8 WORKFORCE

To recruit and maintain a workforce skilled in mental health across all sectors including primary care that is sufficient in numbers, well motivated, well trained, well led and well supported to deliver this National Service Framework. Human resources must be identified clearly as central to the service delivery and planning agenda.

National Service Framework: key action 42

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Health and Social Care service commisioners and providers are to work together to undertake workforce reviews using a "Care group" workforce planning approach. [Key action 42 paragraph 34.1]

The reviews are to make clear how potential staff will be identified and attracted into services. They should also outline staff retention strategies that aim to ensure high staff morale. [Key action 42 paragraph 34.1]

How best should staff be recruited in existing services and planned service developments?

What evidence is available to support workforce planning?

The *statements* | The *evidence*

8.1 Recruitment and retention

8.1a The review identified that there was little evidence for the influence of **continuing professional development** on **staff recruitment and retention** and that no study had set out to explore the relationship between the two in isolation. What evidence was available suggests that recruitment and retention are influenced by a combination of personal and professional factors. In concluding, the findings outline the implications for research and practice.[i]

Caveat: Information regarding the search strategy is not very detailed. Unpublished literature was not sought.

i. Hunter E, Nicol M. Systematic review: evidence of the value of continuing professional development to enhance recruitment and retention of occupational therapists in mental health. *British Journal of Occupational Therapy* 2002; **65**: 207-215

(Type IV evidence - systematic review of 13 questionnaires, interviews and focus group studies (involving a total of approximately 1951 occupational therapists in mental health). 5 studies investigated recruitment and retention in response to local need, and 8 studies considered recruitment and retention in relation to grade. Research published between 1990-2000 was sought.)

The *statements*

The *evidence*

8.1b The results suggest that **psychiatric nursing education** produces more **positive attitudes towards the mentally ill.** A significant increase in the popularity of psychiatric nursing was evident in the experimental group in the post-test phase, while no significant change was detected in the control group. Despite this increase, a large number of students from the experimental group indicated their reluctance to undertake a career in psychiatric nursing without first consolidating their skills in the medical surgical area.[i]

Caveat: 118 students completed questionnaires regarding their most desirable areas of nursing practice (~ 70% of year 1 students) and 114 returned at the second stage. However only 57 questionnaires could be cross-matched. As students chose the course they attended it is likely that they would be more interested in a career in mental health.

i. Rushworth L, Happell B. 'Psychiatric nursing was great, but I want to be a "real" nurse': is psychiatric nursing a realistic choice for nursing students? *Australian &.New Zealand Journal of Mental Health Nursing* 2000; **9**: 128-37

(Type III evidence – quasi-experimental study of students enrolled in a Bachelor of Nursing programme in Australia, to measure the impact of a psychiatric nursing education component upon the level of interest of students qorkingin this area after graduation. Students self selected to receive psychiatric component of the course (experimental group) or a unit on nursing people with long-term illness and aged care (control group). Students were assessed during week 1 of the first year programme, and post test in the second year of study.)

8.1c There are currently shortages of appropriately **skilled staff**. There are current and potential difficulties in the supply of staff in terms of both quantity (the numbers of staff available) and quality (the skills and competencies) of staff. There are practical and evidence-based steps which can be taken to tackle **recruitment and retention** difficulties. The Government has now provided a helpful policy and financial context. Much can also be done to unlock energy and commitment from existing staff. A whole systems approach is needed. Problems with recruitment and retention need to be approached within a whole systems approach which has the overall aim of strengthening the structures of good employment and good management practice. The authors identified 3 strategic priorities: attract and retain: 1) ensure that HR strategy is at the heart of the wider organisational strategy; 2) lead and inspire: promote high quality leadership and management of mental health services; 3) support and sustain: ensure that mental health promotion for staff is at the heart of the HR strategy.[i]

i. Sainsbury Centre for Mental Health. *Finding and keeping: review of recruitment and retention in the mental health workforce*. London: Sainsburys Centre for Mental Health, 2000.

(Type V evidence – expert opinion. Methods of data generation for this report included in-house analytic work, literature reviews, contact with experts, analytic work commissioned from the Institute for Employment Studies and fieldwork involving focus group discussions with professional staff and managers.)

