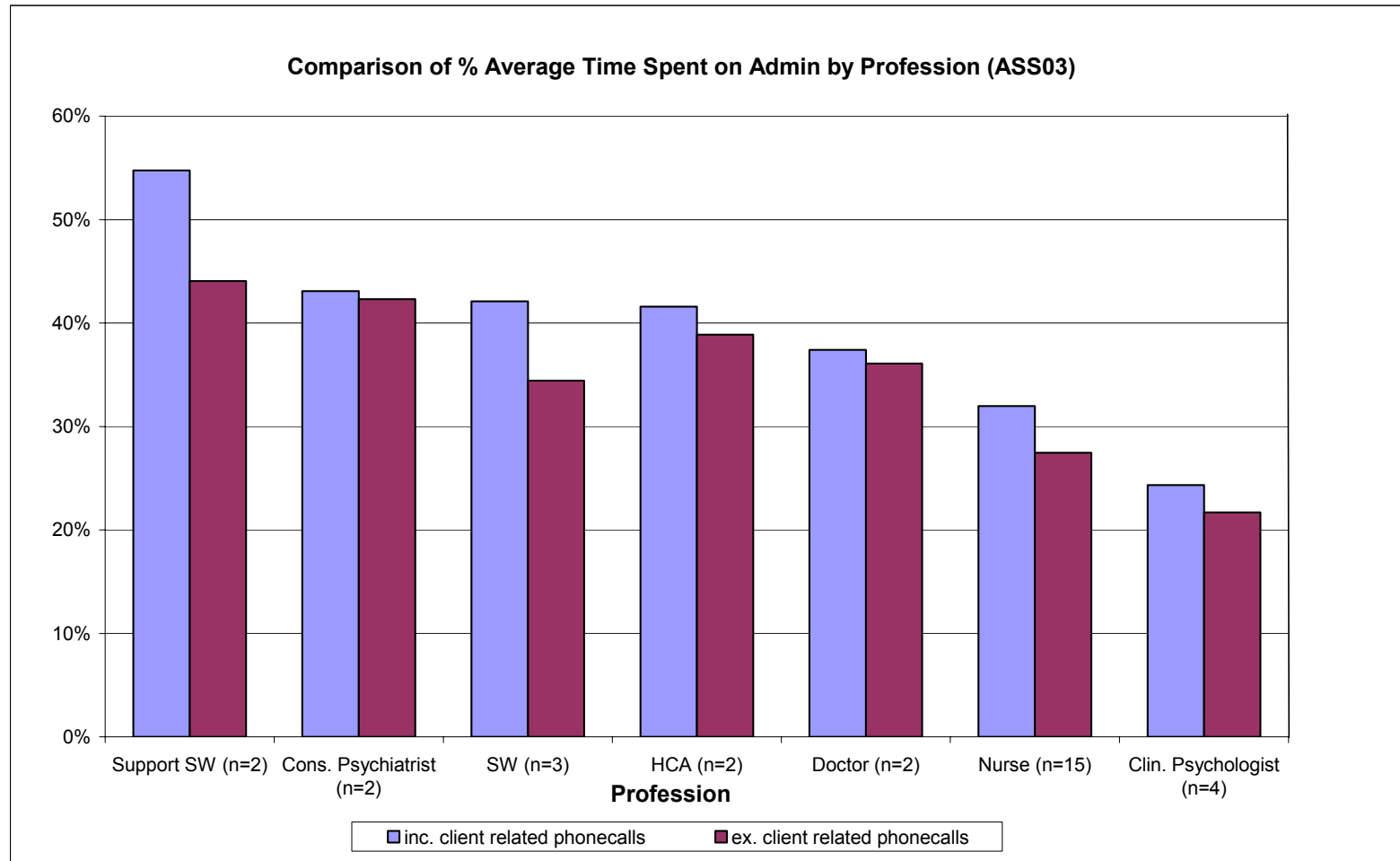
Appendix V cont.

