The Sainsbury Centre for Mental Health

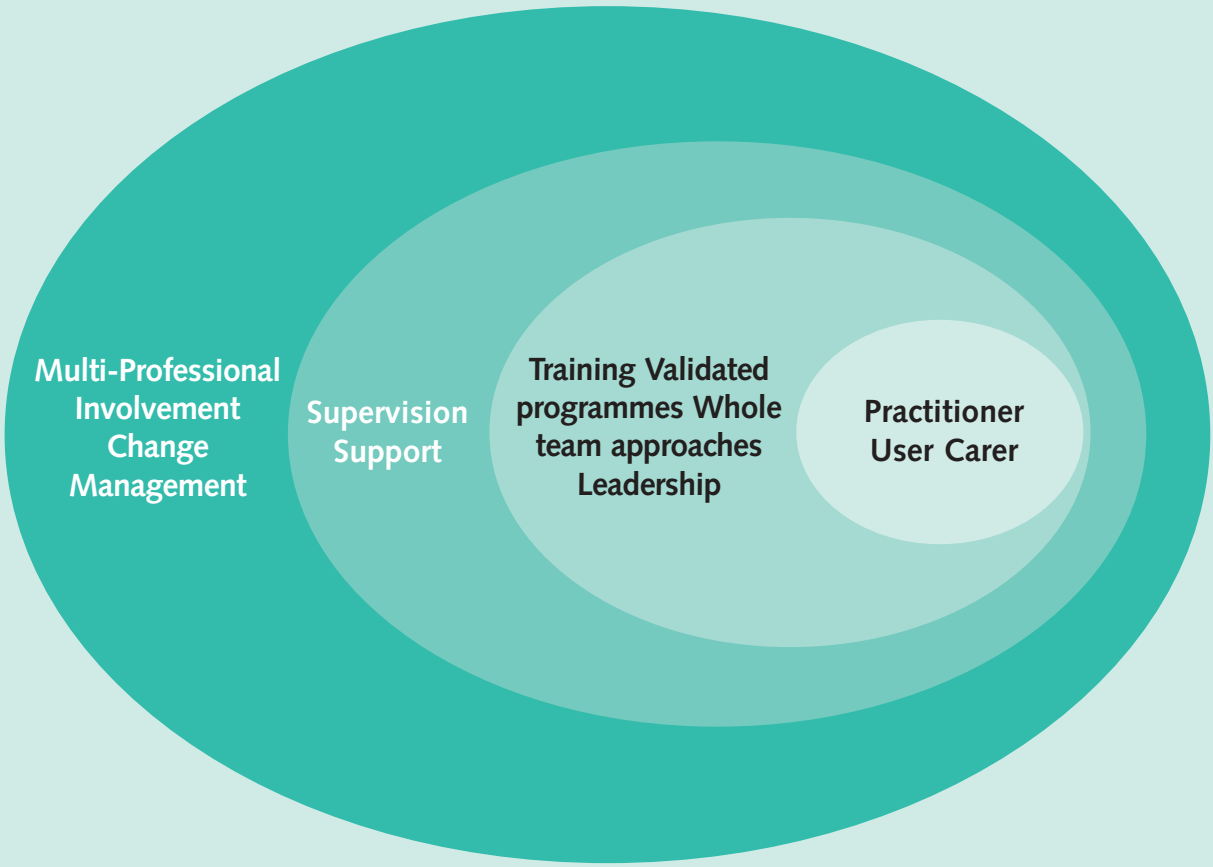
NHS

National Institute for Mental Health in England

Acute Inpatient Mental Health Care:

Education, Training & Continuing Professional Development for All

By Steve Clarke



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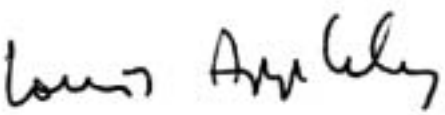
Foreword by Professor Louis Appleby

Acute in-patient care has moved on in the last few years, with new policies, new practices and improvements in buildings and services throughout England. The task that now faces us is one of continued consolidation, development and renewal. This new development guidance will add significantly to this process.

The guide offers practical ideas and suggestions for all those involved in service improvement in in-patient care from practitioners through to service users, healthcare organisations and higher education. It offers a range of suggestions for new curricula at all levels and for all groups coupled with realistic means of making things happen.

Of course this work will not end with the publication of this document. NIMHE will continue to work with its partners to ensure that standards of care continue to improve in acute in-patient care. These first steps are however, an important part of our development programme for acute mental health care in equipping staff with the necessary competency and confidence to meet the needs of service users.



Professor Louis Appleby
Director of Mental Health
Department of Health

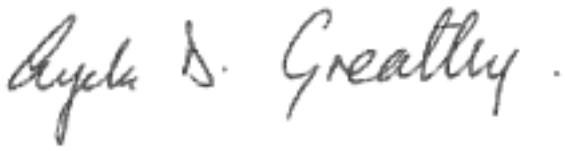
Foreword by Angela Greatley

Within the framework of the NHS plan, mental health has at last taken its place at the forefront of health service developments in recent years. As the largest single component of the mental health services, acute in-patient care is now well placed to capitalise on this position.

Prior to the launch of the National Service Framework for Mental Health and the Policy Implementation Guide, acute in-patient care had suffered from a dearth of guidance on how the service should adapt given the context of developing services such as crisis resolution and home treatment. Indeed, a growing body of evidence was emerging that highlighted a service that was struggling to meet the expectations of those people who use the service or practitioners who work in it.

This new guidance takes a positive view on how practitioners, service users and others can come together to transform education, training and practice development. Its focus on the values of building on strengths, partnerships and networks is welcomed. As a consequence this may well address the sense of isolation and exclusion experienced by many who strive to develop the service, and those who use it.

The Sainsbury Centre for Mental Health places these values at the very core of its work and we hope to continue to support you in developing your in-patient services.



Angela Greatley
Director of Policy and Research
Sainsbury Centre for Mental Health

Foreword by Steve Clarke – Author

The Adult Acute In-patient Care Guidance launched in April 2002 sets out the way forward to refocus and reshape the provision of acute in-patient care. Many practitioners will be involved in or at least aware of some of the changes that have already occurred e.g. local Acute Care Forums. The guidance signalled a shift away from identification of the problems of acute in-patient care towards making real changes that can have a positive impact for those who use and work in the service.

These education and training guidelines are supplementary to the existing guide for acute in-patient care. They aim to help those who are involved in training and development, be they receiving it or designing it, to make more effective use of the opportunities they have to use learning as a means of improving the service. The overall aim is to make in-patient services examples of lifelong learning cultures, which may improve service users expectations from an in-patient stay and help to retain staff or attract practitioners back into in-patient practice.

Creating these learning cultures is not without its problems. There is a history of under-investment in training and education that recognises the specific strengths and the limitations of acute in-patient care. Development of such programmes is paramount, as is creative means of releasing staff to undertake them. Several practitioners have led visionary good practice examples that go some way to addressing these issues. Some of these are referred to in the guidance, though many others continue to work relentlessly on similar projects without recognition. It is hoped that through regional and national networks, that many more such projects will flourish and help to develop the body of knowledge around acute in-patient training and education.

This document is also informed by the principles set out in the Workforce Action Team Report, including the Capable Practitioner framework and the emerging shared capabilities, as well as expert opinion from service users, carers, practitioners and higher education staff as well as commissioners of both training and services.

For the purposes of this document, the terms staff and practitioner are used interchangeably to signify anyone who is engaged in care and treatment in an acute in-patient setting, be they ward based or not. More specifically this would include:

- Ward based nurses
- Healthcare assistants

- Occupational therapists (OTs)
- Social workers
- Psychologists
- Psychiatrists

These guidelines primarily address the requirements for continuing professional development, but acknowledge the need to develop shared learning initiatives in pre and post registration courses, and the centrality of service users and carers in shaping curricula, as well as the teaching and assessment of learners in mental health settings.

It must be recognised that the bulk of practitioners in acute in-patient care are from a nursing or non-aligned background. Most other professional groups who contribute to acute in-patient care have other roles in community services e.g. psychiatrists and social workers, or may be based off the ward e.g. occupational therapists and psychologists. This guidance works towards training and education that has a multi-professional and inter-team approach but remains grounded in the daily work of acute in-patient care.

This daily work can often involve high degrees of crisis management and it is recognised that practice in acute in-patient care can be complex and demanding. Our aim here is to support practitioners with the task of making their services more proactive, whilst acknowledging that this requires additional development, training and resources.

This guide is targeted at all health professionals, managers, commissioners of both care and training, service users and carers, and aims to unlock some of the potential that exists within acute in-patient care for development and change. It is hoped that this may ensure a specific, innovative and relevant educational and developmental focus on the needs of acute in-patient services within the context of an integrated whole systems approach to mental health.

Finally, many of the points raised in this document have relevance outside the world of acute in-patient care. For instance, some of the core capabilities discussed may well be just as relevant to those people developing educational programmes for practitioners working in a Community Mental Health Team (CMHT). However, the pivotal role of acute in-patient care, and the specific development needs of practitioners in this area are recognised and can now be addressed.

Steve Clarke
Programme Lead for Acute Care
Sainsbury Centre for Mental Health

Acknowledgements

The National Institute for Mental Health in England (NIMHE) National In-patient Steering Group for Acute In-patient Care is very grateful to everybody who has contributed to the development of this document. However, several groups and people deserve specific mention.

Firstly, many thanks to Simon Rippon, David Richards, Lis Jones and Justine Faulkner who completed the initial sets of drafts for the steering group, much of which have been incorporated into the final document.

Secondly, thanks to the service users and carers who participated in the focus groups that have informed this document. Particular mention must go to Lyn Shore, Andrew Wetherall and Roberta Grayley-Wetherall for their assistance with setting up and running these groups, often at short notice. Also, thanks go to Nick Gauntlett at SCMH for the acute in-patient education and training best practice search.

Finally, thanks to all other contributors including the regional programme leads for acute in-patient care, NIMHE, Sainsbury Centre for Mental Health, practitioners in the field and service users and carers who contributed by mail

Executive Summary

Introduction

This training guidance is supplementary to the Department of Health Acute In-patient mental health policy implementation guidance published in 2002. It aims to make current training and development opportunities more relevant and available to in-patient practitioners and is targeted at all professional groups, NHS Trusts, Workforce Confederations, Regional Development Centres and training and education providers.

The Context

Much of the current education and training available is not grounded in the work of acute in-patient care. Future provision must put service users at the centre of the design, delivery and evaluation of programmes. Capacity for learning can be developed through changing processes in acute in-patient care. Optimism and recovery must also be recognised as essential features of acute in-patient training.

Values for practice

The values of the workforce have a significant part to play in the development of effective in-patient care. Employment, engagement with service users and carers and diversity must all be a feature of training programmes, as well as a strong focus on recovery.

