



*Practical ideas for improving  
the daily experiences and  
treatment outcomes of acute  
mental health in-patients*

## **INSIDE**

- ★ *75 ideas for making the most of in-patients' time*
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# STAR WARDS

*‘This is a recipe book for doing things right,  
rather than another list of what is wrong.’*

*Louis Appleby*

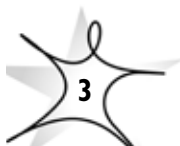
*‘People talk to people now; it’s so bloody  
basic, isn’t it?’*

*Service manager, Search for Acute Solutions*



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# Introduction

I welcome the StarWards Initiative and this publication collecting and describing so many practical and simple ideas for improving the inpatient experience. In fact, the StarWards concept was created by a service user who felt supported when she was an inpatient, and wanted to seek improvements for others.

There is much excellent work in acute wards, undertaken by many highly skilled and committed staff – though too often this is unreported and unrecognised. The great thing about this publication is that it is a recipe book for doing things right rather than another list of what is wrong. It can be a real asset to staff and service users working together to improve their local service.

The challenge is to make sure all services are achieving the highest standards. The local Acute Care Forum in each area will find much here to encourage and support local project work. National initiatives such as the forthcoming Health Care Commission Improvement Review on acute in-patient care and the Royal College of Psychiatrists Accreditation Scheme (AIMS), will do much to help wards sustain or reach standards of excellence. The StarWards initiative is a valuable adjunct to these initiatives.

Marion Janner has worked wonders in obtaining valuable contributions from experts from other sectors, such as Henry Stewart and Phil Dourado, that can be applied to developing a more therapeutic and nurturing ward environment.

Hard pressed front line staff need to feel appreciated by colleagues, service users, carers and the general public. Staff and patients need to have scope to let their aptitudes and skills flourish, working together in partnership and promoting self-management. Feedback, too, is an important part of the emotional healing and well-being process.

The StarWards initiative will help to accomplish this. It should set an example to both service users and mental health staff working in acute inpatient care, motivating them and showing them what can be achieved.

## Louis Appleby



*Prof Louis Appleby is the National Director of Mental Health*

# Editorial

Our cover model, Buddy, is my dog. Some might regard her starring role on a report about acute mental health wards as being a gratuitous exercise in publicising Buddy and her website ([www.buddyjanner.org](http://www.buddyjanner.org).) But there is a legitimate reason for her appearance. She represents one of the many losses that people experience when they're admitted to hospital – whether this is the abrupt loss of pets, children, partners, home, work or the autonomy that goes with these relationships.

And Buddy (in case the name has slipped your memory) is also an example of how acute wards could operate in a way that is much more patient-centred. If other patients on the ward are comfortable or even enthusiastic about it, why shouldn't pets visit? In some private mental health hospitals, dogs are allowed in the garden. Wards could take more advantage of the many energetic and caring voluntary organisations that exist, such as Pets As Therapy. PAT brings well-behaved animals into hospitals and other places where people are at risk of being isolated and in need of special affection. (Ah yes. Converting an acute ward into a cute ward.)

My life is characterised by a high degree of personal and professional autonomy. To find myself sectioned to St Ann's Hospital, North London, on a locked ward, and on 'special observation' (including while I slept soundly through the night), was pretty crushing. But there were two nurses in particular who were always approachable, concerned, and good company. Alison and Linda, and the other staff, were patient and non-judgmental, even when my behaviour was unreasonable and disturbing. They enabled me to convert my experience into one which became healing and beneficial.

Unfortunately, talking to other patients and reading reports shows that my experience was unusual. Because of the numerous pressures that staff and patients are under, inpatient stays tend to be characterised by an absence of therapeutic, or even recreational, engagement.

The charity, Bright, is working with partner organisations to help animate acute wards, and its Star Wards project has collected a range of practical ideas for substantially improving inpatients' daily experiences. Our vision is of acute wards where:

- talking therapies play as substantial a role as medication

- patients are supported in enhancing their management of their symptoms and treatment
- there is a strong culture of patient mutual support, with the potential for this extending once they've left hospital
- a full programme of daily activities doesn't just eliminate boredom but actively contributes to accelerating patients' recovery
- patients retain and build on their community ties

Despite the enormous pressures of time, finance, etc. facing hospital staff, it is still possible for changes to be made today which would improve patients' quality of time. An impressive example of this is the work of Nick Bowles and the 'Refocusing' projects, which have transformed wards into dynamic places which are healing for patients and satisfying for staff.

Increasing patient engagement isn't a controversial proposal. There is complete agreement. Service users want it. Staff want it. Managers want it. Carers, commissioners, councillors. Everyone believes that time spent on acute wards should be actively therapeutic and patients should have the option of a constructive programme of activities each day.

This publication sets out the reasons why new ideas are needed – and why old old practices, such as having volunteer co-ordinators, are also essential in the process of creating the sorts of wards in which patients are able to recover and in which staff want to work.

## Marion Janner





# Opinion

As I think about what to say, I reflect that we are in the middle of a summer sporting extravaganza of World Cup Soccer, Test Cricket, Wimbledon, Open Golf, and the start of the Tour de France. So, sporting themes, quotes and analogies will figure throughout this piece.

I hope you agree that it is fitting to do so in a publication concerned about activities, recreation, and encouraging positive experiences. Sport mirrors life and its dramas and also mental health, its unpredictable outcomes, the plummeting of emotions and morale, and its uplifting experiences. Sport offers important messages for those involved in health and social care, on how we motivate, organise and conduct ourselves, and those who look to us for leadership, inspiration and support.

We can learn from sport how best to cope with pressures and get the best out of ourselves and others who may have tired minds, or may be stale, feel flat or lack confidence. We can appraise and emulate the way coaches apply psychology and different motivational techniques to support and encourage their protégés or teams, to create enthusiasm, stimulate internal drivers, and achieve goals and ambitions. We can learn from sportsmen and women how they handle failure and disappointment and use it as a spur for achievement. We can also learn from them the crucial difference between obsession and focus.

Sport also offers many ideas and approaches for us to adapt for therapeutic purposes, motivation and social inclusion opportunities for service users.

Positive association with sport can also help with health promotion initiatives, exercise, diet and nutrition, esteem and lifestyle, thus reducing stigma and overcoming adversity barriers. Nelson Mandela said, 'Sport speaks many languages.'

We can follow the example of Owen Luck, a young staff nurse from Oxleas Trust, who, together with service users wrote to a number of football clubs requesting football shirts and autographs to adorn and brighten up the ward.

We can also learn from sport by adapting techniques of visualisation and scenario planning, to prepare individuals for situations, or explore possible uncertainties or ambiguities, and improve an individual's thinking style, skills, and self-manage-

## Malcolm Rae



**Malcolm Rae OBE is Joint Lead for CSIP/NIMHE's Acute Care Programme**

ment. In her insightful piece (see page 19) Joanna Bennett observes that successful working with patients requires shared decision-making, team learning and leadership, which correlate with the approaches of enlightened coaches from the world of sport.

The StarWards project not only challenges us as individuals and service providers to raise the bar and perform better, but provides us with a coaching manual with a range of ideas, examples and suggestions to think about and action, which can be a springboard for improvement and positive results.

The document also provides us with a range of initiatives and a menu of choices, which in itself provides a sense of optimism and hope at what can be achieved. Success in any sphere can lead to the raising of spirits, feelings of well-being, and can prompt pride.

If we cannot be world champions we should aim to be best in our field or league in our own region or area. 'Successful people don't always have the best of everything, but make the best of what they have.'

The StarWards initiative must be owned and acted upon at all levels locally. As a start, the document should be discussed at ward meetings

and in one-to-one discussion between service users and their key worker. Principles of good practice require service users to set the agenda.

Managers should take the lead and have therapeutic engagement on their radar screens and leadership dashboards, and avoid acceptance of mediocrity. *'If better is possible, good is not enough.'* Managers must lead, drive, support, monitor, evaluate and deliver positive engagement activities. Managers and leaders must empower front line staff to work, learn and think differently, and give them the space, time and opportunity to put into practice the ideas in the StarWards project, and help staff to deliver what matters to service users.

*'Not to know is bad, not to wish to know is worse'*  
**(an African proverb).**

Managers therefore, should examine, perhaps by audit, the present position, taking account of incidents and complaints arising from boredom or frustration. In addition, hard-pressed frontline staff should receive support from experienced clinicians and academic staff, who should be expected to undertake sessional work in a range of creative ways, and role-model good practice in helping frontline staff in meeting both the basic and complex needs of individuals. Senior clinicians and educators should be expected to help to innovate, see new possibilities, and assist staff in shaking loose from traditional approaches.

Jean Claude Killy the former world champion skier said, *'The best and fastest way to learn a sport is to watch and imitate a champion'*.

In recent times, Acute Services have often been the target of criticism, despite the commitment of many outstanding mental health professionals to improve the experiences of service users. Service users and staff alike have often been let down by the absence of appropriate resources and systems. It seems to me that any spectator can criticise the players, however; it takes skill and dedication to play the game.

*'A word or demonstration of encouragement can make the difference between giving up and going on.'*

The StarWards initiative substantially adds to the guidance and support available to ward staff and will enable them to make better use of existing resources and the latent skills and talents of ward teams.



# What's going on?

## The need

Acute mental health inpatients have about 600 hours of potential activity during the average 7 week stay. Currently you'd be lucky to have constructive activity, including one-to-one conversations with nurses, for 10 of those 600 hours. Report after report documents patients' intense frustration and boredom – feelings which are mirrored amongst ward staff. Typical are comments such as 'Boredom. Too much time to think' and 'Nurses should spend more time with patients.' (*Acute Care*, Sainsbury Centre for Mental Health.)

A recent consultation exercise highlights that improved in-patient care is a priority for mental health service users. In *The Sainsbury Centre for Mental Health Service User and Carer-Centred Services Research*, the number one concern among service users was the conditions on acute inpatient wards.

SCMH listed a range of benefits from patients having an actively therapeutic time in hospital in their report *The Search for Acute Solutions*:

- Increased patient satisfaction, especially in relation to ward staff and activities
- Reduced use of medication
- Reduced use of observation
- Reduced rates of readmission within 90 days

*'The staff also benefited from the activity programme. They improved their skills and their confidence in running groups. They also had a sense of achievement; their relationships with patients improved and they felt they were aiding patients' recovery.'*

There are a parallel set of negative factors to be avoided through the provision of a dynamic programme for patients. The *Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision* quoted staff from Oakburn Ward, Bradford: 'Nurses are more proactively engaged and spend less time 'firefighting'.... High therapeutic intervention and interaction environments diminish disturbance, violence and boredom.'

The Guide also includes a very compelling reason for reversing the current norm of minimal patient engagement, along with other aversive features of life on the wards:

*'For many service users previous experience of acute inpatient ward condition and practice is such a negative experience that they may try to avoid contact with mental health services when acutely ill for fear of admission.'*

The National Audit of Violence identifies 'high levels of boredom' as one of the six main factors contributing to unsafe wards. Their *Final Report (2003–5)* includes examples of good practice in providing activities, making changes in staff training and roles, and in providing protected time.

***'As we all know, acute units have been starved of resources, marginalized when it comes to service development, and then criticised for an excessively custodial form of care.'***

***Consultant Psychiatrist quoted in  
The Search for Acute Solutions***

Finally, there are compelling financial reasons for improving acute services. As stated in *Cases for Change – Hospital Services*, 'Hospital services still account for the vast majority of mental health expenditure'. Specifically, in 2000–2001, inpatient services accounted for 60% of mental health expenditure (£2,303,000,000), with the next largest element – community services – costing £775,000,000, or about 20% of the total.

The article on the evidence base (see pp 26–29) outlines the strength of the research on the urgent need to transform patients' experiences of acute wards.

***'It is unlikely that at any point in their life anyone could feel more vulnerable, and would be more in need of high quality and sensitive care.'***

***Acute Problems***

## What's gone wrong?

There's a potentially rather daunting list of why the state of acute wards is so far from what users, carers and staff want. The following is just a selection from the research reported in *The Search for Acute Solutions*:

- Lack of time, due to large amounts of administrative work, shortage of staff and high numbers of patients creating a pressurised environment
- The predominance of the medical





## **Creating a Star Ward**

### **Recreation and Conversation**

1. Each ward has sufficient board games, a TV and VCR/DVD
2. Volunteer(s) on ward for at least 3 hours a day
3. Decent ward and hospital libraries, including leisure reading and self-help resources
4. Bank staff are specifically recruited for their skills in running group activities
5. Domestic staff are encouraged & supported to interact with patients
6. Hospital's non-medical staff are involved (catering staff, admin, management)
7. Hospital volunteer co-ordinator appointed
8. Artwork is commissioned, borrowed and displayed
9. Cooking in ward kitchen is encouraged
10. Activity co-ordinator assigned for each ward
11. Community groups, including BME groups, hold regular sessions in hospital
12. Wards have internet-connected computers
13. Hospital has gym, multi-sensory room, library, music room, computer room, multi-faith prayer and chill-out room, lecture theatre (sic).
14. Regular comedy evenings arranged
15. Community Service Volunteers recruited



## **Creating a Star Ward**

### **Physical health and activity**

16. Each ward has an exercise bike and/or treadmill
17. Patients can meet individually with dietician and/or pharmacist
18. Walking groups are held regularly
19. Half an hour of exercises each day, led by suitably trained person, possibly a volunteer
20. Advice and encouragement for healthy eating and giving up smoking available on all wards.
21. Patients encouraged to help in ward garden
22. A physio or sports trainer runs group exercises and individual coaching and planning
23. All patients who want one leave hospital with exercise plan



## **Creating a Star Ward**

### **Visitors**

25. Written information about visiting arrangements given on first day
26. Family/friends links nurtured.
27. Private visiting room.
28. Nice mags & games for visitors' room
29. Flexible visiting hours
30. Good info for visitors & carers
31. Help with visits eg with phone calls
32. Pets are welcomed as visitors, or residents
33. Visitors' budget, managed by patients
34. Friends, family & carers' support groups
35. Visits arranged for the visitorless

model, preventing staff taking a more psychosocial holistic approach

- Limited availability, access and knowledge of specialist services, voluntary sector and other community resources, with little time for inpatient staff to network with these
- Few opportunities for training and development, and inadequate supervision
- A lack of confidence among all staff groups in supporting people from different ethnic backgrounds to their own, people with a diagnosis of personality disorder and people with dual diagnosis

Other reports, agencies, service users and carers identify factors additional to those in the above report, including:

- The focus having been on the community and the prevention of hospitalisation over the last two decades
- Because many more mentally ill people can now be treated in the community (partly thanks to the introduction of new services like crisis resolution teams) those in hospital have very high levels of complex mental and physical health needs – often including dependence on alcohol and drugs. Despite strenuous hospital efforts at prevention, the use of drink and drugs in wards, compounds other challenges faced by staff and patients.
- The role of the acute ward as well as of its staff is ill-defined
- The physical condition of wards is generally very poor
- Paperwork for care planning takes a lot of staff time but patients are minimally involved in the process
- Among other staffing problems, there is an over-use of agency and bank staff
- Ward rounds dominate, in terms of time, disruption and perceived importance and patient benefits

## Current initiatives

It's a good time to be campaigning about improvements in acute mental health wards. There is a recent heightened concern about these, and a national and local desire to introduce the changes needed to transform wards from places of 'a sort of suspended animation' (quoted in *Mental Health Policy Implementation Guide*) to ones which are highly respected for their beneficial emotional impact.

This section lists a few of the most exciting, current developments.

### Refocusing, WRAP and Recovery

Some wards have introduced very substantial changes to staff approaches and practices. The most successful seem to be those energetically centred on Refocusing. Refocusing is described as being 'based upon psychological perspectives of work strain and solution-focused principles, supported in practice by rigorous project management and audit systems.' It has been introduced by Nick Bowles to over 60 acute wards in the UK including in Doncaster, Cumbria and Wrexham through providing solution-based brief therapy training to staff. The results have been excellent:

*'Refocusing has proved to be effective in increasing staff satisfaction, improving patient care and reducing untoward incidents. Refocusing sites report reduced sickness, spending on bank and agency staff (savings of between £45K to £60K in the first year have been reported), complaints and increased morale, motivation and improved recruitment and retention. Refocusing is popular with clinical staff, their managers, commissioners and service users / carers.'*

*Refocusing Acute Psychiatry -  
An Overview (2005) Nick Bowles*

Hard to ask for more than that, then. And of course it begs the question about why all trusts, commissioners, ward managers, nursing and other professional staff aren't clamouring for it to be introduced to their wards.

Wellness Recovery Action Planning was developed in America by Mary Ellen Copeland. She describes it as, 'a self-designed plan for staying well, and for helping you to feel better when you are not feeling well, to increase personal responsibility and improving your quality of life.'

It's very practical. For example, it guides service users in developing a personal Wellness Toolbox. 'This is a list of resources you can use to develop your WRAP. It includes things like contacting friends and supporters, peer counselling, focusing exercises, relaxation and stress reduction exercises, journaling, creative, fun and affirming activity, exercise, diet, light, and getting a good night's sleep.'

WRAP resources have been taken up by some wards around the country and it's clear to see why they offer something constructive and empowering to patients. Similarly, the Recovery model is inherently optimistic and forward looking. *Social Inclusion and Recovery* by Repper and Perkins covers various areas of service users' lives, including work, relationships and dealing with discrimination. It describes ways of approaching each of these in order to maximise people's autonomy and, as the title states, social inclusion.