8 WORKFORCE

The *statements*

The *evidence*

8.1d To **improve recruitment**, the College should focus on influences before and after **undergraduate training** - the kind of student entering medical school and the factors favouring sustained psychiatric practice after graduation. The number of psychiatrists required depends on the role of psychiatry, which is constantly changing. The present requirement is about 250-300 per year, including replacements and new posts. The number of psychiatric trainees has always been higher than expected from the career plans of newly qualified doctors, but the number of British graduates passing the Royal College of Psychiatrists' Membership examination has still fallen short, requiring a supplement of foreign medical graduates. The recent 50% expansion in medical students may make this country self-sufficient.[i]

i. Brockington I, Mumford D. Recruitment into psychiatry. *British Journal of Psychiatry* 2002; **180**: 307-12

(Type V evidence – literature review covering 244 references almost all from Britain or America to inform the strategy for improving recruitment.)

8.2 Job satisfaction and the working environment

Job satisfaction

8.2a Changes to improve the nature of work in mental health services must reflect the concerns of the different groups of mental health professionals. Results showed that **community mental health nurses** (CMHNs') sources of **job satisfaction and dissatisfaction** were more similar to those of psychiatrists than to those of their hospital-based counterparts. All 3 groups cited the intrinsic worthwhileness of their work, autonomy, the scope for creativity, the variety their job offered and their contact with clients as contributing to their overall job satisfaction. Hospital-based nurses listed the support they received from colleagues as their second source of job satisfaction, whereas CMHNs and psychiatrists cited the provision of care to patients. Excessive administrative duties and the absence of or poor quality of management were perceived by all 3 groups as sources for dissatisfaction with their work. Hospital nurses cited job insecurity as a principal concern more frequently than CMHNs and psychiatrists.[i]

i. Dallender J, Nolan P. Mental health work observed: a comparison of the perceptions of psychiatrists and mental health nurses. *Journal of Psychiatric Mental Health Nursing* 2002; **9**: 131-137

(Type IV evidence – cross-sectional survey of 50 psychiatrists, 50 first level hospital-based mental health nurses and 50 first level community-based mental health nurses working in five NHS Trusts in the West Midlands.)

The *statements*

The *evidence*

8.2b This study revealed a fairly satisfactory situation, possibly thanks to **social support, advantageous care-planning strategies and supervision**. However, managerial staff must be aware that measures need to be taken continuously to counteract detrimental forces. The study pointed to a need for further research that relates occupational therapists' job satisfaction with issues such as support, control and individual need for growth. **Job satisfaction** factors that emerged were: general satisfaction with work, communication and co-operation among team members, managerial feedback, the patients' influence on care and the relatives' influence on care. The respondents rated their general satisfaction, co-operation and communication as high. Having supervision was positively associated with co-operation and communication.[i]
Caveat: Response rate to survey was low (67%). Results may have limited generalisability to a UK setting.

i. Eklund M, Hallberg IR. Factors influencing job satisfaction among Swedish occupational therapists in psychiatric care. *Scandinavian Journal of Caring Sciences* 2000; **14**: 162-171

(Type IV evidence – cross-sectional survey of 499 occupational therapists working in psychiatric care. 332 therapists (average age of 44 years, 96% female) responded with an average 12 years of employment.)

8.2c The most salient findings of the present study were: (1) in spite of working in a clinical environment characterised by **violent patients** and conflict, work satisfaction was almost the same as nurses and occupational therapists in Swedish general psychiatric care; (2) the item with which they were most dissatisfied concerned the patients' relatives involvement in the care process. Seven factors were identified. The nurses were most satisfied with 'co-operation', 'information', and 'workrole', and they were less satisfied with relatives' and patients' influence. The focus of **clinical supervision** was mainly directed towards a patient's mental problems and how to interact with him/her. The nurses preferred that the patients problem should be formulated by the patient, or by the patient and the nurse together.[i]
Caveat: The results of this study may have limited generalisability to a UK setting.

i. Rask M, Levander S. Nurses' satisfaction with nursing care and work in Swedish forensic psychiatric units. *Journal of Mental Health* 2002; **11(5)**: 545-556

(Type IV evidence – questionnaire survey of 350 nursing care staff permanently employed for more than 6 months in 5 Swedish forensic psychiatric are units. Data analysis was based on 246 respondents (mean age 42.4 years).)

