Mental health inpatient scope workshop summary

18th December 2014

Attendees included representatives from the following stakeholder organisations:

- Lancashire Care NHS Foundation Trust
- National Collaborating Centre for Mental Health
- NHS England
- Royal College of Paediatrics and Child Health
- Rotherham Doncaster and South Humber NHS Foundation Trust
- South Essex Partnership University NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust.

Apologies from:

- Care Quality Commission
- Department of Health
- Royal College of Nursing
- Sheffield Health & Social Care NHS Foundation Trust
- Unison
- Kings College London

The two hour stakeholder workshop consisted of a short introduction to the Safe Staffing Guideline programme and to the Safe Staffing for Mental Health Inpatient Settings draft scope followed by a structured discussion. The discussion was designed to answer key areas of the scope and to provide opportunity for discussion on any other relevant issues.

Below is a brief summary of the issues discussed.

Q1. What are the current staffing issues for the nursing team in inpatient mental health settings?

General discussion around staffing issues included the following points;

- Currently there is a lack of evidence around staffing in inpatient mental health settings and where evidence exists, it is generally not linked to outcomes. There is also very little data in terms of benchmarking. There is, however, anecdotal evidence and topic expert opinion which may be valuable to the guideline. Funded work through NHS England in the West Midlands has been carried out using a tool developed by Keith Hurst and found that the data used in the tool is relatively old but it is similar to the data needed to assess safe staffing. The results were erratic across different units with higher levels of variation for smaller units. It was noted that the tool may be more helpful in larger staffing establishments. Keith Hurst is doing further work this year on developing a tool for assessing staffing levels. The time categories used in the current tool were found to be out-dated, and these will be updated. The group also commented that it is challenging to make sure the new categories still link to the evidence that exists.

- Currently there is variation in staffing and services across wards, hospitals, trusts and geographical locations. There are also differences around who is included as part of the nursing staffing establishment (for example there is local variation around the inclusion of unregistered associate practitioners as part of the staffing establishment). Routes and methods of admission for service users varies across trusts with some having large proportions of unplanned admissions through triage units or 72 hour assessment units, compared to other trusts that may have more planned admissions, or admission directly from A&E to an acute ward. In inner London, high numbers of service users are admitted under the

mental health act compared to less urban settings. There is also variation in the structure of services, for example 136 rooms are sometimes part of acute ward and sometimes part of another inpatient mental health ward.

- Experienced staff recruitment and retention is a problem across the UK.

- Delivery of therapy is an issue, if staffing levels are appropriate, nursing staff should be able to deliver therapies and on-to-one time with service users and this may be associated with reduced levels of aggression, harm to self and others and absence without leave. It was noted that while there is a lack of evidence to support this, there may be general consensus that this is the case. For example, NICE guideline on schizophrenia recommends that family therapy should be delivered early in the acute phase and should ideally start in the acute ward, but this cannot be delivered without adequate staffing levels.

- Safety of patients and staff, and maintaining a safe environment is another demand on staff.

Q2. Is the focus on mental health registered (specialist and non-specialist) nursing staff, healthcare assistants and assistant practitioners appropriate?

The group felt that the focus is appropriate. The differences in registered general adult nurses and specific mental health nurses were noted. Specifically it was agreed that while a registered general adult nurse may be part of the staffing establishment, they would not be the nurse in charge as this role would need to be a registered mental health nurse. The specific legal duties and activities carried out by registered mental health nurses were discussed (for example being able to apply the mental health act) and it was also suggested that every mental health inpatient ward should have at least one registered mental health nurse on duty at all times. There were discussions around the wording in the scope and there was consensus around the following:

- Reference to paediatric mental health nurse should be removed from the scope as this role does not exist in practice.

- The balance of skill mix should be included in the section on what this guideline is about as well as in the review question.

- The broad range of titles for non-registered nursing staff who may be part of the nursing establishment to provide support was discussed. These roles included recovery workers, associate practitioners, and healthcare assistants. The term ‘non-professionally qualified staff’ or ‘healthcare support workers and equivalent support staff’ was suggested to encompass all non-registered nursing staff.

- Ward managers often have nursing roles and may be included as part of the nursing establishment as they are not in a full-time managerial position on the ward.

- Advanced nurses have different roles and it is not appropriate to include them in the nursing establishment on inpatient mental health wards.

- It may be important to mention the availability of therapists and other allied healthcare professionals such as occupational therapists as this may impact on staffing levels required.