Capability Development

Multi-professional training has a part to play in the complex web of provision for acute in-patient practice. All programmes must include ethical practice, knowledge, the process of care and interventions training.

Core Capabilities

All practitioners should have access to training that helps them develop their capability and no barriers should be placed in the way of further development. The emerging shared capabilities must also be addressed. Different levels of capability in acute care include:

- Basic level – including basic skills of engagement, diversity training and theoretical underpinning
- Post basic – including medication management and leadership
- Advanced practice – including specific intervention skills and cultural competence
- Independent practice – developing high level skills and providing advice/consultancy

Good practice in learning activity

Practice in acute in-patient care presents some unique difficulties that must be recognised and dealt with. Some areas of good practice exist in:

- Validated programmes
- Whole team approaches
- Implementing skills in practice

More work is needed on the evaluation of training and developing capacity for learning in acute in-patient care. Replacement costs remain a significant barrier to training in acute in-patient care and creative measures are required to overcome this obstacle.

Leading and supporting learning

Creative supervision and support arrangements are required to ensure changes are sustained in practice and access to supervision must be guaranteed. A coherent strategy for the development of learning environments is required to attract and retain staff. e learning and work-based learning can be useful tools in the development of learning environments. Leadership, as the lynchpin of change, must be given a higher priority.

Recommendations

Recommendations include:

Training provision that must integrate the following points:

- Values
- Meaningful service user and carer participation
- Thorough evaluation
- Capacity building
- Integration of skills into practice
- Barriers to collaboration e.g. confidentiality arrangements
- Cultural competence
- Leadership

Additionally, issues that require resolution include:

- Clinical skills of insert Higher Education Institutions (HEI) staff
- Development of an acute care training strategy
- Identifying 'champions' of multi-professional practice and training
- Policy development on replacement costs
- Central databases of training and development providers and funders
- Pilot programmes for work based learning and e learning in acute in-patient care

1. The Context of In-Patient Education and Training

1.1 Introduction

Historically, there has been an absence of education and training provision specifically designed to address the particular needs of acute in-patient practitioners, and training has been delivered using a largely uni-disciplinary approach that has often been delivered by professional educators remote from the practicalities of the workplace.

Given the deficits in clinical leadership present in many acute wards (SNMAC 1999), and the general levels of 'firefighting' activity and administration (SCMH1998) it seems unrealistic to expect large scale change to come from this sort of approach. Indeed, many practitioners who attain high level skills find practice of these skills in acute wards difficult or impossible, and often do not manage to lead changes in practice for others. Several of these cycles of incomplete change can contribute to a lower sense of self-efficacy and lower morale within teams, and may have a negative impact on retention of skilled and motivated practitioners.

1.2 Innovation in acute in-patient training

In recent years, innovative programmes have been developed by a number of services and training providers to address these concerns, offering valuable models for future provision - both in terms of design, content and mode of delivery.

The design, delivery and evaluation of education and training programmes needs to become not only more innovative but also:

- More inclusive of service user and carer training roles
- More relevant to everyday practice
- More flexible and accessible to practitioners
- More integrated into service monitoring and governance

The Workforce Action Team Report set out some 'guiding principles' to underlie all developments in education and training. Lifelong learning and continuing professional

development should be actively promoted, with staff given the necessary supervision and support to ensure that they meet continuing professional development requirements:

- The workforce should be trained to deal with the emotional impact of the work and actively seek ongoing support and supervision
- Staff involved in the delivery of training and supervision in the workplace should be trained and supported in these roles
- Service users and carers should be involved in planning, providing and evaluating education and training
- Education and training must ensure that the workforce can operate collaboratively and effectively in a whole systems model of service provision

Though learning has the potential to be an inspirational and transformational experience, we must be cautious in our expectations of what it can achieve. As is well documented acute in-patient wards can be very chaotic environments where staff have little capacity to absorb new learning (SCMH 1998). Failure to address structural problems such as levels of 'firefighting' activity on acute wards will severely limit the ability of acute in-patient care practitioners to make the required changes in their work. Although the focus is on training and education guidance, this document will also attempt to shed some light on these issues and how they may be addressed.

1.3 Optimism and recovery

Historically, people with mental illness were often expected to use services for long periods of time, and this has led to diminished contact with their communities. This isolation is somewhat reinforced by the fact that people who work in acute in-patient care generally work with people who are at their most distressed and rarely see people at their best levels of function. When coupled with a rise in acuity and an ever decreasing length of stay in in-patient units, it is hardly surprising that some in-patient staff sometimes have a less than optimistic view of recovery.

This lack of optimism has influenced public attitudes, service provision and the content and delivery of education and training provision. It also has a significant impact on service users and carers. Contemporary evidence from the experience of service users, supported by research evidence, challenges this perception emphasising that the vast majority of people have every prospect of recovery – if they are able to access appropriate care and support, driven by the right values and attitudes. Training and education programmes need to be able to project a more positive and optimistic approach, equipping practitioners with the knowledge, skills and attitudes that make it possible for them to work with users towards recognising what factors are critical to their own recovery.

2. Values for Practice In Acute In-Patient Care

2.1 Introduction

Modern mental health services must be planned and delivered around the needs and aspirations of service users, delivered by a workforce who are skilled, of high morale and able to adopt new ways of working. Those working in the services must be able to:

- Treat individuals living with mental health problems with dignity and encourage their full involvement in their own care
- Respect diversity, acknowledge similarities across cultures and confront discriminatory practices
- Respect the roles and skills of carers, acknowledging them as partners in care and supporting them in this role
- Promote positive mental health and take effective steps to reduce stigma and discrimination
- Make the best and most effective treatments and interventions available, when and where they are needed
- Respond appropriately to need, so that people receive prompt access to care when it is required, and so that those with a broad range of health and social needs – including housing, occupation, education, spiritual, medical and financial – receive comprehensive care
- Emphasise safety – particularly of service users themselves

Service users, families and carers should expect to be treated in a manner that preserves their rights and their dignity. Whatever their age, background, gender, disability, sexual orientation, history of service use or use of illicit substances, service users have a fundamental right to receive services in the least restrictive manner conducive to their safety and the safety of their families and their communities.

"The purpose of an adult acute psychiatric in-patient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be available for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restricted residential setting."

(DoH 2002)

Admission to hospital represents a critical, but often brief point in the life of any individual. Therefore, the experience needs to be understood in the context of the rest of the person's life beyond the ward/unit, be that their social role e.g. parent, adolescent, or their occupational role. Training and development can provide opportunities to examine current values and principles and enable a more positive outlook towards recovery.

2.2 Work and employment

Though work provides a regular income, it can also provide a focus and a sense of self esteem for all of us. Interestingly, a survey in one hospital indicated that 40% of people admitted to its acute wards held a job at the time of their first admission. One year later 80% of those who had previously been in work were unemployed, mainly due to lack of timely support to keep them in employment. (Butterworth 2001)

The role of in-patient practitioners in this area is finite due to the limited length of stay on in-patient wards. However, this role is vital to enable the continuation of work roles after admission. Training around this area should aim to:

- Raise awareness of employment as a protective factor and a source of self esteem for many people
- Focus on the changes acute in-patient wards need to make to help people to return to work
- Enable a speedy referral to appropriate services e.g. a specialist statutory or voluntary sector mental health /disability employment agency or OT
- Make contact with and support and inform employers, should service users wish this to take place.
- Raise awareness that the longer a person is out of the labour market, the harder it is to get back. Return to work planning should begin early in admission as by the time a person has been signed off sick for 6 months, there is only a 50% chance they will ever work again (British Society for Rehabilitative Medicine 2001)

2.3 Family and carer engagement

Feedback from the carer consultation suggests that in-patient practitioners feel hindered from working with families and carers by confidentiality arrangements. This often leads to situations where carers are unclear about treatment plans, and are not involved in the care process. Isolation of a service user from their families and their social role can have serious consequences:

> *"Once on an acute ward, social roles and routines are suspended, family relationships are disrupted, time is taken off work and friends are rarely encouraged to visit. Lengthy and repeated admissions may erode these relationships, roles and activities until the person is left with only the devalued role of mental patient."*
>
> (Repper 2002)

Acute Care Forums need to clarify existing confidentiality arrangements for acute care practitioners. In turn, a more collaborative approach to acute in-patient care is required of practitioners. Training around legal and confidentiality arrangements, as well as engagement skills is required.

2.4 Diversity issues and spirituality

Religious, spiritual and cultural needs are not well assessed or provided for on in-patient wards. The needs of specific minority groups are not being addressed (SCMH 1998) with reports of harassment and discrimination being unfortunately not uncommon.

Lesbians, gay men, bisexuals and transgendered people (LGBT) are disproportionate users of mental health services. One study found that 1 in 5 had attempted suicide in the past year and 1 in 5 LGBT people under 25 taking anti-depressants (Count me in 2001). Many people who use in-patient care find it difficult to identify themselves as belonging to these communities.

The separate and distinct needs of women are another unmet area of need in acute in-patient care (SCMH 1997). The specific economic challenges for women and mothers are not recognised and there is often a lack of visitation facilities for children
The concept of cultural competence encompasses cultural awareness, and sensitivity, but is focused on values, attitudes and how these enable professionals to work across a range of diverse situations (Cross et al 1989). This could have particular relevance to in-patient care regarding ethnicity, gender, race, sexual orientation etc.

All staff who work in in-patient settings must have access to cultural sensitivity/ awareness training that allows time to explore how these concepts interact with their values and their work. Acute Care Forums should explore the concept of cultural competence from an organisation-wide perspective.

Characteristics of culturally competent organisations

- Value diversity
- Have the capacity for cultural self–assessment
- Are conscious of the "dynamics" inherent when cultures interact
- Institutionalise cultural knowledge
- Develop adaptations to service delivery reflecting an understanding of diversity between and within cultures

2.5 Service user and carer involvement

Many current programmes involve service users and carers to some degree. Often this involves personal testimony around their experiences of services. This personal testimony has a valid and important place in all education and training.

> *" In three years of training I have only once, as far as I am aware, been taught by someone who has used the services for which I am being trained. However this lesson was one of the most important in my training so far. It enabled me to truly understand some of the issues that will be crucial to the way I work in the future."*
>
> Quote from a Student Nurse

However, more meaningful involvement of service users and carers is vital to help ground programmes in their real world experiences. With this in mind, service users and carers must be involved in the design, delivery and evaluation of training and education programmes for acute in-patient care.

2.6 Recovery

Hope of recovery and optimism about the future have a significant impact on the well being of many people. These factors can have a significant impact on recovery rates from diseases as varied as stroke and cancer. Recovery and optimism are an important, but often neglected part of mental health care.