The *statements*

The *evidence*

8.2d The results of the study have implications for the **retention of mental health nurses** in their profession. Nurses need to be made aware of how stress can cause emotional reactions , and about the concept of Emotional Competency (EC) and skills involved. A significant relationship was found between EC and Personal Self-doubt in male nurses only; however, no association was found between EC and Experienced Emotions. Trait Affectivity was found to be associated with Experienced Emotions but not Stress. Gender differences were found in Trait Affectivity and Experienced Emotions.[i]

A significant relationship was found between emotional competency and years of experience. Nurses with 6-years and more experience had higher levels of emotional competency. This relationship was stronger for female than male nurses. Nurses with less than 2-years in the nursing profession were found to experience significantly more personal self-doubt than nurses with greater nursing experience.[ii]
Caveat: The sample size is small.

i. Humpel N, Caputi P, Martin C. The relationship between emotions and stress among mental health nurses. *Australian & New Zealand Journal of Mental Health Nursing* 2001; **10**: 55-60

ii. Humpel N. Caputi P. Exploring the relationship between work stress, years of experience and emotional competency using a sample of Australian mental health nurses. *Journal of Psychiatric & Mental Health Nursing* 2001*;* **8(5):** 399-403

(Type IV Evidence - exploratory correlational questionaire study of 43 mental health nurses in Australian regional hospitals (aged 20 years or more, 41.8% male).)

Causes of stress and burnout

8.2e The review found a great deal is known about the **sources of stress at work**, how to measure it and about the impact on a range of outcome indicators. A translation of these results into practice into research that assessed the impact of interventions that attempt to moderate, minimise or eliminate some of these stressors.[i, ii]

8 studies were identified that investigated **interventions to reduce stress in psychiatric nurses**. Training in behavioural techniques improved **work satisfaction**, levels of sickness and strain in psychiatric nurses. Personal stress management relaxation techniques significantly improved ability to cope with anxiety and stress. Stress management workshops were effective in reducing level of burnout.[ii]
Caveat: Study designs for all of the included interventions are unclear.

i. Edwards D, Hannigan B, Fothergill A, Burnard P. Stress Management for mental health professionals: a review of effective techniques. *Stress and Health* 2002; **18**: 203-215

(Type I evidence - systematic review of 46 primary research studies on stress management for mental health professionals.)

ii. Edwards D, Burnard P. A systematic review of stress and stress management interventions for mental health nurses. *Journal of Advanced Nursing* 2003; **42(2)**: 169-200

(Type III evidence - systematic review of 77 primary research studies investigating stressors, moderators and outcomes (69 studies) and stress management interventions (only 8 studies) for mental health nurses.)

The *statements*

The *evidence*

8.2f **Stress, burnout and attrition** may not be directly linked. **Personality factors** at course entry contributed significantly to the prediction of burnout and programme completion, but the relationships were not strong enough to be practically useful. Students experienced increasing levels of stress and use of negative coping mechanisms as the programme progressed and psychological morbidity increased. Positive aspects of personality were more likely to lead to aspects of burnout, and personality was a more important indicator of attrition than cognitive ability.[i]
Caveat: There was a large attrition from the study, only 90 students (53.6%) were followed up at 24-months.

i. Deary IJ, Watson R, Hogston R. A longitudinal cohort study of burnout and attrition in nursing students. *Journal of Advanced Nursing* 2003; **43**: 71-81

(Type IV evidence – longitudinal cohort study of all 168 adult nursing and mental health nursing students (mean age 25.4 years, 82.7% female) in a department of nursing in Scotland. Students were assessed using questionnaires, tests and college information on entry to the programme, 12 months into the programme and 24 months into the programme.)

8.2g The paper discusses the implications of the findings in terms of a comprehensive approach to intervention aimed at minimising the **risk of burnout in psychiatric nurses**. Such an approach will involve interventions at the organisational and individual level. The respondents reported on average, low and average levels of emotional exhaustion, depersonalisation and personal accomplishment, respectively. The study sample had significantly lower scores on emotional exhaustion and depersonalisation than normative data but also significantly lower levels of personal accomplishment than a normative group of physicians and nurses. Only 2.0% of the study sample could be categorised as having high **burnout** overall and they differed significantly from the rest only in terms of males being over-represented. Hierarchical regression analysis revealed that selected explanatory variables accounted for 41.9% of emotional exhaustion, 16.4% of depersonalisation and 25.6% of personal accomplishment in the study sample.[i]
Caveat: Response rate to participate in the survey was low (48.8%).

i. Kilfedder CJ, Power KG, Wells TJ. Burnout in psychiatric nursing. *Journal of Advanced Nursing*. 2001;**24(3)**:386-396.

(Type IV evidence – cross-sectional survey of 510 psychiatric nurses (mean age was approximately 40, 86.9% female) from one Scottish Trust. Burnout, stressors, mediators, moderators and strains of the nurses' work were examined.)

