



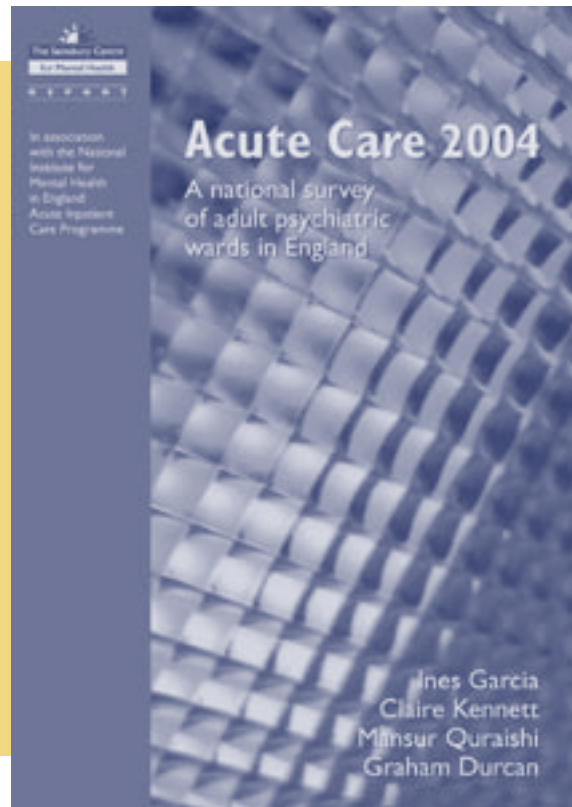
The Sainsbury Centre

for Mental Health

BRIEFING 28

An introduction to a topic of current importance or controversy, giving clear and independent comment and analysis of the issues that lie behind it.

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BRIEFING 28

The Sainsbury Centre for Mental Health (SCMH) is a charity that works to improve the quality of life for people with severe mental health problems. We carry out research, development and training work to influence policy and practice in health and social care. The Sainsbury Centre is affiliated to the Institute of Psychiatry at King's College, London.

Acute Care 2004: A National Survey of Adult Psychiatric Wards in England is available @ £20 plus 10% p&p from SCMH Publications on 020 7827 8352 or www.scmh.org.uk.

Acute Care 2004: A national survey of adult psychiatric wards in England

Introduction

Acute Care 2004 is a major survey of acute mental health inpatient wards across England which was commissioned by the National Institute for Mental Health in England (NIMHE) Acute Inpatient Care Programme from the Sainsbury Centre for Mental Health (SCMH).

This survey offers a snapshot of acute inpatient services in 2004 and acts as a benchmark by which future improvements can be measured. It highlights key issues to be addressed by mental health trusts, commissioning bodies and regional and national support systems.

The survey is based on the results of two questionnaires. The first asked for information on ward staffing levels and bed occupancy and was sent to the chief executives of NHS mental health trusts. The second asked for a wide variety of information about the acute inpatient ward and was sent to acute ward managers in England. Response rates for both were over 60%. Response rates to individual questions may vary. Returns were analysed by staff at SCMH both nationally and by region.

The full results of the survey are available as an SCMH report. This briefing paper covers some of the key findings

to emerge from the survey and some of the most important recommendations that follow. The survey revealed many positive findings which reflect the national and local work being carried out to improve services. Our briefing aims not to provide an exhaustive summary of the report but to raise some cross-cutting issues that are in need of the greatest attention.

Staffing levels

The provision of adequate and appropriate staffing levels and skill mix is one of the biggest challenges facing mental health services today. Our survey collected information on the number of funded posts for the wards, how many of those were filled and how much bank or agency staffing was required to fill any gaps.

The vacancy rate for qualified nurses (funded posts minus actual staff) was 13% at the time of the study. In London, it was 22%. When the recruitment of qualified nurses is difficult, health care assistants may be recruited to improve overall staffing numbers. Therefore we show qualified nurses and health care assistants as a combined group per bed in Figure 1. It shows that the actual number of staff does not meet the funded establishment in any region. On a ward with 16 beds, for example, this would suggest a difference between actual and funded staff of 2 whole-time equivalent posts.

