

Staff satisfaction in the functionalisation of psychiatric in-patient care

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Abstract

In many UK mental health services, in-patient psychiatric care is being separated from community care by having dedicated in-patient medical team. We evaluated staff satisfaction in this functionalised in-patient care. A survey was conducted amongst multidisciplinary staff from various teams using a questionnaire survey. On an average 14.3% of staff returned a satisfactory response for functionalisation, 57.3% had unsatisfactory response and others were undecided or perceived no change. There was no difference in responses amongst age, gender and professional groups. Mean scores of all groups were within unsatisfactory domain; however community staff compared to in-patient staff and staff with more than 5 years of experience compared to those with 1-5 years of experience returned significantly more unsatisfactory responses regarding functionalisation. Many positive and negative aspects of functionalisation were raised. The results of this evaluation suggest the need for further studies on the effectiveness of in-patient functionalisation. Short and long term clinical outcomes and the satisfaction of the patients should also be studied.

Introduction

The concept and practice of functionalisation in psychiatry have existed for many years. Functional teams in community *e.g.* assertive outreach, crisis resolution and home treatment (CRHT), and early intervention teams are commonplace and many advantages have been put forward in their favour. It has been suggested that functionalised community psychiatric services have decreased the use of in-patient beds.¹ However, it has also been argued that the fall in the number of people in hospital was not only due to the functionalised teams but also because there were fewer beds, more staff working in the community, and other places for patient admission.²

Furthermore, it has been observed that functionalisation does not necessarily lead to better clinical outcome. A study on patients in assertive outreach team over two years found that there was no improvement in symptoms, risk behaviours or social functioning; and even though they remained in contact with services and spent less time in hospital there was little change with respect to clinical outcomes.³ These findings highlight the need for evaluative studies in service redesigning. It is acknowledged that different ways of organizing mental health services are rarely studied systematically, and such studies are difficult and resource demanding.⁴

In-patient psychiatric care has been functionalised in many trusts around UK.^{5,6} Patients admitted to hospital or to CRHT team are now being seen by a dedicated team of doctors, in contrast older model where community psychiatrists continued to see their patients during admission. The perceived benefits as well as concerns regarding the functionalised model have been raised in many areas.^{7,8} It has been opined that there has been little evidence of careful consideration of the potential consequences.⁷ It remains to be formally tested whether or not hospital services that are separate from community services provide better mental health care than sectorised care.⁵

In the event of structural changes to services, frontline staff are best placed to observe and interpret their consequences. Following implementation, they come across the issues regarding the difference in practice, service provision and their effect on the patients and carers. The first-hand experience of the staff would understandably reflect in their satisfaction in the newer method of service provision. This study intended to evaluate the staff satisfaction about the functionalised in-patient care. It was expected that the experiential responses from multidisciplinary staff involved in the functionalised model will help to understand the changes and their effectiveness.

Materials and Methods

Adult in-patient services in Wolverhampton were piloted for the functionalised model from April to December 2009. Two dedicated teams of doctors, each consisting of a consultant, staff grade and junior trainee doctor looked after the two psychiatric wards and the CRHT patients. There was no change in the non-medical staff for the wards or community mental health teams (CMHT).

A questionnaire was developed taking into account various care events that take place in a patient's journey from the community to in-patients and back in community. The researchers discussed major care events/

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Conflict of interest: all the authors were the employees of the Wolverhampton Primary Care Trust.

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themes and questions were designed around these through a consensus method. The questionnaire was modified following further input received from doctors, nurses and managers. The questionnaire was face-validated by discussing it with mental health staff from a range of professional backgrounds. The questionnaire had 16 items with Likert type of answers for the opinion of the mental health professionals. Response to all questions were scored from 1 to 5, where score 1 meant highly unsatisfactory or much worse; and score 5 meant highly satisfactory to much better in relation to functionalisation. Score 3 indicated no change or undecided response. Higher scores favoured functionalisation. In addition to specific questions, there were open ended questions for qualitative information to assess

staff views on the positive and negative aspects of functionalisation and suggestions for improvement.

