



**New ways of
working for psychiatrists:
Enhancing effective,
person-centred services
through new ways of working in
multidisciplinary and multi-agency
contexts**

Final report 'but not the end of the story'

Royal College of Psychiatrists
National Institute for Mental Health in England
Supported by the Changing Workforce Programme

October 2005

A collaborative venture between the following organisations:



Care Services Improvement Partnership **CSIP**

*National Institute for
Mental Health in England*



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For Recipient's Use	

A Service User's view

'The modernisation of psychiatry and its workforce is essential to delivering the kind of care that service users want, need and deserve.

It is my hope and wish that those who read this report will see it as a helpful and informative resource which can be put to good use in developing their organisations and people.

Whilst recognising that this report is only a start, I would support and recommend it to you.'

David Tombs, Service User

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Foreword

This report on new ways of working (NWW) details the progress that has been made over nearly three years in reviewing and refocusing the roles of consultant psychiatrists.

The aim of this document is to provide a framework for mental health services to help them develop new roles for psychiatrists, which both support the delivery of modern person-centred care and provide satisfying and sustainable roles, making the best use of this valuable, finite resource.

Effective and acceptable mental health care can only be achieved by multi-professional collaboration based on mutual understanding and respect for the contribution of colleagues.

Whilst the primary focus of this document is psychiatrists, who play a key role in mental health care, it is essential that this change is rooted in the broader local context of service improvement and New Ways of Working for all.

Finally, we would like to thank all those who have contributed to the development of NWW, with special thanks to the National Steering Group, and its subgroups, whose commitment to partnership working and open and honest debate sustained us through the peaks and troughs of the process.

Mike Shooter
Past President
Royal College of
Psychiatrists

Steve Shrubbs
Director – NEYH
Care Services Improvement
Partnership

Setting the scene

Summary of Interim Report 2004

The National Steering Group (NSG), jointly chaired by the Royal College of Psychiatrists and NIMHE, was set up in response to a groundswell of opinion that there was a need for new and changing roles for psychiatrists. An Interim Report was produced in 2004 to raise awareness on how this might be achieved and encourage innovative practice across the country. The table below highlights actions planned and the current position at the time of writing the final report.

Action points to be addressed in 2004

Position in 2005

To clarify the professional responsibilities of consultant psychiatrists with the General Medical Council (GMC).

Achieved

To make use of clinical governance powers in Trusts to clarify expectations of consultant psychiatrists, using guidance from Avon and Wiltshire Partnership Trust as an example.

Adopted in some Trusts nationally

To develop a matrix model for multidisciplinary teams to review their workforce requirements and skill mix options.

To be published Xmas 2005

To extend pilot development sites to test out NWW to all NIMHE regions from the existing two in Newcastle and Avon.

20+ sites in progress

To establish work with other professions to develop NWW.

Underway

To survey the use of locum psychiatrists in England.

Completed

To revise the guidance offered by the Royal College of Psychiatrists on job descriptions and norms.

Completed

To review innovative practice in relation to 'capable organisations'.

Completed

To consider how the Ten Essential Shared Capabilities (ESC) Framework and good practice guidance on involving service users and carers can be used to influence education, training and continuing professional development of all professions.

In progress

To provide a framework for leadership development for all professions, with a preliminary focus on psychiatrists.

In progress

To discuss activity indicators for performance management so as to avoid perverse incentives to NWW.

In progress

To develop and utilise evaluations of NWW.

External evaluation

Executive summary

1. New ways of working (NWW) is about supporting and enabling consultant psychiatrists, amongst others, to deliver effective and person-centred care across services for children, adults and older people with mental health problems. This is about a big culture change, it is not just tinkering at the edges of service improvement. Section two of this report spells out the vision and values that underpin what we are trying to achieve in NWW.
2. NWW is *not* about saving money, releasing resources for other things, nor about undermining the role of the consultant psychiatrist. It is about recognising that we will have increasing difficulty in filling posts, given the high rate of people eligible to retire, the fewer school leavers available to go into medical training, despite big increases in training places, and the continued, growing demand for mental health services. Section three, on workforce challenges, highlights some of the relevant facts and figures to support this.
3. This report highlights the changing context of service delivery and the drivers for change. The continuing, changing organisational and policy landscape places huge challenges to clinicians and managers alike. In section four, we highlight the changes that have been announced in the last year alone.
4. In essence, NWW is about using the skills, knowledge and experience of consultant psychiatrists to best effect by concentrating on service users with the most complex needs, acting as a consultant to multidisciplinary teams, promoting distributed responsibility and leadership across teams to achieve a cultural shift in services. It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce offering a high-quality service.
5. In section five, we outline the steps we have taken to enable people to embrace greater flexibility for change, which were outlined in the interim report, published in August 2004. This work provides significant support to clinicians and organisations to help them have flexibility to change and try out new ways of staffing and delivering services. Of particular importance is the GMC statement providing clarification of medical responsibility in teams.
6. The new joint guidance, issued between Trusts and the College, on the employment of consultant psychiatrists, gives clarity about how best to recruit and retain consultants and offers a much more progressive way of thinking about the consultant role within the context of local need and service configuration.
7. Section six outlines a wealth of new and emerging practice, where psychiatrists and other members of the multidisciplinary are testing out new and better ways to meet the needs of service users and their families. This work is showing that staff, too, benefit from having greater clarity and focus in their roles. Examples are given, not only of settings that have a psychiatrist focus, but also of others where NWW of one profession influences how others work and also how new roles are being developed to bring people in from different sources to expand the workforce as a whole.
8. Sustaining change and modernisation is as important as creating it in the first place and section seven offers approaches to achieve this. The importance of service user and carer involvement, consultative leadership and proactive communication are shown to be vital in successful change management.

9. There is much work to be undertaken to make NWW a reality in all areas and not just in pockets or development sites. Section eight outlines the continuing and developing agenda for NWW for all professions. This includes supporting teams to be creative in developing new roles through the use of the Creating Capable Teams Toolkit (CCTT) and developing appropriate leadership in teams. This section is reproduced in full with the executive summary to ensure that there is a well understood and shared programme of work to be undertaken at local, regional and national levels.
10. We continue to want to collect examples of positive practice and to share this through our Knowledge Community (www.nimhe.org.uk/kc). An independent evaluation is being undertaken of up to ten pilot, development NWW sites and new roles, which will be available in summer 2007.
11. Although, therefore, this is the final report focusing on psychiatrists, there is still much to do, so it is definitely not the end of the story. The NSG will, under revised terms of reference, continue to meet to oversee the considerable NWW programme of work between now and 2007.

1. Introduction

- 1.1 New ways of working (NWW) is about supporting and enabling consultant psychiatrists to deliver effective, person-centred services for people of all ages and disabilities with mental health problems.*
- 1.2 Work began in 2003 in this area because there was a huge groundswell of opinion amongst psychiatrists that their jobs had become undo-able, which had led, in turn, to dissatisfaction and burnout.
- 1.3 At the same time, and subsequently, there was greater realisation of the need for psychiatrists, and other mental health practitioners, to work collaboratively and differently with service users and their families.
- 1.4 There are, and continue to be, difficulties in recruiting and retaining staff in mental health services. This is part of a larger problem in the UK of having fewer school leavers and an ageing workforce, making competition greater for attracting people into the public and non-governmental sectors of health and social care.
- 1.5 NWW is not about saving money, releasing money to do other things, nor about undermining the role of the consultant psychiatrist. It is about working differently to use the experience and skills of consultants to best effect by concentrating on working with service users with the most complex needs, acting as a consultant to teams, promoting distributed responsibility and dispersed leadership across teams. It is therefore a big culture change for many and therefore a real challenge.
- 1.6 So, although the primary focus of this work has been on consultant psychiatrists, the multidisciplinary teams with whom they work are recognised as being of equal importance. Changing the role and focus of one profession affects the team as a whole and often the wider service system, including primary care.
- 1.7 The NSG, jointly chaired by NIMHE and Royal College of Psychiatrists (the College), published its interim report in August 2004. This final report highlights how things have moved on since then and offers proposals on how the work should be taken forward over coming years.
- 1.8 This guidance is primarily focused on England, given that the policy priorities are slightly different in Scotland, Wales and Northern Ireland. Nevertheless, professional bodies such as the College and the British Psychological Society (BPS), span the four countries. It has been agreed with the four countries that the guidance will be used as the basis of change in Scotland, Wales and Northern Ireland.

* The term 'mental health problems' is used throughout this document to cover mental illness, mental distress, mental disorder and mental health needs.

2. Vision and values

- 2.1 As the culture, within which mental health services are delivered, is shifting towards being patient- or person-centred, it is important that we are explicit about how these vision and values impact upon the workforce.
- 2.2 Values influence what we do as individuals and as practitioners, whether we are aware of them or not. It is of critical importance that we are aware of the diversity of the values we all hold in order to work successfully together to meet the individual needs of service users and their families.
- 2.3 The overall purpose of the *National Mental Health Workforce Strategy for England* (2004), led by NIMHE and supported by all partners, including the College, was ‘to ensure that services reflect the needs and preferences of the population they serve, are delivered by sufficient numbers of well-trained staff, who have the appropriate capabilities, are motivated, feel valued, and are well led and effectively managed’.
- 2.4 It is of particular importance to understand an individual’s cultural identity, how this may impact on their behaviour and beliefs, and how this can influence the perception of the mental health practitioner (Dogra and Karim 2005).
- 2.5 Our increasing understanding of the causes of mental health problems and their implications for social inclusion are vital to address with practitioners. To address this specifically, a paper outlining the implications for psychiatrists is included in Appendix 3 (c).
- 2.6 The National Service Frameworks (NSFs) for Mental Health, Older People and Children recommend that services promote mental health for all. In other words, mental health is everybody’s business, whether we use mental health services, care for a relative or friend, or work within the health and social care arenas.
- 2.7 The role of primary care is key in helping people with mental health problems, in promoting good physical and mental health, in helping people at an early stage, and supporting those people where they have long-term mental health conditions.
- 2.8 Where people have need for more specialist interventions and are referred to secondary and tertiary mental health services, those staff must retain the perspective of the whole person throughout individual assessment and care planning.
- 2.9 This perspective should be underpinned by a positive attitude of hope and recovery that each person may continue to lead a self-defined life, thus reflecting their hopes and ambitions. The individual needs to be able to make their own choices, be the key person in interpreting what is happening to them and, therefore, in deciding on interventions they will engage with. Where this is not possible, each person and their families should be fully involved in decisions about their future and treated with dignity and respect at all times.
- 2.10 There are many facets to people’s lives; seeing them too narrowly not only risks failure to meet their needs but can also cause them and their families damage. For instance, many people, who use adult mental health services, are also parents and some of their children are at vulnerable developmental ages.

- 2.11 These values have significant implications for everyone involved in delivering mental health services: commissioners of services and of education and training; employers; professional bodies; and those providing services.
- 2.12 Recognising the importance of this strategic direction, the College set up its own Scoping Group on the Roles and Values of Psychiatrists and it is expected that it will report in 2005.
- 2.13 NIMHE, which has employed a national fellow in values-based practice, has published the NIMHE Values Framework and the set of Ten Essential Shared Capabilities (ESC) for the whole of the mental health workforce. The Ten ESC are underpinned by evidence and values-based practice. A workbook for skills training in values-based practice was published in 2004 and learning materials to underpin the Ten ESC are being field-tested at the time of publication.
- 2.14 NIMHE and the College have also supported international work, piloting the role of values-based as well as evidence-based approaches to diagnostic assessment undertaken by psychiatrists. In partnership with the World Psychiatric Association (WPA), this work will contribute to the development of whole-person ('idiographic') diagnosis, complementing the traditional categories within the currently used International Classification of Diseases (ICD). This work will be the basis for research and development in many countries.
- 2.15 Together, these pieces of work illustrate the commitment of key organisations to work collaboratively to deliver a workforce, which has been supported through education, training and personal development focused on values-based practice, which can make a real difference to service users and their families.

3. Workforce challenges

- 3.1 We are continuing to face increasing demand, year on year, for mental health services across primary, secondary health and social care sectors. This is leading to longer waits, larger caseloads and less satisfactory interventions and outcomes for service users and staff alike.
- 3.2 In recognition that the workforce needs to be expanded to meet greater demand, there has been a big push to increase the number of training places and posts for all professions. Table 1 gives an indication of the types of real increases in the last five years.

Table 1

Whole-time equivalents and percentages

England

Medical staff	1997	1999	2004	Increase since 1997	Percentage increase
Consultant psychiatrists (total)	2,206	2,525	3,231	1,025	46.5%
General psychiatry	1,243	1,418	1,776	533	42.9%
Child and adolescent	390	422	490	100	25.6%
Forensic	114	141	209	95	83.3%
Learning disability	146	168	194	48	32.9%
Old age	231	290	470	239	103.5%
Psychotherapy	82	85	92	10	12.2%

Whole-time equivalents and percentages

England

Non-medical staff	1997	1999	2004	Increase since 1997	Percentage increase
Dietetics (generic)	1,864	2,058	2,664	800	42.9%
Nurses (psychiatry)	35,296	34,974	41,585	6,289	17.8%
Nursing assistants (psychiatry)	17,266	17,725	21,868	4,602	26.7%
Support workers (psychiatry)	1,545	1,881	1,896	351	22.7%
Pharmacists (generic)	7,591	8,404	11,375	3,784	49.8%
Clinical psychology	3,376	3,763	5,518	2,142	63.4%
Psychotherapy	317	365	723	406	128.1%
Art/Music/Drama therapy	418	416	475	57	13.6%
Occupational therapy (generic)	9,792	10,792	13,879	4,087	41.7%

Sources:

Department of Health
NHS Hospital, Public Health Medicine and Community Health Service
Medical and Dental Workforce Census
England at 30 Sep 1997, 1999, 2004

Department of Health
NHS Hospital and Community Health Service
Non-Medical Workforce Census
England at 30 Sep 1997, 1999, 2004

Whole-time equivalents and percentages

England

Social work staff	1997	1999	2004	Increase since 1997	Percentage increase
Social work staff employed in local authority social services departments (generic)	33,000	33,900	37,900	4,900	14.8%

Note: When the word “generic” is used in the above tables, this signifies that the staff shown do not work exclusively in mental health services.