This gap may be covered in part or in full by the use of bank and agency staff. This is expensive financially and can harm continuity of care. Ward

Box 1: Key findings

- ❖ The national average vacancy rate for qualified nurses on acute wards was 13%
- ❖ The national average sickness rate among ward staff was 6.8%
- ❖ The national average use of bank and agency staff per week per ward was 152 hours, equal to more than 4 full-time staff
- ❖ 26% of wards had lost staff to community teams in the previous year
- ❖ 12% of ward managers reported having no administrative support
- ❖ 48% of wards did not have a lead consultant and 13% had no ward manager or nurse above grade F at the time of the survey
- ❖ 35% of ward managers reported that the client group on the ward had changed due to the development of community teams
- ❖ 18% of ward managers reported that they did not have access to a Psychiatric Intensive Care Unit (PICU)
- ❖ Communication with community teams was said to be poor during patient admissions by 16% of ward managers
- ❖ Cognitive behavioural therapy (CBT) was available on fewer than 20% of wards
- ❖ Three-quarters of managers believed their wards offered a good environment for mental health care, while 86% said their wards were safe places to be
- ❖ 55% of wards had a cultural sensitivity policy; but in a quarter of wards no staff have had cultural sensitivity training

Figure 1: Average health care assistants and qualified nurses per bed ratio (268 responses)

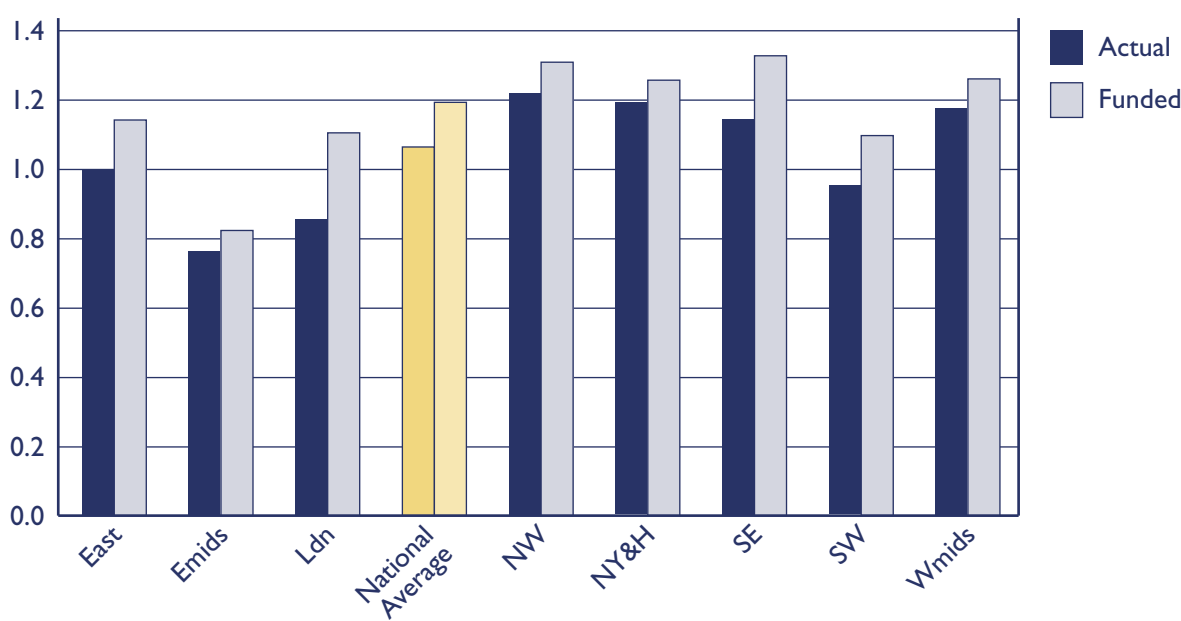
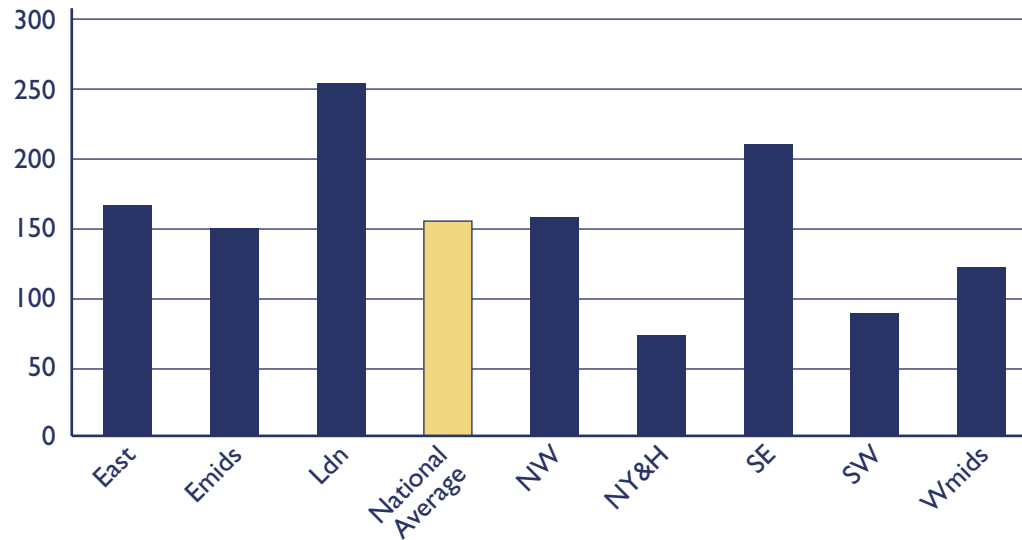