The *statements* | The *evidence*

Providing support for staff

8.2h The results identified that these nurses are working in an environment in which they have to deal with aggression, suicide and a lack of support from their line managers, as well as from medical colleagues. The nurses in this study identified the importance of **team support; clinical supervision and debriefing** as methods which help them deal with issues that affect their accountability, within their practice.[i]

i. Mitchell GJ. A qualitative study exploring how qualified mental health nurses deal with incidents that conflict with their accountability. *Journal of Psychiatric & Mental Health Nursing* 2001; **8(3)**: 241-248

(Type IV evidence – qualitative study of 22 mental health nurses in Middlesborough. Data were analysed from subjects written reports on a critical incident that had affected their accountability.)

8.2i **Critical Incident Stress Management** (CISM) refers to an integrated comprehensive, multicomponent, crisis intervention approach for addressing the psychological aftermath of critical incidents. It includes pre-incident training, acute crisis intervention, and post-incident responses. The **Assaulted Staff Action Program** (ASAP) is a voluntary, system-wide, peer-help, crisis intervention programme for **staff victims of patient assaults**. ASAP is a CISM approach. Taken collectively, the empirical findings from the ASAP studies demonstrate enhanced safety in facilities and high quality care for staff victims. These outcomes provide preliminary empirical support for the validity of ASAP itself and for the general validity of CISM approaches.[i]

i. Flannery RB, Jr. The Assaulted Staff Action Program (ASAP): ten year empirical support for critical incident stress management (CISM). *International Journal of Emergency Mental Health* 2001; **3**: 5-10

(Type V evidence – expert opinion. Literature review of 14 empirical studies published between 1991 and 2001.)

8.2j Results have indicated that because of the dispersed nature of mental health services, across primary and secondary care, and from statutory and non-statutory organisations, **information technology** is viewed as the only realistic vehicle to provide the required information. As specialist mental health trusts are configured, covering wider geographical areas, this can only increase the reliance on information technology, for information access and information sharing.[i]

Caveat: Methods of data collection and analysis have not been reported.

i. Blackburn N. Building bridges: towards integrated library and information services for mental health and social care. *Health Information and Libraries Journal* 2001; **18(4)**: 203-212

(Type IV evidence - qualitative study of consisting of 14 face-to-face interviews, 2 focus groups and 1 telephone interview with 17 mental health, social care and voluntary agency staff members.)

The *statements*	The *evidence*
8.2k This paper discusses aspects of the psychological service known as Staff Groups or **Staff Support Groups**, as provided to the staff of psychiatric wards. A typical example of such a group session is described and discussed, in which the facilitator was able to reach some levels of anxiety in the staff which had become enacted in the care of their patients, but deeper understanding was resisted. Issues regarding evaluation, the use of transference interpretations, and whether such a service has a natural endpoint, are discussed.[i]	**i.** Hess N. The function and value of staff groups on psychiatric wards. *Psychoanalytic Psychotherapy* 2001; **15(2)**: 121-130 (Type V evidence – expert opinion.)

Staffing levels

8.2l Adding resources to **community mental health teams** (CMHTs) without considering how to target the time released amongst existing staff may reduce their capacity to work more innovatively. The amount of time spent in face-to-face contact with patients and carers showed no meaningful change following team enhancement. Patterns of clinical activity amongst team members remained relatively static.[i]	**i.** Kent A, Fiander M, Burns T. Does extra staff change clinical practice? A prospective study of the impact of extra resources in mental health. *Acta Psychiatrica Scandinavica* 2002; **107**: 50-53 (Type IV evidence – prospective study comparing patterns of clinical activity amongst existing staff in two UK inner-city CMHTs 6 months before and 18 months after their enhancement with an intensive case manager and extra resources.)

The *statements* | The *evidence*

8.3 Workforce planning

8.3a Establishing **early intervention services** nationwide will require significant new resources, including **specialist trained staff**, which could prove difficult to provide in inner-city areas. Rather than a single, uniform service model, several models of early intervention services based on locally determined need might be more realistic and appropriate, and also allow research into their relative efficacy. All 39 teams completed the questionnaire, identifying 295 cases of first-episode psychosis (annual incidence 21/100 000/year) referred in the year 2000. Teams manage to engage most patients with first-episode psychosis. A total of 73% of cases of first-episode psychosis were on some form of **Care Programme Approach**. However, many teams **did not have adequately trained staff** to provide psychosocial interventions. Even where such staff were available, care was focused mainly on monitoring medication and risk assessment, with only half the teams providing psycho-educational programmes and only a quarter offering individual cognitive-behavioural therapy to those with first-episode psychosis.[i]

i. Singh S, Wright C, Joyce E, Barnes T, Burns T. Developing early intervention services in the NHS: a survey to guide workforce and training needs. *Psychiatric Bulletin* 2003; **27**: 254-258

(Type IV evidence – questionnaire survey of 39 mental health teams to establish the incidence, specialist staff availability, treatment provision and sociodemographic profiles of patients with first episode psychosis referred to all adult and child and adolescent community mental health teams in South and West London.)