- 3.3 These increases have not been consistent across the service and the country. It may not feel that there have been these increases in some parts of the country, such as the North West and in some psychiatric specialties, such as older adults or Child and Adolescent Mental Health Services (CAMHS). There are also significant staffing problems in other professional groups and settings, such as inpatient nurses.
- 3.4 In 2004, a national survey was commissioned by the NSG, on consultant posts, vacancies, recruitment and the use of locums. This was supported by the College, which carries out an annual survey of posts and vacancies across the UK. In 2003, they decided not to do their survey but to endorse this one, even though it was for England only.
- 3.5 The report found that there were 3,223 consultants in post and 510 vacancies of which 69 per cent were filled by locums. The average vacancy level across England was 15 per cent, although this masked significant regional variations.
- 3.6 Locum numbers are rising and they remain expensive. They cost mental health services an estimated £70m in 2003/04, of which 56 per cent was unfunded overspend, and their value for money variable.
- 3.7 Demographically, we are facing an ageing workforce, fewer school leavers and greater choices of career for those entering the workplace. So, even as we train more staff, make increasing attempts to encourage trainee doctors into psychiatry, we are losing older colleagues who are ready for (and keen to embrace) retirement. So we are, effectively, running to keep still.
- 3.8 We need a positive approach that will support experienced colleagues to stay working for longer as well as attracting people to come and work in psychiatry, including from other countries.
- 3.9 But we also have to be much more radical than that – we need to be creative in how we use the staff we have in order to make the very best use of their distinctive capabilities. We need to work together to help individuals and teams to review their practice to see what tasks could be done differently. Inevitably, this means a shrinking and more focused role for senior professionals, shedding repetitive activities or doing them more smartly. In turn, this means that other staff need to take on new and different responsibilities. The knock on effect is that those staff need to be expanded.
- 3.10 There are lots of students who graduate annually, who want to work in health or social care, for example, 13,000 psychology graduates per annum alone. Not all can become clinical psychologists, and many do not wish to train for nursing nor the other traditional professions. New roles are being explored and developed to multiply entry points, such as the role of the graduate mental health worker in primary care. Equally, there are people who did not leave school with the necessary five GCSEs but who wish to develop a career later in life. Foundation degrees and new posts such as Support, Time and Recovery (STR) workers can encourage those people to swell the mental health workforce.
- 3.11 In thinking about psychiatrists, therefore, it is also vital to think of the workforce as a whole. Table 1 gives an indication of the size of the workforce in each profession; it should be noted that there are no mental health figures currently available on physiotherapists, pharmacists and dieticians, who are recognised as key players in the mental health workforce.

- 3.12 The NWW initiatives need to be set positively within the revolution taking place in medical training under the direction of the Postgraduate Medical Education and Training Board and Modernising Medical Careers. Their aim is to address the mutual dissatisfactions of patients, who feel they do not have a communicative relationship with their consultant, and consultants, who feel they do not have the time to develop such relationships.
- 3.13 Basic medical training across all the specialties will concentrate on the sort of skills that underpin the development of therapeutic relationships and will be tested by assessment in the field of how doctors get on with patients, their carers, and colleagues within the multidisciplinary team in which they work. Exam tests of knowledge will still be important, but it is how that knowledge is put into practice that is crucial.
- 3.14 None of this will be possible unless consultants have a smaller caseload of patients with whom they are able to exercise their new-found competences directly. And this, in turn, means distributing tasks around the members of the multidisciplinary team on the basis of interest, skills and experience rather than discipline of origin, with doctors acting as consultant to them in the broadest sense of the word. These are exactly the principles behind the NWW projects in mental health.

4. New and changing context: drivers for change

- 4.1 Change is constant and continuing – this will not change. It is important for all to acknowledge and accept this, however challenging it may be. We have to make progress whilst situations alter and people move on; this is possibly the biggest challenge facing us all.
- 4.2 This is of real concern for staff working under pressure, who feel unable to have any ‘headroom’ for reflecting on new requirements and their implications.
- 4.3 Within the last 12 months there have been a number of major policy initiatives and publications that will drive change and these include:
- *Mental Health and Social Exclusion Report* (2004);
 - *Choosing Health – Making healthy choices easier* (2004) (the Public Health White Paper);
 - *The NHS Improvement Plan* (2004);
 - the draft Mental Health Bill (2004);
 - *National Standards, Local Action – Health and Social Care Standards and Planning Framework* (2004);
 - system reform, for example Foundation Trusts (first set out in *Delivering the NHS Plan*) and *Payment by Results* (2004);
 - *Independence, Well-being and Choice – Our vision for the future of social care for adults in England* (2005);
 - *Creating a Patient-led NHS – Delivering the NHS Improvement Plan* (2005);
 - *Practice-Based Commissioning: Promoting Clinical Engagement* (2004); and
 - workforce issues, such as Agenda for Change, Consultant Contracts, Career Frameworks.
- 4.4 A common theme is the importance of services taking an holistic approach to care and of understanding the causes of mental health problems; which include poverty, stigma, lack of early intervention and disempowerment. This underlines the importance of devolution of responsibility for local action with commissioners and providers working together across primary and secondary care and with local communities. Clinical governance powers of trusts are extremely important in the context of local delivery of NWW to ensure clarity of responsibility and accountability for all staff and for service users and their families.
- 4.5 Evidence-based practice is vital and our knowledge base is expanding through research, service evaluation and National Institute for Clinical Excellence (NICE) guidance. Increasingly this relates not only to medical and pharmaceutical treatments but also to psychological and social interventions. Psychological therapies are now a major government priority for expansion. The challenge is one of implementation.

4.6 The current intention is for the Department of Health (DH) to publish an HR Framework for Health and Social Care for HR directors advising them on the development of local workforce strategies. Within that workforce context, there is a shift away from care groups such as mental health, to NHS Improvement Plan priorities:

- long-term conditions (5 per cent reduction in non-elective inpatient length of stay);
- reducing 18-week waits from primary care (treatments and diagnostics);
- emergency and urgent care (nearer to home); and
- public health.

It is vital that mental health services for children, adults of working age and older people are linked into these four priorities.

4.7 There is a strategic move towards developing a competence-based rather than a professionally-based workforce. This is enhanced by Agenda for Change, and the consultant and General Medical Services (GMS) contracts for medical staff. Work on a career framework to enable people to develop as traditional, or new, practitioners is well underway and a key theme for the DH as a whole. This brings with it the importance for all of professional regulation and the roles of the Health Professions Council (HPC) and the GMC in achieving this.

4.8 The training of all professional staff, including that of psychiatrists, needs to be reviewed to ensure that newly qualified practitioners emerge who are fit for practice. This is still not happening in many places. Modernising Medical Careers (MMC) is a key initiative in addressing this issue for doctors and it remains to be seen how it will impact across the board, including on the practice of consultant psychiatrists and general practitioners.

4.9 Professor Louis Appleby, National Clinical Director for Mental Health, published his report *The NSF for Mental Health – Five Years On* in December 2004. Although significant progress has been made and NWW is relevant to most of these areas, priorities for change in the next five years include:

- mental health of the whole of the community – social exclusion, race equality and public health;
- primary care;
- access to psychological therapies;
- suicide prevention;
- inpatient wards;
- dual diagnosis;
- carers;
- NWW; and
- information systems.

- 4.10 Although the form is being consulted upon, the intention is to introduce a new Mental Health Act by 2007. This challenges the workforce in terms of capacity and capability to undertake new responsibilities. The Scottish Act 2004 has highlighted this issue. In Scotland the Mental Health (Care and Treatment) (Scotland) Act 2003 came into force on 5 October 2005. This Act was designed to be human rights compliant. It introduces Mental Health Tribunals to consider Compulsory Treatment Orders and appeals, Advance Statements, the Named Person that the patient wishes to be informed in the case of compulsion, and appeals against the level of security. It has been estimated that additional work related to the Act will be equivalent to approximately 30 whole-time equivalent (WTE) consultants in Scotland. In addition, 100 medical members of the tribunal will be required, 70 of whom have so far been recruited, many of them NHS consultants. In England, estimates have been made of workforce requirements and it is clear that the availability of consultant psychiatrists will be a key consideration in some areas and specialties.
- 4.11 There continue to be organisational changes, with the proposed merging of the Healthcare Commission (HCC) with the Commission for Social Care Inspection (CSCI) as the main vehicles for performance assessment. The shift to practice-based commissioning and the longer-term implications for Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) and the development of Foundation Trusts all need to be understood. These could present risks as well as opportunities to mental health services and there is a need for engagement at both a national and local level.
- 4.12 The National Programme for Information and Technology is of key importance, because there are many technical advances that can influence clinical practice and the rapid evolution of information technology arguably has significant potential to drive enormous change. Better-informed service users, more competent school leavers and clinicians with readily accessible knowledge and decision support, are likely to alter profoundly all of our expectations and our ability to provide high-quality treatment and care.
- 4.13 Integrated electronic care records will ultimately give us access to all the key clinical information necessary in the full range of care environments at any time. Communication with other members of teams and colleagues in primary and social care should be faster and easier providing the opportunity to make interfaces along the care pathway less problematic.
- 4.14 Whatever views individuals may have of these changes, they are coming and we will have to respond. In order for this to happen, we need more than ever to have flexibility in our working practices and we will need to ensure we have both the capacity and capability to adapt accordingly.

5. Promoting flexibility to achieve change

- 5.1 Since the publication of the interim report, significant progress has been made in creating ways to provide flexibility for practitioners and organisations to change.
- 5.1.1 It is important, however, before considering new opportunities, to acknowledge the continuing barriers to change at all levels. These include medical responsibility; public, organisational and clinical perception of risk; professional boundaries; lack of time to reflect; uncertainty about process; assumptions about other professions; concerns about and credibility of new and changing service models; personal anxieties about the capacity and capability to do things differently; and finally, differing values, perspectives and formulations about the needs of people with mental health problems, and their carers, families and friends.
- 5.1.2 What follows is essentially giving people permission to change.

5.2 Medical and clinical responsibility within teams

- 5.2.1 A major stumbling block to NWW has been the perception that the consultant psychiatrist carries clinical responsibility for all service users in secondary and tertiary care. Although this is not true, the advice given from the GMC, British Medical Association (BMA) and the College has used terminology that has led to ambiguity in interpretation.
- 5.2.2 The GMC has agreed to clarify its guidance with respect to consultant psychiatrists, as follows:

Accountability in multidisciplinary and multi-agency mental health teams

Consultants' roles and responsibilities are developing and changing. They vary according both to the specialty and the type of healthcare environment in which they are provided. Changing working practices, such as multidisciplinary and multi-agency team work, and changes in the range of skills and competences of other healthcare practitioners, present a number of opportunities as well as challenges in providing safe and effective care. Many of the issues are best resolved by clarity between consultants and their employing organisation about appropriate roles and responsibilities. Consultants should raise with their employing bodies any issues where ambiguity or uncertainty about responsibilities may arise. Consultants also need to be clear about the expectations of the GMC.

All doctors are accountable to the GMC for their conduct and the decisions they take. *Good Medical Practice* (2001) sets out the principles which should underpin their professional work and against which their conduct may be judged. *Good Medical Practice* does not try to address, in detail, all the circumstances in which doctors may work. This guidance explains how the principles in *Good Medical Practice* apply for doctors working in multidisciplinary or multi-agency mental health teams.

1. Doctors should be competent in all aspects of their work including: reviewing and auditing the standards of the care they provide; training and supervising colleagues; and managing staff and the performance of the teams in which they work, where and when they have direct line management responsibility.

2. Doctors should do their best to ensure that the systems in which they are working provide a good standard of care to patients. Where doctors cannot be satisfied, nor take steps to resolve problems, they should draw the matter to the attention of their trust or other employing or contracting body.
3. To these ends, doctors should establish clearly with their employing or contracting body both the scope and the responsibilities of their role. This includes clarifying: lines of accountability for the care provided to individual patients; any leadership roles and/or line management responsibilities that they hold for colleagues or staff; and responsibilities for the quality and standards of care provided by the teams of which they are a member. This is particularly important in circumstances in which responsibility for providing care is spread between a number of practitioners and/or different agencies.
4. Doctors are not accountable to the GMC for the decisions and actions of other clinicians.
5. This means that if a consultant delegates assessment, treatment and care to a more junior doctor, the consultant is not accountable to the GMC for the decisions or actions of the junior doctor but the consultant is responsible for ensuring that the junior doctor is appropriately trained, experienced and supervised.
6. Psychiatrists can delegate the care of those patients for whom they agree to take responsibility. But many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multidisciplinary teams of which they are a member may provide health and social care services to a substantial number of patients. Referrals are made directly to such teams and decisions about allocation to an appropriate professional are made according to the teams' policies. In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team. Consultants retain oversight of a group of patients who are allocated to their care and are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team. However, in accordance with paragraph 2, they must do their best to ensure that arrangements are in place to monitor standards of care, and to identify potential or current problems. They should notify their employer about any unresolved concerns or problems.