The questionnaires were distributed to the available staff in the hospital and CMHT who had worked in the new system since its introduction. Variables like place of work (in-patient or community), professional background, age, gender and years of experience in mental health services were ascertained. Identifiable information regarding staff was not collected; and confidentiality of the responses was assured. Two reminders were sent to staff to consider submitting their responses. The protocol for this project was discussed in the local research group meeting and was approved as service evaluation by the Clinical Governance, Mental Health Directorate, Wolverhampton City PCT.

The quality and accuracy of all data were re-checked following initial data entry. Missing data, which are commonly observed in surveys,⁹ were imputed using the Multivariate Imputation by Chained Equations (MICE) software package.¹⁰ Distribution of categorical variables were analysed by chi-square tests; and the means were compared using student t-test and analysis of variance (ANOVA). The level of statistical significance was kept at the standard 5%.

Results

A total of 92 responses were returned from 127 staff (response rate: 72.4%) within the general adult psychiatric services involving 2 wards, 3 CMHT and an assertive outreach team. Five evaluation forms with no response and a further 4 forms with less than 50% response in the 16-item questionnaire were excluded to maintain minimum quality requirement. This resulted in the final sample size of 83 for the study. There were 62 (3.56%) missing values from the full data which included 33 (2.48%) from responses to questions 1 to 16. These missing values were imputed using polyreg option in the MICE setting. The sample consisted of 52 (62.6%) female staff; 29 (34.9%) from in-patient and 54 (65.1%) from community setting; and 49 (59%) staff were in the age group of 18-40 years. Participants were categorised into administrative staff (4, 4.8%), doctors (24, 28.9%), nurses (41, 49.4%) and other clinicians (14, 16.9%). There were 37.4% staff with 1-5 years of experience in mental health services; 26.5% had more than 5 to 10 years, 14.5% had more than 10 to 15 years, and 21.7% had more than 15 years of experience.

For analysis and clarity of comparison we added the two lower scores (unsatisfactory responses) and two higher scores (satisfactory responses) in the Likert scale separately. The

frequency of responses for each item is given in Figure 1. The response averages considering whole questionnaire are provided in the last row. This suggested that 14.3% of staff returned satisfactory response for functionalisation;

57.3% had unsatisfactory response; and 28.4% of staff were undecided or perceived no change. Frequency distribution of responses in various categories of staff based on age, gender, profession or work base was not significantly differ-