### **CSIP/NIMHE (National Institute for Mental Health, England).**

NIMHE, (now part of Care Services Improvement Partnership) has a very active Acute Inpatient programme which is focused on supporting mental health providers to redesign and improve acute inpatient services. A key driver for generating and implementing change, has been the establishment of Acute Care Leads in each of the 8 regional development centres which NIMHE has set up. Their work has been enhanced by the development of dynamic regional networks and 'collaboratives'. These operate as action learning projects for wards, where staff can exchange and enhance good practice ideas.

In addition, NIMHE has established a multi-agency project in partnership with the Department of Health, National Mental Health Partnership and other key stakeholders to focus on accelerating service improvement in acute inpatient care. Three of the project initiatives which should result in improved inpatient engagement are:

NIMHE and the Healthcare Commission are working in partnership to develop a common acute care standards assessment framework. This will underpin the 2006/07 statutory Healthcare Commission's Improvement Review into acute inpatient services. This will, for the first time, provide all mental health providers with a performance management framework for service improvement in acute inpatient care.

A Workforce subgroup is identifying and developing different approaches to staffing levels and skill mix and exploring the role redesign of consultants and lead consultants in acute inpatient care. Both pieces of work will be developed into publications.

The Virtual Ward website, which will be a fabulous source of information not only for staff but also for service users and carers. It will showcase an ideal acute pathway and feature examples of positive practice on acute admission wards and throughout each stage of the patient's journey.

### **Sainsbury Centre for Mental Health**

As a follow-up to their reports *Acute Problems* and *Acute Care*, SCMH ran a project with similar features to the regional collaboratives. Ward staff in four partner sites identified the ideal functions of acute wards and were given support in practice development and training to help them move closer to their aspirations. The changes included those beyond-the-ward, or 'systems', changes that were needed for patient care to be significantly improved. The work of this project is written up in *The Search for Acute Solutions*.

### **Royal College of Psychiatrists**

Accreditation for Acute Inpatient Mental Health Services (AIMS) is a new, independent accreditation service, based on standards harvested from 'a huge range of authoritative sources'. The wards piloting AIMS, and achieving these standards will unquestionably be in the forefront of the provision of excellent care. RCPsych's existing accreditation service for ECT has been pivotal in improving consistently high standards for this controversial treatment. If AIMS is similarly successful, acute care will be truly transformed.

### **Healthcare Commission**

In a comparable exercise to (and co-ordinated with) RCPsych's, the Healthcare Commission is carrying out an improvement review of acute inpatient mental health services in 2006/7. They are working with a number of development sites across England to get closer to the issues faced by inpatient services and to get help with developing and testing the assessment framework. This will review services nationally against established standards and will follow up with those services that are doing least well. It's hard to overstate the importance of this improvement review, as it will be mandatory and will lead to an assessment of







## **Creating a Star Ward**

### ***Care planning***

36. 5 day structure used, with different topic each weekday.
37. Minimum 1/4 hour with key worker or another member of staff to discuss these
38. Employment status is recorded on admission
39. Designated member of staff with care planning remit on 9 - 5 weekdays.
40. Advice on DSS benefits is provided in different formats
41. Patients get a 'leaving pack' of information resources
42. Quick-ticks used rather than notes wherever possible
43. Personal Recovery File for each patient.
44. Patients can, but don't have to, take the lead in care planning

performance for all trusts. This will undoubtedly help raise acute care's profile and priority with chief executives.

### **Other national developments**

Nursing staff have by far the biggest impact on in-patients' day to day experiences. The Chief Nursing Officers' review of mental health nursing will significantly enhance relationships, processes and outcomes for patients if its recommendations are implemented.

Although the White Paper *Our Health, Our Care, Our Say* concerns community services, the emphasis on patient self-determination and self-management should be influential in changing the culture of all aspects of mental healthcare, including on acute wards. It usefully identifies the damaging effects of stigma associated with mental illness and the need to actively combat this.

The beneficial impact of talking therapies, and specifically cognitive behavioural therapy, has been given a huge boost in profile and credibility through the publication of *The Depression Report*. Tellingly, the origin of Lord Layard's report is in the London School of Economics, but it doesn't restrict itself to the compelling financial reasons for extending CBT to thousands of people. In arguing for 10,000 more therapists over the next seven years, it doesn't explicitly exclude therapy being given to in-patients. The argument for systematically including inpatients in the expansion of psychotherapy needs to be put more widely and with more strength.

### **Star Wards project**

Through working with national and local partners, including service user groups, the Star Wards project hopes to contribute to enhancing the quality of inpatients' time. We anticipate this would result in patient benefits such as:

- Symptom reduction
- Symptom-specific self-management (eg managing voices, mood variations)
- Knowledge of medication management
- Progress in 'Stages of Change' processes and techniques



# Inpatients' current experience of how their days are spent

We know a lot about patients' experience of acute wards, since most reports on the state of these wards are at least partly based on patients' and carers' views.

Concerns regularly raised include women hating being on the residual mixed wards; safety issues and relationships with staff.

And boredom.

Boredom, boredom, boredom.

Really seriously nothing to do all day, all week, all the average of seven weeks long.

This, therefore, is the primary area of interest for the Star Wards project, and the following article about patients' experiences focuses only on the quality of patients' time.

## Lack of therapeutic and other activities

Acute Problems stated that:

*'Many patients receive only limited therapeutic input... [and are] bored during their stay and few if any are involved in planned programmes of social activity.'*

A worryingly high proportion of patients in the study – a total of 40 % - passed their stay without taking part in any social or recreational activity, while 30% were not engaged in an activity of any form, whether therapeutic or recreational'. Similar figures appear in the SCMH follow-up research, *Acute Care 2004*. Only 5% of patients in the study took part in psychological therapies. Acute Problems stated the issue succinctly as:

*'Care that involves patients sitting all day in a chair watching television (and often not a programme of their choice) should be considered as anti-therapeutic.'*

While NIMHE's *Cases for change – hospital services* refers to 'enforced inactivity'.

Staff are undoubtedly handicapped by the physical design and upkeep of the wards. The *London Acute Care Collaborative* describe it as follows:

*'The ward environment was not historically planned to deliver activities. Rooms are often reserved for ward rounds which take precedence over provision of either therapy or activity groups. Staff do not feel 'trained' to deliver such groups. Ward budgets have not been revised for years and are geared to nursing establishments rather than provision of activity co-ordinators. Occupational therapy services are often stretched across a number of wards... Day care is often designed for service users in the community and occurs off the ward and there is little or no budget for incidental activities or equipment.'*

Mind carried out a survey as part of their Ward Watch campaign and 'identified some excellent examples of good practice regarding inpatient care in hospitals. The challenge is to make them the norm rather than the exception.' They quote patients who had a very beneficial time in hospital:

*'In spite of quite severe short staffing, I believe the care I received, particularly from nursing, was first class.'*

*'The foundation for my mental health recovery was laid in hospital for which I am very thankful.'*

But it also records the feelings of patients who felt damaged in some ways by their experiences:

***'Many patients emphasised the intense boredom that they experienced on the ward.'***

***'The complete absence of meaningful daily activity led my condition to worsen.'***

***'There was little therapy apart from smoking and television.'***

*Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision* said 'a key factor contributing to a sense of boredom and lack of service user engagement on inpatient wards is inadequate clinical input for the ward from the full range of care professions that comprise the mental health multi-disciplinary team.' And the impact of boredom on physical health, and the partly resultant 'smoking culture' on wards was identified as problematic in *Not all in the mind*.



## **Creating a Star Ward**

### ***Talking therapies***

45. Self-help books and tapes.
46. 'Protected engagement time' for nursing staff, for uninterrupted patient contact
47. Women's and men's groups take place
48. Psychology assistant for each ward.
49. Weekdays, at least one member of staff on duty has counselling qualification (or equivalent)
50. Each patient has option of at least one hour of therapy or recovery management a day
51. Full day's programme of therapy groups available.
52. Placements for student counsellors
53. Individual psychotherapy for everyone who needs it
54. On-ward and cross-ward involvement of OTs & creative therapists
55. Core programme of activities on and & off ward
56. Patients can choose to use a Personal Recovery Workbook
57. Wards have mini-library of Mind publications and hospital library has full range

## Contact with staff

When patients are asked what would make the biggest difference in their experience of acute wards, more one-to-one contact with staff is always one of the top wishes. Not having someone to talk to:

*'...can largely be explained by the centrality of medication, the limited availability of talking therapy and the passing relationships users have with nurses.'*

*From Toxic Institutions to Therapeutic Environments*

A 1996 study found that patients spent only 4% of time with staff compared to 28% doing nothing or watching TV (*The Mental Health Nursing Care Provided for Acute Psychiatric Patients*). More recent reports agree: a quarter of wards visited by the Mental Health Act Commission for their 1997 census found no staff in contact with patients at that particular time. 'Lack of 'something to do', especially activity that is useful and meaningful to recovery', was recognised as a significant problem in the *Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision*.

In an earlier study by Mind, *Environmentally Friendly*, only 35% of respondents said they had enough contact with staff. In a journal article in 2000, Walton identified the problem: most staff time is spent on administrative tasks, talking to each other in the office and watching patients rather than engaging with them.

The phenomenon of staff watching rather than speaking to patients is interesting. If staff have the time physically to be with patients, why aren't they talking to them? One reason is that there is a strong culture of being 'on standby for difficult incidents'. *The Search for Acute Solutions* describes 'over-cautious organisations leading to defensive, restrictive practices through fear of litigation and blame.' No member of staff is likely to be in trouble if they don't talk to a patient in any given hour; but if they don't successfully anticipate, diffuse or handle a volatile or violent incident, this could have major repercussions for them.

This must feel like a daunting tension for individual staff. Northumberland, Tyne and Wear NHS Trust are developing an approach based on defensible rather than defensive decisions. And Broadoak Unit and Windsor House, Liverpool found that introducing activity workers improved patients' experiences and reduced

the number of incidents. So diverting staff from watching to engaging with patients is in fact one highly responsible and effective way of preventing untoward incidents. The research on violence on wards stresses that preventing boredom is a key element in preventing violence.

The ward staff in a number of acute wards in Chichester and Worthing, Sussex Partnership Trust have established a daily planning meeting, which involves the staff on duty and as many of the service users who want to attend, in planning the day. They meet at 9.00 a.m. each day, have a cup of tea and plan the day. Sometimes it is the ward staff who generate the ideas for activities; sometimes the service users; usually it's a combination of both. Activities often include healthy walks, information about formal groups available that day, music and art groups and video evenings. These daily planning meetings haven't cost anything to establish and they have a positive effect on the ward atmosphere by reducing boredom and facilitating engagement. Usually 11 of the 16 service users admitted to the ward attend the planning meeting.

So it can be done. But one puzzle remains: why don't staff routinely ask patients how they're feeling? One reason might be that they feel deskilled and under-confident, making them concerned that they won't be able to respond appropriately if patients describe complex or distressing emotions.

There is another, more mundane reason for the lack of conversation between patients and staff: knowing what to talk about. In some ways there's too much – patients' current emotional state, their symptoms, their physical health, their feelings, the practical complications of being away from home in a difficult environment, their relationships, work, finances... In other ways there's too little to talk about – nothing's happening on the wards so there's nothing to say. Many of the Star Wards' ideas are designed specifically to overcome the barriers to staff chatting with patients, both through the provision of activities and also through 'contriving' conversation, e.g. by having a different theme for each weekday.

***'The ward staff are very helpful if they've got the time but, like all hospitals, they haven't always got the time to sit and talk and listen and when you're mentally ill, that's what you want.'***

*A Qualitative Analysis of the Views of Inpatient Mental Health Service Users*



## **Patient involvement**

Patients on some wards profitably spend their time in having a say about their own care and that of others. Unfortunately, at the moment the norm is as described in *Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision*:

*'Lack of involvement and engagement in the planning and reviewing of their own care and in how the ward is run.'*

It's a strange irony that ward staff generally have, or feel they have, too little time, while patients have far too much. Many of the tasks that staff are carrying out could be done with, if not by, patients. Much of the Herculean daily allocation of patient notes could be done with, rather than about, each person. As *Not Just Bricks and Mortar* says:

*'Patients should be involved in generating their own care plans and should know what is written about them.'*

One way of both speeding up the admin process and involving patients in their own care planning, is to make more use of tickboxes. The time this frees up could be spent discussing (and ideally agreeing) with patients what should be written about them. For example, rather than writing out in full 'Patient ate meal without any difficulties', this could be one of the printed options on a daily form and could simply be ticked (or not.) There would be space for comments.

One of the strongest contrasts between some private mental health hospitals and NHS wards is that the former often have a strong, carefully cultivated culture of patient mutual support. This is facilitated by well-programmed days, which not only enable patients to get to know each other quite intimately, but also provide a focus for patients' conversation. This could easily become a feature of all NHS acute wards, through introducing some of the StarWards' ideas.





## **Creating a Star Ward**

### ***Ward community***

58. Day begins and ends with ward community group
59. Prayer, faith & cultural meetings are supported
60. 'Buddy system' encouraged
61. Patients are encouraged to support each other
62. Different faith communities' festivals are celebrated
63. Patients are encouraged to continue to support each other when they have left hospital
64. Each ward has recreation budget which patients decide on
65. Patients run 'special interest' sessions in own or other wards



## **Creating a Star Ward**

### ***Patient responsibility***

66. No more queuing for medication!
67. Patients write their own personal profile for staff
68. Patients have copies of their care plans
69. Responsibility for keeping 'public' patient information displayed up-to-date
70. Patients have their own appointments' diary
71. Ex-patients involved in staff recruitment and recruited as staff
72. Patient involvement in how the ward is run
73. Patients complete a self-review at the end of each day
74. Each patient has 'recovery budget'.
75. Patients can extend their stay by a day or two to support new patients



## Meeting the needs of patients from black and ethnic minority communities

The National Audit of Violence (2003–2005) Final Report reported that 78% of respondents said their cultural needs were respected on the ward (e.g. religious festivals and diet). This is an impressive figure, given the level of patient dissatisfaction with other aspects of ward life recorded elsewhere. (It does, however, contrast with *The Search for Acute Solutions* finding that 'the needs of people from black and minority ethnic groups were not being met and there was a lack of appropriate services.') It's not clear whether the 12% of respondents who said their cultural needs were not met were mainly from ethnic or faith minorities, which would explain this discrepancy between the two sets of findings.

A catalogue of disproportionately inferior services experienced by black people is given in *Breaking the Circles of Fear*. This indicates that black people are more likely to experience compulsory admission and police involvement in hospital admission, over-diagnosis of schizophrenia, over-use of psychotropic medication and under-use of talking therapies. Given the heightened emotional experience of hospitalisation and the opportunity that time spent on acute wards offers, it is particularly important that the needs of people from black and other minority ethnic and faith communities are appropriately met.

*Count Me In* – a national census of 34,000 people using mental health services in England and Wales – found that black African and Caribbean people are three times more likely to be admitted to hospital and up to 44% more likely to be detained under the Mental Health Act. The census, carried out in March 2005, also found that black Caribbean men were more likely to have experienced incidents of control and restraint.

The primary current dynamic for improvement to mental health services for black people comes from the inquiry into the tragic death in a mental health hospital of David (Rocky) Bennett. The report, *Independent Inquiry into the Death of David Bennett*, calls on the Department of Health to 'cure this festering abscess [racism], which is at present a blot upon the good name of the NHS'. Among its recommendations were appropriate staff training and a culturally diverse workforce.

Subsequently, the Department of Health produced *Delivering Race Equality in Mental Health Care*, which describes itself as 'an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status'. One of its commitments is to deliver:

*'...a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.'*

David Bennett's sister, Joanna, is a mental health professional and former lecturer in mental health. Giving evidence to the inquiry into his death, she warned against services focusing on 'cultural matching' and argued in favour of staff spending more time talking to patients and their families. Taking time to respect an individual, and ask what was troubling him and what he needed, was likely to be more effective than 'talking about culture, ethnicity and cultural competence,' she said.

*Breaking the Circles of Fear* takes a slightly different perspective. It reports:

*'A common feature was that most staff in the site visit programmes shared the cultural traditions of their client group. However, this was not seen as the most important requirement to work in these organisations. Key qualities were that staff understood and appreciated the structural position of black people, a commitment to the service philosophy, an understanding or experience of mental illness and an ability to build and maintain positive working relationships with service users.'*

Good practice included discussion groups and educational opportunities which focused on black identity. Other factors of positive practice aren't specifically race based but, as Joanna Bennett advocates, are ones that apply to successful work with all patients, e.g. 'non-hierarchical team approach, emphasising shared decision-making, team learning and leadership'.

