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ORIGINAL RESEARCH ARTICLE

Evaluating the impact of team formulation on staff perceptions of patients and impact on care in an acute inpatient setting

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Team formulation is a widely used method of conceptualising mental health needs and aims to develop staff understanding of the complex challenges and behaviours that can occur when providing care; however, research understanding application to acute wards is limited. This study assessed whether team formulation using the Comprehend Cope Connect model in an acute inpatient setting impacted staff perceptions of patients, and whether it influenced subsequent care. A mixed-methods study with a primary repeated-measures, quantitative questionnaire design was used with staff self-rating their knowledge, understanding, confidence and motivation pre- and post-team formulation meetings and providing feedback about the helpfulness of the formulation. Patient notes were examined for evidence of formulation plan action points. Staff ratings increased significantly on all areas of knowledge ($t = 10.89$; $p<0.001$), understanding ($t = 7.96$; $p<0.001$), confidence ($t = 7.74$; $p<0.001$) and motivation ($t = 11.12$; $p<0.001$) following team formulation, with a significantly greater increase in confidence reported by less experienced staff. Feedback was positive, with the opportunity to learn and share information particularly valued. An inspection of clinical notes two weeks later found evidence of completion for almost 40% of actions identified in the plan from the formulation meeting (a 65% completion rate if actions which were unlikely to have been recorded in clinical notes within two weeks were excluded from the calculation). The results provide evidence of a positive impact on staff perceptions and patient care, and suggests that team formulation may particularly help less experienced staff to feel more confident.

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Introduction

The need to improve the therapeutic nature of acute inpatient mental health care is regularly highlighted by reviews, policies and guidelines (Mind 2011; NHS England 2019; Staniszewska et al. 2019; Schizophrenia Commission 2012; Ebrahim & Wilkinson 2021). With a strong focus on medical treatments, the setting is seen as a temporary place of stabilisation, risk reduction, recovery from crisis and prevention of readmission (Schizophrenia Commission 2012; Phillips et al. 2021); inpatient stays, therefore, are frequently short with high 'turnover' of patients. To provide effective care, staff need to have a sufficient understanding of the unique experiences of each person to allow them to contextualise and respond appropriately to expressions of distress which can result in risky and challenging behaviours and restrictive staff practices (Kramarz et al. 2023). However, the fast-moving, high-need context presents challenges for staff when trying to develop holistic and meaningful understandings of the individuals receiving care on their wards.

Regarded as a core competency within clinical psychology (DCP 2011), formulation is a widely used tool in modern mental health practices. In contrast to diagnosis, formulation aims to develop an in-depth understanding and offer hypotheses about the functionality of an individual's behaviour. At the core of the approach is the idea that distress is an understandable human response to unbearable feelings and situations; a trauma-informed reframing from 'what's wrong with you' to 'what has happened to you' (Bateman et al. 2013). This does not place blame on the individual, and feedback from patients suggests formulation is often experienced as a relief, empowering, and enabling them to move forward (Redhead et al. 2015).

Whilst their structure differs between practices, many formulations take place within teams; both during structured formulation meetings and through informal routine interactions (see Geach et al. (2018) for a systematic review). Multidisciplinary staff report that team formulation sessions result in a more holistic understanding of patients' problems, strengths and difficulties, whilst also facilitating intervention planning (Hollingworth & Johnstone 2014). In non-acute inpatient settings, these benefits extend to improving a range of staff perceptions of patients with psychosis (Berry et al. 2009) and improving patient experience of ward atmosphere and their relationships with key workers (Berry et al. 2016). Through retrospective interviews with staff working on acute mental health wards, Kramarz et al (2023), reported that team formulation meetings were experienced as a safe and supportive space to develop an holistic understanding of patient behaviour patterns, increasing clinical confidence, team relationships and communication, whilst enhancing their sense of therapeutic alliance and increasing job satisfaction. Their qualitative data was supported by a range of high ratings on visual analogue scales relating to the perceived helpfulness of the team formulation process (Kramarz et al. 2023). Another retrospective evaluation of a trauma-informed care approach on acute mental health wards (involving team formulation using the Power Threat Meaning Framework (Johnstone & Boyle 2018) alongside staff training in psychological stabilisation skills) found significant reductions in the rates of self-harm, seclusion and restraint in the years following implementation (Nikopaschos et al. 2023), although the multi-stranded approach makes it difficult to understand the specific impact of team formulation.