5.3 Joint guidance on the employment of consultant psychiatrists

- 5.3.1 The College produced guidance on *Model Consultant Job Descriptions and Recommended Norms* the most recent revision being published in 2002. The purpose of the guidance was to drive up standards and ensure that consultant psychiatrists had doable jobs. In some respects, it was successful in achieving this, but the assumptions of service models and staffing, which underpin the norms, are now acknowledged to be out of step with modern mental health services, and in practical terms, unachievable. Although issued as guidance only, in some areas, there have been some problems related to inflexibility in interpretation. This has led to conflict between trusts and regional advisers on occasion and resulted, where there are problems of recruitment and retention, in the use of locums that has incurred costs both in terms of quality of service and financial overspend.

- 5.3.2 In a major step to promote flexibility in NWW, the College has worked in collaboration with Trusts to replace College guidance with new guidance to be issued jointly between College, the NHS Confederation (NHS Employers) and the National Mental Health Partnership Group, supported by NIMHE and DH.

Table 2

Joint guidance on the employment of consultant psychiatrists Key components
<ul style="list-style-type: none">• Developing the foundations for an effective working relationship – <i>what a consultant can expect from the employer, what the employer can expect from the consultant, and what service users and carers can expect of consultants</i>• Service development implications for change – <i>the relevance to all psychiatric specialties</i>• Creating posts for consultant psychiatrists – <i>moving from population indicators to a team development model underpinned by the consultant contract job planning process</i>• Role of College regional advisers – <i>clarifying their role within the new context</i>• Process of recruitment – <i>summarised for ease of access</i>• <i>Pro formas for local production of job descriptions and person specifications.</i>

- 5.3.3 The essence of the change is to move from indicators, without prescription of other team members and resources, to a process which we have described as a ‘creating capable team’ approach, using job planning as part of the consultant contract.
- 5.3.4 The Joint Guidance document is being issued simultaneously as a standalone but complementary document to this final report.

5.4 Creating Capable Teams Toolkit (CCTT)

- 5.4.1 Major progress has been made in the last five years in modernising services with significant investment in service improvement processes. The Changing Workforce Programme, previously part of the Modernisation Agency, has led on developing new roles to enable experienced professionals to use their skills and experience to maximum effect. The NHS Plan set targets for new teams and new roles including Primary Care Graduate Mental Health Workers, STR and Black and Minority Ethnic (BME) Community Development Workers (CDWs). However, it seems that some services are struggling to make the best of these developments. There is a tendency to either add on or re-badge posts and there appear to be too few examples (that we are aware of) of a reflective review of current services, of how new models can be integrated and of how teams can be re-engineered to meet service user needs more effectively.
- 5.4.2 Although there are a number of helpful tools for developing teams in a variety of ways there are none that take teams through the process in the way outlined in the CCTT. This was the impetus for developing a tool to help teams reflect on their functions and skill mix and on their options for staffing in a pro-active and comprehensive manner. The key components of the toolkit are captured below:

Figure 1 Analysing service demand and the consultant role



Example

Local multidisciplinary teams served a population of 20,000 older adults. It was predicted they would have 15 new referrals each week. Care pathways were analysed and operational policies developed providing a single core assessment to be used by all professionally-qualified staff, single service entry point and a seven-day service with home-based assessment and intervention. The amount of time for assessment was agreed and used to benchmark qualified staff operating as case managers; time for observation and practical support was identified and translated into health care assistant roles, the balance of qualified and unqualified staff was set at 1:2.

5.4.3 The CCTT is currently being field tested to ensure it is as accessible and usable as possible for teams. It will be issued as a stand-alone document at the end of 2005.

5.5 Defining the distinctive contributions of practitioners in multi-agency and multidisciplinary teams

- 5.5.1 When the NSG was established with a key focus on the role of the consultant psychiatrist, it was recognised, at the outset, that we needed to consider cross-boundary working between professionals, practitioners and agencies. To this end, a 'Cross-Boundary Sub-Group' was established to examine these broader issues. Membership included the representatives and individuals from the following fields: advocacy, art therapy, carers, clinical psychology, dietetics, management, nursing, non-professionally affiliated staff, occupational therapy, pharmacy, physiotherapy, primary care, psychiatry, service users, social work and the voluntary sector.
- 5.5.2 Initial work focused on each profession and stakeholder identifying what they considered to be their 'unique' contribution, what aspects of their role they could pass on to others (and to whom) and what additional work they might undertake given more capacity. This, in turn, led to a series of short papers being produced by each profession and stakeholder about its 'distinctive contribution'. (Appendix 3 [a])
- 5.5.3 It is true for all practitioners that there is a change from what they have traditionally expected or been expected to do and what they aspire to in modern services. These have been summarised and appear in Appendix 3 (a).
- 5.5.4 Every practitioner wants to be clear and wants everyone else to be clear about their distinct contribution. This is entirely reasonable and commissioners need to be reassured that they are commissioning the appropriate education and training to achieve the right balance of capabilities in the workforce and best value for money. Nevertheless, the single biggest message that emerges from this process of comparison is how much is shared across practitioners, particularly in their aspirations to become more person-centred.

5.6 Shared contributions of practitioners in multi-agency and multidisciplinary teams

- 5.6.1 The Sainsbury Centre for Mental Health (SCMH) published the *Capable Practitioner Framework* (CPF) in 2001, commissioned by the Mental Health NSF Workforce Action Team (WAT). This focused on the assessment, formulation, care planning, intervention and discharge pathway of an individual entering mental health services. The framework began to identify what was shared by all in this pathway and what was undertaken only by some.
- 5.6.2 A national mapping of education providers in mental health, covering pre- and post-registration courses for all professions, also commissioned by the WAT, demonstrated significant gaps in service user and carer involvement, working with families, evidence-based practice (for example cognitive behavioural therapy), values-based practice, mental health promotion and inter-disciplinary working.
- 5.6.3 There is a continuing debate about the Care Programme Approach (CPA) and the role of the care co-ordinator. Experience to date suggests that psychiatrists, and frequently clinical psychologists, have not undertaken this role, sometimes causing friction in teams. NWW indicates a clearer focus on working with a fewer number of people with complex needs. The implications of this for care co-ordinator responsibility should be discussed within the team to understand and agree how this impacts on the best use of the expertise of all concerned.

5.6.4 Research and feedback from service users consistently gives the same messages about their experience of mental health services. The following was presented by Sophie Corlett, from Mind, in 2004 in a workshop on leadership for psychiatrists.

Table 3

Messages from service users about what they want to change in mental health staff

- **Listening** – this was the most frequent concern raised, relating to:
 - making a diagnosis too quickly;
 - failure to take account of all domains of a person’s life;
 - focus on symptoms and illness;
 - failure to listen to medication preferences and side effects.
- **Respect**
 - inevitable power imbalance needs to be sensitively handled;
 - lack of trust impedes information giving e.g. medication non-compliance;
 - failure to see the ‘whole person’.
- **Information**
 - lack of information about personal records, diagnosis, care plans, medication choices. (doctors seen as unapproachable by 60 per cent of service users and by 75 per cent of those from BME communities).
- **Knowledge**
 - lack of expertise around interaction of drugs and impact on physical health.
- **Choice**
 - lack of involvement in decision making about treatment;
 - clash of approaches can hamper recovery e.g. crisis prevention strategies can be undermined by the medical model.
- **Conclusions**
 - people value services that foster symmetric relationships e.g. talking therapies, drop ins, access to Support, Time and Recovery workers;
 - service user involvement in education and training is valuable to effect culture change.

5.6.5 There is a clear message for all practitioners that they need to change to address the above concerns. NIMHE, in conjunction with the SCMH and NHSU, produced the *Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce* in August 2004. These are the building blocks for all staff working across health and social care. These are summarised below and further information is in Appendix 6.

The Ten Essential Shared Capabilities

Table 4

- Working in Partnership
- Respecting Diversity
- Practising Ethically
- Challenging Inequality
- Promoting Recovery
- Identifying People's Needs and Strengths
- Providing Service User Centred Care
- Making a Difference
- Promoting Safety and Positive Risk Taking
- Personal Development and Learning.

5.6.6 Learning materials to underpin the Ten ESC, commissioned and funded by NHSU, are now available. These are being field tested in trusts, social care sectors and Higher Education Institutions (HEIs) until the end of 2005. It is vital that the Ten ESC are incorporated across pre- and post-registration training, in higher and further education institutes as well as becoming embedded in continuing professional/personal development.

5.6.7 The message is that we have more in common than we have which is different. This is a helpful starting point. It can also allow for the development of new and changing roles, based on competences identified in the NHS Knowledge and Skills Framework, National Occupational Standards and profession competences, which can be mapped onto the developing Career Frameworks.

5.6.8 The Career Framework for Health aims to provide a guide for NHS and partner organisations to implement a flexible career and skills escalation approach, enabling an individual with transferable, competency-based skills to progress in a direction which meets workforce, service and individual needs. The Career Framework for Health will support health sector staff by illustrating possible career opportunities and movement.

5.6.9 Work is underway to populate the nine levels of the Career Framework with roles from the following initial areas for 2005/06: Emergency Care, Primary Care, Long-Term Conditions, Mental Health, Diagnostics, Elective, Children and Maternity. These roles will correspondingly be mapped against related frameworks, such as competence, knowledge and skills, and pay. Work is also progressing on the development of Career Frameworks for Healthcare Scientists, Allied Health Professions and Social Care Staff.

5.7 Primary care

5.7.1 The focus on the psychiatrist in this NWW programme has necessitated an emphasis on secondary care. Nevertheless, it is self evident that, if consultants reduce their caseload to concentrate on those with complex needs and to provide advice to teams, that this will have an effect on primary care.

5.7.2 We know that up to 40 per cent of people attending their General Practitioner (GP) will have a mental health problem and that 90 per cent of these will receive all their care in a primary care setting. It would be sensible to consider and treat primary care as a mental

health provider, indeed, the biggest mental health provider in terms of numbers presenting. There can be a lack of trust, and sometimes respect, between primary and secondary care practitioners, but if we are to improve services for the people who use them, through NWW and new roles, then we need to address this.

- 5.7.3 GPs and other members of the Primary Health Care Team (PHCT), have the benefit of usually having a long-term relationship with the patient; the focus is care as well as cure. Primary care is ideally placed to signpost the person to local resources, to provide health and mental health promotion, to deliver assisted self-help and some psychological therapies for the majority of its patients and, essentially, to provide continuity of care. This is of key significance at a time when secondary care is seeing an increasing specialisation of services and where care co-ordination remains inconsistent. The distinct contribution of the GP is included in Appendix 3 (a).
- 5.7.4 Taking a care pathway approach, we need to support GPs and their teams to develop their mental health skills. We need to identify and help develop NWW for the PHCT and for the multidisciplinary team in supporting them, including how new roles, such as the primary care mental health graduate worker, can be used most cost effectively. Current positive practice would suggest that there should be a dialogue and more joint working, including:
- joint discussions to develop individual crisis management plans;
 - shared learning, case discussion and problem-based learning;
 - working on systems together – liaison on mental health reviews as part of new contract for GPs;
 - working across primary and secondary care and GPs with a special interest in mental health in specialist teams;
 - commitment from primary and secondary care to achieve a greater understanding of each other's roles;
 - sharing knowledge and contacts to allow service users a greater range of treatment choices; and
 - the development of more primary care trailblazer training programmes.
- 5.7.5 Development of mental health provision in primary care is one of *The NSF for Mental Health – Five Years On* priorities for all of the above reasons. Although there are examples of innovative and positive practice within primary care and between primary and secondary care, it is variable.
- 5.7.6 An example of what a collaborative relationship could look like is identified in a detailed paper on Liaison and Interface issues (Appendix 3(b)).
- 5.7.7 A major piece of work on primary care will form part of the future work programme.

This will include:

- collection of current examples of positive practice from NIMHE Primary Care Programme;
- pilot development sites in primary care to address capacity and interface issues; and
- links with the planned new programme on increasing access to psychological therapies.

5.7.8 These initiatives and their implications should be recognised in the GMS contract and in the future revisions of the Quality and Outcomes Framework.

5.8 Non-governmental organisations

The voluntary and private sectors have an important part to play in the delivery of services. In considering workforce issues and new ways of working, it is felt important to reflect on what they can offer, particularly from a service user and carer perspective.

5.8.1 Community and voluntary sector

5.8.1.1 The voluntary and community sector has long been valued by many service users and carers as offering greater choice, flexibility and services which meet local need, independent of statutory providers. Organisations are usually commissioned by local authorities and Primary Care Trusts (PCTs) where they are direct service providers, but are also funded by charitable donations, grants and trusts. Increasingly, the voluntary sector is a major provider of mental health services through national organisations such as “Together – Working for Wellbeing” (formerly MACA), MIND and Rethink, and smaller, local organisations – working to limited-term contracts. Most voluntary organisations involve service users and carers in governance, planning and management, and some are entirely user-led.

5.8.1.2 The workforce in the voluntary sector attracts people from very different backgrounds, experience and training, including many who are or have been service users. It employs social workers and NHS professionals as well as independent practitioners such as counsellors. Many staff undertake National Vocational Qualifications (NVQs) as the core competency framework for social care. Many organisations also make significant use of volunteers.

5.8.1.3 The social inclusion report and its programme underline the importance for the statutory sector of working in partnership with the voluntary and community sector to provide routes out of mental health services and towards recovery. It is vital, therefore, that NWW develops this cross-agency work and promotes the deployment of staff to work in settings relevant to service users, for example at home, leisure, work, community, etc. New roles such as the STR worker can easily facilitate this approach. Equally, PCT and local authority commissioners need to develop key partnerships with the voluntary sector by commissioning more core local services to support this strategic direction.