# Staff perspectives

Patients' frustrations with the current culture of wards and content of their days is, of course, just one side of the story. Many staff are only too aware of the impoverishing effects of such a culture. The following excerpts from *The Search for Acute Solutions* provide a good snapshot of the main issues:

*'There was generally poor risk management, with a tendency towards defensive practice and a custodial ethos... Staff felt they had lost sight of what acute inpatient care was for... the wards were pressured and stressful.'*

*'Staff complained of a predominance of medically-dominated interventions, with a reliance on physical treatments preventing staff from taking a more psychosocial, holistic approach. Therapeutic programmes for service users were generally not available and there were not enough activities or therapies provided.'*

*'Inactivity and boredom can delay recovery and can sometimes cause increased levels of aggression and frustration.... Service users often reported they felt bored, under-stimulated and would return to bed if there was little going on.'*

*'Generally staff felt trapped by their working circumstances, powerless and had no confidence that change was achievable.... fragile staff who anticipated criticism...'*

In addition to the reasons cited above, an important observation is made by Alison Cox quoted in *Cases for Change*:

*'... we have to recognise that the people who provide the mental health services – who are under considerable pressure to meet policy criteria – are as undervalued by the system as their clients.'*

And staff dissatisfaction with rapidly increasing administrative duties and reduced contact with patients is identified in the 1999 article *Nursing Acute Psychiatric Patients*.

The mental health tsar, Prof. Louis Appleby, describes the situation even more forcefully in an article:

*'The second risk is that clinical staff will be too battered by the pressures that have hit clinical practice in the last decade or so, too worn down*

*by the staff shortages, barren wards and press hostility, too fed up of being asked to mop up the consequences of society's problems of drugs, violence and poverty, and too demoralised and defensive to embrace radical change.'*

So. A hefty range of obstacles for staff to contend with. But we know from those wards where staff feel stretched but valued, that it is possible to employ and retain committed staff and enable them to engage dynamically with patients. The recent Chief Nursing Officer's review of mental health nursing set out a range of ways in which excellent staff can be attracted to and kept within mental health nursing. And it made strong recommendations for the context in which nursing staff should work with mental health patients, including:

- Recognising in-patient nursing as a specialism in its own right, 'with a clear career pathway and the provision of appropriate educational and developmental opportunities for in-patient staff.'
- Minimising administrative tasks and increasing the amount of direct contact with in-patients
- Basing practice on the principles of the Recovery Approach and working holistically so that patients' physical, psychological, social and spiritual needs are taken into account.

A fascinating, daunting and simple explanation for the constraints on nurses to spend time in direct contact with patients is provided by the London Acute Care Collaborative (see table opposite). With shifts like these, it's no wonder that staff feel over-stretched and patients feel neglected.

Of course, while nurses are the main staff that support in-patients, other professions also have a crucial and potentially significantly increased role to play. Occupational therapists, psychologists, psychiatrists and creative therapists provide specialist input on and off the ward. Some patients have reported that the best relationship they had was with the ward domestic – especially the case if they share the same minority language. (And briefly on the subject of domestics, having a great ward domestic is one of the most essential requirements for making a ward feel safe and patients feel valued.)

## A TYPICAL SHIFT ON A LONDON ACUTE WARD

The figures, tasks and timings are based on average findings of the HAS report (2003, Sainsbury Report (2005) and the London Acute Care Collaborative (2005).

21 bedded wards

22 beds actual occupancy

Total funded establishment 21

Total actual staff 16 (5 vacancies)

### **Staff per morning shift 7.30AM – 3.00 PM**

Ward manager (Most likely G grade)

WM hours available of 9-5 shift = 5

2 qualified staff (Most likely E or D grade)

Qualified hours available = 15

2 unqualified staff (Most likely A or B grade)

Unqualified hours available = 15

Second shift cross-over (4 staff x one hour)

Hours available = 4

### **Total person hours available = 39 (not including staff breaks)**

One member of staff will most likely be bank or agency

12% of wards will have no admin support

Average number of ward rounds per week is 4.6

The majority of inpatients will be on a section of the Mental Health Act

Task	Staff required	Timing	Total person hours
Handover planning & allocation &/Or reading notes (am and pm)	Am – all staff PM – 1 qualified	¾ hour	4.5 hours
Ward round	1 qualified	3 – 4 hours	3.5 hours
Medication x 2	2 qualified	0.5 hour	2 hours
Escorted leave for up to 8 patients	1 any	0.5 hour	4 hours
Special observation for 1 patient	1 any	7.5 hours	7.5 hours
General observations	All	0.5 hour each	2 hours
One admission	Qualified	1.5 hours	1.5 hours
One discharge – clearing bed, TTAs etc	1 any	¾ hour	¾ hour
Breakfast	1 any	0.5 hour	0.5 hour
Lunch	1 any	1 hour	1 hour
Patient one-to-one (15 of the patients – half hour each)	Any	0.5 hour each	7.5 hours
Covering locked door, greeting visitors	Any	5 mins each	25 mins
Student teaching session or mentoring	Qualified	0.5 hour	0.5 hour
Community meeting	1 Q & 1 UnQ	¾ hour	1.5 hours
Supervision	WM + 1	1 hour	2 hours
Incident (own wards or response to other ward)	All	¾ hours	3.75 hours
Unit sleep holding/bed management	WM or qualified	3 hours	3 hours
Meeting	WM	1 hour	1 hour
Induction bank/agency staff	Qualified	0.5 hour	0.5 hour
Activities/group work	Any	1 hour	1 hour
Paperwork/notes/admin/organising/liasing	All	0.5 hour each	2 hours
Ward manager admin & paperwork	Ward manager	2 hours	2 hours

**Total person hours required = 52 hours 25 mins**  
**Deficit = 13 hours 25 mins (About 2 WTE staff)**

**NB** A third of ward staff regularly worked unpaid overtime. A quarter of acute inpatient staff left to join community teams in the 12 month period of the Sainsbury survey

Fourth Acute Care Collaborative report – August – October 2005  
 'Trying out small changes to improve services'

The newly created Support, Time and Recovery (Star) Workers don't seem yet to be a strong presence on wards but their training and orientation would make them welcome additions. (Well, with our name, we *would* think that.) And like Star workers, there are people from other disciplines who could also help transform patients' experiences. Youth and community workers, in particular, have values, skills and experience which lend themselves perfectly to providing activities and support to this group of, sometimes difficult to engage, service users.

Pharmacists have an interesting relationship with patients. For example, when patients are struggling with the purpose and/or side-effects of their medication, pharmacists can be seen as 'honest brokers'. They aren't responsible for the prescribing, and can explore ways with a patient how they can best manage their medication.

Other health professionals such as physiotherapists and dieticians used to be valued members of the staffing team in the bad old days before community care. It's ironic and unfortunate that they are now only rarely available to support inpatients with their physical health needs.



# The public view

It's very clear what mental health patients themselves think should happen on acute wards. But what about the public? The media feeds them a regular diet of sensationalised, disturbing news stories about the tiny minority of mentally ill people who are violent to other people. So does the public think that mental health patients should be confined to austere environments, receiving only a limited range of 'orthodox', medical treatments?

The voluntary sector think-tank, nfpSynergy, carried out a survey for StarWards in July 2006. It was a nationally representative sample of 1,000 adults aged 16+ in Britain, with the fieldwork conducted online as part of nfpSynergy's Charity Awareness Monitor.

The heartening results showed (as media studies academics have been saying for ages) that the public don't simply and uncritically swallow the overwhelmingly negative messages about mental illness in the media. They appear to recognise both the ordinariness and complexity of mental ill health, repeatedly expressing the view that a holistic rather than purely psychopharmacological response is needed.

When asked to consider what support they would need if admitted to a psychiatric hospital, the average person in Britain wants access to a wide range of services. Yes, the more traditional services (e.g. psychiatrist and medication) but also a range of supports which are currently less widely available, including counselling, advice from a psychologist, other therapies, physical exercise and impartial advice and support from other patients

The highest proportion choosing 'very important' for any option was 81% (from a prompted list) for Counselling/Psychotherapy. This is an important finding, not least in the context of the Layard report which recommends greatly extending people's access to talking therapies, especially cognitive behavioural therapy.

Almost 9 in 10 (89%) people in Britain feel access to physical exercise would be important, including

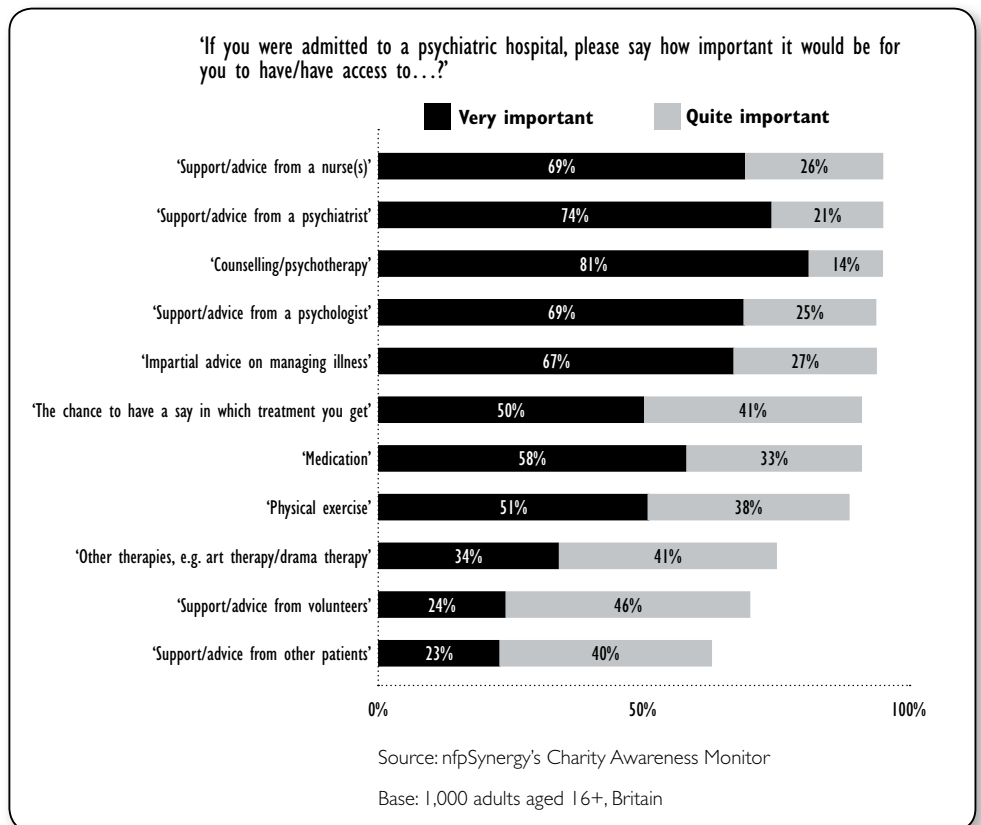
the majority of the sample (51%) who said this would be 'very important'. And more than three quarters of the sample (76%) would want access to other therapies eg art and drama therapy.

Despite being the lowest on this list of options, still well over the majority of people in Britain (63%) feel advice and support from other patients would be important. Again, given the pervasive portrayal of people with mental health problems as dangerous maniacs, we welcome this finding as it shows that the public recognise that even when acutely ill, mental health patients can have reliable judgement. And also, it shows that people value the benefits of mutual support between in-patients.

Similarly reassuring is the fact that 91% of the public feel that patients should have a say in their treatment, with only 2% saying patients should never have a say. This view was consistently high across both sexes, social grades, age and broad regions of Britain.

So, it's not just mental health patients who want to see a much more constructive and more broadly therapeutic use of acute in-patients' time. The public strongly support this.

The full results of the survey are available on our website: [www.starwards.org.uk](http://www.starwards.org.uk)





# Psychology on the Wards

*Dr. John Hanna*

All ward-based staff know the sense of achievement acquired by successfully helping a service user through a purposeful admission which aids in recovery and social inclusion. Many or most also know the frustration involved in not feeling adequately trained or qualified to meet a major area of a client's presenting need. Most ward staff want psychologists working alongside them and want training so that they, too, can feel competent in providing psychological interventions.

The purpose of an inpatient admission to a mental health hospital will vary from individual to individual, but generally service users want an admission to be safe, to be meaningful, ideally to be brief and to facilitate optimal community re-integration. This article sets out to promote the involvement of psychologists and the provision of psychological therapies on mental health wards, in order to achieve these valued outcomes for service users.

The current thinking about distress associated with mental health difficulties is that such distress is brought about within a biopsychosocial field; in other words, distress can be generated as a result of a biological predisposition or deficit, a psychological conflict or pattern of thinking, an aspect of social deprivation or any combination of the three. A breakdown in one area of the biopsychosocial field affects all three components of this field—if the distress is viewed to originate in biology, it will no doubt negatively impact on the psychological and social life of the individual; if problems begin in the psychological sphere, the person will suffer biologically (manifest by physical and biochemical changes) and socially; if social deprivation renders acute distress, the person will likewise struggle biologically and psychologically.

A biopsychosocial model of distress in mental health therefore requires a tripartite treatment solution: clinical interventions that, collectively, encompass the whole of the individual's difficulties. This is not a revolutionary idea—the biopsychosocial model has held sway in mental health services for years and is widely accepted by all professional groups. It is difficult, however, to argue that the biopsychosocial needs of inpatients on mental health wards are universally met within the NHS. Psychology, in particular, has been largely absent or in very short supply on the wards for many years. But, as a result of research-



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based evidence, service user demand and new sources of funding, thankfully this is now changing – psychologists and psychological therapies are on the rise within inpatient settings.

Clinical psychologists – professionally chartered, applied psychologists who practice psychological therapies after many years of doctoral-level training – are widely recognised as the most capable psychological therapy practitioners in the context of severe, enduring and/or complex and risky distress. They are also the best candidates for training and supervising other mental health professions, such as nurses, psychiatrists, occupational therapists and social workers, who would ordinarily use psychological interventions in their everyday practice. Although clinical psychologists are specialists in delivering psychological therapies, especially with challenging clinical presentations, all mental health professionals are responsible for providing psychologically therapeutic interventions—from supportive counselling to solution-focused problem-solving to behavioural symptom management. Without psychologists and other specialists in psychological therapy, however, both service users with challenging difficulties, and staff with psychological training and supervision needs, will struggle to meet challenges in the psychological and psychosocial treatment spheres.

The evidence base for psychological therapies, especially cognitive behavioural therapy (CBT) has grown substantially over the past few years. Specific psychological therapies for all of the mental health conditions related to hospital admission, from suicidal depression to psychosis to borderline personality difficulties, have been demonstrated as effective through numerous research trials. Each is endorsed and recommended as an essential part of standard care by the National Institute for Clinical Excellence (NICE). Not only does psychology now have a weighty evidence base, but psychological therapies are now more in demand from service users than ever before. Many people who use mental health services state a preference for talking therapies, or a combination of therapy and medication, over medication alone. Yet the NHS has a long way to go before meeting either the NICE guidance implementation targets or achieving widespread satisfaction in its psychological therapy service delivery: Every review of mental health services from service user and other organisations, such as Mind and the Sainsbury's Centre, note a widespread dissatisfaction among service users with the quality and quantity of one-to-one therapeutic contact with staff, especially on wards in mental health hospitals, as well as with access to psychologists, who remain in short supply.

For all of these reasons, psychologists are increasingly being employed to help train and support multidisciplinary staff while taking on the most challenging psychological therapy work on inpatient wards. Some psychologists work mainly in a community team and work with their sector-based ward for a session or two a week, while others are employed within a hospital and work across wards exclusively with inpatients. Psychologists assess and formulate their clients' difficulties and, as such, provide a different and valuable perspective on distress to both the client and the treatment team. They often provide an individual assessment and therapy service while contributing to or supporting an inpatient group programme. In therapy, psychologists help to address existential challenges related to suicidality, make sense of delusions and hallucinations, work through past trauma and loss, focus on thought patterns and lifestyle choices which can promote recovery and improve relating within social systems. Psychologists are increasingly called upon by other professional groups to support training initiatives, as all professions are now expected to

provide at least basic psychological interventions as part of routine care.

It has, in the past, been argued that scarce psychological therapy resources should be reserved for outpatients, as they may be in a better position to engage in such treatment. A counter-argument to this is offered by the evidence base for psychology: NICE regularly recommends prioritising psychological therapy for those candidates whose distress is persistent and whose risk of relapse is high—this clearly includes inpatients.

The counter-argument is further strengthened by the Department of Health's National Service Framework, which similarly argues that gaps in services for people with severe, enduring and complex difficulties must be a first priority. There is no doubt that NICE recommendations need to be adapted to the time-limited nature of an acute admission, as well as to the acute distress experienced by many inpatients which will, at times, pose challenges to effective engagement. But the immediate aftermath of a breakdown necessitating admission is often the best opportunity to make sense of the precipitating factors contributing to a personal crisis.

As psychologists grow increasingly confident in effectively meeting the challenges presented by the acute distress of inpatients, more within the profession are drawn to the prospect of working on wards. And the more inpatient service users find benefit from the efforts of psychologists and those they train and support, the more demand there will be for psychologically-oriented wards in mental health hospitals.

Can your local ward meet the psychological and psychosocial challenges presented by its service users during hospital admissions? If not, what can you and your Trust do about it?



# The Evidence Base

## Talking therapies

Talking therapies are popular and they work. There's plenty of evidence. Research by the Future Foundation for the British Association of Counselling and Psychotherapy exploded the myth that we Brits are too uptight to want therapy, especially in response to life traumas. A large-scale American consumer survey by Seligman demonstrated, not only its effectiveness and popularity, but also that the relationship between the therapist and client was the key factor in determining success, rather than any one type or school of psychotherapy being better than another. The strength of the 'therapeutic alliance' is an important consideration in efforts to introduce talking therapies into acute wards. It echoes the primary need expressed by inpatients of wanting more one-to-one time with staff.