Figure 8



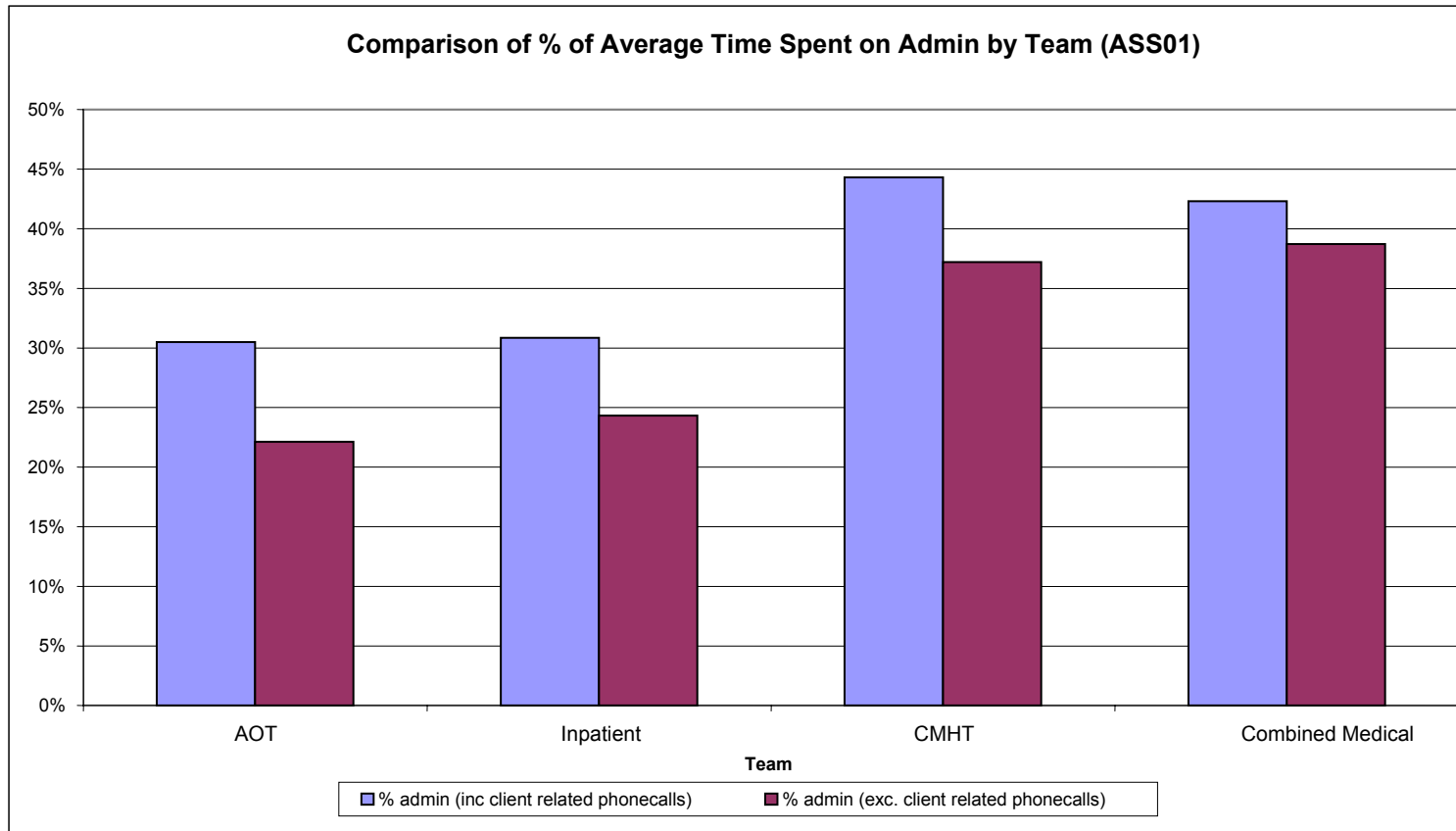
Appendix V cont.