5.8.2 Private and independent sector

5.8.2.1 Independent sector organisations make a significant contribution to the provision of mental health care, particularly in areas of specialist inpatient care, for example forensic services. Although some have developed innovative roles for their staff, including psychiatrists, many may require support in further developing their workforce.

5.8.2.2 Independent sector provision is likely to continue to increase in the future as will a growing movement of staff between the sectors. It is important, therefore, for the sector to be partners in the process of developing a modern mental health workforce.

6. New and emerging experience

6.1 National consultant psychiatrist pilot development sites

These sites began as part of the Modernisation Agency's Changing Workforce Programme, which had pilot sites across 12 different care groups. In mental health services, the initial sites were in Newcastle, Northumberland, North Tyneside Mental Health Trust and North Cumbria Mental Health and Learning Disability Trust, later joined by Avon and Wiltshire Mental Health Partnership (AWP) Trust. The first two Trusts provided an opportunity to examine the issues that service users, carers and staff felt should be the focus of changes to the ways that pharmacy, psychology, nursing, occupational therapy, support staff and consultant psychiatrists worked.

From this work and since the production of the interim report, 21 sites have been recruited. NIMHE regional development centres have received funding from the Changing Workforce Programme to develop at least one additional site per region.

6.1.1 Avon and Wiltshire Mental Health Partnership NHS Trust

Redefining the consultant role in a multidisciplinary context

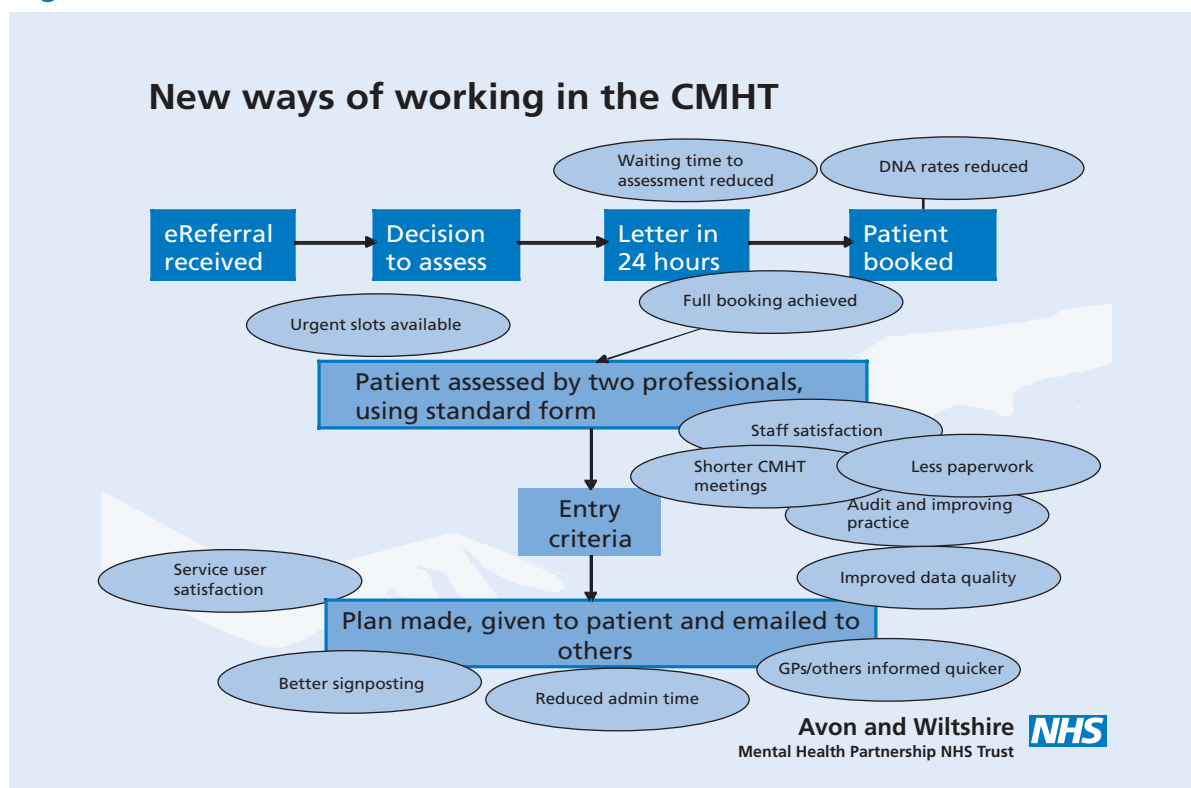
This Trust fostered the development of new ways of working (NWW) for consultants by providing a central steer and then supporting local initiatives. One of these, in West Wiltshire, was one of the first pilot sites, and the changes there are now being rolled out more widely.

AWP's approach has been to encourage the development of NWW in the following way:

1. *Support from the executive team and the board.*
2. *Defining the boundaries of the role of the consultant.* The trust produced its own *Trust Guidance on the Role of the Consultant Psychiatrist* in response to requests for more clarity from staff. In this document, it sought to interpret the currently available national guidance, clarify what is law and what is guidance, and define responsibilities of individuals (including consultants) and teams. The guidance supported a model of distributed responsibility, and led to a number of practical changes, which emphasised a new approach (for example defining episodes of care by team rather than by consultant, PCTs no longer commissioning GP to consultant referrals). Legal advice and the endorsement of Clinical Negligence Scheme for Trusts were obtained before the document was approved by the Trust Board. This guidance was recommended for use by other trusts developing NWW and is reproduced in Appendix 5 (a).
3. *Defining the boundaries of the work of the team.* A trust-wide workshop was held, with commissioners, service users and carers, to produce a 'framework' for the development of entry and exit criteria for services and teams. The framework was then modified according to local/specialty need.
4. In West Wiltshire a project was then launched to move from a traditional referral and outpatient model, to a new multidisciplinary assessment clinic. On receipt of the electronic referral (using the local acute hospital system), a senior practitioner in the team makes the decision to assess the patient and initiates the letter inviting the patient to ring to book an appointment. The patient is assessed by two practitioners from different professions; one does most of the assessment whilst the other types the information into a standard template (considerably shorter than the usual 'core assessment'), risk assessment and CPA.

The care plan is decided upon and agreed with the patient, who receives a copy of the form; this is then emailed to the GP.

Figure 2



5. A service user survey has shown high levels of satisfaction with this approach, and although two practitioners see each patient, there is an overall saving of staff time as Community Mental Health Team (CMHT) meetings can be shorter, there is less paperwork, and the Did Not Attend (DNA) rate has fallen to less than 10 per cent. The consultant's skills are well utilised by her involvement in the assessment clinic. In addition, she has stopped 'routine' outpatient appointments and sees patients as and when required, making use of telephone consultation when appropriate. A nurse prescriber is being trained in the team, who will enable the Senior House Officer (SHO) to concentrate on providing more intensive input to a smaller number of community patients, including supervised Cognitive Behavioural Therapy (CBT).
6. This way of working has now been rolled out to other teams, who have decided to develop it after seeing the results, and who have modified the model to suit local need.
7. The next stage of development is to improve the ability of teams to work with new cases as quickly as necessary and to develop their overall understanding of their caseloads; to this end a caseload management tool, which allows for risk and intensity of input as well as numbers of patients, has been developed with NIMHE and incorporated into the trust's clinical information system.

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6.1.2 Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

Development of specialised roles for consultants in adult psychiatry

On 13 September 2004, all consultant psychiatrists working in the Newcastle locality of this Trust changed their roles. This change was preceded by three years of preparation, and is part of a much larger service redesign, which is called the Pathways through Care Project.

The consultants have changed their roles from the traditional 'sector psychiatrist' model to more specialised roles, initially focusing on inpatient care and on Specialist CMHTs. In preparing for this change, consultants discussed a number of possibilities for role changes, including the development of specialist consultant roles in primary care liaison, specialising by diagnostic group, for example schizophrenia, affective disorders, personality disorder. They felt that, whilst these models deserved further consideration, they were not feasible at this particular time. Further developments and changes to consultant roles are part of the ongoing project development.

Reasons for change

Consultants and their multidisciplinary team colleagues felt that the existing service design hampered their ability to deliver high quality service. They felt that their team organisation lacked focus and that they were pulled between different priorities. Consultants, in particular, found themselves stretched between the inpatient and community multidisciplinary teams, and were not able to provide the level of consultancy, clinical leadership and involvement in service planning which was required for optimal functioning of the teams. In the context of scarce resources, consultants found themselves increasingly drawn into providing services, which were of relatively low complexity and high volume. This made for unsatisfying jobs, which in turn, led to difficulties in retention and recruitment. Along with senior executives of the Trust, the consultant group resolved to address these difficulties by considering alternative models. These models were shared with wider professional groups and a broad consensus developed.

The context of service changes

Historically, Newcastle has had a low level of investment in primary care mental health services. This was felt to be a significant factor in diluting the specialist role of the community mental health services. For this reason, it was felt to be important to develop new service models in conjunction with primary care, with social care organisations, with partners in the voluntary sector and with the involvement of service user and carer representatives. All of these stakeholders worked together in developing a draft for a joint strategy, which currently informs the review of commissioning arrangements in the area. Proposed changes to the specialist services were drawn up in such a way as to ensure a close fit with proposed developments in primary care mental health teams.

Success criteria

Early on in the process, consultants and other multidisciplinary colleagues considered what the criteria would be for success of the project. The following criteria were drawn up:

- improved recruitment and retention – of consultants and of other staff;
- service user involvement at all levels – in commissioning, service planning and at the level of individual care plans;

- high-quality information available – to support both delivery of individual care plans and to aid the planning and development of services;
- collaborative protocols agreed and operational – between specialist services at secondary and tertiary level;
- performance indicators show high quality of service; and
- staff who show vision, leadership and ownership of the service.

Key principles underlying the service changes

The group leading the service changes were heavily influenced by the Chronic Illness Care model. This model demonstrates that effective care for chronic illnesses, including severe mental health conditions such as schizophrenia and depression, depends on the delivery of multidimensional packages of care. Crucially, these involve the service user in a collaborative fashion (self-management). In order to achieve delivery of such care, it is essential that the teams must be reorganised around the care that is to be delivered, with clarity about different professional roles.

The new service design

The change of consultant roles has enabled the specialist service to establish full multidisciplinary teams in the inpatient areas and in the community mental health teams. Whilst there always have been multidisciplinary teams in these areas, consultant involvement has been limited because of multiple commitments across teams, with the resulting inability to become fully engaged in the business of these teams. With dedicated consultant time, these teams are now more able to focus upon their core business, establish and develop standards, and focus upon their specialist role. In turn, these developments have been supported by the establishment of primary mental health teams. These specialist inpatient and community teams link with other established specialist function teams such as Crisis and Home Treatment, Assertive Outreach and Early Intervention. Agreements are being developed across interfaces with other age-related services, and with tertiary services.

The realities of achieving service changes

It is important to stress that these changes are still at an early stage. Whilst the new teams have been established, there is much work to be done to further develop their capability. These changes have occurred in 'real world' situations, for example, service change has been complicated by financial issues, requiring the trust to make significant cost savings. Changes have occurred in primary care, the local authority and other organisations, which in turn have had an impact on the change process.

Agenda for the future

The establishment of specialist teams within the adult mental health service allows the opportunity to develop the role of these teams. Their purpose is to deliver the best evidence-based care. This work is being taken forward by respective 'development forums' for the inpatient and community teams.

Examples of work include:

- development of model job plans for consultants in conjunction with their teams;
- development of standards for inpatient care;

- care pathway development;
- communication systems;
- databases for the service;
- development of new roles, for example inpatient nurse specialist, clinic administrator; and
- a system of 'capacity management' has been established and needs further development. Work is under way looking at links between the acute wards, rehabilitation service and the community (local authority and non-statutory sector) provision of accommodation. Consultant caseloads are being audited.

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6.1.3 Humber Mental Health Teaching NHS Trust

This project was launched in October 2004. The Trust provides services to the City of Hull and the East Riding of Yorkshire; the main pilot area for the NWW programme is initially the Hull adult mental health services with a population of 300,000.

Local perspective

The Trust had some long standing problems with the recruitment and retention of consultant psychiatrists. All sectors were well over Royal College of Psychiatrists norms and had high levels of morbidity. At present the 'sectorisation' model of working means that consultants can be spread over inpatient services, community services, Mental Health Act work, CPA reviews and emergency and routine work.

It is important to emphasise that the proposed NWW will not only be the role of the consultant but also the roles of other mental health professionals and the interfaces between primary and secondary care. The process will be supported by a whole systems review, which will incorporate a data cleansing exercise and the introduction of a single point referral and caseload management process.

Progress to date

- Two half day time outs held for Hull consultants.
- Current problem areas identified.
- Proposed new way of working signed up to by all Hull consultants.
- Full day workshop held for all Hull adult mental health staff.
- Whole-system approach.
- Project lead in post.
- A clear vision and outline of where we want to be.

Proposed new ways of working

Consultants will move away from five traditional sectors and focus on a more specialist area of work, for instance inpatients or community. Instead of covering 'all things', consultants

will cover a more specific function over a larger area. The skills of other members of the team will be developed to support this change.