Practitioners in acute in-patient care already see people at their most distressed or sometimes at a repeat admission. This has led to a position where many acute staff are less than optimistic about the prospects for recovery from many mental health problems. With pressure to reduce the length of stay even further on in-patient wards, it could be hypothesised that levels of acuity may actually increase, as may the levels of pessimism.

This lack of hope in recovery is noticed by service users and carers and often has a negative impact on their beliefs about treatment outcomes, their ability to return to work or education, or to continue in a parental role.

Structured work based learning activity around recovery and optimism should form an important part of mental health curricula, particularly those for in-patient practitioners. This learning activity should be highly relevant to the workplace and ideally should involve short practice placements in other services e.g. early intervention, crisis intervention, home treatment. Rotational posts that are already in place should be strengthened to include these services, and should be expanded to include staff who currently work in the service.

3. Capability Development

3.1 Introduction

The Capable Practitioner (SCMH 2001) set out to establish a framework within which all staff could examine their level of practice and identify the capabilities required, in order to work effectively with people with severe and enduring mental health problems. The four key areas that come together to form capable practice are:

- **Ethical Practice** – which respects the rights and dignity of all service users, and is informed by values and attitudes necessary for modern mental health practice
- **Knowledge** – that underpins effective practice - and includes knowledge of policy and legislation, mental health and mental health service delivery
- An understanding of the **process of care** - including effective partnerships with users and carers, care co-ordination and effective team working
- Expertise in **interventions** which are known to be effective in promoting stability and recovery

Four key areas of capable practice (SCMH 2001)

These key factors that comprise effective practice must be addressed in training programmes for all practitioners in acute in-patient care.

In addition to these, a supplementary set of shared capabilities that all practitioners should be able to work within, will become available in the near future. These aim to provide a framework for learning activity, shared or otherwise, that should be undertaken during basic and post basic training.

Shared capabilities for all mental health workers (SCMH/NIMHE 2004)

- Working in partnership
- Respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery
- Identifying peoples strengths and needs
- Providing user centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

This activity must be open to all practitioners in mental health regardless of their role within the system. The basic capabilities for acute in-patient care (see chapter four) compliment these shared capabilities.

3.2 Issues with multi-professional learning

There are particular challenges in designing and delivering programmes that need to be multidisciplinary, relevant and accessible for all in-patient practitioners. Many staff who practise in acute in-patient care have as their base a CMHT or another part of the service. This leads to a unique situation where many staff practising in the in-patient setting have a limited sense of ownership or belonging to the in-patient team

The purpose and objectives of an in-patient stay can vary between professional groups. This can often lead to inter-professional conflicts and contradictory messages being given to service users and carers.

Even when training or practice development is appropriately commissioned for acute in-patient care, it often omits to engage or involve key members of the multi-disciplinary team. This situation reinforces the lack of cohesion between community and in-patient services.

Significant blocks to the release of practitioners for education and training are also present. Replacement costs are readily available for some education and training programmes e.g. BSc in Community Mental Health Nursing. However, similar arrangements are seldom made for practitioners in acute in-patient care who wish to undertake further study. This position must be reviewed as a matter of urgency.

Although the advantages of team training in terms of team building, joint working and consistency of approach are recognised, all professional groups will have specific requirements related to their professional responsibilities and accountability. Indeed, diverse levels of practice also occurs within professional groups. This leads to a position where a high degree of complexity of learning and development need exists within acute in-patient services. This complexity of need is not replicated in any other part of the mental health services.

3.3 Training and development needs

An intricate web of provision is therefore required from work based training, formal education at a basic level, through to post registration/graduate training and continuing professional development. The aim of all such programmes should be to create flexible learning opportunities, within a clear framework of priorities for the development of the required skills, knowledge and attitudes needed to improve the effectiveness and acceptability of acute in-patient care.

Current provision of acute in-patient care lacks responsiveness to the individual problems, strengths and needs of service users, with many aspects of an in-patient stay being standardised, from care planning to group interventions and individual work. The aim of training and education interventions should be to assist practitioners in the development of a highly individualised programme of care and treatment, with an eye on the re-integration of service users into their communities.

4. Core Capabilities for Acute In-Patient Care

4.1 Introduction

All Acute Care Forums should now be formulating the role and functions of an acute in-patient stay. All interventions expected from this stay should broadly fit in with these key functions of acute in-patient services. The levels of capability outlined below are somewhat arbitrary and in some circumstances practitioners may have exceeded attainments in some areas or lag behind in others. The intention is to set out the capabilities required to practice at specific levels in acute in-patient care. These capabilities should help to focus curricula for acute in-patient care programmes on the skills required for effective practice, without being overly prescriptive. Indeed, this list is far from comprehensive and should be expanded on, based on local needs assessment. Specific diagnoses are deliberately avoided e.g. dual diagnosis, though specific skills that are required for working with such clients are discussed e.g. motivational interviewing.

Figure 1 – Core capabilities for acute in-patient practice

Level 1	All staff in acute inpatient care including non-aligned, STR workers, pre-registration students and all registered practitioners	Leadership awareness, cultural awareness, values-based practice, models of causation, care management, risk management, engagement, assessment, side effects monitoring, family engagement, teamworking, supervision, promoting healthy living, whole systems approach to mental healthcare, prevention and management of violence and aggression, basic managment of alcohol and drug abuse
Level 2	Post basic registered practice	Leadership skills, cultural competence, managing care, comprehensive assessment, medication management, intervention skills, self management
Level 3	Advanced practice	Leading services, cultural competence, professional development, intervention skills
Level 4	Independent practice	Excellence in leadership, developing others, practice development, advanced clinical skills

4.2 Level one capabilities

Some key themes for intervention have been highlighted in the evidence base, by service users and carers, and by expert opinion in the field, as being important to the core functions of acute in-patient care. These interventions should be useable by anybody whose role involves contact with service users in acute in-patient care, regardless of professional status. Also included in this level are those people at the pre-registration phase of their career e.g. student nurses.

- **Leadership awareness**
  All practitioners should be equipped with a basic knowledge of what leadership is, how it differs from management, how it can improve healthcare outcome and what their specific role is within leadership practice. They should also be familiar with the principles of effective team working, resolving conflicts and supervision requirements.

- **Cultural awareness**
  All practitioners should be equipped with basic cultural awareness relevant to their client groups and specifically addressing local diversity. The specific needs of women should also be considered.

- **Values based practice**
  All practitioners should be able to consider the core values of the NHS, their values as regards mental health and illness and how values have an impact at every level of mental healthcare and treatment. The role of in-patient care in maintaining work and occupation should also be included at this stage.

- **Models of causation**
  All practitioners should be exposed to a variety of models of causation of mental health problems and should have a good working knowledge of the most commonly used in acute in-patient care i.e. medical and bio-psycho-social.

- **Management of the process of care**
  All practitioners should be in a position to know the regulatory and legal apparatus within which they work, and be familiar with the whole mental health system in their locality including the voluntary sector. Managing potentially violent situations and basic record keeping should also be included.

- **Engagement**
  Engagement is a key tool to effective working in acute in-patient care, and generally involves working with the service user on their agenda, at least initially. All practitioners should be familiar with the key skills required to initiate contact with service users, and particularly with people who are reluctant to interact with mental health services.

- **Assessment**
  All practitioners should be exposed to the basics of assessment technique. This should include an introduction to major assessments used such as risk assessment, mental state examination, assessment of drug and alcohol problems and familiarisation to professionally led assessment such as occupational therapy or nursing assessment.

- **Side effects monitoring**
  All practitioners should be able to identify the main medications used in mental healthcare and their side effects, and be trained in the use of side effects monitoring tools such as SESCAM (Bennett et al 1995) and LUNSERS (Day et al 1995)

- **Family sensitive practice and engagement**
  All practitioners should know the boundaries of local confidentiality arrangements, be aware of the family and carers potential role as collaborators in care and how to ascertain what their needs are.

- **Promoting healthy living**
  The physical health needs of people who have mental health problems are often overlooked by mental health professionals (Friedli and Dardis 2002). Many in-patient teams are developing healthy living groups with the aim of redressing this imbalance. Training needs to be made available to in-patient practitioners to promote healthier lifestyles and enable them to meet the physical health needs of service users (Mentality and NIMHE 2003). Practitioners should also explore the impact that non-prescribed drugs can have on mental health.

- **Whole systems approaches**
  Learning in this area should emphasise the multi-professional nature of mental health care and the evidence base for specific models of care that compliment acute in-patient care e.g. crisis intervention, assertive outreach.

4.3 Level two capabilities

Practitioners in acute in-patient care who have undertaken professional education and training may require a complimentary set of skills to those described above. Though these skills build on the previous level and are more intensive, no barriers should be placed in the way of other non-professionally aligned people accessing this level of a training programme. Issues such as cultural competence, relationships between causation and intervention, engagement and values based practice should be integrated into each learning event.

- **Leadership skills**
  Practitioners reaching this level should be able to assess their own leadership capability, reflect on their experiences of leading others (e.g. leading ward

reviews, groups, shifts or ward staff), consider what their career aspirations are, basic leadership skills (e.g. influencing the practice of others) and develop a leadership learning contract for themselves. Practitioners should also be equipped with the skills required to be involved with service users and carers in analysis and redesign of services, and be familiar with the policy context for acute in-patient care and mental health in general

- **Cultural competence**
  At this level, practitioners should be encouraged to assess how culturally sensitive their services are, how the needs of women are met within the service, reflect how the different cultures present on the ward interact, and be highly flexible in how they work with people from different cultures.

- **Managing the process of care**
  At this stage, practitioners should be given the opportunity to consider issues such as how the environment contributes to issues such as violence, self injury and wellbeing, as well as managing the Care Programme Approach (CPA) process.

- **Comprehensive assessment**
  At this level, practitioners will consider individualised approaches to assessment including the development of care pathways, strengths and needs assessments, symptom assessment which includes drug and alcohol abuse, family, social and occupational assessment. All assessment will be highly collaborative in its approach and will point towards specific, individualised interventions.

- **Medication management**
  Practitioners at this level should expect to attain skills such as motivational interviewing, compliance therapy and side effects management. Issues such as health belief, psychopharmacology and effective prescribing will also be considered.

- **Intervention skills**
  Intervention skills that are useable given the short term nature of acute in-patient care should be introduced at this stage. These include harm minimisation and reduction, structured problem solving, coping strategy enhancement, psychoeducational approaches, motivational approaches, quality assurance and evaluation of care. All interventions will have the aim of increasing the face-to-face time spent with service users.

- **Self management skills**
  To compliment intervention skills, practitioners should also help service users to manage their illness or problems. To this end, planning with service users for relapse and crises must also form part of in-patient practice. Advanced directives can offer choices to service users where few choices are obviously available e.g. events where restraint may occur. In this scenario, an advanced directive developed with a service user around their medication, or around how their distress can be minimised, could prevent or help to manage such difficult situations.