Despite the reported benefits of team formulation, there may be potential issues with the approach including barriers to attending and participating, time constraints of the meeting, formulations feeling too vague (Bealey et al. 2021) and the challenges of consistently implementing any plans emerging from formulations (Kramarz et al. 2023). Equally, the absence of the patient's involvement could result in misinterpretations (Lewis-Morton et al. 2015) and stands in contrast with the 'no decision about me, without me' ethos (Coulter & Collins 2011). Berry et al (2016) highlighted the difficulty of involving patients who are extremely distressed in team formulation meetings, with teams choosing to discuss situations and behaviours which they find most challenging; the need remains for inpatient teams to access structured supervision that provides opportunities to reflect on their experience and practice.

Clarke and colleagues (Clarke 2009, 2015; Clarke & Nicholls 2018) developed the 'Comprehend, Cope and Connect' or the 'CCC' model as a formulation-driven third wave cognitive behavioural approach tailored to understanding mental health crisis. The CCC perspective is underpinned by Interacting Cognitive Subsystems theory (Barnard & Teasdale 1991) and provides a transdiagnostic, trauma-informed, culturally adapted (Phiri et al. 2023) way of formulating the crisis that resulted in hospital admission with the speed required in a fast-paced environment and using language and concepts that are easily understood by patients and staff with differing levels of expertise. Similar to the '5P's' model (Weerasekera

1993) a CCC approach considers early experiences/individual differences (predisposing), triggers (precipitating: in this case for the admission), and strengths/values (protective). The 'problem' is seen to be the 'horrible feelings' that the person is trying to escape which propelled them into crisis. A key CCC strength is the formulation of maintenance cycles (usually multiple attempts at experiential avoidance) which perpetuate the 'horrible feelings'/crisis in a 'vicious flower' format (e.g. Salkovskis et al. 2003; Moorey 2010). Individual and team understanding of these maintenance cycles allows the development of goals and a practical plan, realistic to the setting, which helps to break the maintenance cycles, reduce suffering and stabilise the crisis. Importantly, team formulations invite staff to consider the role that they/services are playing in the maintenance cycles and develop alternative, more helpful responses. Evaluation of an intensive support programme based on the CCC model identified improvements in patient reports of symptoms and mental health self-confidence pre- to post-intervention, although the lack of a control group makes it difficult to differentiate between psychological and non-psychological aspects of care. Research has found that individual collaborative formulations using the CCC model were rated as helpful and mood-enhancing by acute inpatient patients (e.g. Bullock et al. 2021); the present research aims to further extend the evidence base for its use in inpatient work through team formulation.

Despite substantial support for the importance of team formulation, previous research has often been retrospective in nature, primarily qualitative, and focused on overall staff perceptions of formulation (e.g. Summers 2006; Murphy et al. 2013; Kramarz et al. 2023), rather than a real-time evaluation of individual formulation session usefulness and actual impact on care. There is some evidence showing a direct link between team formulation and change in staff perceptions of individual patients (e.g. Berry 2009, 2016; Ramsden et al. 2014) but this has been on longer-term rehabilitation or forensic wards. The present research aims to extend the current evidence base by evaluating the benefit of team formulations in acute inpatient wards specifically and assess whether there is evidence of the impact of formulations on the care provided.

Aims & hypotheses

Aims included measuring the change in staff perceptions pre- to post-team formulation sessions on multiple mental health wards on a single hospital site. Staff were also asked for general feedback about the most/least helpful aspects of the formulation, and any changes to intended practice.

Specifically, it was predicted that:

1. Staff ratings of knowledge, understanding, confidence and motivation to work with individual patients would increase following a team formulation meeting;
2. That a review of planned action points following formulation meetings would show impact of formulation on routine care by identifying that a proportion of the actions were carried out within a two-week time period; and
3. That the impact of the formulation session may be moderated by the level of experience of staff.