Figure 2: Weekly average agency and bank staff hours per ward (266 responses)



managers were asked to provide figures on the number of bank and agency staff used in the week prior to completing the survey. The national average was 152 hours per week for qualified nurses and health care assistants combined (Figure 2). This is the equivalent of 4 whole time staff on each ward. At twice the level of vacancies, this suggests that temporary staff are being used to cover sickness and other absence as well as vacancies. It could also indicate that the number of funded posts is too low.

These figures are compounded by some of the other pressures that face ward managers and staff. The staff sickness rate of 6.8% in acute inpatient psychiatric wards was considerably higher than the NHS average. In addition, 41% of ward managers reported that they had frequently undertaken bed management outside their own ward, while on the day they completed the survey ward managers reported an average of nearly 4 hours of escorted leave taking place.

In total, we found that 4.2% of beds were used solely for the purpose of detoxification. This raises concerns about appropriateness of admissions, clinical and managerial supervision arrangements, quality of training and safety as well as availability of substance misuse services.

Lack of administrative and housekeeper support can add to the pressures and absorb valuable clinical staff time. The survey found that 12% of wards lacked any administrative support, while levels of support elsewhere varied widely. It also found that fewer than 26% of wards had a housekeeper available to them to ensure the ward was clean, equipment was maintained and service user privacy and dignity were promoted. These are important missed opportunities to free up nurses' time.

A further indicator of such pressures is our survey finding that staff on one-quarter of wards

had regularly worked unpaid overtime in the 12 months prior to the survey.

Box 2: Recommendations on staffing levels

- ❖ National guidelines are needed to inform appropriate staffing levels and skill mix on acute wards and across the elements of acute care services.
- ❖ Exit interviews should be carried out when staff leave acute wards. Findings should be collated to learn what can be done to improve retention.
- ❖ Workforce development confederations (WDCs) should give greater support to mental health providers to help them to overcome their current staffing difficulties.

Leadership

Effective leadership is widely recognised as an important factor in providing good quality care to service users. Leadership of acute inpatient wards is usually exercised by ward managers and consultant psychiatrists. In our survey we found that 144 wards (48%) did not have a lead consultant. We also found that 13% of wards lacked a ward manager or nurse above an F grade at the time of the survey.