To deliver this model the roles of the consultants working within Hull Adult Mental Health Services will be as follows:

Community consultants

Community consultants will work within an identified community team/s in one of the five community sectors. They will undertake much less direct patient contact and offer a more consultative way of working, supporting other professionals to develop their roles. They will not hold a personal caseload nor undertake the role of CPA care co-ordinator although they will participate in CPA reviews as appropriate, according to individual need.

It is intended that the consultant job plan will allocate specific time for telephone contact with GPs and that a significant proportion of each day will be identified for close work with the CMHT, including seeing patients with the CPA care co-ordinator as opposed to routine uni-disciplinary follow up.

Additional support will also be available from the individual consultants working within the trust-wide specialist services, for instance Crisis Resolution, Early Intervention, Assertive Outreach and Psychotherapy Services.

Inpatient consultants

Inpatient consultants will each work within an identified inpatient unit. In contrast to community consultants they will have much more direct patient contact and will retain overall clinical responsibility for all inpatients within their unit regardless of where they come from within the Trust. This will make it easier to develop an integrated way of working, building on team relationships and working towards expanding the roles of other professionals involved in inpatient care.

Working relationships

The success of this way of working will be largely dependent on the effectiveness of the consultants working together. In order to facilitate this it is planned that the consultants will meet once every two weeks to discuss working arrangements and interface issues. This will also provide an opportunity for peer support and the potential for the group to develop into a Royal College of Psychiatrists Continuing Professional Development (CPD) review group.

Potential disadvantages

It is well known that service users are understandably very keen for the same professional to stay involved throughout the course of their treatment within mental health services. Under this new way of working this role would still be preserved, but by the CPA care co-ordinator rather than by the consultant. Having a different consultant in inpatient and community services could potentially lead to a disjointed approach. On the other hand it could provide the opportunity for another opinion and a synergetic approach.

One of the other disadvantages may be the potential for professional isolation. However, in this new model each consultant will be not only working as a member of a team of consultants but also as an integral member of the inpatient or community team.

Implementation process

The process will be implemented in five stages.

- **Documentation** – preparation of supporting information.
- **Consultation** with all stakeholders.
- **Endorsement** by the trust board.
- **Transition.**
- **Implementation.**

It is envisaged that the implementation process will take place over the next two years, and will be timetabled to coincide with the SHO rota changes. The process will be reviewed on an ongoing basis; however, formal reviews will be undertaken after six and twelve months in the first year with further reviews to be subsequently determined.

Summary of proposed new way of working

- Single point of entry supported by caseload management.
- A functional model as opposed to locality model.
- Consultant will not hold a personal caseload or take on the CPA care co-ordinator's role.
- The GP will be the consistent medical practitioner.
- The CPA care co-ordinator will be the consistent mental health practitioner.
- Partnership working with Crisis Resolution Service who will triage requests for mental health act assessment, admission, domiciliary visits and all urgent and emergency referrals.
- Consultant will be available daily for consultation.
- Consultants will participate in CPA reviews according to individual need.
- Consultants will no longer see patients for routine uni-disciplinary follow up.
- Consultants will see patients with key worker as required by clinical need for consultation purposes.
- Consultants will not see emergency referrals unknown to the service.
- The opportunity for consultants to develop expanded roles in other clinical staff, deliver informal teaching, and undertake leadership development.

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6.1.4 OXLEAS NHS Trust: Bromley and Greenwich Directorates

Forty-six consultants and middle grade doctors in Bromley and Greenwich Directorates are developing a methodology and toolkit, to support individual clinicians to determine their optimal effectiveness and efficacy. The aim is to facilitate optimal multi-disciplinary team (MDT) working and ensure best outcomes for service users.

The project also has a service and practice development focus to: re-design outpatient clinics, and new models of working with primary care including the development of models of choice in intervention for service users on standard and enhanced CPA. It will develop new models of working with inpatient units including scenario planning for the new mental health legislation, women-only facilities, as well as review of ward rounds.

The consultants and senior doctors have met to plan the above work and are using new tools to assist this work.

- An outpatient audit tool.
- A workload tool that has been designed to help them monitor the work that they do and encourage them to think of alternative ways of working.
- An intelligent information reporting tool:
 - to identify the extent and case-mix of bed use by each consultant and the team in which they work to inform their workload planning;
 - to identify patterns of service use which can inform initiatives to improve quality of care and service development; and
 - to support senior medical staff to prepare for appraisal in the Good Medical Practice section of the GMC appraisal where indicative information is needed on caseload and case-mix.

A fully completed development site application form for this project, and the tools mentioned can be found in Appendix 4 (e).

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6.1.5 Morecambe Bay PCT

The PCT has agreed to fund a G grade Community Psychiatric Nurse to establish a nurse-led clinic alongside existing consultants. It is anticipated that this will improve routine monitoring of physical and mental health and facilitate the transfer of some stable patients with severe mental illness to primary care.

The proposal aims:

1. To review data relating to general practice in Barrow and Furness to develop consistent criteria for severe mental illness registers and their use and to offer development support to other practices.
2. To carry out a skills audit in those practices, which are developing nurse-led Serious Mental Illness (SMI) physical health clinics to identify training needs in each general practice.
3. To carry out an audit of any existing practice nurse-led SMI clinics to examine adherence to NICE guidelines on monitoring the physical health of patients on antipsychotic drugs.

4. To pilot in one general practice, a practice nurse-led SMI clinic which includes monitoring mental state and side effects as well as physical health, and includes routine blood tests for patients on mood stabilising drugs.

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6.1.6 Manchester Mental Health and Social Care Trust

This project aims to review existing patterns of emergency care across the Trust, which currently operates three separate medical on-call rotas. Working with medical staff the Trust aims to introduce a clearer distinction between routine and emergency work and share responsibilities with other staff.

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6.1.7 Hereford PCT

1. The focus is on the changing role of a new consultant psychiatrist in a busy city community mental health team, and the implications for the changing role of other team members. The team have established a multidisciplinary assessment clinic, where assessments are undertaken by two professionals, and they are working to make ward and team meetings as effective as possible. They have established emergency clinics with time released from an outpatient clinic review.

They are using CPA as a standardised assessment tool, and establishing clearer liaison with GP practices and triaging of referrals.

2. The medical director and consultant group have been looking at NWW and following brief data collection looking at workload and the way of working across the PCT, together with use of locums and their implications, the Chief Executive has agreed to establish two further consultant posts, one in rehabilitation and the other in older people's care. This will enable the consultant group to work differently, give improved cover and reduce on-call demands.

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6.1.8 Suffolk Mental Health Partnership Trust

This pilot involves the whole of East Suffolk, with nine adult consultants changing from the traditional role to a fully functional model with two full-time inpatient consultants and others dedicated to community care. The long-term vision is for roles to become more specialised, to establish multidisciplinary community assessments allowing consultants to adopt a more 'consultative' role and the development of community recovery teams. Work is underway to redesign the rehabilitation psychiatry component.

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Contact: Dr Kamal Mohammed
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6.1.9 West Norfolk PCT

Two years ago, West Norfolk PCT had 55 acute adult inpatient beds. Consultant psychiatrists were considered the clinical lead in activating services and the first point of contact for both primary and secondary care providers. Significant service restructuring has enabled the development of an integrated provision of joint Accident and Emergency assessments, home treatment, day treatment and a reduction of inpatient beds to 30. The appointment of Primary Mental Health Care Practitioners and the development of the Active Outreach Service further strengthened community provision. All these services are now underpinned by the role of the care co-ordinator under the CPA. Our consultants report that they feel more supported within this new service framework and now have greater capacity to focus on their roles as medical experts, devote more time to the most severely ill patients and participate in service development.

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6.1.10 Humber Mental Health Teaching NHS Trust

The Hull Memory Clinic and Drop-In Memory Centre

The Hull Memory Clinic was established in 1991, set in primary care to enhance early recognition and timely support for people over 65, with suspected memory problems. Individuals and their families are seen at their GP surgery or a day hospital and offered a quality of life protective intervention.

In 2002 the Hull Drop-In Memory Centre was established to improve access for people who avoided approaching their GP due to fear of dementia and their belief in the inevitability of residential care. At the Drop-In, older people have direct access to memory and mental state review, and receive help to access medical support from their GP. The Drop-In also offers resources, training and community education to minimise disability in older people, by targeting the negative attitudes associated with ageing and dementia.

The clinic is led by a consultant clinical psychologist and has access to consultant old age psychiatry. A memory and mental status assessment, supported by treatment protocol, is provided for the person and family; this is co-ordinated by a nurse or psychologist. Treatment is provided by the memory team, which includes nursing, psychology, art therapy, support workers and psychiatry. Families receive three to five sessions of support and where eligible, prescription of an anti-dementia drug.

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6.1.11 Shropshire PCT

South Shropshire CMHT is a well established, integrated team, with pooled budgets, in a large rural area with a total population of 40,000. There is a team manager, who manages the core team of nurses, social workers, community care workers and an occupational therapist, with a clinical psychologist and consultant psychiatrist as members, but not directly managed.

All Community Mental Health Nurses work in primary care to provide triage and appropriate interventions. Emergency referrals are screened through a CMHT duty system, before medical input is accessed.

Referral pathway meetings are held twice weekly by senior team members to sift and direct (30-minute meetings). Generic assessments are undertaken by the duty worker (three slots per day), and all non-medical referrals are seen within two weeks. Medical referrals (via the team) are on a full booking system and are carried out at dispersed clinics in market towns; waits are between two and six weeks.

The effect of the model has resulted in fewer clinics, with those remaining being more needs driven. The consultant psychiatrist has been able to undertake his full catchment area responsibility as well as being Medical Director of the PCT.

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6.1.12 Humber Mental Health Teaching NHS Trust

Psychosis service for young people in Hull and East Riding (PSYPHER)

PSYPHER provides a service to young people between the ages of 14 and 35 experiencing their first episode of psychosis. Families and significant others are seen as crucial allies in planning and implementation of recovery packages (which may include, for example, cognitive behaviour therapy and family interventions). Considerable focus is placed on the 'fabric' of the everyday lives of service users, such as daily activity (school, college, work, housing) as well as having a belief and expectation that the young person can and will get on with their life. In addition, PSYPHER aims to bring about a cultural shift in how mental health difficulties are thought of and how services are delivered within the mental health system and in the wider community.

The psychiatrist in this service has a number of opportunities and responsibilities. There is the opportunity for a culture change, for example, by abandoning traditional 'clinics', and so having more time to talk to and understand clients' problems and perspectives and having the team resources to collaborate in a holistic package for this client group. The responsibilities of the role inevitably include issues of risk and medication but there is an acknowledgement that it is no longer useful to think along a purely medical model of mental illness and it is important to embrace alternative ideas and approaches and a more collaborative team process than might traditionally happen. This is evidenced by the fact that the team has an equivalent psychology lead to ensure that psychological aspects of psychosis are equally addressed. Another important component of the role is the responsibility to work with primary care in raising awareness of psychosis and collaborating with other psychiatry colleagues (including child and adolescent mental health service) as well as general practitioners to ensure appropriate physical checks are carried out.

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6.2 General learning points from consultant pilot development sites

Table 5

- Small changes can happen quickly and have an impact, for example joint assessment clinics.
- A project plan helps to develop thinking and gives clarity (for example use of expression of interest form).
- The project as a whole will always take longer than you think as it involves culture change.
- The change needs to be project managed.
- Some capacity needs to be built for a part-time project manager.
- The project needs to be team-based as changing the consultant role changes the work of others in the multidisciplinary team.
- Service users and carers need to be involved from the outset.
- There should be a clear communication strategy to ensure that staff, service users and carers are involved to develop and maintain a consensus.
- Data collection is important not only to measure change from a baseline but also to be able to demonstrate the results to sceptical colleagues.
- Shadowing consultants and other staff is a useful tool to review workload and practice.
- Having an interested consultant or group of consultants is essential.
- Having the support of the clinical director and medical director is very important.
- Dissatisfaction with the current situation is a key lever for change.
- Board level ownership is essential to give 'permission' to change.
- Make use of human resources, finance, clinical governance and service planning people in the trust.
- Expect problems to arise and to revise assumptions.

6.3 Data collection measures

Pilot development sites have found the following types of data collection and measures useful

Table 6

• Demographics and population served	Matrix/Creating Capable Teams Toolkit (Appendix 4d)
• Caseload data (weighted for quantity and intensity of input)	South West Caseload Profiling tool – kate.schneider@nimhesw.nhs.uk
• Referral numbers and source	
• Outpatient clinic audit	Outpatient Audit Tool (Oxleas – Appendix 4a)
• Multidisciplinary team meetings	Oxleas substitution diary tool (Appendix 4b)
• Numbers discharged (per week, per annum)	
• Inpatient admission numbers	
• Length of stay information	
• Workload of consultant and team	
• On-call rotas and demand	
• Screening assessment tool	AWP form (Appendix 4c)
• Number of programmed activities available to consultant/service/trust	
• Service user perspective	Service user outcomes tool (Oxleas)

6.4 NWW and new roles across multidisciplinary and multi-agency settings

Modernisation of the workforce is happening on a number of fronts. Agenda for Change offers a valuable opportunity to clarify and extend roles and link these to equitable remuneration. We quote here some examples of how changing the role of one practitioner can have implications for another practitioner or for the service; all of which contribute to the process of role and workforce redesign. Some of these have direct impact on the role of the consultant psychiatrist whilst others may have an indirect effect.

The development of new roles and the increased entry of graduates and people, who had insufficient qualifications at the time of leaving school, will increase the numbers coming to work in services, will provide more ‘hands-on’ time for some service users, and free up highly trained professionals to concentrate on those with the most complex needs. The expanding numbers of people, who have experienced mental health problems and the use of services, adds another positive dimension to the developing workforce.