The government is confident enough about such therapies to be piloting a scheme to make cognitive behavioural therapy much more available to people of working age. NICE (National Institute for Health & Clinical Excellence) is convinced that CBT is an effective treatment for a range of mental health problems. The research (e.g. *What Works for Whom* by Roth and Fonagy) covers a variety of types of psychotherapy, although CBT is a front-runner not only for depression but also for other mental illnesses. Psychotherapy has been proven to work, even for patient groups previously regarded as impervious to this intervention (exemplified by the pioneering work of Anthony Bateman with people with personality disorders.)

Unfortunately, there is relatively little known about the benefits, or otherwise, of psychotherapy for acute in-patients. It's tempting, almost common sense, to think it can only be a good thing. But there are complex issues about patients' ability to engage in what can be painful or challenging therapy when they are seriously ill, as well as concerns about potential discontinuity of treatment when they leave hospital.

A small-scale, very radical American initiative is described by Deikman and Whitake in *Humanizing a Psychiatric Ward – Changing From Drugs to Psychotherapy*. These two doctors transformed a ward from being almost entirely medication-oriented to one operating, instead, largely on the basis of group and individual psychotherapy. There

were considerable gains made by patients during this 10 month 'experiment' but there were all sorts of problems with the process which make it impossible to draw any conclusions – other than it was a pretty extraordinary thing to do.

If you want to get down to some serious talking and soul-searching, therapeutic communities are the place to be. They offer a tantalising model for embracing psychotherapy as a core treatment tool. Several successful therapeutic communities are discussed in the rather accurately titled book *Therapeutic Communities*. There is so much to be learnt from this intensive, people-centred approach, even in the necessarily diluted and short-term form it would take on an acute ward.

A more modest pilot project is included in *From Toxic Institutions to Therapeutic Environments*. Manchester's Edale in-patient unit employed assistant psychologists whose role included, 'carrying out simple [therapeutic] interventions under supervision.' Interestingly, they also worked with the unit's occupational therapist, developing inpatient activities, training staff and supporting ward community meetings. The project seems to have been popular and to have created reasonable benefits for patients, but it's unclear whether, like so many successful pilot projects, it was discontinued.

Perhaps the strongest advocate for psychotherapy on acute wards is Jeremy Holmes, who, like the much admired Anthony Bateman, somehow manages to combine being a consultant psychiatrist and psychotherapist and university lecturer. In an article on *Creating a Psychotherapeutic Culture in Acute Psychiatric Wards*, Holmes laments the fact that the last few decades has seen the paradoxical demise of 'ward groups and the importance of patients playing an active part in decision-making' at the same time as community care was being introduced. (And thank goodness for community care and the end of the old 'asylums'.) Holmes comments:

**'Hard evidence that psychological therapies can play a significant role in in-patient care is far from robust, perhaps because the attention of the research community has been focused elsewhere. Nevertheless, the research literature does provide some grounds for thinking that psychological approaches might play an important role in improving quality of care in the in-patient setting.'**

But until the gap in research on psychotherapy on acute wards is filled, it's a relief to find a practitioner and academic who acknowledges that patients are likely to benefit from talking therapies.

## Being listened to

Give every man thine ear, but few thy voice.  
Shakespeare (Hamlet – not that you needed us to tell you that.)

The one thing that inpatients most want is to be listened to. Basic, yes but elusive. And when it happens, it's great.

*'People talk to people now; it's so bloody basic, isn't it?'*

*Service manager, Search for Acute Solutions.*

Being listened to shouldn't only be in the structured and necessarily rationed setting of 'talking therapy'. Nor need it be mainly between patients and staff. Supporting patients in listening to each other is really important, and involving volunteers who can socialise is also pretty essential. Several research studies about the impact of people in health settings being listened to report the benefits this brings. For example, Wanzer and colleagues found that health care practitioners who use more patient-centered communication, including listening, have patients who are more satisfied with their practitioners and their overall medical care. Of course, it's not just patients who want to be listened to. A recent article in the Boston Globe explained one reason for the popularity of corporate 'online communities' of customers: *'Consumers also participate in the online communities because it gives them a feeling of power. They seem to love the idea of being consulted, and love even more the notion that they are being listened to.'* Who doesn't?

## Physical activity

If you're mentally ill, chances are you may well also have poor physical health. Recent research with nearly 1,000 people across the country with severe mental illness found that on average most were obese, half had high blood pressure and half smoked. An article in the Yorkshire Post goes on to reveal that a third did no physical activity and only 16 per cent had good diets. And the Social Exclusion Unit reported that a person with schizophrenia can expect to die 10 years sooner than average. They are more likely to have heart

disease and diabetes and more than twice as likely to die from respiratory infections such as flu. Being in hospital is a logical place for people to improve their physical well-being, and exercising is an agreeable way of doing so. (It also has a strong evidence base, for its emotional and social as well as physical benefits.)

The Mental Health Foundation had a big campaign in 2005, promoting exercise as a positive option for people with depression. The clinical evidence, from NICE, is that it is particularly beneficial for people with mild to moderate depression, but the benefits listed by MHF include those which are also relevant to people with more serious illnesses, such as its

- popularity
- potential as a sustainable element in a healthier lifestyle
- ability to give some patients 'a sense of power over their recovery, which in itself counteracts the feelings of hopelessness often experienced in depression.'

lancu and Israeli colleagues compellingly describe further benefits beyond physical activity of something as modest as a table tennis tournament in a mental health hospital:

- an enjoyable recreational activity 'during the long leisure time on the wards'
- the potential to develop into a hobby
- could stimulate patients' motivation to engage in the 'rehabilitation process'
- provide an unthreatening form of socialising
- increase people's self-esteem, especially in comparison with the much harder employment route
- channel potentially aggressive energy in a healthy direction

One of the simple but inspired aspects of this table tennis tournament was including a doubles' competition with patients partnering a member of staff.

For people with psychosis, some of the debilitating side-effects of their medication can be fatigue and circulatory disturbances. Chamove and colleagues studied 40 schizophrenic patients and compared their subjective and objective sensations in days of activity as compared to low activity days. Not surprisingly, activity was found to

be beneficial, including as a method of relaxation. And as many as 78% of patients with schizophrenia reported that they used exercise in some way to reduce hallucinations, in research carried out by Falloon and Talbott.

The news recently featured The Priory (private) hospital's latest physical exercise development: horse-riding. They may or may not have read Scheidhacker's research (in the original German obviously) on the benefits this gives to mentally ill patients. A mental health service user in the community is quoted in *Living Outside Mental Illness*:

*'I think this would be an excellent program for everyone because you connect with the animal and you connect with yourself and you're outdoors and it does something to you. It's hard to explain, but when you go home you think, "Wow, another lesson! Wow, I'm getting better!"'*

All sorts of other exercise options would also help their patients, including jogging and dancing. (Indeed, dancing offers the possibility of patients enjoying music as well as dance from their own cultures or communities.)

Whether for immediate or longer-term benefits, for its physical, emotional or social gains, exercise is an activity that should be routinely offered to all mental health in-patients.

## Recreation

Recreational activities (board games, cards – even bingo if people are that desperate) have benefits beyond simply counter-acting boredom. (Although that's a good start.) If one were to put a case to government for the 'functional' rather than pleasurable benefits of recreation, a good source would be Silverman's chapter on *Using Music Therapy Games with Adult Psychiatric Patients*:

*'Depression, anxiety and other disorders can leave individuals with social deficits. Interventions and practice, such as the use of games, to develop skills can reacquaint adults with psychiatric disabilities with healthy social interaction and positive use of leisure time. Music-based games can also be an effective intervention because of the diversity of game types: games can be co-operative, competitive, expressive, and involve strategy, thus bringing forth topics such as decision making, problem solving, team work, role identification, leadership and goal setting.'*

An arguably more 'normal' bunch of factors are given in an article by Charles Sourby about supporting people who are terminally ill:

*'Therapeutic recreation appears to contribute to palliation by providing the dying patient with an opportunity to maintain quality of life through an increased sense of control, social interaction, social supports, the accomplishment of task oriented goals, and by providing an appropriate medium for the expression of feelings as well as creativity.'*

Us funsters at the Star Wards project aren't advocating recreation as therapy – we're keen on therapy as therapy and recreation as enjoyment. While there appears to be no accessible research on recreation on acute wards (bit of a gap, that) there's an interesting article in the *Journal of Leisure Research* by McCormick et al about the experience of boredom among mental health service users in the community. They characterized the lives of people with severe mental illness as:

*'...marked by isolation with 'little to do during the day that they see as useful; they often experience their lives as meaningless and chaotic; and their general health status is often inadequate'. At the same time... leisure activity in the lives of this population appears to be strongly related to quality of life'*

*'Not every individual in the community welcomes and happily embraces free time. For some people, particularly when they have mental illness, leisure time may become a heavy burden because of persistent negative mood states such as boredom, anxiety and depression.'*

This research reinforces the importance of in-patients having a positive experience of recreation which has the potential of being continued when they're back home.

Cooking can be a pleasant way of spending an hour or two, especially if one doesn't aspire to be a domestic goddess. There are obvious benefits in terms of improving nutritional knowledge, which can have a direct impact on some people's mental as well as physical health. (See the Mental Health Foundation's report, *Feeding Minds – the impact of food on mental health*.)

Computers, and especially the internet, offer a seemingly infinite choice of recreational as well as informational opportunities, and ones that can



be engaged with even when you're feeling pretty out of it. The Mental Health Foundation have a stimulating factsheet *The Internet and People With Mental Health Problems* which includes a set of ways in which the 'digital divide' means that this is one of the groups missing out on the benefits of being on-line. Some acute wards have recognised this and are offering patients the chance to try out computers – in at least one place, through a hospital internet café.

What's the opposite state to being acutely mentally ill? One possible answer is being helpless with laughter. There's loads of research about the healing effects of laughing. We feel that anything called Laughter Therapy could be a bit naff, but the principle is great. Comedy evenings come in at number 14 in the Star Wards' chart and among the texts supporting the use of humour in health settings is Wooten's *Compassionate Humor*.

## Other ideas

You probably don't need any persuading at this stage that we've done our homework and can provide an evidence base for our ideas. Here's where to go if you want to check out some of the other ideas:

- Benefits advice – Fitch (2006) *Seeing Red – Debt and Mental Health*. Also [www.mhdebt.info](http://www.mhdebt.info)
- Supporting spiritual activity – Mental Health Foundation (2003) *Inspiring Hope – Recognising the Importance of Spirituality in a Whole Person Approach to Mental Health* and Sainsbury centre for Mental Health (2002) *Breaking the Circles of Fear*
- Patient mutual support – Lavoie (1995) *Self-help and Mutual Aid Groups: International and Multi-cultural Perspectives*
- No queuing for medication – Dubyna (1996) *The Self-management of Psychiatric Medications: a Pilot Study*



# Special issues

## Ward rounds or reviews

A reason frequently given for the challenge or even impossibility of carrying out activities with patients is the timing and disruption of ward reviews. A separate issue, which we won't address here, is that no-one seems content with how ward rounds operate, least of all patients. (*The Search for Acute Solutions* makes some suggestions for organising ward rounds in ways that are functional for all participants – see pages 53–58.)

While traditional 'ward rounds' are still taking place, it seems essential that the ward programme is sufficiently robust to withstand pressures to abandon sessions because of ward round demands.

## Special observation and engagement

The name most commonly used, 'special observation', is a real give-away. Having one-to-one support is currently about being 'observed' rather than actively engaged. Some services have renamed the process 'special engagement', which certainly sets it off in the right direction. It is by definition a very staff intensive activity, and one which many patients strongly dislike, so it needs to be used sparingly and constructively.

People are generally on 'special observation' because of the level of risk they pose to themselves and/or others. This can make them particularly hard to involve in constructive activity – or even conversation – but not necessarily. What's for sure is that if no efforts are made to do so, nothing positive will result and the exercise will be simply one of containment, and generally frustration for both patient and staff member. *The Search for Acute Solutions* noted: 'There was no expectation that patients on observation and the observer could be engaged in activities at the same time.' The report also made the following point about one of the possible antecedents of a period of special observation: 'The correlation between high levels of boredom and increased need for observation was still not sufficiently recognised.'

In an important and challenging article about formal observation, Nick Bowles and colleagues argue for its use to be seriously curtailed and note from their experience of introducing Refocusing

to wards (e.g. in Bradford) how constructive engagement with patients makes this possible. Diane Hackney describes vividly the humiliation and trauma of a very high (perhaps rigid?) level of observation: 'There is nothing more degrading than having to go to the toilet in front of a complete stranger.' The article concludes that:

*'...inappropriate over-use of formal observation as a custodial and defensive practice can contribute to a sense of dehumanisation and isolation within acute psychiatric patients; engagement may provide a genuine (i.e. not just linguistic) alternative.'*

*Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision* expressed the view that 'Many service users find the experience of being formally observed intimidating and for some it may be counter-therapeutic.' But special observation/engagement could be seen as an exceptional opportunity to provide focused support for someone who may well have a high level of complex social needs as well as of acute mental illness. For obvious financial reasons, it is usually the least skilled member of staff who is assigned this task. But placing one of the more skilled nurses with someone under special observation, if only for a few hours a day, could prove a turning point in the person's recovery. The hours of having one-to-one staffing could be profitably used for the patient to talk about their feelings, the reasons leading up to their admission, ways of coping more effectively in the future. Or even just in playing Scrabble. Recreational activities provide an unpressurised space in which to enjoy social contact and at best to build on the 'therapeutic alliance' between staff and patient.

It's ironic that one of the most expensive patient 'interventions' is disliked by the majority of patients who receive it. With even modest adaptation, special engagement could become a powerful, and speedy way of enabling patients to turbo-charge their recovery.

## Locked wards, or 'managed egress'

This issue is closely related to special observation and raises similar dilemmas about patient safety vs autonomy, the rights and needs of a majority of patients in relation to a minority, and how best to

deploy staff time. Of course there is also a central issue here of ward design. This is a complex and emotive issue and one that is being given careful consideration by Malcolm Rae, NIMHE's acute care joint lead.

Our view is that more scope could be made of placing in locked wards only those patients who need, or want, to be in a restricted environment. Other patients could then be in unlocked wards, preventing them from being unnecessarily constrained. There are many more practices which can feel, or be, coercive and disempowering, and if a ward is well run, with empathetic and engaged staff, having the exit doors locked need not feel particularly problematic. Especially if there are staff available to accompany you when you want to go out. Some patients positively like having the doors locked. When I was sectioned, I was initially terrified at the prospect of being on a locked ward. But after a couple of days, when I realised that I was on a very safe, well-managed ward, having locked doors contributed to my sense of security. I was on a single-sex ward and I was relieved that there was no easy access by men, whether other patients, visitors or 'strangers'. And improbable as this may sound, being on a locked ward strengthened my sense of the ward being a mini-community.

But this debate should become redundant once wards adopt the simple system of swipe card entry and exit, with the cards being restricted to those patients who aren't at risk from leaving the ward. One ward in the north has found this to work well and concerns about a roaring 'trade' in the cards have proved unfounded.

## **Agency and bank staff**

Along with the problems of ward rounds and lack of staff time, the third prominent factor cited for the lack of ward activity is the high use of agency and bank staff. Their lack of knowledge of the patients, ward and other staff limit their ability to work effectively with patients. The high cost of agency staff is a paradoxical double-whammy. Acute Care calculated that the national average combined bank and agency usage per week per ward was the equivalent of just over 4 full time members of staff. This points to the

linked problem of recruitment and retention of permanent staff, which is carefully examined in the recent review of mental health nursing by the Chief Nursing Officer.

One way of increasing the positive impact of bank staff would be to recruit at least some members of this team with creative and/or group skills. Combined with other necessary changes to ward culture and structure, they could help provide constructive engagement with patients. It would also be possible to recruit and train former patients for this role, and they would bring the additional insights, empathy and credibility from having had the same sorts of experiences as current in-patients.

## **Protected engagement time**

One of the recommendations of the London Collaborative is that staff should have periods of time (eg 1–3 hours) a day in which the ward is 'closed off' to external people and processes. This time has been successfully used by an increasing number of wards (not just in London) for one-to-one and group activities. There is a minority dissenting view that protected engagement time, can be or become, a reason not to engage with patients for the remaining many hours of the day. Some concern can also be heard about whether on some wards and/or at some times, rather than the experience being one of protected engagement time, it is simply a case of the ward being 'closed'.



# Making Mental Health Wards Great Places to Work

Henry Stewart

What can we learn from the UK's best workplaces?

Imagine that every mental health ward was staffed with highly motivated people who loved their jobs, were full of new ideas and believed their ward was a great place to work. Imagine the patients felt not only nurtured and cared for, but actively engaged throughout the day in activities that they enjoyed. This will be the case in some wards, but how do we get all mental health wards to feel like this?

One place to start is to see what we can learn from the organisations rated the best places to work in the UK, in the Sunday Times and Financial Times lists. My company, Happy (previously Happy Computers) has featured in the Financial Times Best Workplaces list, and we have met with many of the companies who top that list to find out what makes them special.

## When do people work at their best?

Think about your own experience, and times when you have performed at your best. I have asked this question of thousands of people and there is a very clear common theme to those peak performances. Very few occur when people are closely managed and told what to do. I would bet that your peak performance, like 95% of those I've asked, occurred when you were trusted and given freedom to decide how to do something.