8.3b In the West Midlands Region there has been an exponential growth in the number of **flexible trainees**. Approximately a third are within psychiatry alone and most wish to continue **flexible working patterns** as consultants. This has major **work-force planning implications** for the future. The overall response rate was 19 out of 21 (90%). The majority 15 out of 19 (68%) hoped to gain such a post at the end of their training. Of those wanting a consultant post, 15 of the 19 (79%) would only consider working part-time. If such a part-time consultant post was not available, 12 of the 15 (80%) said they would consider a non-career grade post.[i] **Caveat**: Method of data analysis has not been reported.

i. Caswell L, Lowe K. Part-time training: Will it lead to part-time consultant? *Psychiatric Bulletin* 2000; **24(2)**: 64-65

(Type IV evidence – postal questionnaire of 19 flexible trainees in psychiatry in the West Midlands region.)

8 WORKFLOW

The *statements*	The *evidence*
8.3c A **workforce planning tool** that can be used by Local Implementation Teams (LITs) and others to create multi-agency workforce plans is currently available. The development of this tool involved work with two pilot sites in Kent and South Essex to test and revise the process over a period of 18 months. Each stage of the workforce planning process is described and the major issues to be considered when creating a plan are highlighted.[i]	i. Philip M, Brewis R, Durcan G, Knowles K, Lindley P. *A Mental Health Workforce for the Future A Planner's Guide*. London: Sainsbury Centre for Mental Health, 2003 (Type V study – expert opinion. Methods of data generation for this report included workshop sessions, data collection, surveys and expert panel reviews involving key agencies, service users, carers, the voluntary sectors and representatives of primary and secondary care. Two pilot sites were used for development and testing of the tool).
8.3d Guidance is available on the principles and methodology by which local mental health and social care economies can estimate both the **demand for staff** across the statutory sector and to match this against the anticipated **supply of staff**.[i]	i. Allcock J NIMH(E). *Mental Health Services – Workforce Design and Development Best Practice Guidance*. London: Department of Health, February 2003. **http://www.dh.gov.uk/assetRoot/04/06/72/45/04067245.pdf** [accessed 29/07/05] (Expert consensus guidelines.)

National Service Framework: key action 43

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

All staff in the statutory and non-statutory sectors are to be supported and given protected time and resources to develop their skills. Priority is to be given to training to develop knowledge, skills and attitudes required to deliver the NSF and with reference to relevant National Occupational Standards. [Key action 43 paragraph 31.1]

What are effective ways of educating staff?

Are there any examples of effective training programs?

8.4 Developing staff skills

8.4a Despite finding a large body of literature on the evaluation of **interprofessional education** (IPE), these studies lacked the methodological rigour needed to begin to convincingly understand the impact of IPE on professional practice and/or health care outcomes. The total yield from the search strategy was 1042, of which 89 were retained for further consideration. However none of these studies met the inclusion criteria.[i] **Caveat**: Literature search to 1998 only.	i. Zwarenstein M, Reeves S, Barr H, Hammick M, Koppel I, Atkins J. Interprofessional education: effects on professional practice and health care outcomes. *The Cochrane Database of Systematic Reviews* 2000, Issue 3. **http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002213/frame.html** [accessed 29/07/05] (Type I evidence – systematic review to assess the usefulness of interprofessional education interventions. No randomised controlled trials meeting the inclusion criteria. Literature search to 1998.)