A continuing programme of work, led by the NWW Team (formerly CWP) in the NIMHE NWP addresses pharmacy, STR and psychology associate roles.

For pharmacy working, this has meant a growth from 2 to 44 sites; for STR workers, growth from 7 to 60. For psychology associates, 5 Trusts are to help test this role by jointly providing 8 posts that will employ this new worker and evaluate it as it develops.

6.4.1 Use of the consultant contract

Hambleton and Richmondshire PCT provides mental health services to a very rural part of North Yorkshire. For many years, it has provided a sectorised service with consultants being responsible for inpatients, day patients and community patients, as well as responding to crises from GPs. As a result, responsibilities, caseloads and workloads have slowly increased. An action plan was developed jointly between the consultants and the managers led by the Associate Medical Director. There were three elements to this:

New consultant contract As the consultants work so closely together, it was agreed locally that after workload diaries were completed, the hours would be averaged, which resulted in removing any financial incentive for working longer hours.

Appraisal and job planning It was agreed that all consultants would decrease their caseloads. In addition, extra training in management and leadership was offered to all consultants.

Team managers The team managers worked with the associate medical director to facilitate both team and consultant change, for example, a system of crisis intervention was agreed, where all emergency referrals were triaged by the non-medical members of teams.

The combination of these three approaches has improved the working lives of the consultants whilst ensuring they are more available to other members of the teams and service users. This approach was under-pinned by joint working between doctors and managers and facilitated by a robust job planning and appraisal system.

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6.4.2 Shadowing – a tool for reviewing roles

As part of the Changing Workforce Programme work in the Newcastle, Northumberland, North Tyneside and North Cumbria NHS Trusts, a piece of action research was carried out. The aim of this was to obtain detailed information about “*A Day in the Life of a Consultant Psychiatrist*”. This was an attempt to explore where the consultant’s role was presently and how this role could change for the better. Recently, this shadowing work has extended to include other members of the CMHT.

In total, ten consultants, a psychologist and social worker have been shadowed. Four of these consultants have been included in a follow-up exercise two years on from the initial shadowing.

Initially participants were asked four questions in order to set the scene:

- What do you feel is part of your role and is effective?
- What do you feel could be better undertaken by somebody else?
- What would you like to do that you are not able to do at present?
- What are the factors that prevent you from doing this?

The observations gained from the shadowing were then presented in report form for discussion with each person and a list of recommendations drawn up to aid role development and change.

All those involved found the shadowing exercise beneficial as the observations of an 'informed outsider' raised issues that post-holders might turn a blind eye to. The issues raised included job planning, CPD, team work, clarification of role and task, leadership and management, mentoring and the role of the medical secretary.

For more information see *Shadowing Consultants*, Egerton J, Swann A and Foley B 2005. Vol 29 no 5 pages 182–5 *Psychiatric Bulletin*

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6.4.3 The advanced practitioner role in Manchester

An experienced community mental health nurse was appointed to an advanced practitioner role in June 2004, as the first of a cohort of advanced practitioners in Greater Manchester. The post was intended to compensate for scarce junior doctor support to a consultant psychiatrist by developing innovative approaches to a variety of traditionally medical roles. In the first six months, the work has focused on clients in an acute home treatment service, which acts as an alternative to hospital admission.

This has included the following roles:

- assessing all new patients within a few days of admission to gather details of recent and past history and assessment of current mental health;
- gathering detailed information from a variety of sources including families, community staff, GPs and earlier records;
- combining this information to form the basis for a full discussion in team meetings and the preparation of an admission summary;
- reviewing patients regularly and undertaking mental state assessments to be discussed in team meetings;
- liaising with GPs about physical health needs, ordering, and reviewing physical investigations where appropriate;
- acting as a liaison point with the community mental health team to provide updates on shared patients and co-ordination of discharge plans;
- chairing multidisciplinary team meetings in the consultant's absence; and
- teaching medical students.

Areas of current development include:

- developing a physical health screening questionnaire and investigation checklist to ensure patients' physical health needs are met;
- developing a protocol for supplementary prescribing in an acute treatment setting, which will allow for variation in doses and rewriting of medication charts as agreed in team meetings; and
- developing protocols for a nurse-led clinic to operate alongside a more traditional outpatient clinic. The advanced practitioner will see patients with complex needs but who are reasonably stable, discuss them with the consultant, and send shared any care management letters with GPs.

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6.4.4 Use of pharmacy staff to release doctor and nurse time and improve quality

There are 44 sites in England spreading innovative ways of working for pharmacy staff.

Key themes from those sites include:

- increased integration of the pharmacist into the multidisciplinary teams provides greater access to expert knowledge to influence prescribing practice and reduce inappropriate prescribing;
- development of medicines information literature that is easily accessible by service users, carers and staff;
- improved supply and delivery of medicines systems to free up nursing time to spend with service users; and
- training on medicines valued by service users and other staff groups.

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6.4.5 NWW of psychologists to enhance hands-on support to families with children with severe learning disabilities and challenging behaviours

In 2002, a multi-agency team was funded by health, social services and education to provide intensive behavioural intervention to children and young people with a severe learning disability and severe challenging behaviour. Instead of each child being seen individually by a clinical psychologist, a group of healthcare support workers were recruited and trained to go into families and do hands-on behavioural work, working unsocial hours. They were young, were not seen as professionally 'distant' and went down well with families. They were very closely supervised by a psychologist on a weekly basis to enable them to work safely and continue to develop their skills. Two years down the line, they have delivered very positive clinical outcomes at a cost far less than employing psychologists to do the hands-on work.

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6.4.6 Use of psychology associate to free up clinical psychology time

A new post of associate psychologist was established in June 2002 for a one-year period, as part of the CWP, working half time in child and family services and half time in adult clinical psychology services in North Cumbria.

The role functioned within a safe governance framework with supervision, education and training. The worker undertook CBT and subsequently completed a degree in CBT. In adult services, the key role involved providing direct therapy. In the child and family services, the focus was a highly practical approach to working with families.

The role contributed to improving access to the psychological services by reducing length of waits for service users. The post has since been made permanent within the psychology and counselling department.

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6.4.7 Making services more responsive by introducing nurse supplementary prescribing

Nurse supplementary prescribing allows a suitably qualified nurse to prescribe, with a service user's agreement, within the parameters of a clinical management plan initially drawn up by a doctor. This potentially allows for a speedier and responsive service, makes better use of nurses' skills and knowledge, and allows medical staff to be available to meet other needs. Abid Khan, consultant psychiatrist from South Staffordshire, has reported that he is now able to see new patients quicker, as medication reviews of existing service users are now being carried out by nurses.

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6.4.8 Extending the role of the dietitian

In the South London and Maudsley NHS Trust, dietitians, working within multidisciplinary teams, have taken the lead in developing an integrated weight management programme for people experiencing weight gain as a side effect of antipsychotic medication.

Guidelines for prescribers have been developed, together with a screening tool for people at risk of weight gain. Dietitians have re-designed the food service on wards to include menus adapted for the at-risk group, protected meal times and staff training.

In the community, there are healthy lifestyle groups run by nurses and a specialist weight management clinic run by dietitians in collaboration with community staff.

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6.4.9 Physiotherapists role in meeting the needs of clients with both mental and physical health problems

In the Doncaster and South Humber Mental Health Trust, a physiotherapist was introduced into a CMHT.

Their work has focused on clients referred to the CMHT with both physical and mental health problems. The physiotherapist's skills allows them to carry out a comprehensive, holistic assessment of the client's needs which are often multifactorial.

The role has also included the following areas:

- liaison with GPs on physical health issues and developing healthy lifestyle and weight management groups in the community in partnership with leisure services;
- liaison with the general hospital on clients with both physical and mental health needs who require complex discharge packages; and
- working alongside the consultant psychiatrist and nutritionist in the development of a mood and lifestyle clinic for those with mood disorders.

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6.4.10 Use of Primary Care Graduate Worker (PCGW) in mental health

In Oldham, a PCGW, employed in a PCT, has carried out an audit of self-help materials to assess their accessibility and appropriateness for people from minority ethnic communities. This is leading to the development of self-help materials for people, for whom English is not their first language, which can be used in primary care.

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6.4.11 The impact of the Support, Time and Recovery Worker (STR) for service users

In Stoke on Trent, the recruitment of people with lived experience into STR roles in mental health social care settings has created positive expectations of recovery and the real opportunities for employment.

‘The role of the STR worker is to help people with whatever their needs are; this can include tasks like shopping, listening to their needs and promoting their independence as much as possible. The impact on me, personally, as an STR worker with a lived experience of mental health problems, is that I have now reached my goal in recovery – by being able to support others – after all these years.’

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6.4.12 Use of Carer Support Workers to meet carer needs

A Carer Support Worker employed by Rethink, describes his experience with one carer, Mrs Jakes (for the sake of confidentiality this name has been anonymised), who has a son with a diagnosis of schizophrenia who often expresses suicidal thoughts.

‘Initially my role was to spend time with Mrs Jakes to help her articulate – for the first time – the whole situation as she found it. This was a difficult and often tearful time for her – but a necessary one for her to understand her own story before being able to make active decisions about her role.

‘As she gathered confidence, she asked me to support her as an advocate in Section 117 review meetings and she stated afterwards that she felt that for the first time “her voice had been heard”.

‘The next step for Mrs Jakes is to build her relationship with her son, helping her to give as much as she can, yet to set boundaries around her caring role. As a family therapy trained worker I am currently engaged in setting up sessions within her home.

‘A bonus from my work with Mrs Jakes is that she is becoming actively involved in the local Carers Forum and supporting the Local Implementation Team.’

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6.4.13 Use of Community Development Workers (CDWs) to identify and meet the needs of black and minority ethnic communities

The primary role of CDWs in the London Borough of Newham was to support victims of racial harassment to access support services not only to combat the harassment but to support the children (who were inevitably victims).

A Muslim mother was a victim of harassment and the role of the CDW was to empower her family to support themselves and to decrease the self-imposed isolation the family placed upon itself. This was done by putting the family in touch with a conflict resolution service, which arranged for both families to meet and discuss the issues. In addition, the Housing Advice Service was contacted to look at the wider housing needs of the family, including better lighting and door locks. The mediation service was able to engender a greater sense of understanding between the client family and the wider community in which they lived.

The mother experienced severe depression and she was put in touch with a specialist Asian women's advisory service, which provided support through ongoing, confidential counselling. The family were referred to the Child and Family Consultation Service that provided structured counselling and support to the children.

The CDW's main role was, in this case, that of an enabler and co-ordinator.

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6.5 Individual projects and whole-system change

6.5.1 The modernisation agenda has brought about great change in practice, system redesign, new roles and NWW. It is all too easy, however, for these to be and remain 'projects' rather than being part of mainstream service delivery. This is where it is important for localities, and Trusts, as part of those localities, to undertake strategic workforce planning, based on a vision and agreed service plan. There is Workforce Planning and Design Guidance (2003) to assist this process, seven national early implementer sites, workforce modelling tools, and the development of the 'Creating Capable Team' Toolkit under way to assist in a more strategic and comprehensive approach to change.

6.5.2 The NICE guidelines for schizophrenia emphasise the importance of service users and carers being able to access psychological and family therapy. However, there is evidence that even after training in Psycho-Social Interventions (PSI), many nurses and others do not apply these skills due to service constraints. Bolton, Salford and Trafford Mental Health NHS Trust have developed a strategy to ensure the integration of PSI into routine care. This includes ensuring that managerial support is forthcoming for any staff training in PSI and that courses are commissioned up to three years in advance to meet strategic development needs.

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6.6 Some implications for service redesign

Table 7

Redesign of aspects of the service within a whole-systems approach has been relevant in some localities. Important aspects of such changes, which have appeared beneficial, have included some or all of the following:

- make use of the review of programmed activities in the consultant contract;
- consider the whole system of care across the primary/secondary care interface;
- clarify anticipated care pathways for patients through the care system;
- clarify the tasks expected of particular teams and the boundaries or interfaces between services;
- expect consultant psychiatrists to integrate into teams and share their identified and explicit function;
- a single point of receipt of referrals to a team is more effective than multiple entry points, including to a named consultant;
- triaging of referrals should be undertaken by a senior practitioner;
- initial/core assessment, prior to allocation, if carried out by experienced professions, on a planned basis, can improve DNA rates, increase speed of CPA, completion and improve care planning and onward referrals;
- joint working in carrying out assessments can help develop confidence and an improved appreciation of the other professions' perspectives;
- reviewing outpatient work and particularly routine follow-ups in clinics can lead to them being reduced or eliminated thereby freeing up time for consultants to address other tasks;
- establish emergency clinics to increase responsiveness and reduce waiting times;
- review time spent on ward/team meetings – could they be done differently?
- crisis teams should gate keep inpatient beds and facilitate early discharge;
- training of junior doctors can be improved through joint work with other disciplines;
- promote electronic referral and prescribing as it becomes available; and
- reduce long-term caseloads developing a 'graduates' group for example.

7. Creating and sustaining positive change

Leadership and change

- 7.1.1 Positive change doesn't happen on its own. There needs to be a clear vision for the future, a service model to deliver the vision and the engagement of staff and service users to secure influence on and therefore ownership of the process. Good leadership is essential for service improvement.
- 7.1.2 The Chief Executive and Trust board must be explicit and clear about their vision and plans. Effective leadership from the top of the organisation will always mean that staff ownership of the plan has been assured by their participation in its formulation.