4.4 Level three capabilities

- **Leading and managing services**
  Practitioners will be responsible for the leadership of teams, services or practising with a high degree of autonomy. They can expect to be equipped with project leadership and management skills, transactional leadership skills (e.g. budget management), organisational diagnosis and service development tools, negotiation and influencing skills, audit and appraisal skills, the political context of care, whole systems approaches to care, leadership in a multi-professional context and teamworking

- **Cultural competence**
  Leaders of services at this point will be skilled in planning cultural assessment of services, assessing cultural competence of the whole system and will be working towards a culturally competent service.

- **Practice and professional development**
  Practitioners at this stage will be enabled to develop their skills as trainers and developers of other people including integration of skills into practice and assessing the development needs of others. They will also be equipped to provide support and supervision to individuals from their own and other professional backgrounds

- **Intervention**
  At this stage, practitioners will be enabled to develop expert skills for working with specific client groups e.g. people who self injure, or in using specific intervention frameworks e.g. cognitive behaviour therapy, motivational interviewing. They will develop their skills in providing advice to acute in-patient teams about intervention strategies for these specific groups and interventions.

4.5 Level four capabilities

Practitioners at this stage will be engaged in advice, consultancy, education and research with a focus on acute in-patient care. This category will include consultants from a medical, nursing or therapy background. Their roles are highly autonomous but are still of considerable importance in relation to teamworking and in the development of others.

Practitioners working at this level will be developing and sustaining high level skills both for themselves and others. They will be engaged in strategic workforce planning, and be responsible for supervising and supporting the acute in-patient workforce and as such will need to develop or sustain supervisory expertise. They will be prominent practitioners who can influence policy and practice within their organisations and their influence will extend into national and regional networks or through the mentorship of others.

5. Good Practice Learning Activity in Acute In-Patient Care

5.1 Introduction

Much research has been conducted in recent years to examine the efficacy of specific interventions for specific client groups. It is generally accepted that psychosocial intervention, family work and Cognitive Behaviour Therapy (CBT) can all have a positive impact on the lives of people who have severe and enduring mental health problems and their integration into routine practice is to be encouraged. However, there are particular problems with using such interventions in acute in-patient care, mainly related to:

- Levels of acuity on acute wards
- The short-term nature of admission
- The dominance of administrative and fire-fighting activity
- Lack of support and supervision

These issues must be taken into account when developing programmes targeted at acute in-patient practice.

There are some emerging examples of good practice in training and education for acute in-patient care, with many of these having been developed in the last five years. Though a variety of approaches have been taken, the aims are generally similar and include:

- Improving the skills and knowledge base of practitioners
- Improving the values and attitudes of practitioners towards service users
- Promotion of collaborative working between professional groups, service users and carers
- Improvement in outcomes of care for service users

A range of means have been utilised within acute in-patient care to achieve these aims. This chapter aims to explore some of these methods, their outcomes and how they might be sustained in practice.

5.2 Whole team approaches

Many acute in-patient wards plan team events where the whole team goes to external premises for a day. The aims vary from planning future work to improving the service or considering issues around morale and teamworking. The days are costly as bank and agency staff are often used to cover the ward. Though these events may be useful in terms of seeing colleagues outside their traditional roles, there is rarely any means of gauging the success or otherwise of such events.
Whole team training has been attempted in acute in-patient care in a variety of guises, often with the aim of tackling replacement costs associated with whole team approaches. Some examples of these are included below.

Organic training (Lord et al 2003) – This project involved a skilled facilitator working alongside ward staff, with specific aims and learning outcomes for the shift. A debriefing session was held at the end of each shift to collate learning and to consider integration into routine practice. The project utilised two lecturers, a senior nurse and a researcher. Evaluation took place through observation before and after the intervention. Positive outcomes were noted in the areas of wards rounds, handovers and discussion of medication side effects.

The Oxford project (SCMH 2003) – This project took a project management methodology to learning and development. Each of six wards was given a menu of areas to work on and self selected project areas. Most wards chose to work on self injury in acute in-patient context. Teams were provided with ward based, repeated training sessions that had a skills focus. Project work ran concurrently with these sessions with the aim of introducing the skills into routine practice. Positive outcomes were noted in terms of changes in attitude towards people who self injure and integration of some skills into practice.

Addressing acute concerns training (University of Manchester 2003) – This project involved repeating training sessions to ensure maximum take-up by ward staff from the three participating NHS Trusts. The training broadly covered PSI, assessment and ward procedures e.g. observation, with an 18 day programme on offer to all staff. The extensive project evaluation noted changes in assessment and planning care and on morale on the teams involved. Non-aligned staff particularly benefited from this intervention, though issues were raised regarding accommodation of different levels of knowledge and skill within such programmes.

Some commonality exists in the aims of these programmes in that they:

- Focused on developing skills and attitudes and promoted behaviour change
- Trained a critical mass of practitioners, which was seen as important
- Focused on interventions which had credibility, and were useable and meaningful to practitioners in acute in-patient care
- Were open to both professional and non-aligned staff

However, different methods were employed to achieve these aims. For instance, the addressing acute concerns and Oxford projects involved repetition of training events with the aim of including all ward staff over a period of time, whilst the organic training model advocates training whole teams. How the interventions were made credible and meaningful was also achieved through different means. Limitations to these projects include:

- Only one of the projects was evaluated from the perspective of service user outcomes e.g. recovery, symptom reduction or satisfaction (Addressing acute concerns project), or service changes
- Few non-nursing professionals were involved in the training programmes and the lack of participation by other professionals was perceived as limiting the potential for change
- Issues on how to resource such training programmes are not addressed either from the perspective of replacement costs, nor is how to source credible and skilled trainers/facilitators

It is far from certain whether or not multi-professional training has a positive impact on team working or clinical outcomes (Reeves et al 2000). However, multi-professional, whole team training is widely seen as 'best practice', as learning is open and explicit and making change within the system is a shared goal.
Good practice in whole team approaches to learning should include:

- Activities that are open to all, regardless of professional status
- Specific activity by professional group
- Involvement of many professional groups in development, delivery and/or evaluation of the programme, with a particular emphasis on the involvement of medical staff
- Involvement of service users and carers in design, delivery and evaluation

- Representation from 'attached services' e.g. CMHTs
- Modified interventions that are useable in the context of in-patient care
- Involvement of a critical mass of people in the training programmes
- Create capacity through making change in the processes of acute wards e.g. observation, ward reviews, handovers
- Considers support and supervision arrangements necessary for implementation of skill
- An evaluation process that at least assesses outcomes in terms of trainees perceptions and skills, but ideally has a focus on behaviour change

Replacement costs associated with these and indeed all education and training programmes are dealt with later in this chapter.

5.3 Validated programmes

Validated programmes are often seen as the gold standard in training and education. It is perceived that when students have a vested interest in completing a programme, integration of skill is sure to follow. However, this may not be the case, and whilst nurses in particular place a high value of validated programmes that lead to an award (Jones 2001), the changes that such programmes bring about in practice are, in many cases unclear.

Though there are validated programmes that have a focus on acute in-patient care, many of these come from a nursing perspective and are centred around awards from the now disbanded English National Board (ENB) for nursing, midwifery and health visiting. Few programmes exist that have a multi-disciplinary focus.

Postgraduate Diploma in Acute In-patient Care – This two year part time multi-disciplinary programme was developed by Sainsbury Centre for Mental Health and validated by Middlesex University in 1999. Its aim is to integrate engagement skills, PSI, leadership and comprehensive assessment into routine acute care practice. The programme is commissioned by NHS Trusts and delivered in the workplace to teams of practitioners from acute in-patient care. A small scale user focused evaluation discovered changes in user collaboration, medication management and intervention skills.

Enhanced skills for Acute in-patient Care – This two module part time programme was developed and validated by the Institute of Psychiatry. The aim is to integrate structured assessment into routine practice and to develop skills in psychosocial interventions and CBT in order to meet the needs identified through that assessment. The programme is delivered at the Institute of Psychiatry and is evaluated through self report.

Validated programmes have a vital role to play in education and training for acute in-patient practitioners. They help practitioners develop skills for clinical practice but also help increase the status of in-patient care, develop critical analysis and reflective skills and provide career opportunities. However, validated programmes must also:

- Equip practitioners with the skills to make change in their own practice and the systems on their wards
- Have a multi-professional approach to learning
- Ensure the utility of the skills developed in an in-patient setting

As there are so few validated programmes in acute in-patient care, existing programmes should also have a focus on creating graduates who are capable of leading learning activity in their own right. HEIs and local service providers should develop partnership arrangements to increase the numbers and types of acute programmes available. This capacity building approach is explored in greater depth later on in this chapter.

5.4 Implementing skills in practice

The broad aim of all of the programmes detailed above is to equip practitioners with the skills and tools to intervene effectively with people who have mental health problems. Though some thought is put into how these skills can be used in practice, it is evident that none of these programmes on their own will reshape an acute in-patient ward into a more therapeutic environment. Although the level of skill increases, the ability to use this skill is limited by a number of factors:

- Human behaviour is dominated by habit and undertaking to change habit is a difficult process
- Ward processes such as handovers and ward reviews need to change to free up capacity for therapeutic intervention
- Risk management procedures such as 'door duties' and observation dominate the culture of many acute wards. They are at best custodial and at worst can create more risk than they solve

The DH Mental Health Policy Implementation Guide for Acute In-patient Care (DoH 2002) goes some way to addressing the command and control issues on acute wards and is pushing ahead with a modernisation agenda for acute services. However, the issues around habitual and traditional practice must also be addressed. Individual practitioners need to recognise the role that they play in maintaining the current system. Following training or practice development, they should expect to implement at least part of their learning in a manner that addresses habitual practice. Education and training providers should devote time to equipping practitioners with the tools to make changes in the way that they work e.g. through reflective practice and supervision skills.

An example of a model used to initiate and sustain changes in practice was developed by the acute in-patient team at Sainsbury Centre for Mental Health and is outlined in Appendix 2. The implementation cycle aims to address some of the issues around implementation of skills in practice. The cycle starts with exposure to new learning, followed by detailed consideration of the implications that this learning has for the individuals practice and for the service as a whole. The practitioner is then asked to examine their motivation and to estimate their confidence in making the change. Reflection on action taken and prevention of regression to previous practice are also elements of this tool. It is hoped that using such tools will help practitioners in acute in-patient care to sustain some elements of their learning in practical situations.