8 WORKFORCE

The *statements*	The *evidence*
8.4b Results from the study indicate that there is a current lack of rigorous evidence into the effects of **interprofessional education** in this field. All papers report positive outcomes from the use of IPE with staff involved in the care of adults with mental health problems. However after assessing these studies it was found that they generally contain a number of shortfalls.[i] **Caveat:** Grey literature was not sought. In addition, the literature search was completed in 1998 and no studies later than 1997 were included.	**i.** Reeves S. A systematic review of the effects of interprofessional education on staff involved in the care of adults with mental health problems. *Journal of Psychiatric & Mental Health Nursing* 2001; **8**: 533-542 (Type III evidence – systematic review of 19 studies: (7 post-intervention, 3 before and after, 4 longitudinal, 2 multi-method, and 3 unclear). Outcomes measured included learner reaction, behavioural change, changes in organisation practice. Literature search to 1998.)
8.4c Although well received, this **in-practice programme**, which was designed to convey the current consensus on best practice for the care of depression, did not deliver improvements in **recognition of or recovery from depression.** The education was well received by participants, 80% of whom thought it would change their management of patients with depression. 21409 patients were screened, of whom 4192 were classified as depressed by the HAD scale, The sensitivity of physicians to depressive symptoms was 39% in the intervention group and 36% in the control group after education (OR 1.2, 95%CI 0.88-1.61). The outcome of depressed patients as a whole at 6 weeks or 6 months after the assessment did not significantly improve.[i] **Caveat:** There was a large loss of patient assessments at follow-up. At 6-months only 52.2% patients returned questionnaires.	**i.** Thompson C, Kinmonth AL, Stevens L et al. Effects of a clinical-practice guideline and practice-based education on detection and outcome of depression in primary care: Hampshire Depression Project randomised controlled trial. *Lancet* 2000; **355**: 185-91 (Type II evidence - clustered randomised controlled trial of 59 primary-care practices (169 physicians) assigned to receive an educational programme based on a clinical practice guideline or to the control group which were educated with seminars. Main outcomes measured were recognition of depression, defined by the hospital and depression scale (HAD) and clinical improvement. Every patient with a positive HAD score was followed up at 6 weeks and 6 months.)
8.4d **Training in Individual Placement and Support** (IPS) at team level did not improve employment status. A dedicated, vocational worker appears to be essential for successful IPS. There was no difference in change of vocational status. Age, previous employment and diagnosis influenced outcome.[i]	**i.** O'Brien A, Price C, Burns T, Perkins R. Improving the vocational status of patients with long-term mental illness: a randomised controlled trial of staff training. *Community Mental Health Journal* 2003; **39(4)**: 333-347 (Type II evidence – randomised controlled trial of 10 Community Mental Health Teams (CMHT) of a large London Trust. 6 CMHTs (with 645 eligible clients) were allocated to receive 4 seminars of vocational training, and 4 CHMTs (with 392 eligible clients) were in the control group. Vocational status of clients were assessed after 1 year.)

8 WORKFLOW

National Service Framework: key action 44

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Effective systems are to be in place to lead, manage and support the workforce and ensure that all required processes are in place to deliver an effective service. [Key action 44 paragraph 31.3]

How can systems effectively lead, manage and support the workforce in order to ensure delivery of quality service?

What arrangements can be made for workload and staff to ensure optimum staff morale and patient care?

This will require explicit formal systems in place for management and supervision of staff, workload/caseload management, documentation and audit of processes as identified by Best Value and Clinical governance. This is also regarded good practice in non-statutory bodies. [Key action 44 paragraph 31.4]

What are effective systems to manage and supervise staff, workload/caseload management, documentation and audit of processes?

The *statements* | The *evidence*

8.5 Supervision and management of staff

8.5a Overall the **nurses'** statements were interpreted to mean that they were satisfied with the **supervision** intervention and that it constituted great support for them although it also revealed mistrust and lack of openness towards each other in the nursing group. The interpreted meaning was 'confronting the complexity of ongoing life in daily nursing care' and the interpreted significance was 'strengthening the foundation for nursing care'. Reflection on action and confirmation seemed to be core components in the process of clinical supervision. Focusing on the relational and task aspects in nursing care within a group approach may have contributed to the positive experiences of development that occurred.[i]

Caveat: The results of this study may not be generalisable to a UK setting.

i. Berg A, Hallberg IR. The meaning and significance of clinical group supervision and supervised individually planned nursing care as narrated by nurses on a general team psychiatric ward. *Australian & New Zealand Journal of Mental Health Nursing* 2000; **9(3)**: 110-127

(Type IV evidence – qualitative study of 22 psychiatric nurses (mean age 39.7 years, 73% female) who completed tape-recorded, open-ended interviews within 1 month post-intervention (Clinical Group Supervision in combination with Supervised Individualised Planned Nursing Care. Data were analysed using latent content analysis.)