Box 3: Recommendation on leadership

- ❖ Trusts should look at the leadership roles and training of acute inpatient staff, focusing on provision of lead consultants and ward managers and the grading and skills of staff in leadership roles.

Career development

The drain of staff from acute inpatient wards into community services is well known and was reported by over a quarter of managers (26%) as having occurred in the year prior to our survey. Possible causes of this problem are a lack of career development opportunities within inpatient care and a lack of a whole systems perspective on the delivery of care. Only 42% of ward managers in the survey thought there was a clear career development programme within acute inpatient services. It is uncertain at this early stage what the impact of Agenda for Change will be, but one of its objectives will be to improve career development and recruitment and retention.

Box 4: Recommendations on career development

- ❖ National and regional work is needed to define and develop career pathways for acute staff. This should take into account the implications of the Agenda for Change programme.
- ❖ Trusts should review their career development programmes and seek improvements where necessary. This should include ensuring staff are released for training and development opportunities when they arise.

The impact of new community teams

The NHS Plan states that one of the aims of crisis resolution teams (CRTs) is to reduce pressure on inpatient wards by 30% (DH, 2000). Therefore,

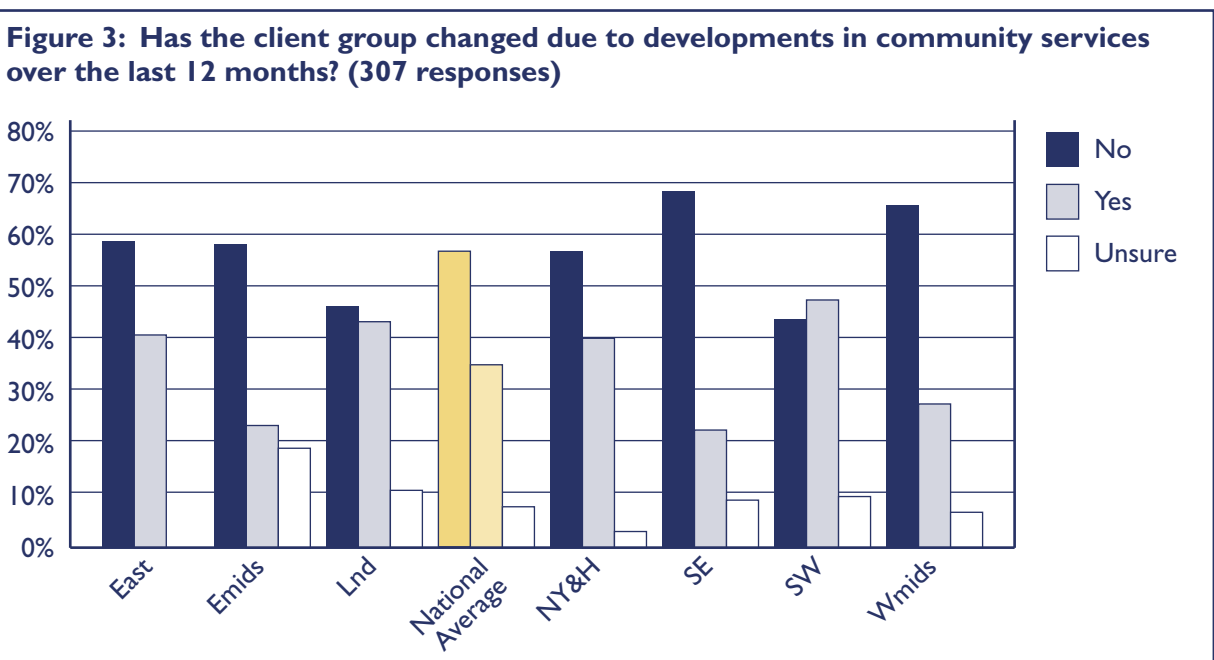
where the impact of new community teams is measured, it is usually seen in terms of length of stay and admission rates. Our survey shows a very important, but quite different, finding: that 35% of ward managers perceived community teams to have had an impact on the constituency of the service user group (Figure 3).