One memorable example outside work was Sue, who decided to learn to swim at the age of 28. Now if we were managing somebody to do that we would arrange lessons, set targets and monitor progress. In contrast, Sue decided to learn when she was on holiday on a boat trip in Greece. She simply got all her friends in a circle in the deep water ... and jumped in.

The fact is that what people are prepared to do if they are self motivated and trusted to do it their way, is far beyond anything they can be managed to do.



Henry Stewart is Chief Executive of Happy, rated 11th best place to work in the UK, in the 2006 Financial Times Best Workplaces list.

## Great Management is about Getting Out of the Way

One of my favourite management stories is told by Robert Waterman in *Frontiers of Excellence*. An engineer called Tom Tribone found himself, at the age of 24, managing a small chemical plant employing 130 people. After some time there, telling people what to do in traditional management style, he realised that the plant produced only 2 million pounds a month of latex goo during the working day but almost doubled to a rate of 4 million at weekends:

To Tribone, this was an amazing statistic - the weekend blip. What was it about weekends? The conclusion was inescapable. The plant did better - two times better - when he wasn't around. Once he learned this the plant began setting production records. 'The most effective direction I could give my people was simply to log the orders that came to the plant and convey that data,' Tribone says. 'These folks know how to run the plant. If they knew what the customer wanted, and didn't have too much interference from me, they got it done.'

What could your people achieve if they were left free to do things the best way they could work out?

## **Freedom within Clear Principles**

I did have a friend who was told his entire job description was 'do cool stuff' (it was an internet company) but most of us need more guidance than that. And many of you reading this will be wondering what chaos could result if you give your people freedom to do whatever they want in their jobs.

Let me tell you the story of how Happy Computers adopted an approach that gives freedom but within very clear boundaries. In the very early days I was the only trainer. I was very confident in myself and felt the challenge, as Happy grew, was to ensure all the other trainers were as good as me!

When I started to employ other freelance trainers I would sit in on them and make detailed notes through the day of what they were doing right and what they were doing wrong. And then I would sit down with the trainer and feed it back to them in great detail. I was well intentioned but you will probably have guessed that this did not go down well. More like a lead balloon in fact.

I was making two mistakes all too common in management. First I was trying to create a clone of myself, doing exactly what I did. And, apart from its effect on motivation, this puts a ceiling on what can be achieved. The best a clone can be is as good as you. Secondly I was trying to create almost a process, where people do the same each time. There is no room then for innovation or improvement.

At the same time I didn't want the trainers to do whatever they felt like. People came to Happy Computers for a particular style of training, fun and involving. I didn't want them ever to sit and listen to a lecture, as was common at other training companies.

So I sat down with the other trainers and agreed a set of principles such as 'Don't tell when you can ask', still at the core of what we do. And they agreed a set of targets, based around the end of course evaluations. These were basically that the student had enjoyed the day and left confident in using the software.

The idea is that the principles and targets provide a flexible framework which allows innovation. As a manager I am happy if my person is working within the principles and achieving the targets. I don't need to approve – or even see – everything they do. It is a concept we call job ownership.

The result, 15 years on, is that the standard of training is far beyond anything I could have achieved. I am now rarely in the top half, on the company's quality ratings, when I do train. Two Happy trainers have been rated the UK IT Trainer of the Year, and two others have won Silver in these annual award. I couldn't have won that. And I couldn't have told people what to do to win that.

Those achievements have been the result of a great set of principles and, more importantly, the freedom to innovate within them. The result is the standard of training at Happy nowadays is far beyond what I could have told people how to do.

*Question: What are the principles (and regulations) that your people need to understand and work within? How can you make the framework crystal clear while giving people the freedom to work out their own way to achieve it - so it creates the landscape in which innovation prospers.*

## **Removing Levels of Approval**

Some years ago I was called into a charity to look at how to improve morale. Talking to staff there I found a lot of resentment around the lack of trust, exemplified by the fact that any external statement (such as a press release) needed three levels of approval. The result was that people felt untrusted and were not motivated to produce great work. One man said he often put stupid things into the press releases, just to see if anybody would spot them. After all, what went out was not his responsibility.

So what would you do to increase job ownership here? Some people respond that they would reduce it to one level of approval but this is missing the point as it still removes ownership. On the other hand the organisation explained that the approval was needed because they were working at the border of charity legislation and could be sued if they were deemed to be acting politically.

The question to ask is what the people three levels up know that those on the front line don't and how can we transfer that knowledge? To its credit the organisation took this on board and trained up front-line staff in the legal knowledge required. They were tested and, if they passed, certified to release press releases without approval.

The result was not just a higher level of morale but a more effective organisation, as it was able to respond much more quickly to the life-and-death issues it was dealing with.





Do you find yourself having to give, or get approval on a regular basis? Do things often get delayed because people are waiting for approval? How could front-line staff be trained or involved to enable them to make the decisions without needing approval?

### **Try Pre Approval**

Do you ever set up a group of people to tackle a problem or come up with new approaches, and submit their proposal to you? Try saying to them that whatever they come up with, it is 'pre-approved'. Now you have to make very clear the parameters, what they must be aware of and what budget they are working within.

A counter example was a medical help-line for a health charity I worked with, where the staff wanted to measure how well they were doing. They came up with six questions to ask at the end of every call and passed them up for approval.

Several weeks later came back the managers' 'improved' version. There were now 30 questions, clearly a total absurdity. But everybody who had seen it felt the need to be helpful and add their own contribution. Far better if the staff had been simply pre-approved to choose their own questions, and adjust them if they weren't working.

**Question:** Where could you pre-approve a group of staff to come up with new ways of working? (But remember, you have to resist the temptation to read their proposal and suggest improvements.)

### **Feedback**

Most of us get pitifully little feedback in our jobs, often only at the appraisal. Sometimes managers tell us how we are doing but research indicates they are three times more likely to criticise us for something done wrong than praise us for something done right.

Feedback in a normal job is a bit like playing a game of football where you only find out if you scored six months later, at the appraisal. And even then, you would only get the manager's interpretation of whether you have scored. Think how well even the Beckhams and Ronaldinhos of this world would do if they never knew whether the ball went in the back of the net.

*'Without information, people cannot take responsibility. With information, they cannot avoid responsibility'*

*Jan Carlsson, SAS Airlines*

How can we give staff on a mental health ward more feedback? Actually, it is incredibly easy as the customers are with you and have plenty of time on their hands. My suggestion is that every patient fills out a daily self assessment, at least part of which is shown to the staff on the ward.

This would be an assessment of themselves, not of the staff. It could include things that had gone well and any of a wide range of well-tested psychological questions that measure well being. Staff would be encouraged to review them and see what they could do to get measures higher. And yes, I said daily – feedback works best in encouraging changes in behaviour if it is immediate and can be related to what people have done recently.

Think of the effect. Suddenly staff on the wards could get a feel for how their patients were doing. They could see if playing cards with the patients or having a work out had a positive effect. It wouldn't be a direct measure of their work (as some patients would be much harder to shift than others), and would be best not used for management assessment but – with well motivated staff – could be invaluable feedback.

I believe the effects would be beneficial for the patients as well as the staff. One colleague of mine described the time he had been in deep depression but decided each day to write down what he had achieved. At first it was things like 'I left my room' or 'I tied my shoelaces'. Over time the achievements grew and recording them gave him a feeling of self-worth and belief he could recover.

**Q:** How can you initiate feedback on your wards?

### **A Blame Free Culture**

At Happy we have a belief in 'celebrating mistakes'. Literally if somebody comes to me and says 'I messed up big time' I say 'great, tell me all about it'.

And it is great, because it probably means they have been trying something new. And the fact they feel able to come straight to me and tell me (because they know they won't get blamed) means that, if they have just upset our best customer, I can deal with it – rather than finding out from the customer a fortnight later when it may be too late.

When told 'I've made a terrible mistake' I often respond by asking 'Oh, how many people died?'.

But it is, of course, important to check that nobody has died before asking that question or treating it that lightly.

On mental health wards, and throughout the NHS in general, there may be health consequences from mistakes. And celebration may not be appropriate. But the key question is whether mistakes are more likely in an environment where blame is common and people can't talk about things that go wrong, or in a blame free culture where mistakes can be openly discussed and learnt from.

Next time you get something wrong, try admitting it. It can be liberating to say 'I got it wrong' and not having to think up excuses or pass the buck.

### **Key Principle: People Work Best When They Feel Good About Themselves**

Think for a moment about whether you agree with this statement. If you do, then what should the main role of management be?

At Happy we believe the primary aim of management is to create a framework where people can feel good about themselves. Based on a principle of 'believe the best', our first response if somebody is underperforming is to look at whether they are being supported properly or if there is anything we can do to help them.

This is especially important on mental health wards where the entire goal is to help the patients to feel good about themselves. This is always going to be easier in an organisation that models making its staff feel motivated and positive.

Remember that statistic about managers spending three times as much time telling people what they've done wrong as what they've done right. Think of the effect on staff morale if you reverse it and spend three times as much time telling people what they did well.

*Question: What can you do to make your people feel good about themselves?*

### **The Best Places to Work**

I have met with people from many of the great places to work in the UK. And those workplaces are never places which are described as tightly regulated (even when they do have to work within clear legal parameters) or needing approval to do everything.

Some are large companies with fantastic benefits. But others, like Happy, are not. When we were first listed in the Financial Times Best Workplaces at No. 12 we did not even have a company pension scheme.

What these companies do have in common is that people who work there feel valued. They are given freedom and trusted to do the job well using their best thinking. Because those companies know that the resulting innovation and great service will be better for their customers, and therefore for the companies themselves, in the long run.

### **How do we get there?**

First, these changes can happen on any ward. They do not need a change in policy at the top of the NHS, or even at the top of your Trust.

If you are a manager, you can start encouraging people to act without approval. You can think about what people need to know to take wider responsibility, and set in motion the training to ensure they do.

If you work on a mental health ward, you can also try initiating ideas. You can make them more active places for your patients and you can implement ideas like the patient self-assessment.

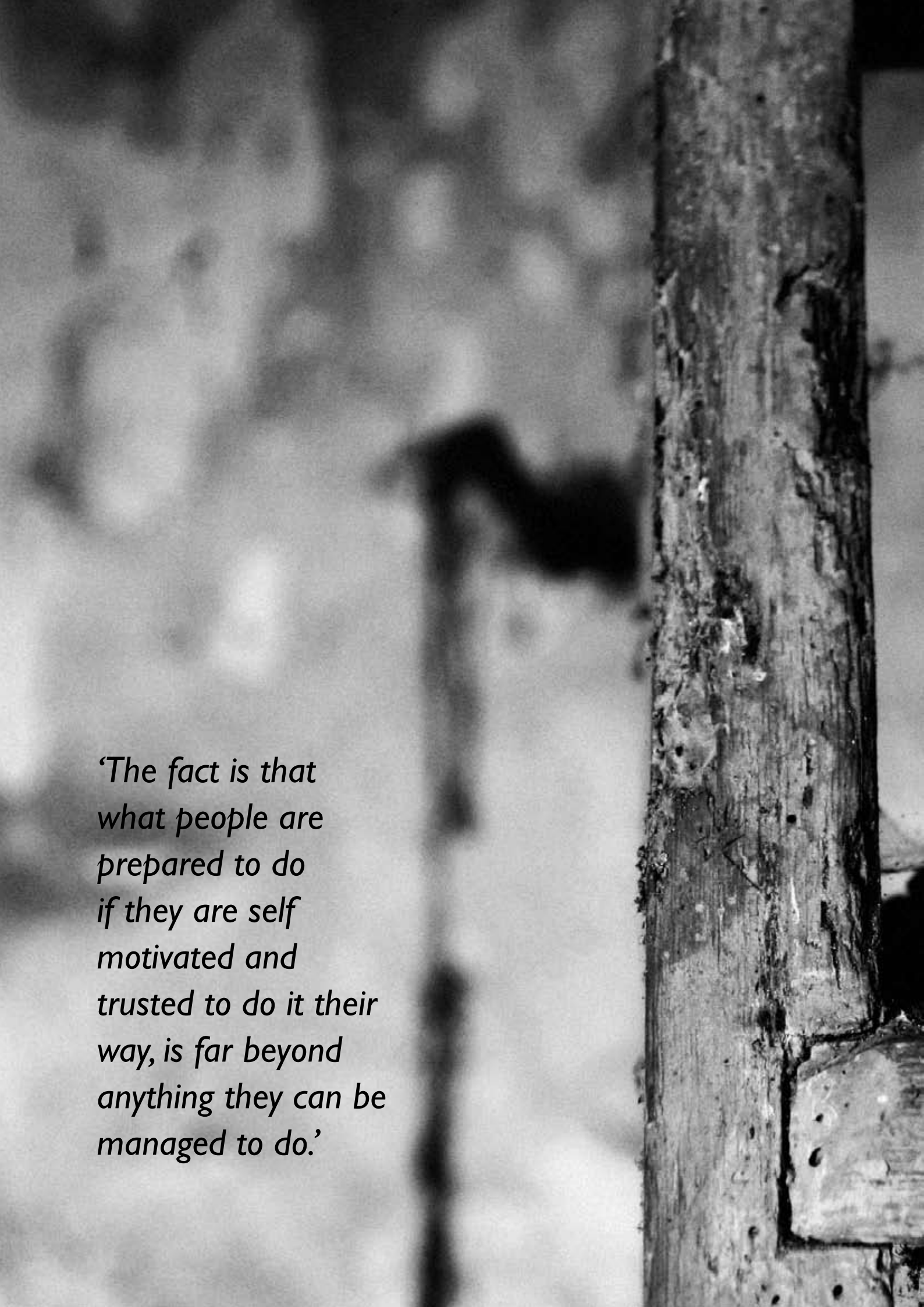
*Question: What first step could you take to give your people more freedom and remove levels of approval?*

### **What would your ward be like if every member of staff was completely trusted?**

This is a question I ask of many organisations and answers range from 'heaven' & 'I wouldn't have to worry any more' to 'complete anarchy'. There is a second question, which is how you move towards it, how you train and inform people to the point where they can be trusted.

*Is this goal worthwhile? Think about how you want our mental health wards to be. Should they be places full of unmotivated staff, where the focus is risk avoidance. Or should they be great places to work, where staff are full of ideas and trying out new ways to engage their patients? Which would you rather go to if you were to become a psychiatric patient?*





*'The fact is that what people are prepared to do if they are self motivated and trusted to do it their way, is far beyond anything they can be managed to do.'*





# Improving Patient-Centred Care: 10 Customer Service Tips



Phil Dourado is a journalist specialising in customer service excellence, and author of *Seven Secrets of Inspired Leaders*. Phil is currently writing a book with his family about their experience of living with Huntington's Disease.

The language and practice of 'customer service' doesn't always transfer easily over into health-care. Developing customer loyalty, for example, is a preoccupation among firms in the private sector lately. But, it isn't something we really want to encourage among patients: We want them to get well and not come back, rather than bringing them back for more!

That aside, if we carefully pick around some of the customer service 'best practice' that has been written up in journals and handbooks over the

past few years, we can find a few ideas for over-worked, over-stretched ward staff to make your life – and the lives of your patients while in your care – more satisfying. So here goes, starting with an icebreaker on how to make staff, and 'customers', happier...

## 1. Induce happiness

Happy staff lead to happy customers, according to the People-Service-Profit Chain, a framework developed at Harvard Business School in the late 1990s that focuses on improving customer satisfaction by improving staff satisfaction. If you and your colleagues are constantly stressed and unfulfilled at work, that mood will transmit itself to your 'customers' in all kinds of ways. Here's a tongue-in-cheek (or pen-in-teeth) idea for reminding you and your colleagues not to scowl at patients or each other unless you absolutely have to. It's from Stanford Professor Bob Sutton. Try it for a couple of minutes on your way into work:

*'Saying the phonemes e and ah, which activate smiling muscles, puts people in a better mood than saying the German ü, which activates muscles associated with negative emotions (Zajonc, Murphy & Inglehart, 1989). Simply activating one of the smiling muscles by holding a pen in the teeth (rather than with the lips,*

*Phil Dourado*

*which activates a frowning muscle) is enough to make cartoons seem more amusing (Strack, Martin & Stepper, 1988).'*

## 2. Listen to the grumpy people

Having said 'induce happiness', it's common for management to frown on staff who are always complaining. Don't. Encourage grumpy people to complain, rather than silencing them with disapproval, because they are usually your best source of improvement ideas. At Intel they teach all employees 'constructive confrontation'. Encouraging people to express themselves honestly this way prevents suck-up attitudes where honesty is suppressed in favour of not rocking the boat. For that kind of honesty you need to recruit a few grumpy people, says Professor Sutton of Stanford University again. Keep most of your people upbeat and persistent and 'can do'. But use grumpy people to bash existing practices and new ideas to test how customer-friendly they are. Grumpiness can be catching, however, and you don't want too much of it, so keep them locked in a cupboard to avoid contagion. Just wheel them out occasionally.