The *statements*

The *evidence*

8.5b The study supported the role of **supervision in retention** and in improving practice. It also highlighted supervision characteristics that might be targeted in training, and provided preliminary data on a new measure. Although supervision was widely received and positively rated, it had low average intensity, and assessment and training of skills was rarely incorporated. Perceived impact on practice was associated with acquisition of skills and positive attitudes to supervisors, but extent of supervision was related to impact only if it was from within the profession. Intention to resign was unrelated to extent of supervision, but was associated with positive attitudes to supervisors, accessibility, high impact, and empathy or praise in supervision sessions. The Supervision Attitude Scale (SAS) had high internal consistency, and its inter-correlations were consistent with it being a measure of relationship positivity.[i]
Caveat: The results of this study may have limited generalisability to a UK setting.

i. Kavanagh DJ. Spence SH. Strong J. Wilson J. Sturk H. Crow N. Supervision practices in allied mental health: relationships of supervision characteristics to perceived impact and job satisfaction. *Mental Health Services Research* 2003; **5(4)**: 187-195

(Type IV evidence – telephone survey of 272 staff (median age was 30-39 years; 79% female) from public mental health services across Queensland. Participants received faxed surveys 1-3 days before a telephone appointment. Interviews were 30-40 minutes in duration)

Organisation of services

8.5c **Changing practice behaviour** is a complex process, particularly at a service level that consists of numerous professional groups with differing cultural norms. **Successful reorganisation of services** is unlikely if those responsible for delivering care are not part of the process of change. Moreover, unsuccessful attempts to change professional practice may exacerbate existing tensions within a workforce, which may be to the detriment of those requiring care. A full diagnostic analysis of the system, including service providers' concerns, should be carried out before introducing change or reconfiguring services.

Continued

The *statements*

The *evidence*

8.5c continued from previous page

The findings indicate that implementation was influenced by 3 interrelated factors: the means by which the model was introduced to the workforce; use of the model itself by service providers; and the broader service context. Thus, negative reactions to the way the model was initially presented strongly influenced service providers' subsequent views of it. Moreover, observations regarding the broader context of mental healthcare revealed a service that was ill-equipped to manage change because of over-stretched resources and that was disinclined to accept imposed change because of poor staff morale. Finally, differential interpretation of the model's tiers by service providers led to defensive practice that manifested itself as over-referral of service users within the system.[i]

i. Kaner E, Steven A, Cassidy P, Vardy C. Implementation of a model for service delivery and organisation in mental healthcare: a qualitative exploration of service provider views. *Health & Social Care in the Community* 2003; **11**: 519-527

(Type IV evidence – qualitative case-study. 25 mental health and social care service providers in Northern England completed semi-structured interviews. Interviews were audio-taped and transcribed. Thematic data analysis was conducted using a coding frame.)

8.5d Best practice guidance is available to support improvements in the **delivery of psychological therapy services**. The guidance highlights issues of access, waits and how to improve care pathways. Information on clinical governance and well trained and supported staff is included. [i]

i. NIMHE. *Organising and Delivering Psychological Therapies*. London: Department of Health. July 2004. **http://www.dh.gov.uk/assetRoot/04/08/60/97/04086097.pdf** [accessed 29/07/05]

(Type V evidence – best practice guidance based on expert consensus.)

8.6 Audit of processes and monitoring quality

8.6a **Clinical audit** is at the heart of **clinical governance**. It provides the mechanisms for reviewing the quality of everyday care provided to patients with common conditions like asthma or diabetes; it builds on a long history of the health professionals reviewing case notes and seeking ways to serve their patients better; it addresses quality issues systematically and explicitly, providing reliable information; and it can confirm the quality of clinical services and highlights the need for improvement. This book provides clear statements of principle about **clinical audit in the NHS**. The authors have reviewed the literature concerned with the **development of audit** over recent years, and are able to speak about clinical services and highlight the need for improvement.[i]

i. National Institute for Clinical Excellence. *Principles for best practice in clinical audit*. Abingdon: Radcliffe Medical Press. 2002 **http://www.nice.org.uk/pdf/BestPracticeClinicalAudit.pdf** [accessed 29/07/05]

(Type V evidence – report on best practice in clinical audit, based on a literature review and expert opinion.)