Figure 9



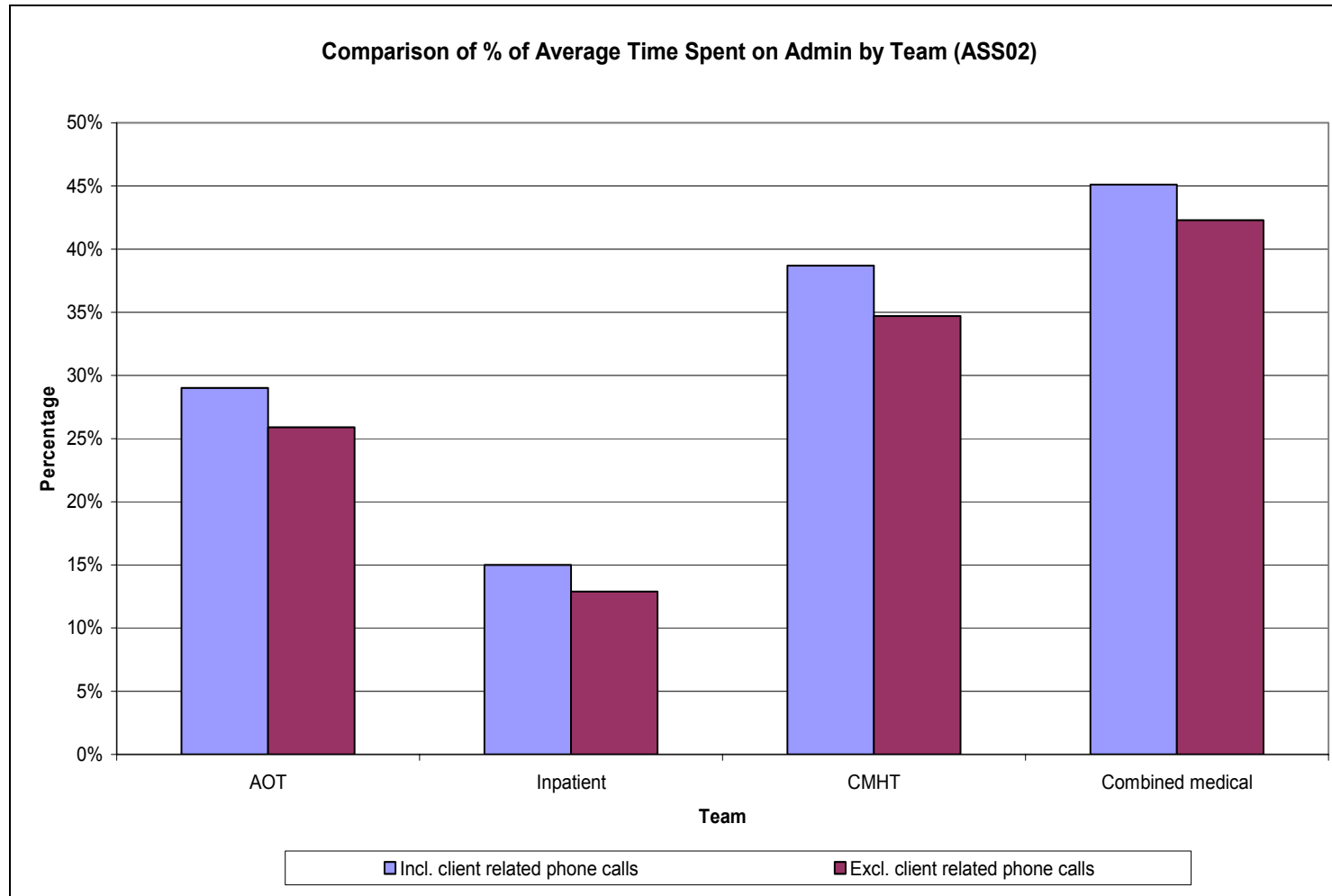
# Appendix VI

Figure 10



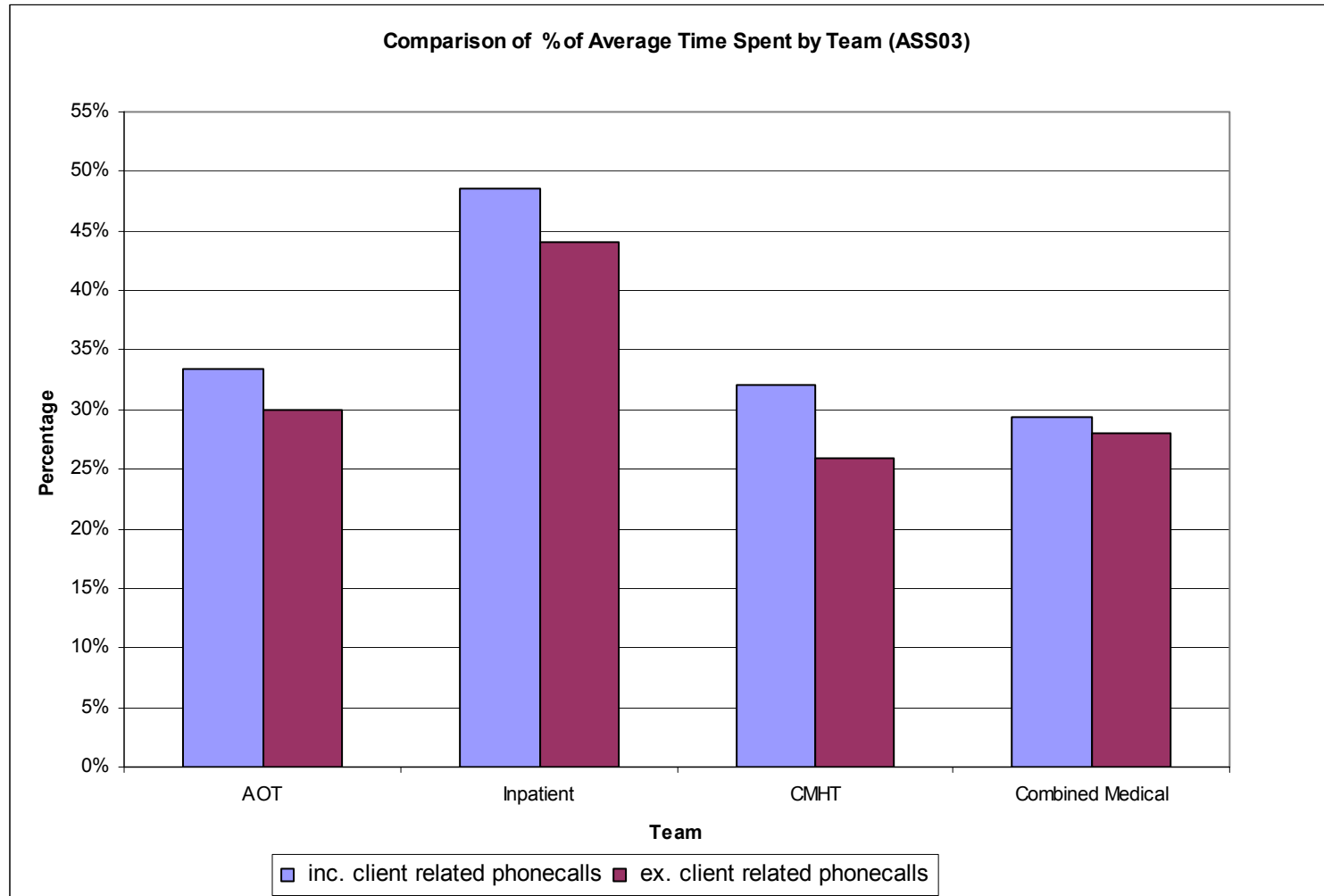
## Appendix VI cont.

Figure 11



## Appendix VI cont.

Figure 12





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