Leadership and management in clinical teams

- 7.1.3 NWW should foster a fundamental rethink of leadership in multidisciplinary clinical teams. For too long there has been an unquestioned expectation in many quarters that responsibility for leadership of the team resides with the consultant psychiatrist. Yet it has often been unclear what that really means.
- 7.1.4 To function well a team requires administration, management and leadership. In brief, administration is about housekeeping – the rotas, meeting schedules, information collection and reporting, management focuses on ensuring that the performance of the team and individuals within it match objectives or requirements, and clinical leadership focuses on decisions concerning the care of service users and their families, both individually and strategically.

All too often, people tend to confuse leadership with being in charge, taking responsibility for people and events, and with exercising responsibility for managing resources.

Kotter (1998) draws the distinctions between leadership and management. He argues that management and leadership are two different yet complementary systems of action, each having its own function and characteristic activities. Management, he says, is about coping with complexity and leadership is about coping with change. Table 8 summarises a survey of the literature that extracted a consensus of opinions about the components or characteristics of leadership and management (Williams 2000).

Table 8 The components of leadership and management compared

Leadership	Management
<ul style="list-style-type: none">• Setting the direction• Values• Vision• Culture• Responsibility to others• Aligning people• Motivating people	<ul style="list-style-type: none">• Planning• Systems• Inputs and outputs• Methods• Accountability for resources• Organising and staffing• Controlling and problem solving

Kotter asserts that both management and leadership are necessary for success. This report makes similar distinctions. The NSG sees management as being about ordering people's work, the conditions in which they work and the resources available to them, responsibility, authority, and accountability. Leadership, by contrast, is an enabling force or set of behaviours that enables others to give of their best and to work well as members of teams to deliver better care for the people using those services.

- 7.1.5 It is not uncommon, however, for teams to become dysfunctional because of festering unresolved disputes. It is important that teams have skills in conflict resolution and problem solving. The NIMHE/Leadership Centre Effective Team Leadership programme provides whole team training to address these issues and skills pro-actively. It is essential, nevertheless, to have someone in the team who will take the lead in the process as a whole.
- 7.1.6 Most teams have team managers and clinical leaders. These roles can (and probably should) be blurred much of the time although there needs to be an explicit understanding about the role(s) within the team. The team leader/manager will be adept at surfacing and clarifying conflicts quickly, facilitating full and fair hearing of different views, ensuring that opinions are openly tested against available evidence or the values of the service, and wherever possible turning apparent conflicts about what is the best treatment approach into choices for patients to make according to their own values. S/he will be capable of winning the respect of all team members – not least by valuing dissent, treating everyone's opinion with respect, but resolving disagreements speedily with the reasons made explicit.
- 7.1.7 Clearly no discipline can claim to have exclusive competences for such a job as a consequence of their professional training. Individuals from all professional backgrounds need to be developed and selected with care to fulfil these crucial team management/leadership roles. Higher levels of management will rely on them to manage overall performance of teams and for integrating the work of the team within the whole system of care.
- 7.1.8 While what follows focuses on leadership development for psychiatrists, in keeping with the title of this document, it should be noted that other disciplines are similarly exploring the leadership development needs and aspirations of members of their own professions which will be reported elsewhere.

Leadership development for psychiatrists

- 7.1.9 There is an essential job to be done of providing leadership and management for psychiatrists in a trust. Such medical management is important for managing a major programme of change like NWW.

There are significant problems

- 7.1.10 There are excellent examples of effective medical leadership in trusts around the country. But this is not universal. Many consultant psychiatrists express concern about their lack of influence on service development. Some consultants also report frustration about their inability to solve continuity (Kennedy and Griffiths 2001). Such problems could get worse as service development accelerates, and the number of teams and interfaces increases throughout care pathways.

Towards solutions

- 7.1.11 Psychiatrists would be helped by more training and personal development at the four levels depicted in the table below:

The four levels of leadership development for psychiatrists

1. **Specialist registrars:** to learn how mental health services are organised and led, and about the rights and duties of those who are led, colleagues and service users.
2. **New and current consultants:** to learn about leadership in clinical teams, and how to work effectively with other leaders and disciplines.
3. **Clinical directors:** to define the role more clearly, and how to realise its full potential in operational management and clinical governance, in partnership with the other service directors and managers.
4. **Medical directors:** how to play a major part in setting the strategic direction of the trust and the development of its medical workforce to match, in partnership with the board.

- 7.1.12 Medical and clinical directors in many trusts describe deficiencies in role clarity, time capacity, skills capability, and organisational context – the four big Cs required to do a good job (Griffiths and Redhead, in press). Without effective leadership in these formal roles, implementation of new ways of working will hardly be possible, nor the desired engagement of consultants in service development and clinical governance of the whole system of care achieved.

7.1.13 Clarity – of roles

Both medical directors and clinical directors can find themselves burdened by administrative tasks that others are better equipped to do. The urgent can take over from the important, for example, chasing locums to fill vacancies rather than implementing ways of working that reduce the need for locums.

7.1.14 Capacity – time for the job

Sessions for medical management are not uncommonly ‘paid notional sessions’ – meaning there is no allotted time in the working week. So the job is done, or not done, after hours when the people with whom dialogue is essential are not available. Yet it is possible for medical managers to remain clinically involved with a realistic number of real sessions to do the management job properly.

7.1.15 Capabilities – skills required

The capabilities required for consultant leadership jobs are the same as those required by all leaders. A skill area that is particularly important is how to influence and work in partnership with other leaders across all disciplines and sectors relevant to the service. Hence, there is much to be said in favour of leadership of development programmes that are multidisciplinary.

- 7.1.16 The diffidence that some consultants have shown towards multidisciplinary leadership development is understandable. Often starting with less management experience, less role clarity, and less time and higher expectations from others can make them nervous. There

may be a need for brief uni-disciplinary programmes for doctors, therefore, preparatory to multidisciplinary leadership development.

- 7.1.17 Chief Executives and service managers in some Trusts are concerned about difficulties they have in engaging consultant psychiatrists in planning and implementing improvements. There may be many reasons for this but frequently cultural differences between clinicians and managers remain unacknowledged and poor communication can be the result. Consequently, the difficulties and constraints each experience may be misunderstood and the circumstances for paralysis, or even confrontation, created. Such problems require active resolution that depends on skilled managerial and clinical leadership.

Generally, development programmes that are locally based, involving colleagues in the same trust addressing common challenges, are more helpful than trying to learn on courses detached from local realities.

7.1.18 Context – organisational support

The context in which a leader is expected to lead can promise success or guarantee failure. The seemingly prestigious jobs of medical or clinical director are proving difficult to fill in some areas. The jobs are seen to be high risk, even career limiting. There appears to be the need for a good deal more analysis with Chief Executives in some Trusts about the conditions they must offer if the jobs are to be personally rewarding and serve the needs of the trust well. The working arrangement between the Medical Director (MD) and Chief Executive is of critical importance. So is the design of the medical management structure within the overall trust management framework.

- 7.1.19 Clinical directors may find conflicting priorities with service directors and managers with whom they are supposed to be partnered. Stated crudely, the former have a tendency to focus on concerns of front-line staff, whilst the latter may have a tendency to be required to implement directives from above. For the partnership to work they need to have similar objectives consistent with the expectations of the Chief Executive and the Board as a whole.

It is not only a medical matter

- 7.1.20 Sound medical management is essential for the Chief Executive and Trust boards to fulfil their statutory responsibility for quality of care. Clinical governance vitally depends on a medical management system that taps the expertise of every consultant on what is right and wrong with current delivery of care and how to improve it. The consultant's selected caseload of complex and higher risk cases will constantly test the system of care.
- 7.1.21 To communicate concerns and ideas a consultant needs close and continuous dialogue with a clinical director who thoroughly understands the service in which he or she works and with the relevant middle and senior manager. If the clinical director's span of control is too small s/he will lack the flexibility to deal with most service problems and improvement opportunities. If that span of control is too large there will be reduced understanding and effectiveness. Whatever, there will be significant issues that clinical directors and service directors cannot handle. They must have ready access to the MD, the director of nursing, the Chief Executive and other members of the trust board for resolution of such problems. Correspondingly, the Chief Executive, MD and other board directors will require the clinical and service directors to interpret, adapt, and implement policies developed at higher levels.

7.1.22 Appraisal and job planning with consultants could come alive and be welcomed as a vehicle for handling this two-way traffic between consultants on the front line who can see what is happening to patients, and top management responding to complex economic, political, and technological pressures.

7.2 Levers for change

7.2.1 Performance indicators

NWW and its implications for service delivery need to be reflected in the ongoing development of Performance Indicators (PIs).

However, current PIs may inadvertently promote inappropriate practice, for example:

- Activity levels – this is usually counted as consultant outpatient attendances; there is likely to be a reduction in consultant psychiatry attendances as consultants concentrate on those with complex needs and reduce routine follow ups.
- Waiting times – this is usually counted as waiting for consultant OP. With a single point of entry to the team, the waiting times for the patients may reduce, but the consultant psychiatrist may well not be the clinician seen.
- Finished Consultant Episodes (FCEs) – this is defined as completing an inpatient episode, by diagnosis. Inpatient care is now seen as part of a care pathway, captured in the person's care programme plan, where the consultant may have continuing involvement. The FCE is therefore an unhelpful measure in modern mental health service performance.

7.2.2 Inspection bodies

Well-trained and satisfied professionals receiving continuing personal development and training who work together in integrated teams, are a means of improving the quality of care delivered to users and ultimately their clinical and social outcomes.

In England, the HCC exists to promote improvements in the quality of healthcare and public health, and is responsible for reviewing the performance of healthcare organisations and awarding an annual rating of the organisations' performance. The Commission for Social Care Inspection (CSCI) currently has a similar role for social care organisations. Central to the assessment of healthcare organisations is the evaluation of the DH's targets and Standards for Better Health, which include continued training, supervision and support for professionals. Standards relevant to NWW include:

- clinical training, supervision and leadership;
- delivering treatment and care based on evidence-based practice;
- staff appropriately recruited, trained and qualified for the work they undertake;
- continuous participation in further professional and occupational development relevant to their work;
- having an appropriately constituted workforce with cost effective skill mix; and
- continuous improvement through better ways of working.

Indicators of these standards could include:

- a Board-approved policy defining the role of the consultant psychiatrist within the Trust and a strategy to implement and support this;

- evidence of policies to implement NWW for other clinical professionals;
- evidence of reduced caseloads for psychiatrists;
- evidence of team skill mix modernisation (use of CCTT);
- consultant job plans with, for example, flexible sessions, special interest sessions and fewer outpatient clinics;
- evidence of data collection on team activity and user needs; and
- evidence on action to reduce costs of locums and agency staff.

It would be timely for NIMHE to enter into a discussion with the DH, HCC and SHAs to explore more appropriate performance indicators that more appropriately reflect the intentions and effect of NWW.

7.3 External support for change

- 7.3.1 SHAs have received people and resources from the Modernisation Agency to focus on service improvement and NWW. Although generic posts, mental health has a legitimate call on these resources.
- 7.3.2 The Changing Workforce Programme Mental Health Team moved to become part of the NIMHE National Workforce Programme (NWP) in 2005. Areas wishing to pursue development sites for NWW and CCTT will continue to be able to access the NWP for local support.
- 7.3.3 NIMHE has become part of the Care Services Improvement Partnership (CSIP). CSIP brings together a number of development resources, which have been working to support services, delivering services to different client groups (children, older adults, individuals with learning disabilities and people with physical disabilities).
- 7.3.4 Workforce is seen as a key theme that runs across all the CSIP programmes; the need to support staff to further develop their roles is an early priority.
- 7.3.5 CSIP is organisationally based on the NIMHE Regional Development Centres. NIMHE's programmes, including the NWP, will continue to run from these centres, through their workforce leads, to provide local support to mental health services wishing to undertake the workforce development outlined in this document.

7.4 Professional and regulatory bodies

- 7.4.1 The approach of the NSG has been to work with the professional and regulatory bodies wherever possible. In Section 6 of this document the concerns of doctors and others to have a clear statement from the GMC that enables doctors and other professions to feel supported in changing and undertaking new roles has been addressed. Non-medical staff also need to feel that their professional bodies will support the development of new ways of working. Likewise, the new roles emerging to enable professionals to have time to take on change that meets new service models and the changing needs of service users and their carers need clear governance.
- 7.4.2 The DH has ordered a review of the revalidation of doctors and related matters, following concern expressed by Dame Janet Smith in her fifth report from the Shipman Inquiry.
- 7.4.3 A new review, to report at the end of 2005, into the regulation of a broad range of healthcare professions, will consider changes to the measures that pharmacists, nurses and other health

professionals undergo to check they remain fit to do their jobs. John Reid, the then Secretary of State for Health, said when he announced the above review that ‘Patients rely on a team of health professionals during their care, not just doctors. Ensuring there are proper measures to test doctors’ fitness to practise is only one part of assuring the safety of patients. Many lessons emerging from the Chief Medical Officer’s review of revalidation and the role of the GMC will have implications for the regulation of other healthcare professions and vice versa.’

7.4.4 The review will consider and advise Ministers about the measures needed to:

- strengthen procedures for ensuring that the performance or conduct of non-medical health professionals and other healthcare staff does not pose a threat to patient safety or the effective functioning of services, particularly focusing on the effective and fair operation of fitness to practise procedures;
- ensure the operation of effective systems of continuing professional development and appraisal for non-medical healthcare staff and make progress towards regular revalidation where appropriate; and
- ensure the effective regulation of healthcare staff working in new roles within the healthcare sector and of other staff in regular contact with patients.

7.4.5 In addition, the review will consider whether any changes are needed to the role, structure, functions and number of regulators of non-medical healthcare professional staff.