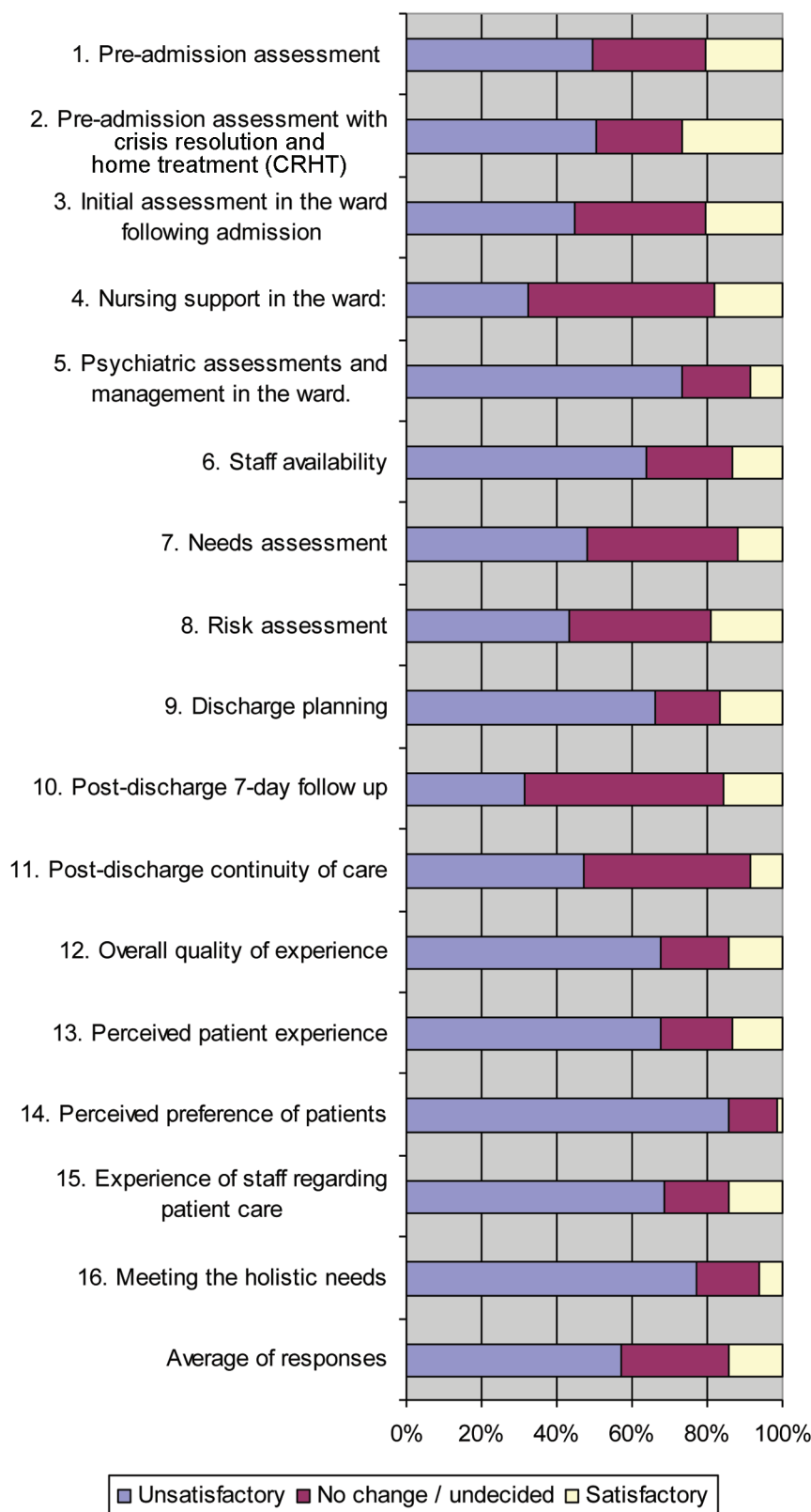


Figure 1. Pattern of responses on the in-patient functionalisation.

ent. A high proportion of staff (77.0%) felt that the in-patient functionalisation would not meet the patients' holistic needs.

The mean score of the questionnaire was 2.37 (SD: 0.69). There was no difference in scores amongst age, gender and professional groups. Even though all groups had scores below the midpoint; scores of in-patient staff (2.6 ± 0.7) in comparison with community staff (2.3 ± 0.7) ($t=2.2$, $df:81$, $P<0.05$); and staff with 1-5 years of experience (2.8 ± 0.7) compared to those with more than 5 years of experience (5+ to 10 years: 2.1 ± 0.6 ; 10+ to 15 years: 2.2 ± 0.6 , and 15+ years: 2.1 ± 0.6) had significantly ($F: 6.33$, $df: 3$, $P<0.01$) higher score.

Qualitative analysis

Positive aspects of functionalisation

A number of comments ($n=34$) were given regarding the benefits of functionalisation. Perceived benefits of functionalisation as reported by the staff were a dedicated team of medics for in-patients and improvement of the overall work conditions of staff in various teams especially in the wards. Staff commented that the doctors would have more focused time for patients in their respective teams; that the functionalisation would improve patient access to doctors, possibly speed up the discharge process, improve CRHT service provisions, create opportunity for second opinion or offer additional clinical perspective from a different clinician, help to streamline Mental Health Act related processes; and may provide an opportunity to develop other new services locally.

Negative aspects of functionalisation

It was felt that functionalisation had its own downside. A total of 61 comments were received in this regard. It was perceived that functionalisation increased the communication gap between in-patient and community staff, eliminated the continuity of care from community to in-patient services and vice-versa. Other problems reported were: too many assessments on the patients by the different teams, frequent changes in working diagnosis and treatment plans, disagreement amongst teams, uncoordinated admission and discharge processes, problems in arranging 7-day follow ups, increased number of delayed discharges, increased readmissions and supervision related issues for the trainee doctors especially for the in-patient experience.