5.5 Developing capacity

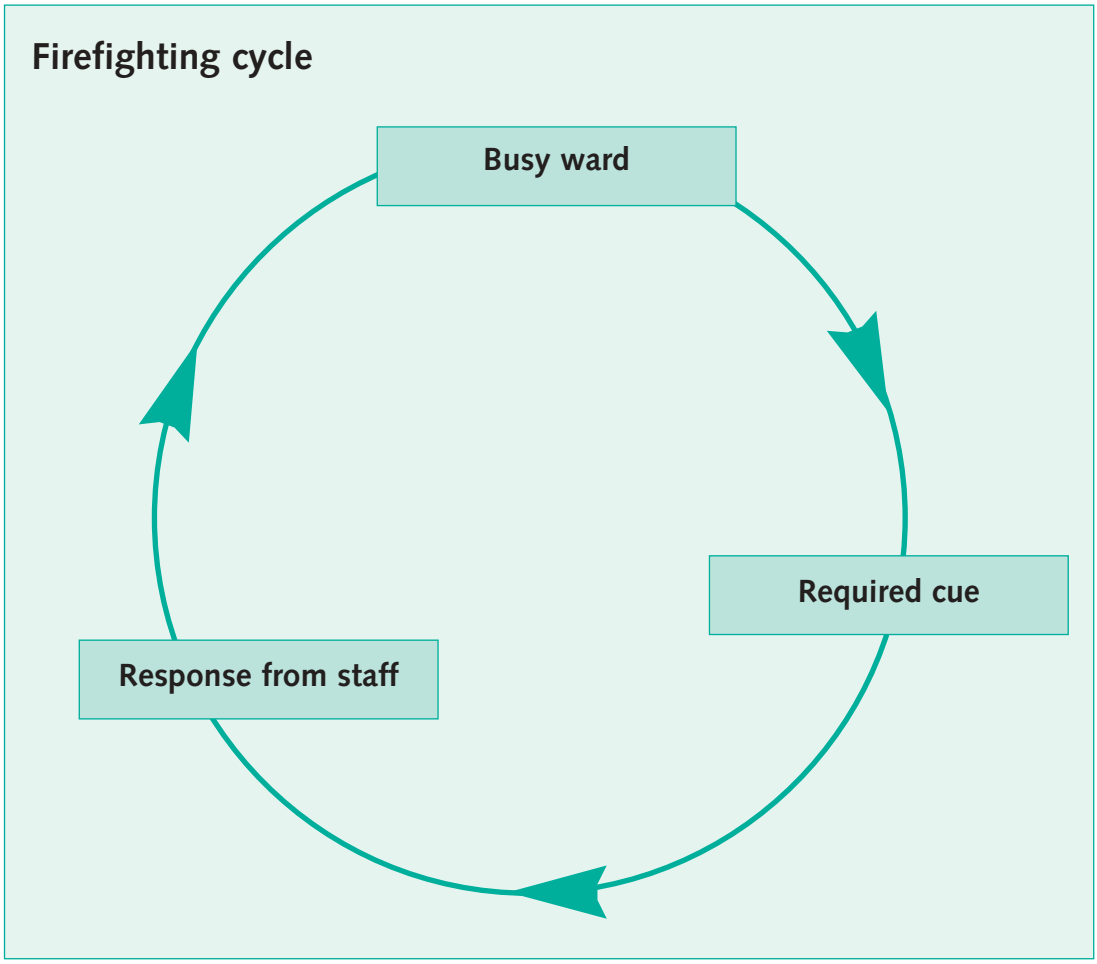
Implementing new skills in an unchanged environment may only add to the complexity that exists in acute in-patient care. This in turn may have a negative impact on the sense of self efficacy of ward teams and on recruitment and retention. Two elements of capacity building need to be explored in order to meet the ongoing learning needs for practitioners and to make the required changes in processes. They involve:

- creating capacity for absorption of learning and implementation of skills into practice, and

- creating capacity to design, deliver and evaluate learning activity

To create capacity ward teams must first address the levels of 'firefighting' activity on their wards. Though laden with negative imagery, firefighting is the common terminology used to define the administrative, crisis management and containment burdens that dominate the workload of ward based practitioners in acute care. Firefighting activity arises for a number of different reasons on acute wards, including the asylum based history of in-patient care.

The diagram below aims to demonstrate a cycle of how firefighting can develop:



Acute wards are by their nature busy places and it is arguable that the core activities of acute wards have become administrative and containment orientated, though many would wish it different. With a lack of structured, meaningful daytime occupation, and staff time dominated by the aforementioned activities, certain cues are required in order to have needs met. These cues form a continuum from demonstrative verbal cues like boisterousness, through to emotional cues such as crying, anger etc. These cues sometimes receive an immediate response from staff in the form of containment activity, which in turn hinders structured engagement with service users. This then adds to the sense of disorder that can be present on some acute wards.

The ongoing programme from the modernisation agency of process mapping and process redesign aims to make the service users journey through the system a more seamless and coherent one. This process can be useful to practitioners in acute in-patient care, as it can highlight where processes such as ward reviews are dominating workloads for all concerned, but providing little in the way of service user outcome or satisfaction. Modifying how these processes take place can free up time within busy schedules to allow for more focused, therapeutic activity.

Even outside the process redesign mechanisms, practitioners are engaged in activity that aims to improve service user experiences of acute in-patient care, as well as build capacity to work in different ways with service users.

The refocusing work conducted in Bradford (Dodds et al 2001) aimed to shift the balance away from observation of service users, toward engaging them in meaningful activity that had a therapeutic value. Positive results were noted in terms of user satisfaction with the service and in morale of ward staff.

It is clear that in-patient care can and should change the current models of working away from ones that feed the into the cycle of firefighting, towards ones that have a positive outcome for service users and help staff focus their work on therapeutic intervention.

Developing capacity for ongoing learning and development in acute in-patient care involves more than just changing processes and refocusing activity. A range of educational and learning activity is required to improve the skill and knowledge base of practitioners. Neither the education or service providers have significant amounts of capacity at present to meet these needs. A long-term view on how to develop and sustain learning activity is required.

Advanced or consultant level practitioners are a superb learning resource and often have teaching and training commitments as part of their posts. Practice development facilitators are available in some areas, but not in others. Most wards will have a link with their local Higher Education Institution (HEI) through link lecturer or lecturer practitioner arrangements. Local service user groups often have extensive training and development experience and expertise. Acute Care Forums should consider drawing these local resources together with the aim of developing a coherent and long term strategy for practice development and learning in their services.

In developing such strategies, Acute Care Forums should work with the above mentioned groups and local HEIs to develop validated modules and awards. These programmes must have a strong focus on skills development, leadership, psychosocial interventions and implementation, all with the aim of improving acute in-patient care. Such programmes will be offered on a multi-professional basis to all practitioners working in acute in-patient care.

With the NHS University (NHSU) now in place, there has never been a better opportunity for practitioners and services to be involved in curriculum development. Regional Development Centres should make contact with their regional office of the NHSU to ensure a high priority is made of acute in-patient training and development in its post-launch programme.

5.6 Evaluation

Most programmes of training or education include some form of evaluation. This is an essential tool for the continued maintenance of quality and improvement of such programmes. Kirkpatrick (1967 cited in NIMHE 2003) details a hierarchy of evaluation for training that consists of four levels of training evaluation.

Figure 2 – Kirkpatrick Model of evaluation for training

Level 1		Trainees reactions to training
Level 2	**2a** **2b**	Modification of attitudes or perceptions Acquisition of knowledge or skills
Level 3		Changes in trainees behaviours
Level 4	**4a** **4b**	Changes in organisational practice Benefits to users from changes in practice

Many programmes evaluate to the level of trainees reactions to the training programme (level one), and though such evaluation can be useful in improving training programmes, it does not demonstrate how learning has been integrated into practice. Using Kirkpatrick's model it is suggested that training and educational input to acute in-patient care be evaluated to at least a 2a level (Modification of trainees attitudes or perceptions) or level 2b (Acquisition of knowledge and skills). Thus it is hoped that such evaluations will contribute to the body of knowledge around training and education in acute in-patient care.

It is also crucial that NHS Trusts, Workforce Development Confederations (WDCs) or Regional Development Centres (RDCs) are able to gauge the success or otherwise of learning activity. With this in mind, commissioners of training and educational programmes should expect formal reports from training and educational providers on:

- Whether or not learning outcomes have been met
- Levels of academic attainment
- Progression for successful participants
- Integration of skills into routine practice
- How local capacity has been developed as part of the programme

The Northern Centre for Mental Health has developed a tool for the evaluation of training programmes for Mental Health (NCMH 2003). It is suggested that all WDCs and NHS Trusts who commission training or educational programmes adopt this tool to assess their current provision. It is proposed that this tool could also be used to provide a template for the design and delivery of new programmes focused on acute in-patient care.

5.7 Replacement costs

The emerging picture of training and education for acute in-patient care is one of paralysis, with few providers currently offering training and education with a specific aim of improving the service. It is arguable that this position has been caused to a large extent by the failure to address the issue of replacement cost.

As a truly twenty-four hour service, acute in-patient services are required to provide round the clock medical and nursing care. This is a costly service to run and is still the largest single element of cost in the mental health budget. Despite this, in-patient service budgets are lean, and there is little flexibility within them to release staff for training and education. Some innovative 'in-house' training programmes have collapsed due to the lack of financial support. Releasing whole teams of in-patient staff on a regular basis is a financial impossibility for most organisations.

It is clear that there is no straightforward answer to the issue of replacement costs. Asking WDCs to fund replacement costs for acute in-patient wards in their entirety would bankrupt them within a few months. However, asking acute wards to bear this significant cost pressure on their own is no longer realistic if we expect an improved in-patient service.

Service providers should be working with WDCs at an early stage in the commissioning of acute in-patient training and education. It may be possible to demonstrate more efficient use of staff resources or improved healthcare outcomes through programme evaluation or cost/benefit analysis. Indeed, learning environments and access to training can all have a positive impact on retention of staff. With this in mind, training and development must be viewed as an investment in the future recruitment, retention and satisfaction of staff. This may be a powerful argument for at least some of the replacement costs.

Service providers should be able to meet the replacement costs for a percentage of their workforce from existing budgets. WDCs could cover another matching percentage. The rest of the replacement staff compliment could be met in a variety of ways:

- Through a 'buddy' system e.g. where a Community Mental Health Nurse (CMHN) will cover for acute in-patient staff nurse when they are to be released for training.

- Through a whole team buddy system e.g. where a crisis intervention team will cover an in-patient ward for day release of the ward team.

- By staffing acute wards in innovative ways for short periods of time e.g. a mix of OT, medical and nursing staff to enable day release.

Using work based learning approaches may significantly reduce the need for replacement costs. These approaches are highly reflective and are aimed at producing learning that is highly relevant to the work people do.

There are many grant-giving organisations outside the NHS that could be used as a source of funding. NIMHE should establish a central database of such organisations and regional development centres should co-ordinate approaches being made to such organisations.

The Commission of the European Union provides funds for the development of lifelong learning cultures within organisations, and this could be a potential source of replacement and development costs for acute in-patient programmes.