Method

Design

A within-subjects repeated measures, quantitative questionnaire design was used to investigate whether the delivery of formulation had an effect on staff knowledge, understanding, confidence and motivation to work with individual patients. Self-reported ratings were collected at the beginning of the team formulation meeting (T1) and immediately after the meeting (T2). Qualitative data about experience and usefulness of the formulation meeting was also collected at T2. An inspection of the actions derived from the plans developed in the formulation session was conducted two weeks post-formulation meeting using an audit tool to investigate multidisciplinary progress notes.

Participants

The study was conducted at an NHS acute inpatient mental health hospital. Data was collected across six wards of the hospital, including five acute wards (one older adult acute), and a rehab ward. In total, 84 clinical staff completed both pre- and post-formulation responses over 16 separate formulation sessions; 76.2% (n = 64) were females, 19.1% (n = 16) were males, and 4.7% (n = 4) did not report their gender. The total mean age of the participants was 37.29 (SD = 14.6). Participant roles were: Charge Nurse (4), Registered Nurse (11), Student Nurse (9), Healthcare Assistant (44), Doctor (5), Consultant Psychiatrist (2), Occupational Therapist (2), Student without profession identified (2), Arts Psychotherapist (1), OT student (1), Matron (1), Support Worker (1), not reported (1).

Measures

Each participant completed the Consultation Questionnaire (Knauer et al. 2017), comprising four questions designed to examine the impact of the formulation in four key areas: (1) knowledge of the patient; (2) confidence in working with the patient; (3) motivation to work with the patient; and (4) understanding of the problem behaviours

Table 1. Changes in staff perceptions pre to post-intervention (team formulation).

Item (Scale 0–10)	Mean score pre-intervention (SD)	Mean score post-intervention (SD)	*t*-value (df)	Significance level (*p*)
How would you rate your knowledge about the individual you are meeting about?	4.72 (2.18)	7.15 (1.60)	10.893 (83)	<0.001
How would you rate your confidence of working with the individual you are meeting about?	5.91 (2.14)	7.29 (1.67)	7.961 (83)	<0.001
How would you rate your motivation to work with the individual you are meeting about?	6.77 (2.28)	8.02 (1.39)	7.742 (83)	<0.001
How would you rate your understanding of what's behind the problem behaviours for this individual?	4.6 (2.18)	7.29 (1.75)	11.125 (83)	<0.001

displayed by the patient. Each item was self-scored on a 11-point Likert scale, ranging from 0 to 10 immediately before and after the team formulation session.

At the second round of data collection, the questionnaire included three further questions asking participants what they considered to be the most and least helpful aspects of the formulation, as well as whether they will do anything differently in relation to their care work as a result of attending the meeting and if so, what.

An audit tool was used to guide the evaluation of actions derived from the plan developed in team formulations. A single rater recorded whether there was: no evidence found for action found; evidence found for action found; evidence was unlikely to be found within the timeframe (i.e. for actions that would take longer than two weeks to complete); or evidence was unlikely to be found within progress notes (e.g. for subtle changes to staff interactions that were unlikely to be captured within the progress note format).

Procedure

Staff attending each team formulation meeting were given study information and consent forms on entering the formulation meeting. If they were happy to participate in the completed T1 questionnaire before the team formulation started; the T2 questionnaires were completed at the end, before staff left the meeting. On average, each meeting lasted for 40–60 minutes and was facilitated by a clinical or counselling psychologist. Sessions were held over staff handover periods to maximise attendance. All available ward staff involved in the patient's care were invited to attend. The number of attendees differed across the meetings (min. 2; max. 12), due to competing demands on ward time/staffing levels and size of different teams. Following each meeting, a written version of the formulation was completed and sent to the relevant ward via email. A review of the formulation plan was conducted two weeks post-formulation meeting through a structured review of the patient electronic records system using an audit tool designed for this purpose.