## 3. Think 'external customer control'

...instead of internal hierarchical control. In other words, acknowledge when designing or re-designing your ward's working practices that the customer needs to be in control, which means decision-making moves down to the frontline, away from management. It's hard for many managers to acknowledge that their role is not to accumulate power anymore, but to support frontline people in exercising their own decision-making. Allowing front-line people to design processes and even their job roles is based on the 'lean production' processes pioneered by Toyota. When this 'customer pull' as opposed to 'supplier push' model is applied to service organisations, it is known as 'lean service', because it strips out bureaucracy and unnecessary practices. Lean service consultants even have their own 'lean service' joke, which they like to tell corporate clients to break the ice before they present their not-so-lean bills. It goes like this:



*Sign seen outside an Australian gym  
'Fat and ugly? Why not just be ugly?'*

Involving customers in designing their own service or products is something carmakers and others are experimenting with lately. So, maybe get your ward members together to design their ideal ward or, more realistically, to come up with a list of improvements that they – and the staff – jointly put into practice. See below, point 4, for how galvanising it can be to give people more control over their own lives in this way.

#### **4. Connect people around a common cause**

What's the most powerful force in the Universe? The need to have some control and direction over our own lives; exactly the thing that is largely taken away by group living in a ward. So, create opportunities for people to 'do' rather than just be done to. Creating a customer community that allows patients to connect and to act around a 'mission' of some kind is one route.

One example of connecting people around a common cause that they find fulfilling can be seen in [www.join-me.co.uk](http://www.join-me.co.uk), set up by a redundant TV producer who recruited thousands of people to join him and then had to come up with a mission for them. He decided their mission would be random acts of kindness, which members had to report to the website, with an accompanying evidence to prove the kindness committed. Could you adapt this idea to get some of your patients united and active around a common cause – maybe educating people outside about what it means to be mentally well and unwell through a joint video project or writing a booklet together?

#### **5. Be a consumer**

Train station tannoy announcements: how come they are nearly always impossible to understand? Because the person broadcasting it isn't hearing what the customers down on the platform are hearing. So, it's often at the wrong volume setting. The obvious lesson? Be where your customers are. Spend a day a month or so in your patients' shoes. Be admitted. Go through, on the receiving end, whatever induction or settling in programme you have for new patients (what do you mean 'What induction programme?').

Yes, you are busy. Yes, your staff resources are stretched. Yes, this may seem like role play for which you have no time. But, it reconnects you

with what in the private sector and, increasingly, the NHS, they refer to as 'the customer experience'. By going through what your patients go through, you will spot an endless number of opportunities to improve the experience for patients.

#### **6. Small things make a big difference**

In a relationship, it's often the small things that drive you up the wall – the top constantly off the toothpaste, the dishes always in the sink. Similarly, for your patients, it's often the small, easily fixed things that diminish the quality of life. So, if a root and branch overhaul of your ward practices is too much for you (and them), try one improvement a week or even every two weeks. Maybe get people in the ward to vote on which procedure or practice or rule they find most infuriating and work on that for a week or two before moving onto the next one. Carmakers have been using this continuous improvement method – feeding customer complaints back to the factory to fix irritating problems at source – for years.

#### **7. Do you like your customers?**

The lateral thinker Edward De Bono summed it up best. He was doing some consultancy work with the Board of a major bank, trying to get to the bottom of why customers seemed to hate them. One of the Board arrived at a 'Eureka' moment: *'Our customers hate us because we act as if we hate them! No matter how we try to hide it or dress it up, they realise that we treat their money as if it's our money and see them as a nuisance. It kind of seeps through'*, reported De Bono.

Of course you don't hate patients (er, if you do, time to get out quick) but to what extent do your ward practices treat your patients as a bit of a nuisance, as getting in the way of work rather than being the reason you are all there? And to what extent do you take refuge in paperwork and other bureaucratic 'back office' work to get away from the sometimes intensive and perhaps tiring 'face time' spent one-to-one (or, more often than not, one-to-many) with your 'customers'?

#### **8. Ditch the jargon**

Deloitte Consulting created a computer programme it calls The Bullfighter. It sifts the 'bull' from company reports. Deloitte says The Bullfighter has discovered a direct link between jargon and business failure. When Deloitte applied The Bullfighter to a survey of America's top 30 companies, they found a recurring pattern: jargon and goobledgook increases as profits shrink.

The mental health profession – like all professions – is full of bureaucratic jargon which distances you from patients. In fact, that's the very reason jargon develops; to create a secret language the uninitiated are kept out of or have to learn if they are to understand you. So, seek out and destroy jargon wherever you find it. We are all overpowered by the volume of information pumped at us today. Jargon just makes it worse.

## **9. Try something new: live a life less ordinary**

*'Never be afraid to try something new. Remember that amateurs built the ark. Professionals built the Titanic.'* Dave Barry

Some degree of repetition is inevitable in any job at any level. That's what experience is: 'I've done this before. I know how to do it.' But, experience can lock you into ways of working that quickly become outmoded or just plain run of the mill. Yes, many of your patients will value routine and find change unsettling. But, that doesn't mean you have to bore them to death.

We need to leaven the repetitive stuff by regularly, deliberately doing something different, to maintain freshness. That doesn't mean changing your entire job; just ensuring you, and your people, have the freedom to try new things on a regular basis. It's about creating a life less ordinary at work.

## **10. And, finally...encourage patients to tell you off!**

'A complaint is a gift', the sunny optimists on the other side of the Atlantic say. They're right on this occasion. Here's a story from a hospital in Singapore that shows how useful it is to let patients tell you off regularly: Alexandra Hospital had one lousy service reputation: long waits, unkempt facilities, unpleasant surroundings, surly staff...and an unpleasant association with suffering in Singapore's history. The complaints were long and tempers often ran short.

A few years ago, a new management team took on the challenge of transforming this one-star hospital into a five-star service showcase. It took discipline, imagination and hard work. Today, Alexandra Hospital is developing a strong service culture and world-class patient care.

One of the culture-building tools used by the new management is 'Scolding Sessions'. These unusual sessions were described by hospital CEO

Liak Teng Lit, to service consultant Ron Kaufman, who wrote it up in his e-newsletter as follows:

*'We receive 1,000+ feedback forms from patients and their families each month. Most feedback is positive. About 5% is negative or gives suggestions for improvement. We contact this group and invite them to our patient focal group discussion. Typically 10 will come back.'*

*'Held over lunch on a Saturday, the sessions last about 90 minutes. We seat the patients in front in a circle. I chair the discussion. In my absence, the Chairman of the Medical Board or the Chief Operating Officer chairs. While attendance at these discussions is not compulsory, members of our management, clinical leadership team, nursing officers and supervisors are usually present. They sit behind to listen.'*

*'We tell the participants that we are providing lunch for them to scold us. Bad news tell us, good news tell others because criticism helps us improve while praise makes us complacent. I also 'threaten' to charge them for the lunch if they do not point out our weaknesses.'*

*'While the participants are making comments we do not attempt to give any response. I merely take notes and urge them to elaborate further. Usually the participants will bring out 40-50 upsetting points over an hour. When they are done, I apologise for our failures and briefly explain what we intend to do to correct our mistakes and weaknesses. Where we are unable to respond positively, I explain why we cannot.'*

*'Feedback obtained is tabled for discussion and action at our Quality Steering Committee meeting and other hospital and departmental meetings. We have been doing this every month for the past five years. The original intent was for our customers to help us identify our failures and also to obtain their suggestions. But we realised that we achieved much more.'*

*'Our staff, especially the senior doctors, got to listen directly from patients how they felt about our care and services. The emotions communicated through their words, tone of voice, body language and facial expressions could only be expressed in a face to face meeting like this. These sessions make us feel the pain of our patients and force us to be honest with ourselves. 'Scolding Sessions' have played a significant role in changing the culture of the organisation.'*

# The Star Wards' ideas

At the heart of the Star Wards project are 75 ideas for improving patients' quality of time and treatment outcomes. The crucial changes we would like to see are in relation to:

- talking therapies having as substantial a role as medication
- helping patients to enhance their own management of symptoms and treatment
- having a strong culture of patient mutual support, with the potential for this extending once they've left hospital
- sustaining a full programme of daily activities that doesn't just eliminate boredom but actively contributes to accelerating patients' recovery
- helping patients retain and build on their community ties

The ideas are arranged under seven main themes:

## 1. Recreation and conversation

## 2. Physical health & activity

## 3. Visitors

## 4. Care planning

## 5. Talking therapies

## 6. Ward community

## 7. Patient responsibility

Within each theme, we list three stages:

*'Tweaking' suggestions require minimal changes to current staffing arrangements, at little or no cost.*

*'Turning' suggestions take things further and require some staffing changes and new resources*

*'Transforming' suggestions are the biggies – ideas which probably require the most investment.*

All ideas are suitable for patients who are sectioned and unable to leave the ward. For those who *can* leave the ward, many of the suggestions are adaptable for use in the community, which should usually be the preferred option. For example, some wards use local gym facilities and even have 5 a side football at the local football club. Others could take on an allotment for patients who'd like to do some gardening. Blurring the boundaries between the hospital and the outside community is vital not just in terms of the quality of those experiences. It also challenges the stigma of being a mental health patient.



## 1. Recreation and Conversation

### Tweaking

1. Each ward has, for example, **5 board games, a TV and VCR/DVD** + 20 videos/DVDs
2. **Volunteer(s)** on ward for at least 3 hours a day. Volunteers' energy and particular skills are ideal for generating recreational activities which are otherwise engaged in by only a minority of inpatients .
3. Each ward has a good **library** of easy-reading novels, including in local minority languages, and self-help books

### Turning

4. **Bank staff** are specifically recruited for their skills in running group activities. This would help turn what is a negative (bank staff not knowing and therefore not engaging with patients) into a positive – a satisfying role for bank staff and well-run activities for patients.
5. Shift in perception, role and support of **domestic staff**, who 'are often experienced as particularly approachable.' (*Not Just Bricks and Mortar*) 20% of their time could be direct contact time. There are additional communication benefits to this when both staff and patients have the same mother tongue.
6. Getting hospital's **non-medical staff involved** (catering staff, admin, management) - e.g. an hour a week visiting a ward. Focus could be sharing a skill, hobby, experience or just schmoozing.
7. **Volunteer co-ordinator** appointed. No large healthcare institution should be without this crucial, cost-effective post.
8. **Artwork** is commissioned, borrowed and displayed. It's not just about improving the ward environment; having attractive, interesting or challenging paintings provides a source of conversation and inspiration. Some local libraries run art borrowing schemes, and there's the excellent Painting in Hospitals charity. Artwork by patients can also be displayed
9. **Cooking** in the ward kitchen is encouraged, and is one way of helping patients from minority communities enjoy culturally appropriate experiences.



## Recreation and Conversation, cont.

### Transforming

10. **Activity co-ordinator** assigned for each ward, to organise activities, including evenings and weekends, working with patients to ensure these activities are interesting and relevant and that the programme interfaces with other therapeutic and occupational therapy programmes. Co-ordinator likely to be one of the nursing staff but could also be an OT or other professional
11. **Community groups**, including BME groups, hold regular sessions in hospital - e.g. photography, gardening, Jewish table tennis
12. **Internet connected computers** for each ward. Unbeatable for information, recreation, skills-building. Could set up an Internet café.
13. **Hospital facilities** include gym, multi-sensory room, music room, computer room, multi-faith prayer and chill out room, lecture theatre (sic), well-stocked library of recreational, reference and self-help books. Who could forget the centrality of the library in Shawshank Redemption? (Different institution, same principle.) Books could be donated through GPs' surgeries as well as innovative book schemes which would bring neighbours into the hospital.
14. Regular **comedy evenings** are arranged, with DVDs, guest comedians and discussions about people's favourite humorous films, books and comedians.
15. **Community Service Volunteers** are recruited, to chat with patients and share other social and recreational activities.



### Creating a Star Ward

#### Recommended games

Scrabble  
Monopoly  
Mastermind  
Boggle  
Connect 4  
Rummikub  
Cards  
Chess  
Jenga  
Sudoku puzzles  
Rush hour, Stormy Seas, etc.

www.gameslore.co.uk has a massive stock of board games as does www.games-web.co.uk and www.boardgamecompany.co.uk



## 2. Physical health and activity

### Tweaking

16. Each ward has an **exercise bike** and/or treadmill. Putting it within viewing distance of the TV would help motivation, as in the best gyms
17. Patients can have individual appointment with **pharmacist and/or dietician**
18. **Walking groups** are held regularly

### Turning

19. Half an hour of **exercises each day** are led by a suitably trained person, whether member of staff or volunteer. Stretching, yoga, Tai Chi – physically and emotionally strengthening
20. Advice and encouragement given for **healthy eating and giving up smoking**.
21. Patients encouraged to help in the **garden**. Gardening can be enjoyed as a solitary or group activity, can be soothing or stimulating and some people will be able to sustain this interest when they are back home. In winter gardening can be indoors, with house plants and cultivating seeds.

### Transforming

22. A physiotherapist or sports trainer visits ward several times a week for **group exercises and individual coaching** and planning.
23. All patients who want one, leave hospital with an **exercise plan**.
24. Patients can choose to have a **physical health check**.



### Creating a Star Ward

#### Resources and spaces

Books & magazines could be donated via local GPs, health centres etc - novels, self-help books, puzzle books  
Self help tapes, plus equipment to borrow  
Child friendly area on each group of wards with toys for small children





### 3. Visitors

#### Tweaking

25. As soon as they are admitted, patients are given **written information** about visiting arrangements.
26. Patients are actively encouraged to maintain their **social and family links** while in hospital, not just through care planning but in everyday conversations with staff. Similarly, the ward culture is welcoming of visitors, e.g. by making transport, phoning and visiting details easily available by phone, post and Internet and offering visitors refreshments on arrival.
27. There is a **private, attractive room** where patients can meet with their visitors.
28. **Good quality magazines, board games and cards** are available in the visitors' room.

#### Turning

29. There are **flexible visiting hours** and patients and visitors understand the rationale for when visits aren't allowed.
30. **Information for carers** is available on the ward and elsewhere in the hospital, e.g. the café.
31. **Obstacles to arranging visits are minimised** – e.g. patients without money, or needing particular privacy, can make phone calls from the staff office; patients with literacy problems are helped to write letters.
32. There are **pets as visitors and/or as residents**. The therapeutic benefits of being with pets is well-proven, and (like artwork), they can be borrowed – from staff or from the charity Pets As Therapy. Visitors could also bring in patients' own pets, as separation from pets can be distressing. Simple solutions can be used for times when it's not appropriate to have an animal on the ward, e.g. wards pairing up for pet sharing.

#### Transforming

33. There is a **visitors' budget** for each ward, covering things like travel costs and games for kids. It could be managed by patients, providing another source of contact and autonomy.
34. The hospital runs a range of friends and relatives, and carers **support groups**.
35. Staff including the volunteer co-ordinator and chaplains are imaginative in **facilitating visits** from local volunteers, members of patients' faith communities and others for those patients who would otherwise not have anyone coming in to see them.



### 4. Care planning

#### Tweaking

36. **5 day structure used for themes**, e.g. Mon. mental health, Tue. physical health, Wed. occupation, Thur. relationships, Fri. home. This simple idea could have a huge impact, by being an ice-breaker not only between staff and patients but also between patients. It also offers a framework for inviting in relevant community and specialist organisations.
37. **Minimum ¼ hour with key worker** or another member of staff to discuss relevant issues of that day's topic. This would configure the CPA into manageable daily chunks, and would fit well into the use of personal recovery files and workbook.
38. **Employment status** is recorded on admission, to ensure those employed are given immediate help to retain their job.

#### Turning

39. **Designated member of staff with care planning remit** on 9 - 5 weekdays. Having a key worker, or named nurse, is beneficial but leaves a gap when they're not on duty.
40. **Advice on benefits** is provided through leaflets, application forms, CPA planning, help with phone calls and sessions run by the local Citizens Advice Bureau.
41. Patients get a **leaving pack**, with information about benefits, mental health and local services – some local Mind groups produce comprehensive service directories.
42. Pre-printed sheets with **quick-ticks** are used rather than hand-written notes wherever possible – e.g. for 'patient asleep', or 'patient enjoyed evening activity'. The time saved can be used for making notes in consultation with patients, or in other care planning conversations with patients.

#### Transforming

43. **Personal Recovery File** for each patient. This would consist of a ring binder into which patients would keep their care plans, daily and weekly timetables, notes from therapy sessions and 'homework' (eg for CBT) and also a record of their feelings each day (see page 43).
44. Patients can, but don't have to, **take the lead in aspects of care planning** e.g. convening meetings, deciding who to invite, etc.







## 5. Talking Therapies

### Tweaking

45. **Self-help books** – the best of these are relatively easy to follow, particularly if there is someone to go through the key points with you. Ideally patients who could benefit from these would have a copy to take home. (Perhaps in the 'turning' or 'transforming' scenarios.) Could include relaxation and self-help tapes personal tape system to borrow.
46. **'Protected engagement time'** for nursing staff – the ward is closed to all visitors, including other professionals, to provide opportunity for staff to talk with patients
47. **Women's and men's groups** take place and other culturally specific groups such as black identity or black history.

### Turning

48. **Psychology assistant** for each ward. Psychology graduates, suitably supervised, can provide valuable specialist input.
49. Weekdays, at least one member of staff has **counselling qualification (or equivalent)**.
50. **Each patient has at least one hour of therapy or recovery management a day:** diagnosis related (eg eating disorders), treatment related (eg CBT), creative therapies (eg drama therapy). Group therapy could be carried out across wards, especially for inpatients with a minority condition, e.g. body dysmorphic disorder.