5.8 Multi-professional practice

Due to its complex and multi-professional nature, acute in-patient care is bound to uncover differences in philosophy and approach between different practitioners. Though this diversity can be a source of strength, it can lead to inter-professional conflicts, especially where there are different views of what the aims and objectives for an in-patient stay are.

Though training and education along professional lines may go some way to equipping practitioners with the skills they require, it does little to address the interface issues when working in complex environments.

Inter-professional training and development activity is perceived by some as of low value, often because it does not satisfy Continuing Professional Development (CPD) requirements. It can also be perceived as threatening to expose gaps in knowledge or skill in the presence of other professional groups.

Cohesion between professional approaches depends to a degree on:

- Understanding the core philosophy and principles of a range of professional groups
- Building relationships between practitioners from a variety of backgrounds
- Developing a degree of role clarity between the professionals
- Strong leadership facilitating the above

With this in mind, Acute Care Forums should engage the different professional groups in discussion about the above issues prior to any further multi-professional programmes. This should be achieved by the identification of 'champions of multi-professional practice' from each of the groups concerned. It is hoped that this group will develop a vision of how the different professional groups can work in collaboration, and hence provide clarity of role, responsibilities and the purpose of acute in-patient care.

6. Leading and Supporting Lifelong Learning

6.1 Introduction

Systems for ongoing learning, supervision, training and appraisal should be a fundamental part of the working arrangements of all acute mental health services. The reality in acute in-patient care is somewhat different at present, with few ward based practitioners having access to regular supervision or learning activity. The forces restraining change in these areas are similar to those previously mentioned i.e. replacement costs, accessing skilled supervisors and firefighting activity takes precedence. Creating capacity within the service may go some way to liberating time for these activities.

The policy implementation guide for acute in-patient care has ensured that service users and non-ward based practitioners have a say in how acute wards are led. Through this medium, the specific learning needs related to leadership skill need to be addressed for all practitioners in acute in-patient care.

6.2 Supervision and support

If practitioners are to embed new learning and skills into their routines and make changes in the way that they work, then adequate support and supervision is essential to making this happen. Without it, use of new skills and learning may well be compromised.

Many practitioners and researchers have attempted to embed supervision arrangements in acute in-patient care, with varying degrees of success. The firefighting processes previously mentioned often restrain such changes and a co-ordinated programme of change for acute in-patient care to address these issues is recommended. Also, there are wide variations in the structure, form and purpose of supervision, even within ward teams.

Informal supervision is often a significant form of support to ward based practitioners, and this should be recognised as a useful and important part of in-patient practice. However, more formalised approaches should compliment these arrangements.

All practitioners must have access to learning activity about the role of supervision, how it should take place, local policies and practices and minimum requirements. This activity could take the form of a work-based learning handbook that encourages practitioners to experience reflective and experiential processes, as well as giving and receiving feedback.

Acute Care Forums should be tasked with assessing the current provision of supervision and supervision training and the informal support arrangements that take place.

Diversity in the provision of supervision may well be required, but a basic level of supervision must be available to all practitioners in acute in-patient care. Complex 1:1 supervision arrangements may be operating successfully in some areas, but may also be far beyond the reach of others. Acute Care Forums should address the basic requirements of supervision by considering:

- Group supervision arrangements that have a specific approach e.g. CBT
- Buddy systems where ward based practitioners are supervised by non-ward based practitioners
- The involvement of small, mixed professional peer groups that provide caseload supervision

Also, Acute Care Forums should consider where supervision arrangements are strong e.g. Occupational Therapy, and use this learning to influence supervision structures that require further development.

6.3 Creating learning environments

Improving the effectiveness of the acute in-patient care workforce requires personal, professional and organisational development, and cannot be achieved in isolation from the rest of the mental health care system, or the NHS in general. The Department of Health set out future of education and training in the NHS in its 2001 document "Working together – learning together" (DoH 2001b), with the aim of meeting the challenges set out in the NHS Plan (DoH 2000). Part of this document established the characteristics of a learning environment. These include:

- A coherent, well resourced learning strategy
- Appraisal and personal development planning
- Flexibility of and access to training and learning activity
- Access to learning resources e.g. computers, libraries
- Linking career progression and reward to education and training
- A variety of learning activities e.g. mentorship, placements
- Evaluation, monitoring and publication of training

The characteristics of a learning environment DoH 2001b

Much work on implementing "Working together – learning together" will already be underway in NHS organisations. Acute Care Forums should be aware of the steps already taken within their organisation to make the required changes. They should be developing strategic and developmental five year programmes of learning activity for their services based on the organisational and service aims. Access to learning facilities on in-patient wards must be audited and provision made for all ward staff to access internet ready computers.

Individual practitioners have the opportunity and the responsibility to turn their work into learning activity for themselves and for others. Taking the time to meet colleagues from different professional backgrounds can open up new perspectives. Placements in other services can help to prevent inter-professional conflicts and can support a sense of teamworking.

6.4 Work based learning

Work based learning (WBL) is an approach that allows practitioners to learn from their work in a structured manner, test out changes in practice and to be highly reflective and reflexive. It enables participants to become more in control of their learning and can form whole or part of academic awards from foundation degrees to doctorate level study.

Though most elements of work based learning programmes are self selected, acute forums could develop specific modules that would lead to attainment of a specific set of skills.

Example of work-based learning

A newly qualified staff nurse joins an acute in-patient team. She needs to develop an awareness of engagement and assessment processes used on the ward, and needs to develop her skills in this area too. She works though a work based learning handbook that encourages her to reflect on her current skills, identify her learning needs and identify potential learning activities. She develops a programme that includes:

- A taught session from a charge nurse on the CAN and BPRS
- Two supervised practice sessions with the charge nurse
- Feedback from the service user and the charge nurse
- A reflective account of the process

On the downside, WBL is not for everybody as it can require a degree of personal motivation – the 'what's in it for me' factor. NIMHE, WDCs, RDCs and individual NHS organisations should stimulate the development of work based learning resources that have a specific remit to in-patient care. These programmes should be developed with a local HEI and accreditation should be sought for learning achieved in this way.

6.5 e learning

Using modern technology to assist in the development and delivery of training and education could bring benefits to acute in-patient teams. The development of web-based learning is a priority area for the UK government and several initiatives are underway to support this. It is envisaged that at least part of the NHSU programme will be delivered through e learning. This will help practitioners to undertake learning activity at a time that suits them and to plan their learning around their other commitments.

The UK eUniversity (UKeU) is a government initiative that supports HEIs that wish to develop e learning initiatives. Curricula can be developed and delivered over the internet with the support of UkeU and this could have real benefits for acute in-patient practitioners. Education providers wishing to provide learning and training for acute in-patient practitioners should explore the options of e learning. NIMHE should support a pilot programme in training and education through web-based learning and video conferencing for acute in-patient practitioners. The Information Technology (IT) infrastructure and study time required to maintain such programmes must be explored in further detail following on from this pilot.

6.6 Leadership issues

Effective leadership is the lynchpin of all successful interventions within the NHS. Without it, no project can meet its aims and objectives, and this is especially true of acute in-patient care. There has been a clear deficit in clinical leadership in acute in-patient care, with many skilled and experienced practitioners taking better paid and higher status positions in the newer services such as crisis intervention (SCMH 2000).

The core function of leadership in the NHS is change management, and given the high expectations for change from inside and outside acute in-patient teams, this deficit is alarming and a priority that must be addressed with the greatest urgency.

Each acute care forum should define the local leadership priorities, whilst addressing the core functions for acute in-patient leadership described below:

The core functions for acute in-patient leadership

- Leading and sustaining changes in clinical practice and ward routines
- Making in-patient care more collaborative with service users, carers and other teams and professionals
- Developing the leadership skills of the whole team
- Encouraging other professionals to take a role in in-patient leadership
- Developing enthusiasm and optimism around acute in-patient care

The skills required to deliver these might include:

- Negotiating skills
- Influencing skills
- Conflict resolution and motivational skills
- Project management and planning
- Developing a collaborative vision
- Coaching, mentorship and supervisory skills
- Training and teaching skills
- Political development

Many, if not all of the above skills could be attained through mentorship, work based learning and training approaches. Ward leaders and consultant level practitioners must have access to some learning activity around leadership in the initial stages of the development of training and educational plans for acute in-patient care. The aim should be to produce competent, credible and authoritative leadership styles.

Many leadership programmes are available through a variety of approaches including e learning. Prior to commissioning, these programmes should be audited against the local priorities for leadership in acute in-patient care. However, none has a specific remit to develop leadership skills at a variety of levels whilst acknowledging the uniqueness of acute in-patient care. NIMHE should explore the development of such programmes on a regional or national level.

6.7 Regional acute in-patient networks

Many of the NIMHE development centres are currently developing collaborative networks of acute in-patient services across their regions, based on the significant successes of the Northern Trent, and Yorkshire Acute Mental Health Collaborative (Robert et al 2002). These networks provide a vital link to areas of good practice and can help motivate and sustain change. As with training and educational activity, they should include representation from all in-patient practitioners, service users and carers. Collaboratives can take many different forms and no one model can be shown to provide the greatest change. Their very nature means that acute care collaboratives must be sensitive to regional diversity and local need. Some key factors that influence success within collaborating organisation include:

- The extent of senior management support
- A transformational and supportive leadership style
- Organisational ability to adapt to the collaborative style
- Level or empowerment of the collaborative by the organisation
- The organisations attitudes towards innovation and risk

(Roberts et al 2002)

Given the highly diverse approaches to collaboration, RDCs and collaboratives must be cognisant of these issues. Also, careful evaluation of this approach using a standardised framework, developed by NIMHE, will allow meta-analysis at a later date of the findings from each, which may point towards the most effective collaborative approach.

7. Recommendations

7.1 Introduction

This final chapter of the training guidance for acute in-patient care aims to highlight some of the areas for change that have been described in this document. Each recommendation includes a suggested organisation or individual who could take responsibility for action, though in reality many of these points will only be achievable through partnerships and networks.

An overarching recommendation is that a partnership be formed in each region to further develop the ideas laid out in this document. This partnership must include the WDC, RDC, NHS Trust acute care leads, HEIs, Service User and Carer organisations, the voluntary sector and others. These regional partnerships must be networked into the national in-patient steering group through the acute care lead for each region to enable sharing of expertise and prevent unnecessary duplication.

7.2 Recommendations for education and training providers

7.2.1 – Training and education providers must acknowledge the current values base of the workforce and reinforce the importance of recovery, optimism and hope as significant tools in the promotion of mental wellbeing. All programmes of training, education and development that have a focus on acute in-patient care must integrate values-based practice, prioritise recovery and reflect the emerging shared capabilities.