Results

Main analysis

A repeated measures *t*-test of data from staff ratings showed statistically significant ($p<0.001$) changes in staff ratings of knowledge, confidence, motivation and understanding whereby all ratings increased from pre- to post-intervention (team formulation) towards the patients discussed (see Table 1). A paired *t*-test was judged to be appropriate for analysis of the non-continuous data considering other test assumptions were met.

Role of staff experience

Further analysis using a mixed model ANOVA looked at whether there was an interaction between staff experience levels and the impact of the formulation session on staff perceptions over time (Table 2). Staff were split into two groups: less experienced (e.g. up to 5 years in role) and more experienced (more than 5 years in role). Analysis found no significant difference in changes in knowledge, motivation or understanding between the groups. However, for the rating of staff confidence level, there was a significant main effect of time ($F(1,72) = 55.43$; $p<0.001$), main effect of experience ($F(1,72) = 6.17$; $p<0.05$), and a significant interaction ($F(1,72) = 4.75$; $p<0.05$) whereby less experienced staff confidence ratings increased more than those of experienced staff.

Helpful/unhelpful factors of formulation

Staff were also asked to identify the most helpful factors of the team formulation from a range of options reflecting

Table 2. Changes in staff perceptions pre to post-intervention (team formulation).

Experience level	Mean confidence score pre-intervention (SD)	Mean confidence score post-intervention (SD)
Up to 5 years (n = 40)	5.22 (1.96)	7.00 (1.76)
Over 5 years (n = 34)	6.58 (2.06)	7.55 (1.48)

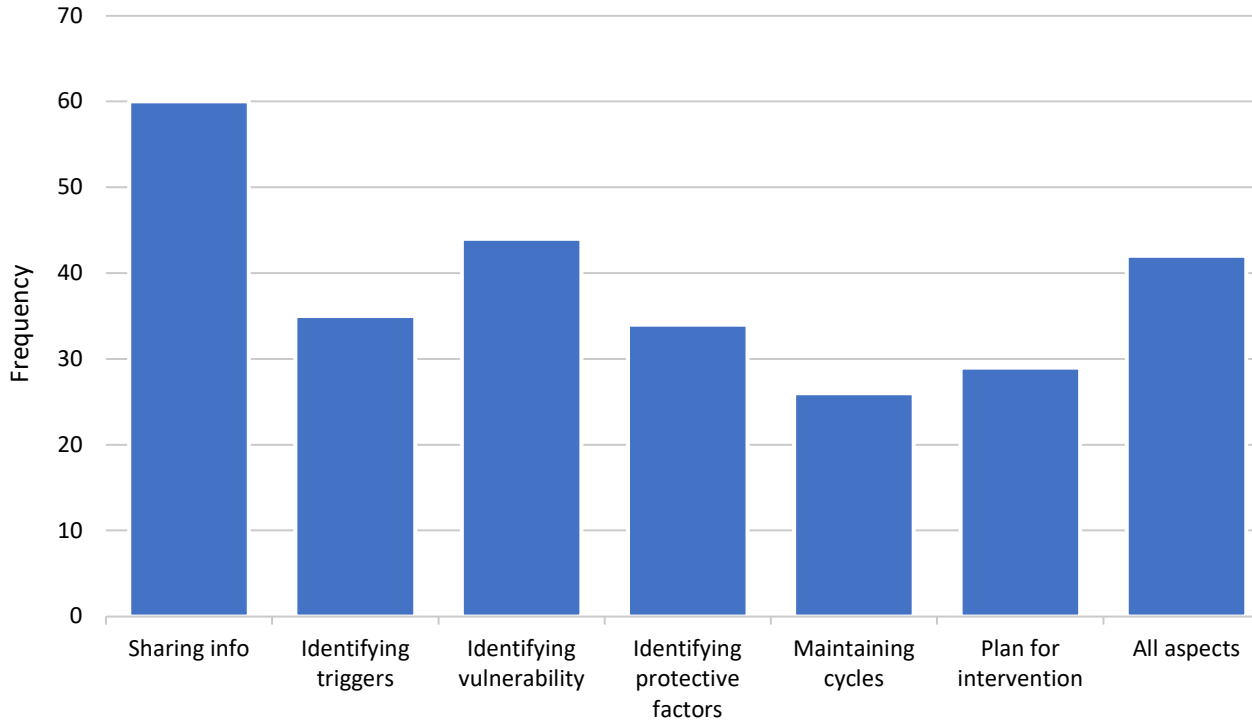

Fig. 1. Ratings of helpful factors of formulation.