### Transforming

51. **Full day's programme of therapy groups** available. This is achieved in private hospitals and is felt robust enough to charge whacking great fees for.
52. **Placements for student counsellors**, providing one-to-one sessions. These would augment the work of fully qualified therapists and counsellors and would offer something beyond a 'listening ear'
53. **Individual talking therapy** for all who need it, with continuity when patients leave hospital. It's ironic that talking therapy was common if not the norm, in previous decades.
54. On-ward and cross-ward involvement of **OTs & creative therapists** (e.g. drama therapists).
55. **Core programme** of on- and off-ward activity (see page 46).
56. Patients can choose to use a **Personal Recovery Workbook** (see page 48).
57. Each ward has mini-library of **Mind information leaflets** and hospital library has full range.



## 6. Ward community

### Tweaking

58. Day begins and ends with **ward community group**. This is established practice in many residential therapeutic communities.
59. **Prayer, faith & cultural meetings** are supported. This would take a combination of staff support, a hospital culture of religious diversity and absence of actual or perceived dominance of one faith, and the provision of a quiet room which can be used by people of different faiths, and none, for prayer and contemplation.
60. **'Buddy system'** encouraged so that well-established patients supporting new patients with the ward routine, geography and people.

### Turning

61. Patients are encouraged to **support each other**. This can be structured e.g. by a nurse facilitating two patients sharing similar experiences and coping strategies, but equally important is a ward culture which values patient mutual support. Staff training should emphasise this as an area which could best be delivered by service users. The benefits of mutual support include:
  - Identifying people as someone who can help, not just be helped
  - An equality and balance of relationship
  - People can empathise from a position of direct experience
  - The source of support is very credible and unthreatening
  - Service users invariably generate valuable techniques and problem-solving ideas for dealing with their situation
62. Different faith communities' **festivals** are celebrated. This will console those patients in hospital around November and December who get the chance to enjoy Diwali, Chanukah and Christmas.

### Transforming

63. Patients are encouraged to **continue to support each other** once they leave hospital. This brings the strong benefits gained by new mothers who continue to see friends made in National Childbirth Trust classes, and by people on programmes such as Alcoholics Anonymous.
64. **Each ward has recreation budget** (e.g. £20 a week) which patients decide. This provides a useful focus for some of the community meetings and reinforces patients' responsibility for their own and each others' well-being. This model is relatively developed in supported housing.
65. Patients run **'special interest groups'** on their own and other wards, based on their skills and hobbies. How nice to leave hospital having picked up a bit of Yiddish or some achingly hip fashion tips.



## 7. Patient responsibility

### Tweaking

66. **No more queuing for medication!** Each patient has system (chart, alarm clock, whatever) and asks for medication. This would take more staff time than the current infantilising arrangement, but would not only reduce unnecessary humiliation while in hospital but would also help patients establish medication routines they can sustain when back home.
67. Patients write their own **profile** for staff, with information about themselves, their mental health, their treatment and anything else they want staff to know. A valuable resource for staff and empowering for patients.
68. Patients have **copies of their care plans**. This requires lockable personal storage, which is pretty essential in itself.
69. Responsibility for keeping **'public' patient information displayed** up-to-date. This is a manageable task and would be appreciated by other patients, and by staff who don't have to do this. Could be the end of notices stuck up advertising a bingo session that took place 5 months ago.
70. Patients have **their own diary** to keep track of groups, appointments etc.

### Turning

71. **Ex-patients involved in staff recruitment.** This has been long established practice in homes for people discharged from long-stay hospitals.
72. **Involvement in how the ward** is run e.g.
  - How staff time is spent
  - How patient time is spent
  - Use of spaces, e.g. for smoking, loud music
  - Patient movement – e.g. ability to go for walks, including sectioned patients
  - Locked door (or 'managed egress') policy and practice
  - Decisions – e.g. with budgets eg Ward Environment £5k initiative
  - Welcoming new patients, going through info booklet with them
  - Access to ward kitchen for preparing snacks including culturally preferred food (perhaps not chip butties or fried Mars Bars, but Halal-pies, gefilte fish etc.) and for ward staff to support people in preparing for discharge by doing some of their own cooking as part of their therapeutic programme.
73. Patients complete a **self-review** at the end of each day. This would provide the opportunity for reflection on their mental health progress and could be used as part of their care planning. It could also contribute to the feedback that staff receive about the impact of their work.

### Transforming

74. **Each patient has 'recovery budget'.** This is an extension of ippr's recommendation of personal recovery budgets for mental health patients. There could be advocates for people not able to manage this budget
75. Some patients can **extend their stay** by a day or two to support new patients. If this isn't possible, then during the last day or two of a patient's stay, some people can be encouraged to help other patients with care planning, learning new self-management techniques etc.



## A core programme

Having an overarching structure for therapeutic and other activities may well contribute to safeguarding their delivery and quality, and also support wards in their work to achieve and sustain national standards. One model would be similar to schools' literacy hour and national curriculum, with wards providing x hours of talking therapy, y hours of recreational activity etc, and with specified programme outline. Unlike schools, however, this core programme wouldn't be a fixed, centrally imposed requirement.

The idea of a core programme overlaps to some extent with the Care Programme Approach, but is more oriented to the patient's skills' development. The following groups are already being run in some hospitals (on acute wards and in day hospitals).

### 1. Mental health

- core emotional well-being skills e.g.
  - breathing/relaxing
  - affirmations
  - visualisation
  - thought records (CBT)
- medication (pharmacist)
- anger management
- stress management
- relaxation
- **Stages of change** based addiction-quitting, self-help techniques for smoking, drinking, drug use, self-harming, gambling

### 2. Creative & expressive

- drama therapy
- art therapy
- music therapy
- yoga
- groups run by volunteers e.g.:
  - book group
  - media group (like book group but TV instead)
  - music group
  - gardening

### 3. Personal protection

- legal rights - e.g. DDA
- DSS benefits - the main disability ones
- Financial management
- basic self-defence
- crime prevention
- assertiveness
- first aid (including dealing with addiction-related emergencies)

### 4. Relationships

- men's groups, women's groups
- positive parenting

### 5. Employment

- Social skills/employment preparation group
- Vocational specialist provides leaflets, advice sessions on work and training.
- Occupational therapy assessments to focus on work aspects.

These sessions would need to be provided on an opting-in (rather than obligatory) basis, and patients would be more likely to attend, and to benefit, towards the end of their stay when acute symptoms have partially subsided. Each patient would need to have their own programme. Some activities, for some patients, would best be provided by patients from different wards who have similar emotional and/or practical needs. (See the **Sample Ward Programme** below for an idea of what a week might look like.)

Achieving this sort of guaranteed constructive input for patients would be a particularly good way of making best use of nursing and other staff skills, very much in line with the recent Chief Nursing Officer's review of mental health nursing.



## Creating a Star Ward

### Sample Ward Programme

#### Monday to Friday

10.00 – 10.15 – ward planning meeting

10.30 – 12.00 – emotional support and development, including discrete or combined sessions of:

Talking therapies, delivered by trained nurses, psychologists and psychiatrists, on an individual and group basis

Symptom management

One-to-one sessions with key worker

2.00 – 3.00 – information sessions (eg DSS benefits) including ones run by local voluntary organisations (eg Mind, CAB)

4.00 – 6.00 – recreation activities

#### Weekends

Mainly recreational activities, including those shared with visitors (friends, family and volunteers). Staffing timetabled to allow for one-to-one sessions of quarter of an hour a day for each patient.

## Personal Recovery File

Each patient being admitted to an acute mental health ward could have their own Personal Recovery File which would be a combination of:

- Information resources
- Feelings journal
- Care planning

It would be in ring-binder format to allow patients to choose what information and other resources they want. (Display folders with plastic folders could be used for patients who might self-harm with the metal rings.) On arrival, only the minimum of information necessary would be offered – e.g. details about the ward, visiting arrangements etc. The file would include blank paper for people to use for their journaling (writing how they're feeling and their thoughts) and also booklets such as those from the Mind series – e.g. *How to Cope with Hospital Admission*.

Each hospital and ward would create their own information resources. Patients would choose from these according to their needs, e.g. for information on drugs, or on a particular DSS benefit.

Lilacs ward, St George's Hospital has created an excellent patient information resource, which covers what patients need to know about the ward, the hospital, and includes a resources list of local and national services.



### Creating a Star Ward

#### Personal Recovery File

The contents of a Personal Recovery File might include:

1. *About me*
2. *Daily feelings*
3. *Care plan and weekly timetable*
4. *Hospital & ward*
5. *Illness & treatment*
6. *Alcohol & drugs*
7. *Physical health*
8. *Money*
9. *Contacts*
10. *Other notes*

*'Staff at The Lakes in Colchester developed self-held personalised recovery folders which developed over the period of admission and showed the person's recovery journey. They could include care plans, information about individual and group interventions/opportunities, assessment documents, medication information, records of therapeutic work, reviews and any other information the service user chose to include. The service user took their folder away when they were discharged.'*

*The Search for Acute Solutions*

The survivor activist Liz Mayne described on BBC's Ouch website the idea of service users providing information about themselves for mental health staff. The 'About me' section would start with a sheet for patients to write what they want nurses, psychiatrists and others to know about them. It could have a series of simple prompts, e.g.:

*I am* (This would offer the opportunity for people to say whatever is most important to them about themselves, whether it's about their lifestyle, family, mental health or their feelings about being in hospital.)

*This is how I feel about:*

- My mental health diagnosis or condition
- My medication
- Other mental health treatment
- Being in hospital
- Leaving hospital

*At the moment I'm particularly concerned about:*

A small but important detail is that the front of the Personal Recovery File would have the patient's name on it. There is a real risk of de-personalisation in hospital, especially when patients may be at their most vulnerable on admission. The simple act of having your own name on a resource created for and partly by you could have a very positive effect on patients' self-esteem, in addition to the intended benefits of the contents. Similarly, having in one's possession some or all of one's care plans would go a long way to equalising the perceived power imbalance between patients and staff. There would be issues of confidentiality, but these could be overcome by a combination of locked storage for each person and the facility to have one's PRF lodged with staff at least some of the time.

The PRF would build up to a valuable personal resource and by patients taking it home when they leave hospital, it would be one of the positive outcomes of their time in hospital.





## **Personal Recovery Workbook**

MDF, the Bipolar Organisation, has for many years supported people with bipolar disorder to self-manage their symptoms. Other organisations are also developing self-management training and resources.

A guided self-help resource, such as a Personal Recovery Workbook, would be a fabulous supplement and aid to the support patients get from staff.

As a workbook, it would have a mixture of small amounts of information but mainly space for writing down one's plans and concerns in relation to each topic.

Some wards are already using a resource of this kind, the WRAP book (see *page 10*). Others may want to develop their own version, with input from service users, carers, specialist charities and clinical psychologists, including diagnosis and acute care specific elements.

Whether an off-the-shelf or custom-made one is used, clearly it is important that staff encourage and support patients to use this, both by themselves, with other patients and as one strand in one-to-one sessions.



### **Creating a Star Ward**

#### **Personal Recovery Workbook**

A Personal Recovery Workbook, would aid the support patients get from staff.

Its contents might include:

- Understanding your diagnosis
- Managing your symptoms
- Managing your medication
- Stress management



# Star Wards – At A Glance Guide

## Tweaking

### Recreation & conversation

1. Board games, a TV and VCR/DVD
2. Volunteer(s) for at least 3 hours a day
3. Ward & hospital libraries

### Physical health & activity

16. Exercise bike and/or treadmill
17. Individual sessions with dietician and/or pharmacist
18. Walking groups

### Visitors

25. Written info about visiting given on first day
26. Family/friends links nurtured.
27. Private visiting room.
28. Mags & games for visitors' room

### Care planning

36. 5 day structure used, with different topic each weekday.
37. Min 1/4 hour with key worker to discuss daily topic
38. Employment status recorded on admission

### Talking therapies and self-management

45. Self-help books and tapes.
46. 'Protected time' for nursing staff
47. Women's and men's groups

### Ward community

58. Ward community group meetings
59. Prayer, faith & cultural meetings
60. 'Buddy system'

### Patient responsibility

66. No more queuing for medication!
67. Patients write own profile for staff
68. Patients have copies of their care plans
69. Patients keep displayed information up-to-date
70. Patients' diaries

## Turning

4. Bank staff recruited to run group activities
5. Domestic staff are encouraged to interact with patients
6. Hospital's non-medical staff involved
7. Hospital volunteer co-ordinator
8. Artwork commissioned, borrowed, displayed
9. Cooking on the ward

19. Half an hour of exercises daily
20. Advice on healthy eating and giving up smoking.
21. Gardening

29. Flexible visiting hours
30. Good info for visitors & carers
31. Help with visits e.g. with phone calls
32. Pets as visitors and residents

39. Care planning remit
40. Benefits advice
41. Leaving pack of information & advice
42. Quick-ticks used rather than notes whenever possible

48. Psychology assistant
49. Someone on duty has counselling qualification
50. Option of at least one hour of therapy or recovery management a day

61. Patients' mutual support
62. Faith festivals celebrated

71. Ex-patients involved in staff recruitment and recruited as staff
72. Patient involvement in how ward is run
73. Patients complete a daily self-review

## Transforming

10. Activity co-ordinator
11. Community groups hold regular sessions
12. Internet connected computers
13. Hospital has full suite of activity rooms.
14. Regular comedy evenings
15. Community Service Volunteers support social activities

22. Physio or sports trainer
23. Exercise plan
24. Optional physical health checks

33. Visitors' budget, managed by patients
34. Friends, family & carers' support groups
35. Visits arranged for the visitorless

43. Personal Recovery File
44. Patients can take lead in care planning

51. Full day's programme of therapy groups.
52. Student counsellors
53. Individual psychotherapy
54. OTs & creative therapists
55. Core programme of activities
56. Personal Recovery Workbook
57. Ward has mini-library of Mind leaflets and hospital has full range

63. Patients mutual support after hospital
64. Recreation budget controlled by patients
65. Patients run 'special interest' sessions in own or other wards

74. Each patient has 'recovery budget'
75. Patients extend stay by day or 2 to support new patients

'Tweaking' suggestions can be done with minimum changes to current staffing arrangements and at little or no cost.

'Turning' suggestions build take things further and would require some staffing changes and new resources

'Transforming' suggestions are the ideas which probably require the biggest investment.



## Creating a Star Ward

### The best of...

#### Biggest impact

- Hospital volunteer co-ordinator
- 5 day structure with different theme each weekday
- Benefits advice
- Personal Recovery File
- 'Protected time' for staff contact with patients
- Core programme of activities
- Full day's programme of therapy groups
- Individual psychotherapy

#### Most radical

- Bank staff recruited for group activities' skills
- Hospital non-medical staff involved
- Personal Recovery Workbook
- Patient mutual support, including for when they leave hospital
- Each patient has 'recovery budget'
- Medication self-management
- Patients can extend stay by a day or 2 to support new residents

#### Least expensive

- Domestic staff involved with patients
- Artwork commissioned, borrowed, displayed
- Patients do gardening
- Family/friends' links nurtured
- Patients have copies of own care plans
- Using quick-tick pre-printed forms
- ... and almost all the ones which involve patient self-management and mutual support

#### Most fun

- Regular comedy evenings
- Pets as residents

#### Kindest

- Visits arranged for the visitorless
- Visitors welcomed
- Support groups for carers, family & friends

#### Most likely to over-excite health & safety folk

- Gardening
- Cooking
- Exercise bikes & treadmills
- Patients running 'special interest' sessions (especially any which involve lifting or exerting limbs)



## Creating a Star Ward

### Ward ideas' chart

Appendix 1 (see page 59-61) for an interactive resource – a chart which wards can use the chart to write down their own versions of some of these ideas, and also to note action

# Geoff's day



8AM, Monday morning, Bono Ward.

Geoff Cohen is woken up by the sound of clattering crockery and cutlery. He grunts good morning to his neighbours, washes and dresses.

'No bacon for you, young man' says one of his room-mates, Devan, whose turn it is to serve breakfast. Geoff grins weakly and reaches for the aeroplane-type dish marked 'Kosher'. Sitting himself next to someone he doesn't recognise, he's relieved that there's a newspaper on the table so that he doesn't have to struggle to make conversation so early in the morning.

'Hello, I'm Geoff.'

'Hi. I'm bewildered. Bewildered of Cricklewood. Better known as Mike.' Geoff smiles and picks up the paper. He hopes that Mike has been fixed up with a ward Buddy to help him get used to being there.

After breakfast, Geoff unlocks the top drawer by his bed and takes out his medication chart. The proposed change in medication hasn't been implemented yet as he's sceptical about its benefits and worried about its side-effects. Sonia the pharmacist is coming in later to discuss this with him; in the meantime he goes to the staff nurse to collect his usual medication. They both sign his medication chart, and the one that the ward keeps. Geoff wonders whether Mike will remember to ask for his medication, and whether his Buddy will remember to remind Mike. It seems a shaky system compared to making a disorderly queue and having the medication dished out by staff. But Bev the ward manager said that it works well in practice and also helps patients manage their medication better once they're back home.

There's 40 minutes before the daily ward meeting, and Geoff slumps in a chair in the day room. He feels... crap. Everything in his head is dark and he starts his familiar, comfortingly negative, ritual of listing why he will never be able to find another job or partner and why this means his depression is permanent. Retreating to bed seems the best plan for now.