7.5 Commissioners

7.5.1 PCTs have an important role to play through their commissioning relationships with provider organisations in supporting the implementation of NWW. Commissioning specifications, which acknowledge the value and potential outcomes of consultant psychiatrists changing their roles, need to be developed.

7.5.2 These could, for example, include reduction in the use of locums, with consequent improved quality and reduced overspends and reduced waiting lists.

7.6 Trust boards

7.6.1 NWW represents an important contribution to Trusts’ approaches to developing a modern mental health service. Trust boards generally, but Chairs and CEs in particular, have an important role to play in continuing to signal that NWW are central to delivering improved services. The support of the Chair and CE is crucial if staff are going to overcome the challenges that NWW can present.

7.7 Capable organisations

7.7.1 The NSG wanted to explore what a capable mental health organisation, achieving change through NWW, might look like. Whilst there is anecdotal information, there is little empirical evidence.

7.7.2 To begin exploring capability in mental health organisations, six case studies of positive practice, across the NIMHE regions, were identified on the basis of known innovative activities. Two of these were directly related to NWW in psychiatry (Avon and Wiltshire Mental Health Partnership and Newcastle, North Tyneside and Northumberland Mental Health Trusts), while the others focused on implementing new workforce roles such as STR workers. Key stakeholders, including service users and carers, the ‘strategist change-agent’ and other team members were interviewed to explore what had worked locally. The following three inter-related themes emerged:

Active involvement of service users and carers

7.7.3 When the focus and rationale for change was located with the service user and carer, the intervention being tried was seen by the key stakeholders to have credibility, thereby reducing the potential of resistances to change. Furthermore, the active involvement of the service users and carers in the change process not only made the consultation process an empowering one for them but also generalised to staff. In the Humber Trust, an STR workers pilot site, the focus on service users has resulted in one-third of these new workers being people with service user history.

A consultative and visionary leadership approach grounded in hope and integrity

7.7.4 Leadership, unsurprisingly, emerged as a vital theme in successful capability in all the cases investigated. Key aspects in this context included: clarity about the current situation, hopefulness about the future, and effective project management skills. Consulting and actively involving, with integrity, as many stakeholders in the process was deemed essential for success. In the two cases where new ways of working in psychiatry were being tried, the innovations were enhanced where the key change agents held joint clinical and managerial lead roles.

A proactive communication strategy underpinned with trust and transparency

7.7.5 It is vital that people affected by the change agree with, or at least understand, the need for change. They also need to have a chance to influence how the change will be managed and to be involved in the planning and implementation of the change. The communication modes in which this is done have a bearing on the level of success. For example, in all the cases investigated, there were new forums, surveys and workshops, which worked towards fostering openness, security, trust and transparency in the agenda between the stakeholders.

7.8 Research and evaluation and continual learning

7.8.1 The DH is commissioning external evaluation of NWW and of new roles. Up to ten sites piloting NWW for psychiatrists will be evaluated by 2007. Areas, which will be explored, will include:

- what is changing and what is actually being delivered, what are the outcomes for health and social care staff and organisations within local health economies, and what are the outcomes for service users, their carers and dependants;
- implications for the continuing development of policy and practice relating to how people work in the NHS and social care systems/communities; and
- how best to support effective implementation of NWW, which improve services for service users and for staff.

- 7.8.2 In addition, new roles to be evaluated included psychology associates, STR, Gateway Carer Support and BME CDWs as well as pharmacy/medicines management initiatives.
- 7.8.3 Evidence and learning from areas not included in the DH project, will be captured through the pilot development site project plans and stored on the NIMHE Knowledge Community.
- 7.8.4 Sites involved in NWW will continue to be involved in a national group to enable direct feedback and exchange of information.

8. The continuing story

8.1 To implement NWW for psychiatrists across Trusts through:

8.1.1 **Formal launch at two major conferences** will be held, one in the north and one in the south of England. These will be significant events to encourage engagement from consultant psychiatrists and all stakeholders in mental health services to share the work so far, and support the next steps.

Action: NIMHE NWP and the College.

8.1.2 **Press, journal articles and briefings** during autumn 2005 to encourage debate and take up of the recommendations of relevant parts of the report.

Action: All professional bodies and NIMHE workforce and communication leads.

8.1.3 **To develop communication and support networks by:**

- formalising regular national and regional meetings of pilot development sites to share learning;
- using existing regional networks of workforce, CAMHS and other leads;
- using the 'Workforce' NWP newsletter to provide updates; and
- utilising the NIMHE NWP NWW website www.nimhe.org.uk/nww

Action: NIMHE NWP and regional leads.

8.1.4 **At a local level, to implement the recommendations from the report in all trusts, so that:**

- Chief Executives and Boards of Trusts can ensure a successful programme of implementation through engaging in further pilot development sites or extending and mainstreaming them into whole-systems change;
- service users and their families and supporters are encouraged to engage with their local Trusts and practitioners to discuss the implications of NWW; and
- PCTs and SHAs can support and require change through NWW in local Trusts.

Action: Trusts, PCT and SHAs to disseminate report and seek a report to their Boards on progress.

Action: NIMHE to offer support for local change and seek out more pilot development sites.

Action: NIMHE RDCs to circulate to service user and carer networks.

8.1.5 **To link with key bodies at a national level to support implementation by requesting:**

- National Mental Health Partnership Group and NHS Confederation (NHS Employers) to support and monitor implementation;
- Royal College of Psychiatrists to support and monitor progress; and
- discussions to be undertaken with the HCC to explore how NWW can be effectively reflected into monitoring and inspection.

Action: All to receive report and review action taken by July 2006.

Action: The NSG (in a revised form) and its member organisations will continue to support and develop the programme to encourage its implementation.

Action: NIMHE to enter into discussions with HCC and DH.

8.2 To implement the Joint Guidance on the Employment of Consultant Psychiatrists immediately by:

- ensuring that all Chief Executives, Medical and Human Resource directors have access to and utilise the guidance from autumn 2005; and
- ensuring that regional advisers have access to and utilise the guidance from autumn 2005.

Action: The College to monitor through regional advisers and faculty heads; Trusts to monitor through the National Mental Health Partnership Group (NMHPG) and NHS Confederation (NHS employers).

8.3 To make use of Creating Capable Teams Toolkit for workforce redesign and skill mix purposes as part of the spread of pilot development sites, by:

- developing a cohort of ‘capable trainers’; and
- working with College regional advisers to facilitate rapid progress towards a team-based recruitment process as identified in the *Joint Guidance on Employment of Consultant Psychiatrists*, making use of the CCTT.

Action: NIMHE NWP to focus support through RDCs.

8.4 To support the further development of tools outlined in this report to assist mental health organisations engaged in integrating new and changing roles work by:

- establishing workshops to spread the successful shadowing technique used in pilot development sites; and
- using and developing the outpatient, diary and other tools in Appendix 4.

Action: Pilot development sites and NIMHE NWP.

8.5 To establish a joint national NWW group for applied psychologists to:

- consider the relevance of NWW to applied psychologists;
- consider career framework and new roles;
- consider current education and training pathways;
- multi-disciplinary teams; and
- psychological therapies

Action: BPS and NIMHE NWP.

8.6 To review the role of mental health nursing by:

- engaging with the CNO Review consultation in 2005;
- implementing the workforce implications of the results in 2006 onwards; and
- establishing a process by which the work can be co-ordinated.

Action: NIMHE/DH Mental Health Nurse Lead.

8.7 To raise the profile of the future contribution of social workers to mental health services by:

- producing a discussion document in 2005;
- facilitating regional debate and feedback;
- holding a joint national conference in 2006; and
- establishing a joint programme of work.

Action: NIMHE NWP with BASW, SCIE, GSCC, DH, S4C, ADSS, SPN.

8.8 To raise the profile of medicines management and the role of mental health pharmacists by:

- working with the HCC on medicines management in mental health;
- collating lessons from pharmacy spread sites;
- undertaking a workforce mapping exercise;
- producing a discussion document; and
- holding a national conference in 2006.

Action: UKCPMH and NIMHE NWP.

8.9 To explore new ways of working in primary care by:

- supporting the implementation of the joint proposal between the College and the Royal College of General Practitioners;
- supporting the new programme on increasing access to psychological therapies; and
- supporting NWW in primary care.

Action: NIMHE Primary Care, Increasing Access to Psychological Therapy and National Workforce Programmes.

8.10 To explore new ways of working for allied health professionals: (creative therapists, dietitians, occupational therapists, physiotherapists, and speech and language therapists) by:

- establishing a sub-group of the AHP strategic forum, drawing from a number of stakeholders, including the AHP Federation, professional bodies, NIMHE, DH and the SCMHS; and

- developing from this a joint work programme.

Action: DH AHP lead.

8.11 To raise the profile of occupational therapists' contribution to mental health services by:

- the development of a strategy for occupational therapists in mental health services;
- exploring the new roles for occupational therapists under Patient Group Directives;
- exploring the new roles for occupational therapists under the Mental Health Bill;
- establishing an occupational therapist secondment to the Social Inclusion Unit; and
- considering a career framework for occupational therapists reflecting both generic and specialist functions of occupational therapists.

Action: COT, SCMH, NIMHE NWP, Social Inclusion Programme, DH, HPC.

8.12 To raise the profile of physiotherapy and the future contribution of physiotherapy in mental health:

- to further explore NWW for physiotherapy in mental health;
- to undertake a workforce mapping exercise; and
- to develop a strategy for physiotherapists in mental health.

Action: Chartered Society for Physiotherapy and Chartered Physiotherapists in Mental Health

8.13 To explore how the leadership needs of psychiatrists and all professions can be effectively addressed by:

- building on the work being tested of the four-level model for leadership training for psychiatrists;
- running and learning from experimental learning sets nationally;
- linking into medical managers' networks; and
- exploring and testing out the relevance for all professions.

Action: NIMHE, Trusts and new National Institute.

8.14 To implement the framework of the Ten Essential Shared Capabilities by:

- rolling out the framework and learning materials into continuing personal development, pre- and post-qualifying training for all professional and non-professionally affiliated groups.

Action: All professional bodies to cross reference to pre-registration curricula; Trusts and other employers to address as part of standards for appraisal and continuing personal and professional development planning; HEI's to demonstrate their incorporation into curricula; NIMHE NWP, SHA and RDC workforce leads to support local field testing and full delivery.

8.15 To create opportunities for multidisciplinary learning by:

- providing a framework that will influence the commissioning of education and training programmes;
- encouraging and supporting the use of the national Mental Health Education Quality Audit Tool;
- supporting the development of the Mental Health in Higher Education (MHHE) project;
- collaborating with the HEFCE-funded mental health-focused Centres of Excellence in Teaching and Learning (CETL);
- working closely with professional bodies to support education and training changes required to support NWW; and
- commissioning education and training programmes for new workers that take advantage of existing programmes.

Action: NIMHE NWP/SHAs/professional bodies/CETLs/MHHE.

8.16 To support the spread of supplementary and independent prescribing:

- for nurses;
- for pharmacists; and
- AHPs.

Action: DH/NIMHE nursing and specialist pharmacy groups.

8.17 To monitor and disseminate the outcome of the national evaluation study by:

- participating in the research panel;
- facilitating engagement from sites;
- contributing to the analysis; and
- ensuring outcomes are fed into organisations as quickly as possible.

Action: NIMHE NWP/DH/NSG.

8.18 To raise the profile of nutrition and the future contribution of dietitians to the mental health services by:

- undertaking a workforce mapping exercise;
- producing a discussion document;
- undertaking research into the physical health of service users and influence on treatment outcomes; and
- ensuring that evidence based training is given to fulfil the ESCs, National Occupational Standards, Knowledge and Skills Frameworks in relation to nutrition.

Action: British Dietetic Association – Mental Health Group/NIMHE.

8.19 **To explore how NWW can impact on the workforce requirements for the Mental Health Bill by:**

- establishing a short-term multidisciplinary group to promote dialogue and to oversee a small number of sites to undertake scenario planning.

Action: NIMHE NWP, DH MH Bill team and professional bodies.

8.20 **To continue to support and develop the current programme of work to implement the new and changing roles in mental health to the agreed timescales:**

- 3,000 STR workers by December 2006;
- 500 BME CDWs by December 2006;
- further develop the role of graduate primary care and gateway workers; and
- non-professionally affiliated staff and locally developed new roles.

Action: SHAs, Trusts, Partnerships, PCTs, NWP.

9. Next steps

Multi professional collaboration at a national level

- 9.1 The 'continuing story' of NWW is a demanding and complex one. It is important to ensure that the elements of work inform one another and promote multidisciplinary collaboration and change nationally.
- 9.2 The NSG will be reconvened, with new terms of reference, under the title of 'New Ways of Working in Mental Health'.
- 9.3 The functions of the new NSG will be to:
 - develop and share ideas on NWW;
 - facilitate professional ownership and provide a mechanism for professional body inclusion and sign off;
 - promote multidisciplinary learning and delivery of services;
 - discuss multidisciplinary practice and troubleshoot where necessary; and
 - monitor and support the delivery of the work programme contained in the 'Continuing Story'.
 - commission new work.

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A carer's view

'I trust that the examples of new ways of working in this document will inspire others to look at their services and to break down the barriers which inhibit flexibility and effective care for the whole of the person, and their families, who must not be overlooked.'

'I look forward to our years of experience being employed in meeting the challenges of all aspects of change.'

'Much thoughtful work by many people has gone into this report.'

'It is just the start of what we hope will be a more fulfilling pathway for all concerned.'

Pauline Arksey MBE – carer



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