7.2.2 – Training, education and development providers must ensure that they engage service users and carers in the design, delivery and evaluation of their programmes. Using the National Continuous Quality Improvement Tool (NCMH 2003) will ensure that acute in-patient programmes have a specific focus on this area.

7.2.3 – Training, development and education providers must be engaged in the rigorous evaluation of acute in-patient programmes. This should be above the level of trainee satisfaction. A collaborative evaluation report must be provided to the commissioners detailing learning outcomes met/unmet, academic attainment, progression, integration of skills into practice and how capacity for change has been developed.

7.2.4 – Training and development providers must form partnerships with local service providers to encourage diversity and innovation in the field of acute in-patient training. Such training programmes should produce graduates capable of co-delivering education and training in the workplace or at least capable of dissemination of these skills to others.

7.2.5 – All programmes of training, development and education must have a clear vision about how skills can be integrated into practice and should have a theoretical framework through which this can happen.

7.2.6 – HEIs must develop their capacity to deliver training and education that is focused in the realities of acute in-patient practice. This may require that HEI staff maintain currency of skills and practice in the field of acute in-patient care. With this in mind, HEIs must develop a strategy for clinical skills development of their staff.

7.2.7 – Those developing innovative programmes of training and education should be creative in exploiting funding sources outside the NHS e.g. the Commission of the European Union, charitable trusts.

7.3 Recommendations for Acute Care Forums

7.3.1– Acute Care Forums (ACFs) must clarify existing confidentiality arrangements for acute in-patient wards to ensure that some of the barriers to carer collaboration are removed. Carers, service users and practitioners must be involved in this process.

7.3.2 – With local ACFs leading the way, NHS Trusts should develop a clear understanding of and a detailed plan for cultural competence within acute in-patient care. In-patient practitioners should at least undertake cultural awareness and diversity training.

7.3.3– ACFs should respond to the core capabilities of acute in-patient practice and the shared capabilities framework by developing a complex web of learning activities that have a focus on acute in-patient care. This should include validated and non-validated programmes, individual learning activity, whole team learning and multi-professional learning. They should identify local learning resources to assist in undertaking this activity e.g. consultant level practitioners, service user and carer groups, HEIs, the RDCs and NIMHE could and should support this activity.

7.3.4 – ACFs should identify inter-disciplinary 'champions' who will focus on bringing professional groups closer together and develop a vision for closer working within acute in-patient care, support greater role clarity and opportunities for shared learning.

7.3.5 – Whole team approaches to learning in acute in-patient care must have a robust multi-professional approach if they are to succeed in making and sustaining change. Such programmes should at least involve nurses, psychiatrists and occupational therapists in order to be truly multi-disciplinary.

7.3.6 – ACFs should make recommendations to their Trust Boards about replacement costs for training. Close collaboration around meeting these costs must be developed between NHS Trusts WDCs and the RDCs. Each NHS Trust should be involved with WDCs in their formation of a policy in this area.

7.3.7 – ACFs must assess current supervision practice in terms of availability and take-up. All practitioners must have access to basic supervisory skills development. Diversity of provision should be created through team, 1:1, group or mixed professional supervision. These arrangements must be regularly audited and improvements made, with the aim of providing some level of supervision to all practitioners in acute in-patient care.

7.3.8 – ACFs should develop a strategy for the development of multi-professional learning environments in acute in-patient wards. They should develop five year plans for the development of education and training of acute in-patient practitioners.

7.3.9 – Maintenance of service users employment and educational activity must become a key aspect of an admission to hospital. All in-patient practitioners, be they ward based or otherwise, must have access to training that helps them to facilitate a return to work or education and that ensures collaboration between service users, carers, practitioners and employers/educators.

7.4 Recommendations for Regional Development Centres

7.4.1 – Regional Development Centres (RDCs) have a vital role to play in capacity building in acute in-patient care. Through ongoing process redesign it is hoped that this will provide service users with a more consistent and smooth journey through the service. It should also have a focus on creating capacity for learning and developmental activity for practitioners, through changing some of the customs and practices of acute in-patient wards e.g. handovers, ward reviews. Such changes should be piloted and studied.

7.4.2 – RDCs, WDCs and training and education providers should be in frequent contact with their local office of the NHS University and should ensure that acute in-patient care is a priority for its post-launch programme.

7.4.3 – RDCs, Acute Care Forums and NHS Trusts must ensure the availability of leadership development programmes to all levels and grades of practitioners in acute in-patient care.

7.4.4 – RDCs have a clear, strategic responsibility to take these recommendations forward and to 'jump-start' the process of acute care development.

7.5 Recommendations for Workforce Development Confederations

7.5.1– Workforce Development Confederations (WDCs) and NHS Trusts should assess and audit training and education provision for quality, improvement, service user and carer involvement and outcome. The use of a quality improvement tool e.g. the Northern Centre for Mental Health Quality Improvement Tool (NCMH 2003), is recommended.

7.5.2 – WDCs should review existing replacement cost strategies and produce a policy on replacement costs for training and development in acute in-patient care. This should be available to and developed with NHS Trusts and assist them in making decisions about commissioning training and education. Consideration should be given to ring-fenced funding for the development of innovative training and development programmes that matches financial commitments made by NHS Trusts.

7.6 Recommendations for NIMHE

7.6.1 – NIMHE is developing a central database of good practice in training and education, and this must have a specific category for acute in-patient care. This will highlight providers, evaluation data and sources of funding outside the NHS.

7.6.3– NIMHE should examine the potential for work-based learning and e-learning in acute in-patient care through the development, delivery and evaluation of a pilot programme. Closer ties with the UkeU, NHSU and training and development providers could facilitate this development.

7.6.4 – NIMHE should consider the development of national, high level leadership programmes for consultant level practitioners in acute in-patient care.

7.6.5 – NIMHE must develop a standardised framework for the evaluation of acute care collaboratives. Information from all such collaboratives should be stored centrally to allow for analysis and the further development of the collaborative approach.

Appendix 1
User and Carer Consultation on Guidance

A number of key stakeholder groups were identified as important for consultation on the draft guidance as prepared by NIMHE. These included:

- Carers
- Service users
- Acute in-patient staff
- Higher education staff (HE)
- Others including NIMHE regional leads for acute in-patient care, voluntary sector groups representing one of the above

A key issue for this consultation was the currency of experience of acute in-patient care. All participants were required to have had current experience (in the last six months) of either working in, using, caring for somebody in or developing training and education for acute in-patient care.

As well as a number of ad hoc comments from the sources listed above, a semi-structured focus group approach was adopted to gather people's views on the draft guidance as well as their perceptions of acute in-patient care in general. A structured feedback tool was developed to assist participants in preparation for the focus group or to enable feedback from those unable to attend.

Participants in the focus groups were explicit in their desire to support the people who work in acute in-patient care and as such the results of the focus groups with service users and carers are reported in greater detail.

Carer Focus Group

A number of carers who met the criteria as outlined above, were invited to a focus group. Participants received the draft guidance, commissioning notes and the structured feedback tool well in advance of the focus group.

The group provided significant amounts of feedback on their experiences of acute in-patient care in general and more specifically on the draft guidance itself. Some of the very important issues that were raised included:

- An often contradictory approach from ward staff
- The lack of cohesion between ward and community teams
- An inability to see who was 'in charge' on a day to day basis and able to make decisions about care
- The absence of a clear leader for the ward team
- Reluctance to share information with users and carers
- Drug abuse on wards and the lack of security in general
- The levels of side effects experienced by service users
- The lack of culturally appropriate approaches for clients from all backgrounds
- The dominance of the medical model in acute in-patient care
- The staff teams were often pessimistic about outcomes for service users
- The risk averse cultures that often make risks higher
- The lack of appropriate activity on wards e.g. for younger males

The key themes that seem to emerge from a training and education perspective are:

- Ward and shift leadership
- Psychoeducation skills
- Legal issues e.g. confidentiality
- Working with complex needs e.g. dual diagnosis
- Medication management
- Engagement skills
- Cultural competence
- Discharge planning
- Models of recovery

Service user focus group

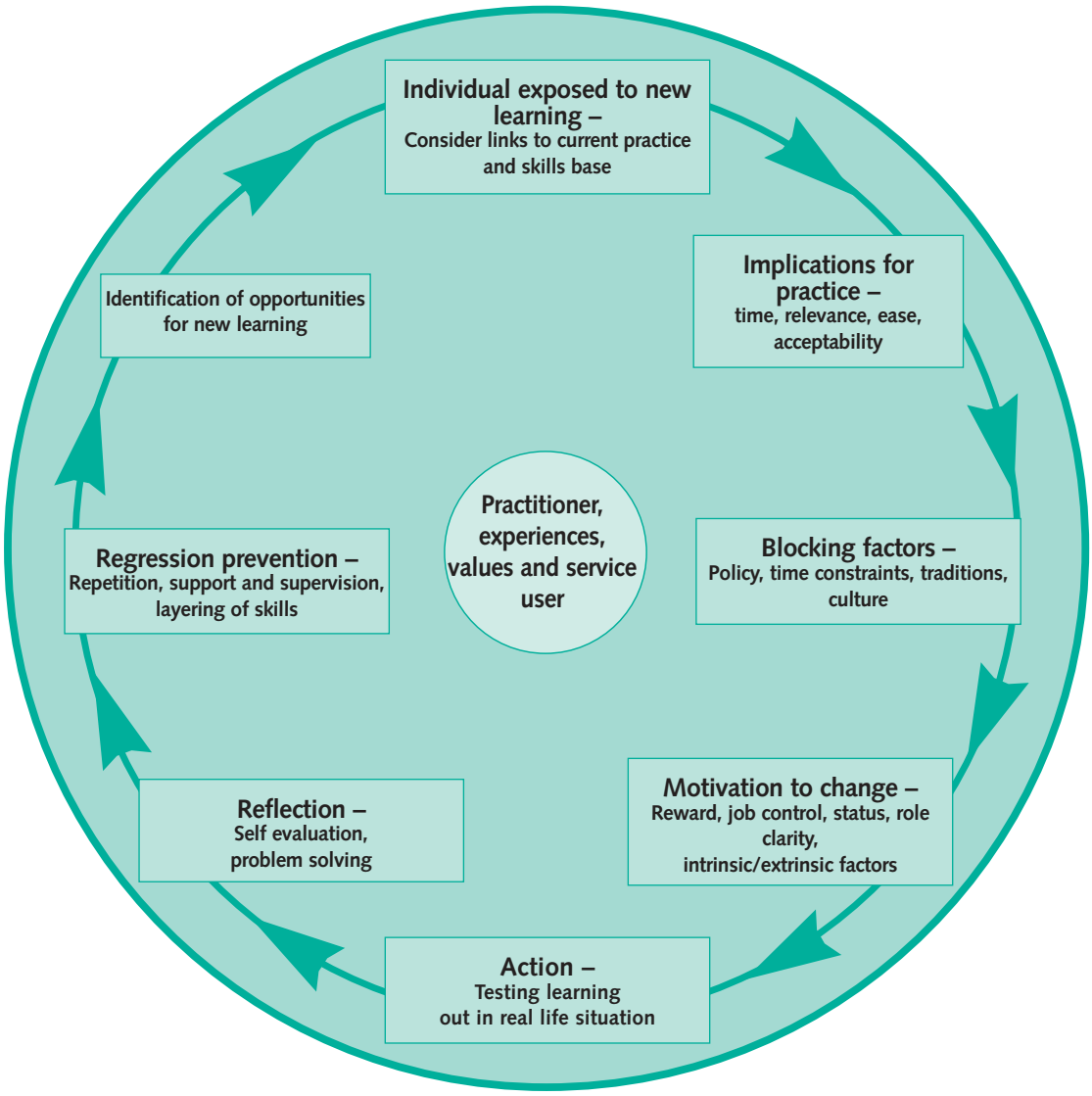
A number of service users were invited to a focus group in August 2003 which was facilitated by two independent service user consultants. Again the draft guidance, the commissioning notes and the structured feedback tool were provided well in advance. Significant feedback on their experiences of in-patient care and the guidance were given including:

- The lack of ward leadership or the skills to improve or change things
- The general feeling of wards being unsafe places
- The fact that professionals don't seem to see things in the same ways and often contradict each other
- Newly qualified nurses, doctors and OTs seem to be under-prepared by their training for the challenges acute in-patient care
- There is sometimes little sensitivity towards people from other cultural backgrounds and that this can also be an issue between people from minority ethnic groups
- The specific needs of women are not addressed e.g. lower income base, childcare
- Lesbians, bisexuals, gay men and transsexuals (LGBT community) are sometimes subjected to prejudice from both staff and other patients. There are significant issues for some people from some minority groups working with LGBT people
- Involvement in training and education is often piecemeal
- Service users are sometimes spoken to in inappropriate ways or not at all. Sometimes there views are not listened to
- Some staff have a pessimistic attitude and only see people at their worst
- There is often little connection between services
- Drug use is a fact of life on some wards
- Some staff react to self injury in a judgmental manner

The key themes that seem to emerge from a training and education perspective are:

- Leadership and change management skills
- Lack of inter-disciplinary training
- Inter-team training
- Improved skills development in pre-registration training for all professionals
- Cultural competence
- Service user led training
- Recovery and optimism
- Complex needs e.g. self injury, dual diagnosis

Appendix 2
Implementation Cycle



Appendix 3
Good Practice Search – Academic Programmes

PROVIDER	Institute of Psychiatry
COURSE TITLE	Enhanced Skills Based Training for Inpatient Mental Health Professionals
COURSE AIMS	To introduce participants to current research based assessment, psychological and psychosocial interventions and management of serious mental illness. Using evidence based practice it will provide specific skills and knowledge in taking a proactive role in the management of serious mental illness
DURATION	24 weeks
LEVEL	2/3

PROVIDER	Sainsbury Centre for Mental Health
COURSE TITLE	Postgraduate Diploma in Acute In-patient Care, Postgraduate Diploma in Acute Mental Health Care & MSc in Acute In-patient Care
COURSE AIMS	To prepare practitioners with the skills and knowledge required for specialist practice within acute in-patient care or community based acute care settings. All interventions are evidence based and are relevant/useable in an acute in-patient setting.
DURATION	2 years (1 year for MSc)
LEVEL	3 and 4

PROVIDER	**Nottingham University (School of Nursing and Academic Division of Midwifery)**
COURSE TITLE	Acute Mental Health Care
COURSE AIMS	The purpose of the module is to enhance the skills and practices of health professionals working in the acute in-patient setting by developing knowledge and awareness of best practice within the field of acute adult mental health. The module will encourage students to appraise their own practice through reflection and to consider new ways of working in co-operation with practice supervisors/managers. The module will explore the socio-political and structural influences on acute adult mental health care and how practice can be enhanced through development frameworks and partnership working. There will also be an emphasis on developing specific competencies and knowledge in line with WMC/Sainsbury Centre for Mental Health Guidelines covering the following broad topics: the management and administration of acute mental health care; conducting collaborative assessments; current medical interventions and evidence based cognitive; behavioural and family interventions
DURATION	2 full contact days, 6 web-based days
LEVEL	2/3

PROVIDER	University of the West of England (Faculty of Health and Social Care)
COURSE TITLE	Acute and Crisis Mental Health Care
COURSE AIMS	To describe the key components of a therapeutic milieu. To utilise specific assessment strategies in acute and crisis care. To discuss risk management strategies in the context of acute and crisis care. To discuss effective integrative care programme approaches in an acute mental health setting. To describe the components of an effective discharge planning strategy. To evaluate the provision of effective psychosocial interventions in in-patient and crisis care settings.
DURATION	N/K
LEVEL	2

PROVIDER	University of Sheffield (School of Nursing and Midwifery)
COURSE TITLE	Assessment Skills in Acute Psychiatric Care
COURSE AIMS	The aim of this module is to provide the student with the opportunity to develop an understanding of the underpinning concepts of assessment modalities applied to acute psychiatric nursing. Students will then apply theory to their clinical practice and develop their specialist skills in assessment.
DURATION	100 hours - taught theory/directed study/self directed 100 hours - clinical practice/reflective study
LEVEL	2

PROVIDER	University of Sheffield (School of Nursing and Midwifery)
COURSE TITLE	Developing Evidence Based Practice in Acute Psychiatric Care
COURSE AIMS	The aim of this module is to provide the student with the opportunity to develop an understanding of the underpinning concepts of assessment modalities applied to acute psychiatric nursing. Students will then apply theory to their clinical practice and develop their specialist skills in assessment.
DURATION	100 hours - taught theory/directed study/self directed 100 hours - clinical practice/reflective study
LEVEL	2

PROVIDER	University of Sheffield (School of Nursing and Midwifery)
COURSE TITLE	Developing Evidence Based Practice in Acute Psychiatric Care
COURSE AIMS	The aim of this module is to enable the students to apply their therapeutic and theoretical skills in a changing health care environment. The emphasis of the module is on utilising evidence in practice by applying research to practice and evaluating this process testing the evidence in practice through audit. The wider context of health care is explored in order to increase the student's socio-political awareness and increase their ability to have an impact on developing practice at a local and national level.
DURATION	100 hours - taught theory/directed study/self directed 100 hours - clinical practice/reflective study
LEVEL	2

PROVIDER	University of Sheffield (School of Nursing and Midwifery)
COURSE TITLE	Therapeutic Interventions in Acute Psychiatric Care
COURSE AIMS	The aim of this module is to provide the student with the therapeutic skills needed in offering responsive and effective care to people who are in the acute phase of a mental illness. Students will be able to explore the wider potential for the application of a range of interventions tailored to meet the needs of individual clients in a crisis situation. Students will be encouraged to develop their appraisal skills in order to facilitate their effective application of theory to practice.
DURATION	100 hours - taught theory/directed study/self directed 100 hours - clinical practice/reflective study
LEVEL	2

PROVIDER	Middlesex University (School of Health and Social Sciences)
COURSE TITLE	Fundamentals and Acute Care Process 1
COURSE AIMS	The organisation and management of care and treatment of the acute phase of mental ill health pose challenges and unique experiences for sufferers and staff alike. These experiences are regarded as being influential for the clients' recovery and future response to the health care system, and the professional responses in delivering care. It is nearly always the case that the acute phase of the illness heralds the first contact with mental health care services. This module therefore, is intended to help students a) to appreciate the significance of the patients experience and the factors contribute to effective and sensitive care; b) the need for careful assessment and management of the acute phase of mental illness through effective multi-disciplinary team work and application of evidence based knowledge and skills c) Collaboration with carers and other agencies in the management and administration of care d) to be aware of and appreciate the use of relevant and appropriate patient-centred interventions.
DURATION	N/K
LEVEL	2

PROVIDER	Middlesex University (School of Health and Social Sciences)
COURSE TITLE	Fundamentals and Acute Care Process 2
COURSE AIMS	The care and treatment that a person receives upon first entering the mental health services and during the florid phases of his/her illness sets the scene for that person's future responses to the mental health care system and the outcome of his/her care and treatment. This module is intended to offer participants the opportunity to develop the knowledge, skills and attitudes for effective functioning in the acute area of mental health nursing. It is also intended to introduce the student to patients with critical metal health issues from the point of patient's contact with the mental health service/unit, to their disposal into continuing care services elsewhere. Critical examination of models and interventions are encouraged to develop students' application of these in an evidence-based perspective.
DURATION	N/K
LEVEL	2

PROVIDER	City University (St Bartholomew School of Nursing and Midwifery)
COURSE TITLE	Assessment in Acute, Adult In-Patient Mental Health Settings
COURSE AIMS	This module will enable the mental health nurse working in acute adult inpatient settings to undertake assessment of patients using recognised evidence based assessment tools. The main focus is psychosocial skills in working with severe mental illness. Content also includes risk assessment skills in violence and aggression, the National Service Framework, ethical and legal frameworks, cultural issues and dual diagnosis. A clinical practice assessment in the workplace is also included. This module can be taken at either level two or three depending upon previous academic experience.
DURATION	Flexible
LEVEL	2/3

PROVIDER	City University (St Bartholomew School of Nursing and Midwifery)
COURSE TITLE	Interventions in Acute, Adult In-Patient Mental Health Settings
COURSE AIMS	This module will enable the mental health nurse working in acute adult inpatient settings to undertake interventions with patients using recognised evidence based interventions. The main focus is psychosocial skills in working with severe mental illness. Content also includes interventions in violence and aggression, the National Service Framework, ethical and legal frameworks, cultural issues and dual diagnosis. A clinical practice assessment in the workplace is also included. This module can be taken at either level two or three depending upon previous academic experience.
DURATION	Flexible
LEVEL	2/3

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Glossary

ACF	Acute Care Forum
BPRS	Brief Psychiatric Rating Scale
CAN	Camberwell Assessment of Need
CBT	Cognitive Behaviour Therapy
CE	Chief Executive
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPD	Continuing Professional Development
DH	Department of Health
HEI	Higher Education Institution
HR	Human Relations
IT	Information Technology
LIT	Local Implementation Team
MH	Mental Health
NHS	National Health Service
NHSU	National Health Service University
NIMHE	National Institute for Mental Health in England
OT	Occupational Therapist
PCT	Primary Care Trust
RDC	Regional Development Centre (NIMHE)
SCMH	Sainsbury Centre for Mental Heallth
SHA	Strategic Health Authority
STR	Support, Time and Recovery worker
UkeU	United Kingdom Electronic University
WBL	Work Based Learning
WDC	Workforce Development Confederation

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