Having the independence and privacy to do this feels like a small luxury, having been 'specialied'

for his first week in hospital. At the last ward round, the consultant accepted that although Geoff thought a lot about suicide, he was no longer making active plans and that he was safe without one-to-one staffing 24 hours a day. Although most of the staff who had been on special engagement with him had been good-humoured and empathetic, it was still grim having someone trailing around with you. He'd tried not to feel guilty about the cost to the ward budget of this intensive staffing, and was relieved that the person with him could at least help run activity groups provided he was within their sight, or preferably in their group.

9.30 comes too quickly and the prospect of the ward meeting is unappealing. He'll stay in bed. He's got an urgent task to do, i.e. go over and over; why his life is terminally hopeless. It helps explain and make tolerable his feelings of paralysis and despondency. Curling up, he hears footsteps approaching his bed. It's Devan.



'Come on mate. The ward meeting will be even duller without you.' Reluctantly Geoff manoeuvres himself out of bed and slouches along to the day room.

The ward meeting is briskly chaired by a volunteer from the local mosque. Mira runs through the ward's programme, reminding the 8 patients who have made it to the meeting that Monday is 'physical health' day. Geoff finds the theming of each day contrived but remembers that last Thursday ('money day') he did have a very useful conversation with the man from the Citizens' Advice Bureau. He can't accept that he is 'disabled', but he can put up with labelling if it means £40 or so a week from Disability Living Allowance.

The main item for discussion is the week's recreation budget. Indifference greets scepticism as all eight avoid catching Mira's eye. Finally Tony suggests that £5 could be splashed out on renting the new Jennifer Aniston DVD and a few grunts get this proposal agreed. It seems to wake up Arun who would like a new game for the ward PlayStation. Geoff appreciates the democratic nature of the ward meetings and wonders about suggesting next time that they get in some more self-help books for the ward mini-library.





10.00 and the bed beckons, but Trish, the upbeat health care assistant, intervenes and Geoff agrees to go to the cognitive behaviour therapy for depression group, being held in the next door ward. He remembers to bring his Personal Recovery Workbook with him, so he can refer to notes made at the last CBT group and bung in ones from this time.

Time for a fag break, and a schmooze with the other smokers. Mercifully, today he's spared yet another Groundhog Day repeat of the possibility of smoking being totally banned in mental health hospitals. Instead, conversation meanders between the chances of his team surviving in the Premier League and the disappointing absence of illegal substances on the ward. (Surely no-one takes seriously warnings such as the one in the public loo imploring 'No Drug Taking?')

Lunch is another kosher special, a slightly limp moussaka. A dish which has yet to hit the plates of Golders Green diners but has enough redeeming features to be enjoyed not only by Geoff but by his Muslim co-CBT-groupy, Ali. In a pleasant and surprising splash of relaxed hierarchy, Franczys the ward domestic joins them for lunch.

Geoff grabs the John Grisham book he's borrowed from the ward, and settles down for a quiet read.

Weekday afternoons have been designated as 'protected engagement' time on Bono ward. No outside visitors, even consultants, are allowed in and this gives all four staff on duty the time to work directly with patients. There is a choice of art therapy or a film discussion group, and Geoff opts for the art. When he'd arrived in hospital and was told about the art therapy, he'd anticipated a ghastly mix of Freudian Playschool. But the art therapist, Bill, looks like a 70's biker so Geoff risks it. It turns out that it's not simply painting or sculpting but satisfyingly creating a visual expression of his feelings. This and the chance to discuss everyone's work and its significance are the highlight of his hospital week.

Blossom is Geoff's key-worker and Monday afternoon is the first of their three one-to-one sessions during the week. They've managed to fit in this session because Geoff doesn't need to go to the advice surgery being run by the local housing action group, since his housing is secure.

On the agenda today is physical health (because Monday is 'physical health day'). He's not going to be able to escape Blossom's attempts to get him to sign up for the hospital smoking cessation scheme, but hopes to avoid all mentions of diet.

Blossom has brought some information sheets about exercise and depression which Geoff puts in the physical health section of his Personal Recovery File and promises he'll read later. They talk about how Friday night and Saturday, the Jewish sabbath, went. None of his family live within walking distance of the hospital and as they are orthodox, they can't use vehicles on the sabbath. Happily, the nearby synagogue has built up good relations with the hospital and has a rota of people who can run a sabbath morning service for patients in the hospital's pleasant multi-faith room. Geoff knew this week's visitor as they used to play bridge together.

They discuss his concerns for how his wife, Lilian, is responding to his illness and hospitalisation. Neither Geoff nor Lilian regard her as his 'carer' but Blossom assures him that the carers' support group is a valuable time for sharing anxieties and coping techniques for close family members, not just carers. Geoff reminds Blossom that he's meeting with the pharmacist to talk about some specific difficulties he's having with his anti-psychotic medication.

Ali is waiting for Geoff when he leaves the meeting room, and tries to persuade him to take part in the Tai Chi session at 4.30. It's being run by one of the hospital's finance workers who is also a Tai Chi expert. Geoff fobs Ali off and returns to John Grisham until supper, after which he is similarly successful at avoiding using the exercise bike and treadmill. He realises he'd promised to get the ward's patient information board up-to-date, so gets the notices and postcards from the 'patient information board' cubby-hole in the staff office.

The patients' phone rings and he's called over. It's Lilian, full of news about a report she's working on, and apologetic about not being able to visit for a couple of days. They discuss the carers' support group and Lilian agrees to think about going to it next week.

**More reading, more schmoozing, bed.**



## WISH list

There's a load of StarWards' ideas, many of which can be introduced without any additional funds and with the existing staff group. It can all be summed up in a WISH list, which can be used on every shift. Every action that a member of staff takes, or doesn't take, could be considered in relation to 4 simple criteria: does it contribute to patients'

- **Wellness**
- **Interest**
- **Social contact**
- **Home**

This applies to all staff – nurses, health care assistants, domestics, psychiatrists... When a particular action doesn't directly contribute to something on the WISH list, staff should question why they are doing it. An obvious, and big, example, is admin. Should the most experienced staff be doing a particular task or could it be done by someone with specific admin skills or by someone with fewer mental health skills, freeing up more senior staff to work directly with patients?

These four themes cover the following issues:

### Wellness

- Safety
  - Feeling safe
  - Being safe
- Mental health
  - Being asked how they feel today
  - Medication
  - Talking therapies
  - Creative therapies
- Physical health
  - Being asked how they feel today
  - Medication side-effects
  - Exercising
  - Health checks
- Independence
  - Making choices, whether over health treatment, what to watch on TV or about the ward activities' budget
  - Self-medicating
  - Having responsibility with their care planning

### Interest

- Conversation
- Activities
  - Creative therapies (art, drama, music)
  - Games

- Watching a TV programme they have chosen
- Reading
- Listening to music they have chosen
- Visitors
- Mutual support, including user forums and advocacy
- Pets

### Social contact

- Conversation
  - With staff
  - With other patients
  - With visitors
  - With members of own ethnic minority or faith community
- Escorted leave

### Home

- Visitors
- Phone calls home
- Relationships with friends, family and colleagues
- Religious practices

As well as staff asking themselves whether each action, or each hour, contributes to at least one WISH factor, this could be carefully built into staffing systems. For example, staff could discuss at handover what they've done in relation to the WISH list. And it could be covered in supervision and in appraisals.

The WISH list covers similar issues to those found in research with hospital patients by the Mental Health Foundation's Strategies for Living team. What patients most wanted were:

- relationships
- information/communication
- sanctuary and personal space
- promotion of self-help
- activities
- support and promotion of user forums and advocacy

Most of the items on the WISH list are also good practice in supporting staff, well illustrated by Henry Stewart's article about great places to work (see pp 32–35). Well supported, respected staff, able to use their initiative and specific skills in ways that are safe for patients, themselves and the hospital are the key to providing StarWards.



# Achieving change

We're not seriously suggesting that any ward adopts all 75 ideas. (Although that would be good....) And we're very aware of how difficult it is to make even small changes in the present circumstances of tough competition for funds and so many demands on staff time.

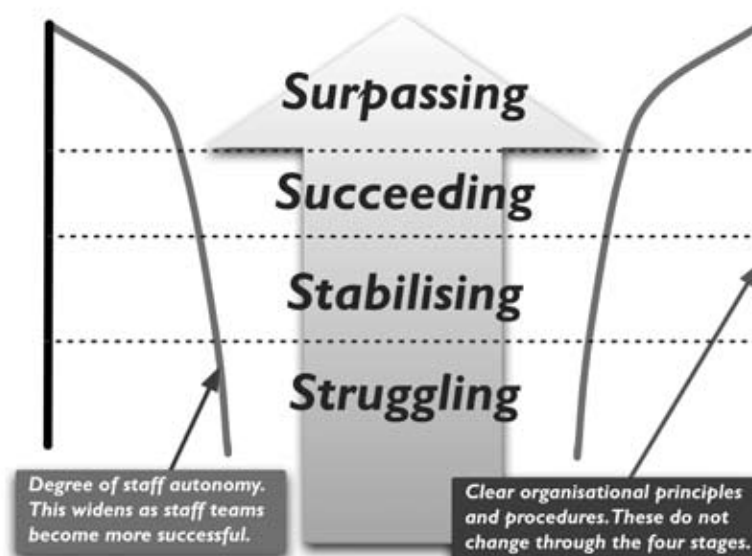
It is striking that the majority of wards that have achieved the most sustainable substantial changes are those which have adopted a new framework of values and practice. Nick Bowles' 'Refocusing' model in particular has given wards a strong sense of purpose and commitment and a realistic way of improving patients' experiences through Solution Based Brief Therapy. It has been proved over and over again to increase staff morale and patient care and to reduce costs and disruptive incidents. Although Nick is stepping back from delivering intensive training and support to wards implementing Refocusing, happily he is producing a book with Pavilion Publishing next year which sets out its main ideas and practices.

An additional way of improving or transforming ward practices is to join the Royal College of Psychiatrist's accreditation scheme AIMS (Accreditation for inpatients Mental Health Scheme). The AIMS accreditation process incorporates elements that research has demonstrated to be effective in bringing about quality improvement. It gives encouragement to identify and prioritise problems and set achievable targets for change. Membership of AIMS can help wards meet the Healthcare Commission's Standards for Better Health and

to conform to NICE guidelines and National Service Frameworks. And there's support and advice to help reach the standards necessary for accreditation.

Henry Stewart's article (see pp. 32–35) provides compelling but still challenging reasons for the need to give staff enough individual scope in their daily practices to enable them to use their strongest skills. Henry is an old college pal of mine and we've had many conversations over the years about the best ways to inspire and sustain staff excellence. My views are influenced by managing residential services for highly vulnerable people with multiple disabilities or social disadvantages. Henry's ideas have evolved from an eclectic range of progressive philosophies and are sharpened by the need for financial success in a highly competitive and technological market.

The following diagram was conceived between the pasta and the profiteroles during a stimulating (and delicious) supper with Nick Bowles and a friend of his who is a very impressive ward sister. It borrows (shamelessly) from various sources and suggests four possible stages that a ward and its staff team might be at, and the increasing amount of scope for staff initiative and autonomy as wards progress to excellence. Or, as Henry puts it, the extent to which staff are 'trusted and given freedom to decide how to do something.' The framework of core principles, procedures and targets remain the same for wards at whatever stage they are.



**Enabling staff teams to flourish**

Everyone wants to be happy at work, and it's impossible to create a warm environment for patients if staff are unhappy. The articles by Henry and Phil detail ways of creating a happy working team. We turn to that giant generator of happiness, the BBC, for a final word on the subject. Their book, *How to be Happy* by Liz Hoggard, features a Happiness Manifesto and encouragingly, every single one of their ideas are achievable for patients on acute wards.

1. **Get physical.** Take half an hour of exercise three times a week
2. **Count your blessings.** At the end of each day, reflect on at least five things you are grateful for
3. **Take time to talk.** Have an hour-long, uninterrupted conversation with your partner or close friend each week.
4. **Plant something.** Even if it's just a window box or pot.
5. **Cut your TV viewing by half**
6. **Smile** at and/or say hello to a stranger at least once each day
7. **Phone a friend.** Make contact with at least one friend or relation whom you have not spoken to for a while – arrange to meet up
8. **Have a good laugh** at least once a day
9. **Give yourself a treat** every day and take the time to really enjoy it.
10. **Spread some kindness.** Do a good turn for someone every day

We hope that the ideas in this publication provide inspiration for making your ward a happier place to work and to recover.





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# Thanks

Bright and the Star Wards project are very grateful for the financial support of the Allen Lane Foundation and NIMH(E). We'd also like to warmly thank the contributors to this publication:

- Louis Appleby
- Phil Dourado
- Brian Garvey
- John Hanna
- Malcolm Rae
- Henry Stewart



## **A personal note from Marion**

I've been able to continue working while mentally ill thanks to the incredible support of friends and family, who have found the three years pretty nerve-racking. Throughout my illness Karen Mattison has been in the 'front-line', checking where and how I am, feeding me, sometimes housing me and always listening to me. I'm enormously grateful to Karen and the rest of my mates and mishpokhe (family), and also to the amazing mental health and other medical professionals who have supported me into, in and out of hospital. Each has been so generous with the precious and pressurised resource of time.

Prof. Anthony Bateman of St Ann's Hospital's Halliwick Centre, who despite mind-boggling clinical, managerial, research, writing and teaching commitments, in the UK and abroad, makes time to see me weekly for psychotherapy. Usually at 8.30 AM so as not to cut into my working day.

Heather Shuman, whose psychotherapy support package included very elastic timings, chocolate (Swiss Extra Creamy Milk), and a dog almost as cute as Buddy

Dr Peter Christian – a perfect GP. I've been a 'high maintenance' patient but he never makes me feel that – only supported and that there are always ways to cope.

Dr Claire Gallagher who made it possible to get over that mountainous first hurdle of taking (quickly much loved!) anti-depressants and to be selectively open with people about my self-harming.



# Useful contacts

Accreditation for Acute Inpatient Mental Health Services (AIMS)  
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# Star Wards Ward Ideas Chart

Use this resource to write down your own version of these ideas and also to note action points

Star Wards ideas	Ward Ideas	Action
1. Each ward has board games, TV + VCR/DVD		
2. Volunteers on ward for at least 3 hours a day		
3. Library with novels and magazines		
4. Bank staff recruited for group activities' skills		
5. Domestic staff involved with patients		
6. Hospital non-medical staff involved		
7. Hospital volunteer co-ordinator		
8. Artwork commissioned, borrowed, displayed		
9. Cooking on the ward		
10. Activity co-ordinator		
11. Community groups hold sessions		
12. Computers + Internet		
13. Hospital has gym, multi-sensory room, library, music room, computer room, multi-faith prayer/chillout room, lecture theatre		
14. Regular comedy evenings		
15. CSVs		
16. Exercise bike &/or treadmill		
17. Individual appointments with dietician and pharmacist		
18. Walking groups		
19. Daily exercises		
20. Healthy eating and quit smoking advice		
21. Gardening		
22. Physio or sports trainer runs exercise classes		
23. Optional exercise plan for departure		
24. Optional physical health checks		
25. Written info about visiting given on first day		



Star Wards ideas	Ward Ideas	Action
26. Family/friends' links nurtured		
27. Private visiting room		
28. Mags & games in visitors' room		
29. Flexible visiting hours		
30. Info for visitors & carers		
31. Help with visits		
32. Pets as visitors & residents		
33. Visitors' budget managed by patients		
34. Friends, family & carers' support groups		
35. Visits arranged for the visitorless		
36. 5 day structure with different theme each weekday		
37. Min. ¼ hour with key worker or other staff to discuss day's theme		
38. Employment status recorded on admission		
39. Designated staff member with care planning remit 9-5 weekdays		
40. Benefits advice		
41. Leaving pack of info & advice		
42. Quick-tick pre-printed forms		
43. Personal Recovery File for each patient		
44. Patients can choose to take lead in care planning		
45. Self-help books & tapes in ward library		
46. 'Protected time' for staff contact with patients		
47. Women's & men's groups		
48. Psychology assistant		
49. Weekdays, 1 staff member has counselling qualification		
50. Option of at least 1 hour of therapy a day		
51. Full day's programme of therapy groups		

Star Wards ideas	Ward Ideas	Action
52. Placements for student counselors		
53. Individual psychotherapy		
54. OTs and creative therapists		
55. Core programme of activities		
56. Personal recovery Workbook		
57. Mini & maxi libraries of Mind leaflets		
58. Day begins & ends with ward community group		
59. Prayer, faith & cultural meetings		
60. Buddy system		
61. Patient mutual support		
62. Celebration of faiths' festivals		
63. Patients encouraged to support each other after hospital		
64. Patient managed recreation budget		
65. Patients run 'special interest' sessions		
66. No queuing for medication		
67. Patients write own profiles		
68. Patients have copies of their care plans		
69. Patients keep 'public' patient info up-to-date		
70. Patients' diaries		
71. Ex-patients interview for new staff + recruited as staff		
72. Patient involvement in running of ward		
73. Patients complete a self-assessment at the end of each day		
74. Each patient has 'recovery budget'		
75. Patients extend stay to support new residents		



# NOTES



Training and consultancy on Star Wards' ideas and other aspects of enhancing patients' experience of acute mental health wards is available from:

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[www.brightplace.org.uk](http://www.brightplace.org.uk)

And the Star Wards website is:

[www.starwards.org.uk](http://www.starwards.org.uk)

Without forgetting.....

[www.buddyjanner.org](http://www.buddyjanner.org)

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# Star Wards

*Another Bright idea*



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