There were concerns that functionalisation caused role confusion among staff. In-patients staff felt that *too much expectation* were placed upon them and were left to deal with *a lot of Mental Health Act related activities*. Community staff felt that their views were not listened to and their previous knowledge of patients was not taken into account when care

plans were being drawn up by the in-patient team. Staff dissatisfaction and low morale were reported secondary to poor communication at all levels, disagreements between teams regarding patient care, poor time management, increased stress and anxiety. In addition, in-patient functionalisation was seen as a medical model instead of being a holistic one. In summary, the notable negative aspects of functionalisation which were frequently reported were the discontinuity of patient care, communication gaps and disagreements between the teams.

Discussion

Key finding of the study was that a large proportion of mental health staff did not feel satisfied with the clinical processes during the functionalisation. In all the areas studied, proportions of the unsatisfactory responses were considerably more than the satisfactory responses. One of explanations for this observation could be that introduction of a new medical team during hospitalisation in the functionalised model might seem to become more fraught for patients, carers and treating professionals. Unlike functionalised community teams like assertive outreach or early intervention services where patients spend considerable time (usually years) with the team; admission periods in psychiatric wards or CRHT are very brief in comparison; and it takes place at a period when the patients are most critically ill.

Acute care involves the complex task of managing patients with mental illness at a critical stage of their lives, when they are most vulnerable and most in need of help.¹¹ During this phase of acute illness requiring in-patient or CRHT care, a majority of staff opined that patients would prefer to be seen by their community psychiatrists without change of doctors. The explanation for this observation could be that during admission, it might be easier for the patients to establish therapeutic relationship with known clinicians from the community. Community clinicians would probably be at an advantageous position of supporting the acutely ill patients because of their previous knowledge. It is interesting to observe that professionals across disciplines and place of work irrespective of whether they were based in the wards or community had similar opinion regarding patient preference to have same doctors in community and hospital.

There was no difference in the views between professional groups, age or gender. However, even though the over all response of both in-patient and community staff suggested a preference for the older model of continuing care from community; a significantly lower

score in the latter indicated that, such preference was more visible in the community staff compared to the in-patient staff. Similarly staff with more years of experience in mental health distinctly preferred the continuing care model compared to staff with 1-5 years of experience.

Qualitative responses from the staff regarding positive and negative aspects of functionalisation provided insight in to the changes and their impact upon the clinical care, perception and functioning of the teams. There were various recurring themes in the staff responses which were primarily lack of continuity of patient care between community and acute services; and the communication gap between the teams. These aspects need to be addressed not only to improve seamless service provision and patient care but also for the staff confidence in the new system.

Strengths and weaknesses

The study involved multidisciplinary staff from both in-patient and community who had first hand knowledge on the functionalisation process since its introduction. The sample included both clinicians and managerial staff. The survey had a good response rate and a satisfactory sample size. The responses were collected anonymously. Percentage of missing data was low (below 5%). However there are few limitations of the study. The evaluation was conducted after around 9 months of in-patient functionalisation; which may be insufficient for the new services to be established. The evaluation was based on staff experience only and did not include views of the patients. A possible reason of staff dissatisfaction could be the resistance to change, which has been described in literature in clinical practice scenarios.^{12,13,14} Changes induce uncertainty and anxiety in any organisation, especially if staff involvement in planning is minimal. These might have influenced the perception and responses of the staff to an extent.

Conclusions

Health service redesigning initiatives are undertaken for various reasons often with little evidence or careful consideration of the potential consequences. These redesigning processes should have opportunities for modifications and improvements taking into account the post-implementation observations and outcomes. Results of this study with feedbacks from the staff suggest the areas of functionalisation where there are concerns and may set the agenda for action to address those areas. There is also a need to evaluate the impact of functionalisation on clinical outcomes in various areas and the patient satisfaction in this model of service delivery.

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