Of those who perceived a change to the service user group, 29% reported that people admitted to the ward were more acutely ill and 22% reported differences in diagnosis. This has major implications for acute inpatient wards, including staffing levels and skill mix.

Another key role for crisis resolution teams is to 'gatekeep' admissions to acute wards (DH, 2001). 53% of ward managers reported that local CRTs were admitting patients to the ward, but that only 12% of those were gatekeeping all admissions. Whilst this means there was a large percentage of teams not following the spirit of the policy guidance, many teams were at early stages of implementation at the time of the survey.

Box 5: Recommendations on the impact of new community teams

- ❖ The full impact of new community services, especially crisis resolution teams, on acute wards, should be monitored closely.
- ❖ Trusts should provide adequate training and supervision to inpatient staff to ensure that they can meet the needs of a shifting client group.
- ❖ Crisis resolution teams need to develop a full gatekeeping function to reduce pressure on inpatient services.



Care Programme Approach (CPA)

The Care Programme Approach (CPA) was introduced in 1990 as the framework for the care of people with mental health needs. Trusts' care programme approach systems implementation is measured by the Healthcare Commission and influences star ratings. The Healthcare Commission specifically asks about electronic CPA.

We found that only 25% of staff routinely used electronic CPA and that the vast majority of bank and agency staff did not have access. As trusts continue to develop electronic CPA, this raises questions about how it can be fully and effectively implemented given the large number of bank and agency staff that are frequently required in mental health trusts throughout the country.

Box 6: Recommendation on the CPA

- ❖ If electronic CPA is to operate successfully, it is vital that the impact of bank and agency nurses not having access is reviewed.

Whole systems working

Admission to an acute inpatient ward is not a stopping point but part of an ongoing cycle of care that may also include GP surgeries, community teams, voluntary services, housing, welfare benefits and others. If people are to be offered services that meet their wide-ranging needs, good communication and effective working across boundaries between teams and services is essential.

In our survey, two-thirds (68%) of ward managers reported that they fully understood the functions and remits of all community teams. Only 38% of ward managers, however, reported having good communication with community teams during admission and 16% said communication was poor at this time (Figure 4).

Although the majority of ward managers reported that community mental health teams and GPs were notified of admissions and discharges within 72 hours, 13% of ward managers reported that this was not happening.

We found that 60% of ward managers had access to crisis plans where these had been drawn up in the community, while 41% had access to advance directives which had been drawn up by service users. This indicates that there is still more that can be done to enhance information exchange.

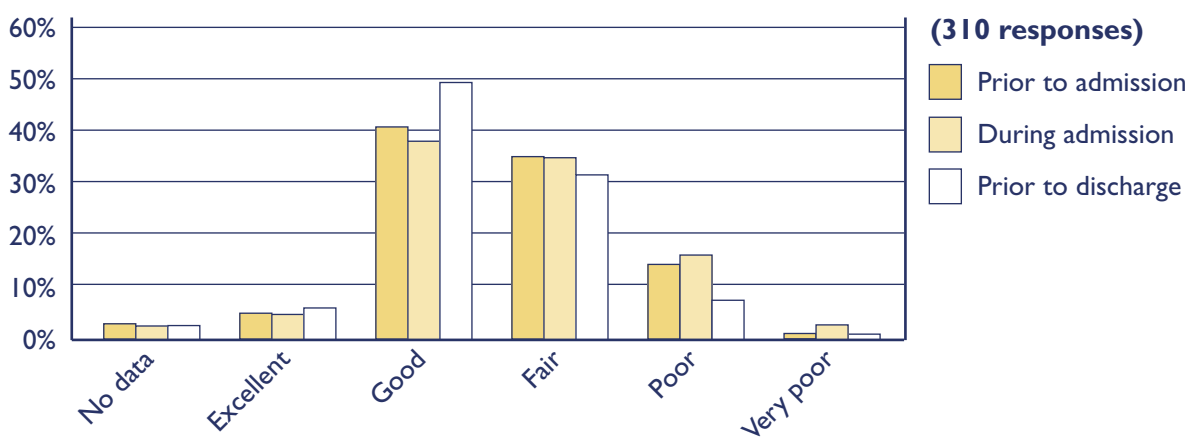
Box 7: Recommendations on whole systems working