the different components of the formulation (see Fig. 1). The most frequently identified helpful factor was sharing information, followed by identifying vulnerability factors (e.g. past experiences/individual differences); however, a large number of staff indicated that all listed aspects of the formulation were helpful. A minority of staff identified unhelpful factors including having difficulty speaking up in a group setting or feeling that ideas were not heard by facilitator (Fig. 2), although the majority reported no unhelpful aspects.

Implementation evaluation of actions

Figure 3 shows the results of the review of plans developed in the formulation meeting. Evidence was found in the electronic notes for implementation of 39% of actions developed in team formulation within a two-week period. Examples of actions which should have been identifiable from care records within two weeks of the formulation included involving the patient in specified therapeutic activities such as individual psychology sessions, therapeutic leave, arts psychotherapies, or physiotherapy. There was no evidence for 22% of actions being carried out. Twenty-five percent of action points were judged to be unlikely to ever be recorded on the clinical notes system because they were too subtle or relational to be explicitly documented (e.g. 'To keep an open mind about ideas around possible autistic spectrum or early attachment problems'), and a further 14% were unlikely to be completed in the two-week time frame (e.g. 'If X requires another examination, to think and prepare her in trauma-informed way e.g. give options and empower her to feel in control'). When analysis excluded actions for which evidence was judged unlikely to be recorded in the clinical notes within the review timeframe (either because they were too subtle to be recorded or there had not been sufficient time to complete the actions), evidence for implementation of 65% of actions was found (and no evidence found for 35% of actions where there should have been evidence of implementation).

Staff qualitative feedback

Staff were also given the option to make any further comments about any changes they would make post-formulation towards the patient. Examples of comments included:

- See [patient] in more holistic way and consider life experiences when working with and helping service user.
- Take more time to learn about the [patient].
- More knowledge about ways to engage/spend time with [patient] to reduce negative behaviour.
- Ensure consistency.
- Be more mindful of the emotions underlying X's challenging behaviours on the ward.
- Ask about patient's emotion.

