the columns

correspondence

Bed numbers as a limitation to acute in-patient care

Dr Middleton suggests that the Mental Health Act Commission's criticism of acute psychiatric in-patient services in its last biennial report is a reflection of rising expectations and increased awareness of human rights, rather than an indication of any recent deterioration in such services (*Psychiatric Bulletin*, November 2006, **30**, 404). As the principal author of the report (Mental Health Act Commission, 2006*a*), I am less sanguine.

Although Dr Middleton lists a number of 'recurrent issues' in acute care, he does not mention the key issue of bed pressures. This has an impact across many acute services, leading to 'over-occupancy' of beds; delayed admissions; and the use of leave for bed-management purposes; as well as disruption and distress for patients and distraction for staff. Concern over these matters has been raised with increasing urgency by many Mental Health Act commissioners over recent years, and now by the psychiatry sub-committee of the British Medical Association Central Consultants and Specialists Committee (*BMA News*, 2006). A recent paper on bed occupancy suggests that, over the past 2 years, certain areas in England have experienced unprecedented problems in finding beds for the admission of patients under the Mental Health Act 1983 (Mental Health Act Commission, 2006*b*).

Dr Middleton is surely correct to suggest that recognition of acute in-patient care as a psychiatric specialty would be unlikely to address the most pressing difficulties facing the acute in-patient sector, not least because the improvement of patient services is a matter for clinical teams (as well as hospital managers and service commissioners) and not just the nominally responsible clinician. Indeed, in some services it would appear that improvement may be reliant upon a much more fundamental question of resources: beds for the patients.

BMA NEWS (2006) Doctors warn of psychiatric bed shortages. *BMA News*, 20 October 2006.

MENTAL HEALTH ACT COMMISSION (2006*a*) *In Place of Fear? Eleventh Biennial Report 2003–2005*. TSO (The Stationery Office).

MENTAL HEALTH ACT COMMISSION (2006*b*) *Who's Been Sleeping in My Bed? The Incidence and Impact of Bed Over-Occupancy in the Mental Health Acute Sector*. http://www.mhac.org.uk/Pages/documents/publications/who's%20been%20sleeping%20in%20my%20bed%20-%20MHAC%20bed%20occupancy%20survey.pdf

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Recruitment and retention in psychiatry – the role of PMETB

A trend has been noted for trainee psychiatrists who obtain their College Membership to opt for staff grade and associate specialist grade (SAS) posts (Vassilas & Brown, 2005). This contributes to consultant shortages (Mears *et al*, 2002) and presents the Postgraduate Medical Education and Training Board (PMETB) with an opportunity to provide solutions.

Our survey of SAS psychiatrists in Birmingham (n=55) found personal reasons (62%) and wanting further clinical experience (45%) to be the most common reasons for taking an SAS post. Of those who have passed the MRCPsych part I examination, 69% and 50% respectively cited personal reasons and gaining clinical experience, but for those with College Membership, pay protection (75%) and additional clinical experience (75%) were the reasons.

It may be that SAS posts are considered more flexible in terms of personal and family life. With PMETB's proposal for two pathways to specialist registration, a run-through training programme and career posts, doctors might still be attracted to career posts with the incentive of pay protection, and endeavouring to keep trainees on the training path might prove difficult. None the less, the majority of those with MRCPsych part I (88%) and all with part II wanted to resume their training, therefore mechanisms need to be clarified for re-entering training systems.

The desire for additional clinical experience brings into question trainees' perception of their basic training. This adds to concerns about reduced working hours and the development of specialised teams impinging on opportunities for experiential learning (Brown & Bhugra, 2005). Could PMETB's more structured, focused and standardised approach to training be the answer?

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MEARS, A., KENDALL, T., KATONA, C., *et al* (2002) *Career Intentions in Psychiatric Trainees and Consultants*. Department of Health.

VASSILAS, C. A. & BROWN, N. (2005) Specialist registrar training: at the crossroads (again). *Psychiatric Bulletin*, **29**, 47–48.

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Documentation of extrapyramidal symptoms

Kuruvilla *et al* (*Psychiatric Bulletin*, August 2006, **30**, 300–303) reported that a high percentage of respondents in their survey had not received formal training in the assessment (52%) or management (36%) of drug-induced movement disorders and mean levels of confidence in these skills were relatively low. We studied the documentation of extrapyramidal symptoms (EPS) in patients' notes at a Manchester teaching hospital.

A psychiatrist (S.M.) conducted a standardised neurological examination on a representative group of 25 psychiatric in-patients and out-patients aged 18–65 years with schizophrenia and under several consultants. Extrapyramidal symptoms were rated on standard rating scales