- ❖ Trusts should ensure all staff are made aware of the roles and functions of the full range of community teams.
- ❖ Trusts should investigate why ward staff are not gaining access to crisis plans and advance directives drawn up in the community and to ensure systems are put in place to address this.
- ❖ Shared operational policies should be developed for acute inpatient services and crisis resolution teams.
- ❖ The single management of acute care services, staff rotation, and acute care nursing posts based in both inpatient and community teams should be considered.

Safety and environment

Creating a safe and therapeutic environment in acute inpatient units has long been acknowledged as a major problem. The need to build new inpatient units was identified in the Royal College of Psychiatrists' report *Not just bricks and mortar* (1998). But, as the report recognised, there is no formulaic solution to the problems of planning and constructing new wards.

Figure 4: How good is communication between the ward and community teams?



There is much recent evidence to suggest that problems associated with violence in mental health inpatient services are widespread. Mind recently reported that 27% of respondents to its *Ward Watch* survey rarely felt safe in hospital (Mind, 2004). Early findings from the Royal College of Psychiatrists' National Audit of Violence indicate that many service users, staff, and visitors are being exposed to highly unsafe situations that are outside of their control (Royal College of Psychiatrists, unpublished).

In contrast with this evidence, 78% of ward managers in the survey thought that the ward environment did promote positive mental health care, while almost a quarter did not (Figure 5).

Very few ward managers were able to provide data on violent incidents that had occurred on the ward in the previous year. 18% of ward managers reported not having access to Psychiatric Intensive Care Units (PICUs) and 34% stated that there were significant reported but unresolved environmental risks.

Box 8: Recommendations on safety and environment

- ❖ Service users, staff and visitors should be surveyed in greater detail about how safe they feel on the wards.
- ❖ Local and regional bodies should investigate the provision of PICU beds and its impact on acute inpatient wards.
- ❖ Trusts should look to update wards to create an ambience of calm and comfort and to reduce risk. Staff, service users, carers and visitors should be consulted on any proposed changes.

Therapies and activities

The Commission for Health Improvement reported that service users in acute wards frequently reported a limited 'range and quality of activities' (Healthcare Commission, 2003), while the Sainsbury Centre for Mental Health's report *Acute Problems* found that as many as 30% of service users said they were not involved in any therapeutic or recreational activity at all during their hospital stay (SCMH, 1998). We asked ward managers about the types and frequency of activities provided on the ward.