Q3. Are the relevant settings appropriately covered in the scope?

Relevant settings are appropriately covered in the scope. It was noted that occasionally, nursing staff from the inpatient mental health nursing establishment may be used to provide care for patients with mental health problems who are on other non-mental health wards. Very rarely, hospitals have a separate pool of registered mental health nursing staff to care for patients with mental health problems on general wards. It was agreed that the nurse in charge should ensure that skilled nurses

are available to cater for patients with specific specialised problems, if necessary. The requirement for one-to-one or two-to-one observation has a huge impact on staffing and establishing the predictability and the regularity of observation requirements would help reduce the impact.

It was noted that acute care is different from continuing care, which is care and hospital beds for older adult inpatients. The needs and type of care given in continuing care differs compared with rehabilitation units as they are comparable in terms of staffing, but have different allied health care support. The group felt that continuing care settings should be excluded from the guideline.

The group discussed the wording of the current settings sections in the guideline and there was consensus that:

- Prisons should remain excluded from the guideline and it may be useful to make this explicit.

- Forensic units should also be excluded as staffing levels and requirements are likely to be quite different from low and medium secure units. The terms low and medium secure are appropriate but it is worth noting that there is a wide range of staffing requirements within each security category and that it could be considered as a complex spectrum of security (for example medium secure units vary from higher security PICU to lower security rehabilitation wards).

- Occasionally liaison teams or crisis teams are included in the inpatient mental health staffing establishment. Alternatively, crisis teams may not be part of the establishment but they may impact on the staffing requirements as they may carry out daily reviews on patients.

- Mother and baby units are specialist wards should be included in the list of specialist wards that are not covered by this guideline.

Q4. Are the possible outcomes appropriately covered in the scope?

The difficulty of defining outcomes specifically related to staffing and safety were discussed. The group noted that Len Bowers from the Institute of Psychiatry is currently conducting a study looking at staffing numbers and skills mix and outcomes which may provide useful information in the future.

The group also notes that it is important to consider containment versus therapy administration outcomes which could be defined in an outcome of access to psychological therapies. Although there may be a lack of evidence to support an association between access to therapies and nursing staff levels, many registered mental health nurses are trained to deliver psychological therapies and if the unit is understaffed, these therapies may not be delivered. It was also noted that staffing requirements that are calculated on the basis of rates of incidents reported may not be accurate as lower rates of reported incidents may suggest that they are under-reported.

Suggested outcomes included: level of one-to-one sessions, one-to-one time, adequate nursing time spent face-to-face with service user, nurse administered psychological therapies, length of stay, occupancy, aggression, self-harm, harm of others, delayed transfer of care, readmission rates, self-harm post discharge, experience of service users in relation to nursing staff, use of rapid tranquilisation, use of restraint, patients feeling safe, diversional care or activities and supporting smoking cessation. Discussions focused on length of stay and readmission. It was however noted that there is huge variation in these measures and it is likely that they are influenced by delivery of the whole service rather than specifically related to either staffing or safety. It was also noted that unsafe discharge is hard to quantify and may be better expressed in terms of self-harm rates post discharge, readmission rates or aggression.

The group also commented that all organisations have a detailed policy on mental health intervention and often this is for cases in which there is a high level of staff required. However, observation requirements differ every day, and are often performed by bank staff. It is important to note that seclusion and time out are different terms in the Mental Health Act and this could be usefully reflected in the list of outcomes.

Q5. Do you think this scope could be changed to better promote equality of opportunity relating to age, disability, gender, gender identity, ethnicity, religion and belief, sexual orientation or socio-economic status?

It was noted that type of admissions (planned or unplanned/timely or delayed) and patient outcomes in mental health settings are greatly influenced by age, ethnic group, gender, geographical location. Issues around the use seclusion across different age groups (for example sending a child to their room) or access to care issues (for example, older service users may not have access to some services such as crisis resolution and home treatment teams) were also highlighted. Older age classification varies between trusts and depending on which category a service user is in, they may be given different treatments or different access to therapies. There was consensus that the use of age limits would not be appropriate in this guideline and service users of all ages should be included.

It was also raised that mental health issues may have an impact on language and communication skills, for example bilingual service users with dementia may lose their second language first causing communication issues and there may be an increased need for confidential interpreters in some cases.

Balance of gender ratios in nursing staff to ensure privacy and dignity for service users and in some cases to ensure sufficient male staff for potential violence and aggression was also raised.