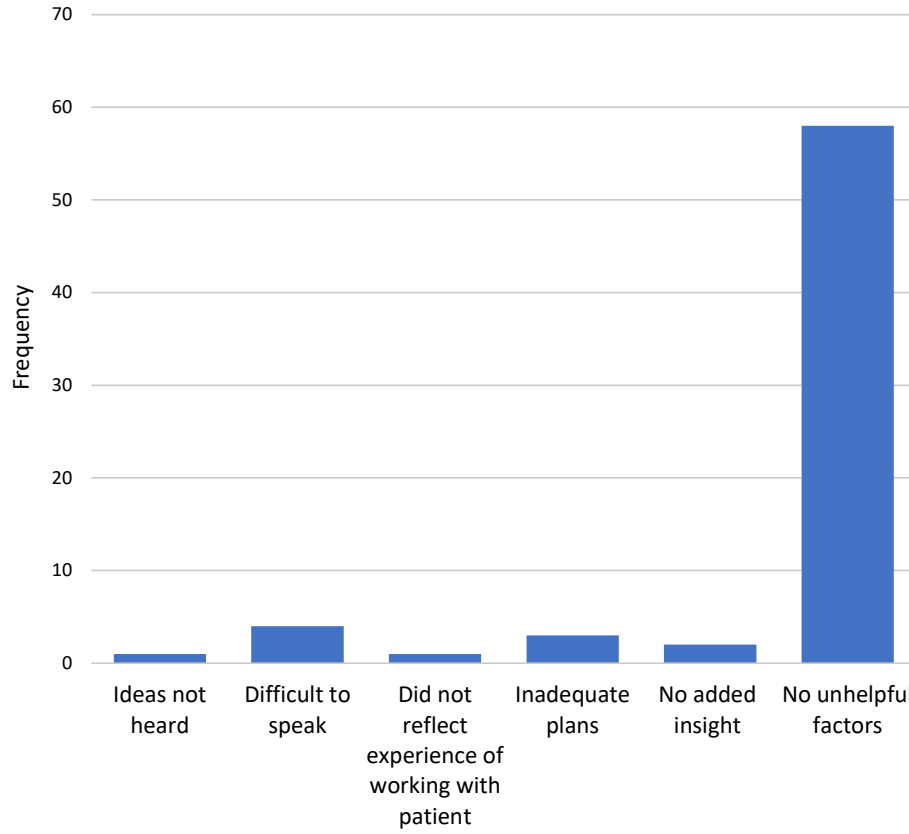

Fig. 2. Ratings of unhelpful factors of formulation.

Discussion

This study provides evidence for the impact of team formulation in acute inpatient settings, indicating a positive change in staff perceptions of patients, as well as leading to the implementation of actions derived from the formulation session. A significant shift was identified in staff-reported knowledge, confidence, and motivation to work with the patients discussed, and an increase in understanding of presenting difficulties. These results echo what has previously been reported (Berry et al. 2016; Knauer et al. 2017; Kramarz et al. 2023; Nikopaschos et al. 2023) highlighting the benefits of team formulation while extending this evidence base within the pressurised acute inpatient mental health wards.

It is of interest that information gathering was identified by staff as one of the most helpful factors in team formulation. This is likely to reflect the reality of competing demands on acute inpatient wards that results in limited time to read a patient's background (Cleary 2004). It is possible, therefore, that without team formulation important information relating to the presentation of a patient may often be missed. This can include the role of previous trauma experiences, the patient's early experiences, personal/professional relationships or roles outside of hospital, as well as important strengths and abilities. Greater implementation of trauma-informed approaches would promote further understanding of the link between past experiences and current patient distress (Muskett 2014).

Further analysis showed that team formulation was particularly beneficial for increasing the confidence of less experienced staff who are nevertheless more likely to have greater direct contact with patients. These findings support existing evidence that suggests formulation space is useful for reducing staff burnout (Kramarz et al. 2023), helping staff to feel 'heard' irrespective of seniority (Totman et al. 2011; Berry et al. 2017) and to feel confident and comfortable raising difficult feelings that they may have towards patients (Bealey et al. 2021; McTiernan, 2021).

The present research benefits from its dual focus on both staff perceptions and the evaluation of actions from team formulations which directly affect care. Bealey et al. (2021) highlighted the value of producing explicit plans in team formulations but there is a dearth of literature establishing whether such plans are implemented. The present evaluation of actions identified evidence that 65% of team formulation-based actions that would have potentially been identifiable from patient records in the two-week time frame had been carried out. This suggests that the impact of team formulations can extend outside of the

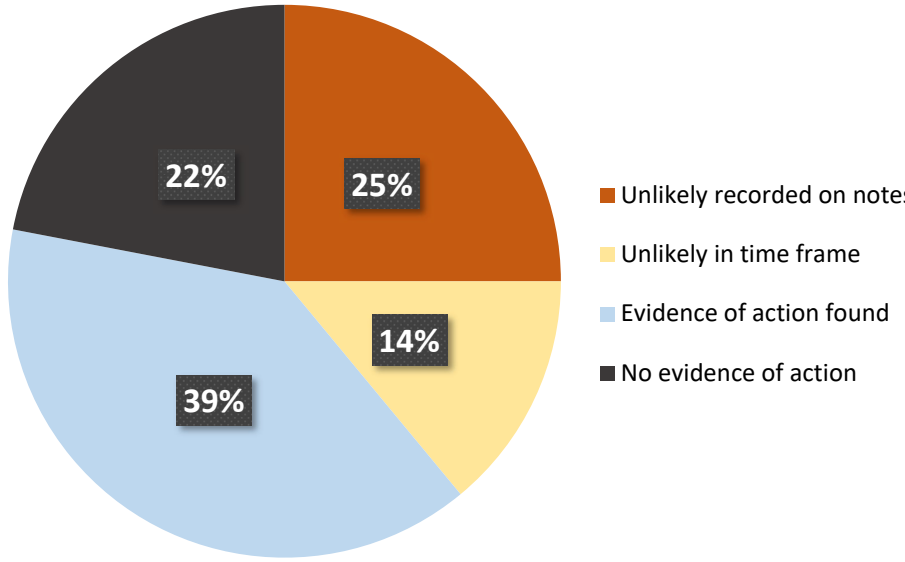

Fig. 3. Results of two-week audit of formulation action points.

session to influence concrete actions as well as improving staff perceptions.