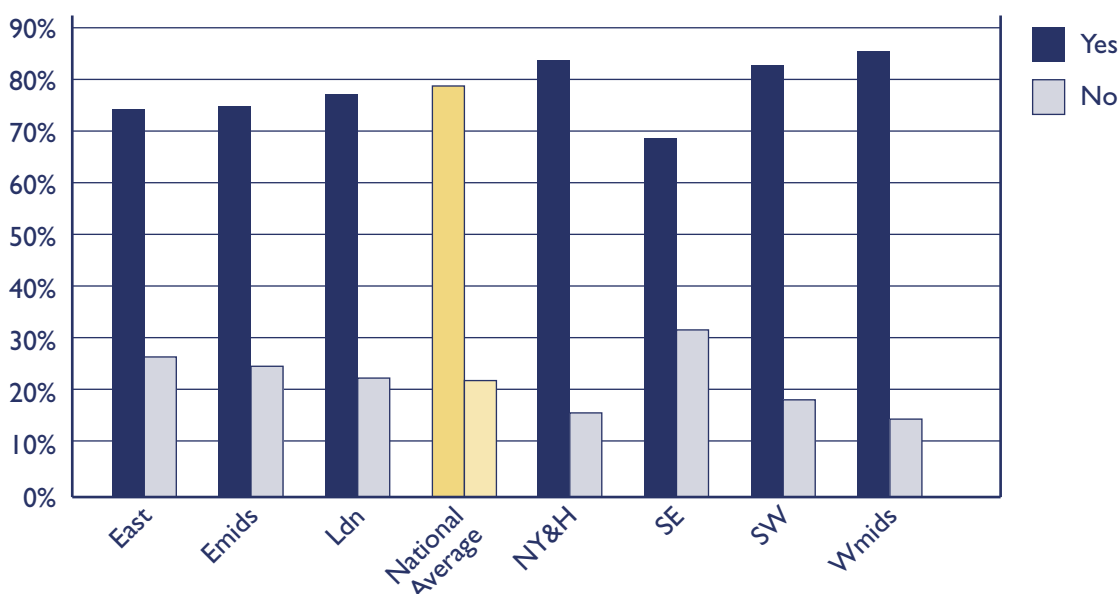
Ward managers reported that art therapy was routinely available on 49% of wards and psycho-social interventions were routinely available on 35%. Despite its strong evidence base, fewer than 20% of ward managers reported that cognitive behavioural therapy (CBT) was routinely available.

Practical therapeutic activities such as learning cooking skills or financial management were reported as being available routinely on 73% of wards. Leisure and social activities, such as coffee

Box 9: Recommendations on therapies and activities

- ❖ Health care assistants, volunteers and activity workers could be involved in facilitating a broader range of activities.
- ❖ Ward staff need training in therapies such as CBT, and sufficient opportunities to practise it afterwards.
- ❖ Inpatient wards need greater input from psychologists (and adult psychotherapists) in delivering therapies and activities.

Figure 5: Does the environment promote positive mental health care for the patients? (298 responses)



mornings, karaoke, music events and going to the gym, were routinely provided on 64% of wards.

Nurses and occupational therapists provide the bulk of input into activities with just under a quarter of ward managers reporting that they had input from psychologists.

Equality and diversity

Everyone who needs mental health care is entitled to a fair and equitable service. However some groups, including people from minority ethnic groups, women and people with sensory/physical impairment, are less likely to have their individual needs met. Our findings show that considerable work still needs to be done to ensure that they do.

We found that 55% of ward managers reported that they had a cultural sensitivity policy. We asked ward managers how many ward staff had had training regarding cultural sensitivity. There was considerable variation both within and between the regions and it is clear that training is not occurring for large groups of ward staff (Figure 6).

We also asked ward managers a number of

Box 10: Recommendations on equality and diversity

- ❖ Mandatory training should be provided for all staff on issues of ethnicity, culture and racism as part of a broader strategy for achieving race equality.
- ❖ Trusts should ensure that staff have disability awareness and disability equality training.
- ❖ The Department of Health should explore how to make services accessible for people with sensory and physical impairments.

questions to find out how sensitive services are to physical/sensory impairment.

We found that 87% of ward managers reported that there was access throughout the wards, including toilets and bathrooms, for people with mobility problems. The range of dedicated mental health information for people with sensory impairment, meanwhile, was reported by 63% of ward managers as being poor or very poor.

Different perceptions

The remit of our survey was to ascertain ward managers' views about the services for which they are responsible. It has become clear, though, that their responses are sometimes at odds with other research. We found, for example, that 86% of ward managers thought that the ward was a safe place to be (Figure 7). This is at odds with service users' views gathered in other surveys (e.g. King's Fund, 2003; Mind, 2004; Royal College of Psychiatrists, unpublished).

Other examples of this difference in perceptions include the generally positive response among ward managers surveyed about the sufficiency of interpreting services – a view not reflected in other studies.

Such disparities are highly important as they highlight where further research, incorporating the views of service users and carers, is still essential.

Conclusion

Acute Care 2004 provides a snapshot of a service that faces many challenges to offer people the quality of care that government guidance says should be available.