8 WORKFORCE

The *statements*

8.6b Clinicians set **self-management goals** with their patients more than 90% of the time. In most cases (77%) the clinicians addressed the issue of suicidally, based on documentation on the Initial Patient Assessment sent from the primary care physician to the care manager. Most patients in the suburban site started treatment that had been recommended to them, as did about two-thirds of the rural patients. Both practices showed essentially the same proportion achieving remission and partial response to treatment. In some cases this was at 8-weeks and in others at four weeks. Patients from both practices showed a substantial improvement in function. Only 37% of patients finished the study on the same medications that they started. One quarter were on different medications by the end of the trial, and almost 30% ended the 8-week period of follow-up on no medication. Qualitative results found that in general clinicians and care managers were positive about this approach to depression care.[i]
Caveat: The method of the qualitative part of the study was not fully reported. The sample size was small and no control group was included.

The *evidence*

i. Korsen N, Scott P, Dietrich AJ, Oxman T. Implementing an office system to improve primary care management of depression. *Psychiatric Quarterly* 2003; **74**: 45-60

(Type IV evidence – pilot observational study of 35 patients (mean age 37.9 years, 86% female) from a suburban (n=15) and rural (n=20) general practice. A 'Three Component Model' to create a prepared practice for the assessment and management of patients with depression was implemented. Patient data were kept by care managers and included baseline symptoms of depression and patient remission. Clinicians and study personnel met to discuss perceived strengths and weakness of he intervention 3- to 4-months after the initial training sessions.)

8.6c Findings reveal that the information provided in the Ethical Practice Guidelines (EPGs) is useful (91%) and the EPGs provide sufficient **guidance for practice** (94%). Most respondents (96%) reported feeling confident dealing with ethical practice situations and 75% indicated interest in further education and training in this domain. These data support the need to explore avenues to facilitate education, discussion and reflective practice in relation to ethical mental health nursing practice.[i]
Caveat: Survey response rate was 35% (121/350). Sample characteristics have not been reported. The results of this study may not be generalisable to a UK setting.

i. Cleary M, Raighne J, Horsfall J. Ethical practice guidelines: An evaluation. International Journal of *Mental Health Nursing* 2002; **11(3)**: 199-202

(Type IV evidence – survey study of 350 community and hospital-based mental health nurses in Sydney, to ascertain feedback on the application of Ethical Practice Guidelines (EPGs) in a clinical setting.)

The *statements*

The *evidence*

8.6d A team-based **quality review process** appears to have a positive impact on the quality of medical record documentation. Improved documentation may improve continuity of care and improve the accuracy of record information used for other quality measurement systems. An analysis of the trend in protocol scores over a 21-month period suggests that the procedure improves the quality of the documentation in patients' records.[i]

Caveat: The methodology of this study has not been fully reported.The authors report that the record sample size was not large enough to ensure quality, but do not state the number of records reviewed.

i. Baker JG, Shanfield SB, Schnee S. Using quality improvement teams to improve documentation in records at a community mental health center. *Psychiatric Services* 2000; **51**: 239-242 **http://psychservices.psychiatryonline.org/cgi/reprint/51/2/239** [accessed 29/07/05]

(Type IV evidence – process review of a quality improvement system in which treatment team clinicians used a scored 30-item protocol to measure the quality of record documentation by peers. The review process took place in 6 clinics at an American mental health centre.)

8.6e Outcomes appear to vary substantially by whether patients stay in care and whether they can be located after leaving care. Public mental health systems that wish to **evaluate treatment quality** using **outcome data** should attend carefully to which patients are being assessed. Bias can result from convenience sampling and from patients leaving care. Of the 1,769 patients in ongoing treatment during a one-year period, 554 (31%) were lost to follow-up. Among a random sample of 102 patients who left treatment, 2 had died and 47 were interviewed. Average outcomes improved both for patients who stayed and for patients who left. Patients who left and could be located for follow-up were less severely ill and showed the greatest improvement and the best outcomes. Patients who left and could not be located may have been more severely ill at baseline.[i]

Caveat: It may not be possible to generalise the results of this study to non-publicly financed health care services, particularly in a UK setting. Only 46% of patients completed interviews at 12-months follow-up.

i. Young AS, Grusky O, Jordan D, Belin TR. Routine outcome monitoring in a public mental health system: The impact of patients who leave care. *Psychiatric Services* 2000; **51(1)**: 85-91 **http://ps.psychiatryonline.org/cgi/reprint/51/1/85** [accessed 29/07/05]

(Type IV evidence – data analysis of routinely collected data, at one publicly financed mental health organisation. Data were analysed for 1769 patients (mean age 40 years; 51% female) and, at 12-months follow-up, a random sample of 47 patients who had left treatment was interviewed.)