Clinical implications

The CCC model underpinning team formulations in the present study is structured and succinct enough to research swiftly and complete in a nursing handover, whilst being jargon-free and resulting in a tailored plan that can be achieved using the interventions available to an acute inpatient mental health MDT. Because of these qualities, the majority of multidisciplinary staff participating in this study reported that they valued multiple aspects of the formulation process with very few reporting that they experienced unhelpful aspects of the formulation. Similarly, the plans emerging from the formulation were realistic and relevant enough to be actioned, as demonstrated by the implementation evaluation. Using the same theoretical model within a multi-ward system where patients step up, down and sideways between wards allows a shared understanding throughout moves in care; similarly, Araci & Clarke (2017) demonstrated the value of this model transferring from inpatient to acute community care, supporting crisis recovery in and out of hospital.

Study limitations

A limitation of this study is that not all outcomes from a team formulation are tangible, and therefore not all are easily examined or measured. As one of the main aims of the intervention is to allow nursing staff to think more holistically about a patient, this may often create subtle change that benefits the patient's care but is a challenge to quantify. Additionally, a single rater evaluated patient notes to identify evidence of action; employing a second rater, with an assessment of inter-rater reliability, would provide an understanding of the objectivity of the assessment of completion of actions from formulation plans.

As this study only focused on the levels of change at two time points (directly pre-intervention and directly post-intervention) it is difficult to examine the extent to which changes in staff perceptions persist over time. Repeating the questionnaire at a third time point would have measured the longevity of staff perception change, although the practicalities of this in a setting where there is a high turnover of patients can be challenging. There is also a possibility of demand characteristics being present due to perceived expectation of change in ratings, although steps were taken to ensure and explain anonymity. Equally, without a control condition, it is unclear how much change in staff perceptions was related to the non-specific aspects of spending time away from a heavy schedule of routine tasks in supportive discussion with colleagues and how much was directly related to developing a psychological understanding of a specific patient.

Future directions

Future studies would ideally involve a control condition which is found rarely in team formulation research (a notable exception being Berry et al. 2016). An experimental design using the measures of the present study to rate perceptions of both the individual being formulated and a matched patient receiving care at the same time would help identify the direct effects of the team formulation and those related to supportive team discussion and time away from a busy shift. Future research could also understand the impact of team formulation in specialist units

such as psychiatric intensive care units (PICUs) where needs, risks and challenging behaviours are most intense.

Future studies could benefit from using more relationship-based measures such as ratings of therapeutic alliance or empathy (McAndrew et al. 2014). As this study focused on staff perceptions of patients, the extent to which patients themselves may feel there has been a shift or a positive change in therapeutic relationships while in hospital was not accounted for (Sweeney et al. 2014), and could be addressed further in future research.

Another area that future studies may benefit from exploring is the link between access to team formulation and staff retention. McKenna et al. (2022) found spaces such as team formulation decreased staff-reported burnout. This may be in line with the finding of this study that less-experienced staff report larger increases in confidence following a team formulation than more-experienced staff. It would be of interest to further explore the possible benefit of team formulation in preserving the well-being of staff generally, and those relatively new to the role.

Conclusion

The present study found that CCC team formulation increased staff ratings of knowledge, understanding, confidence, and motivation to work with individual patients. Less experienced staff particularly benefitted from increased confidence following team formulation. The study provides further evidence of the implementation of formulation-driven plans that directly impact patient care. Team formulation can therefore be considered as a helpful tool in improving the quality of care provided to patients on acute inpatient wards.

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