Figure 6: How many of the ward staff have had training regarding cultural sensitivity? (302 responses)

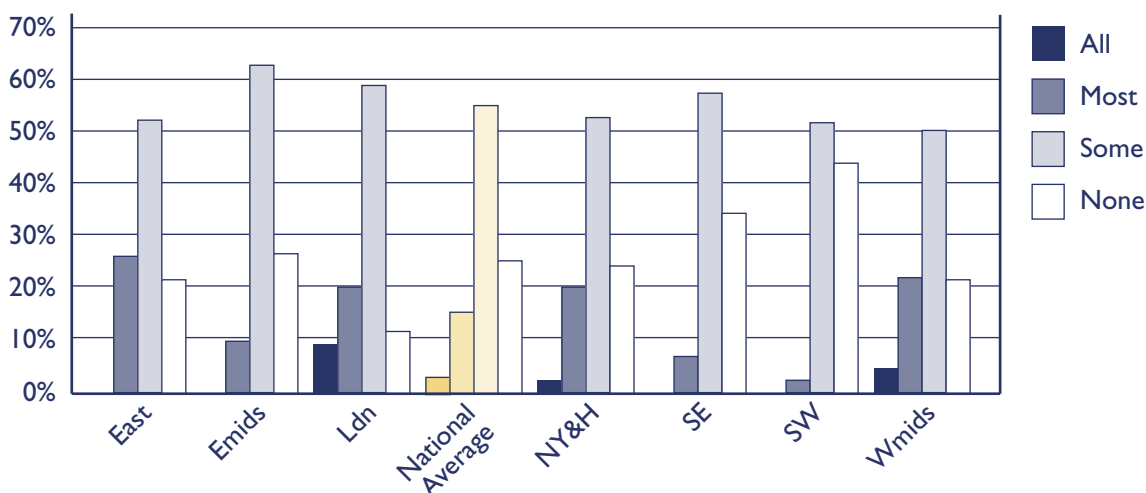
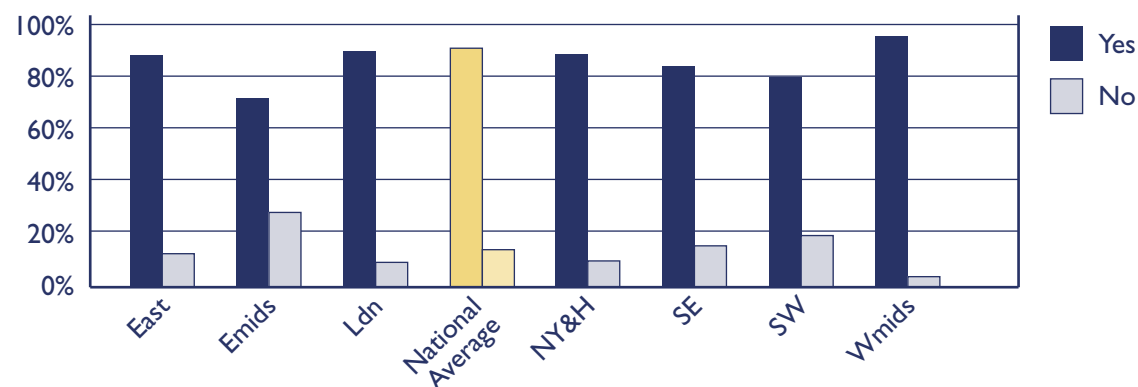


Figure 7: In general, do you consider the ward to be a safe place for patients and staff? (302 responses)



The five-year review of the *National Service Framework for Mental Health (NSF-MH)* highlighted acute inpatient care as a key priority (DH, 2004). NIMHE is taking a lead in the development of an infrastructure and strategy to continue with the implementation of the NSF-MH and the *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. The *Acute Care 2004* survey will be used to inform NIMHE's ongoing work.

In addition to informing national priorities, *Acute Care 2004* should also stimulate local dialogue between service providers, users and commissioners, and act as a spur to compare current services and practices which will inform future service improvement priorities.

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Removing Barriers. Achieving Change.

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