

# Mental Health: New Ways of Working for Everyone

*Developing and sustaining a capable  
and flexible workforce*

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and flexible workforce*

April 2007

## Progress Report

This report is a collaborative venture between the following organisations:



Care Services Improvement Partnership **CSIP**



*National Institute for  
Mental Health in England*



### **Service user satisfaction with New Ways of Working**

Service users in Wiltshire were asked to complete a user satisfaction questionnaire after attending a new style of multidisciplinary assessment clinic. Some 97% were satisfied or very satisfied at being seen by two people; with the length of the interview (45 minutes) and with the questions asked. Some 83% were satisfied with the outcome of the assessment, and 82% planned to make use of advice they had been given.

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# Executive summary

The title of this report – *Mental Health: New Ways of Working for Everyone* – provides a clear signal that both the thinking and implementation of the New Ways of Working (NWW) programme has moved on from the Interim Report of August 2004<sup>1</sup> and the Final Report of October 2005.<sup>2</sup>

Whereas the NWW programme, which forms one part of the National Institute for Mental Health in England (NIMHE) National Workforce Programme, initially concentrated on the consultant psychiatrist and then progressed to the rest of the mental health workforce, it now embraces everyone, and includes service users and carers, who have been key players in the development of NWW and this report (see Section 7, Chapter 1). And quite rightly so, for the whole aim of NWW is to help ensure that new practices are introduced for the benefit both of staff and of service users and carers.

Summary details of how the NWW programme has been taken forward by all the various staff groups are set out in Section 7, Chapters 2 to 10 (allied health professions; occupational therapists; applied psychologists; non-professionally qualified workers; nurses; pharmacists; primary care; psychiatrists; and social workers) with further material being placed on the NWW website at [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)

Despite earlier guidance – and the conferences, workshops, correspondence and meetings – some confusion still remains about NWW and the new and extended roles. This report aims to clarify beyond doubt what is meant by these terms (see Section 1) and in Section 3 we look at what's in it for you, how we make it happen, and what it looks like when we have got there. These sections are supported by Appendix B – Frequently Asked Questions; Appendix C – Indicators and outcomes that help demonstrate what NWW will look like when it is in place; and Appendix D – Diary of a 'New Ways of Working' Consultant Psychiatrist that also shows what NWW means for all the members of the mental health team.

Successful implementation of NWW is all about effective team work, and Section 4.3 makes reference to the Creating Capable Teams Approach, which is being published simultaneously, as a companion document to this report. It provides a structured way of helping teams to

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1 National Steering Group (2004): *Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context: Interim Report*. DH Publication Ref 40379.

2 DH (2005): *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'*. DH Publication Ref 270394A/B/C.

reflect on their current and future capabilities and their skill mix to meet the needs of service users and carers and to help them think about how to implement NWW.

In taking forward this programme of work, a number of cross-cutting or common themes across all staff groups have emerged, and these are set out in Section 4. NWW cannot happen in a vacuum, of course, so Appendix A sets out the National Policy Context. In addition, Section 7, Chapter 13 gives some current examples of good practice as part of the NWW Positive Practice Awards celebration, and these are supplemented by further examples within the text of the report.

NWW is not confined to those of working age: Section 7, Chapters 11 and 12 set out what this means for child and adolescent mental health services and older people's mental health respectively.

Section 3 also shows the current position of NWW across mental health providers. What emerges is that, while there are some encouraging changes, NWW is still being carried out only in a minority of Trusts, and more work needs to take place at all levels fully to embed NWW across health and social care organisations. This represents a major challenge for 2007/08, and how the programme can be implemented and sustained is set out in Section 5; the Next Steps are contained in Section 6.

What practitioners at all levels can feel confident about is that, when they are testing out and implementing NWW, they will be supported by their professional body or organisation, as it will have been part of the consultation process. It is for this reason that both the spirit and the content of this report are fully endorsed by all the professional bodies, organisations and key stakeholders represented on the NWW National Steering Group (see Section 1 and Appendix E).

# Foreword for Service Users

## by David Tombs

Before I declare what are for me a few of the highlights of this report, let me ask you a question. Will you see what I see in this report? Namely the utter and total belief and commitment to the cause on the part of everybody, including all the professions involved – the cause being to improve the lives of service users, carers and the workforce by increasing the skill mix, the flexibility, and the competences of the workforce, alongside the clear intent to be collaborative in delivering the kind of services that service users want in their lives.

The highlights for me are as follows.

- Giving a strong, solid platform, with mass exposure to the three professions (Dietetics, Social Work and Occupational Therapy) that will, I hope, in the lifetime of this document, become widely accepted as the most significant in aiding and maintaining service users' recovery.
- Though it will be published as a separate document, and so has relatively little light shone on it in this report, the Creating Capable Teams Approach and toolkit are very special because they are about creative solutions that are achieved collaboratively. This will be of major help to organisations in delivering New Ways of Working.
- There is a clear and unequivocal thread running through this report that the needs of service users are what shape and determine the need for New Ways of Working to deliver a greater quality of care and service – the most important cross-cutting theme of them all.

Let me conclude by saying this: a huge amount of work has been undertaken in support of this document by everybody and by all the organisations involved. Service users have waited a very long time for this kind of passion, for this desire and total commitment to deliver better care for those who need the best the most. The enthusiasm that drives this report alone makes it worth reading!

If we care about what service users want, need and deserve, then failing to take this report, its content and the concept and principles of New Ways of Working seriously is not an option.

# Foreword for Carers by Jen Kilyon

This document shows how individuals can work together to put service users and their families at the heart of what they do. It describes how new roles and responsibilities help to provide a more creative and responsive service. For example, the feedback from users and carers in areas where Support, Time and Recovery workers have been introduced shows what a difference new roles can make to people's lives. A leaflet entitled 'New Ways of Working With You' provides information for users and carers about what they can expect once this workforce development initiative has been implemented (available at [www.nww.org.uk](http://www.nww.org.uk)). Those Trusts that want to ensure that the New Ways of Working (NWW) programme is introduced effectively can use the Creating Capable Teams Approach to help teams review and plan how they can work more flexibly and embrace new roles. This approach involves mental health practitioners working alongside users and carers throughout every stage in the process, thus ensuring that individual needs are met locally.

Families and friends can have the long view of what an individual needs to make a recovery. They know what the person was like before they experienced mental distress. They are often able to provide useful insights into what may help and hinder progress, and can see them as a whole person in a wider context. NWW may ensure that teams, by adopting the Ten Essential Shared Capabilities, develop good working relationships with all those who have an interest in a person's care. It is therefore vital that teams work in partnership with families and friends to use this valuable knowledge and experience to make a real difference. It is also crucial that all team members understand the complexities of caring, and find ways of supporting family members to continue their role in helping their loved ones on the road to recovery.

All workers have a unique contribution to make. However, it is by working as a team – by supporting one another to challenge existing practices that do not meet the needs of users and carers – that the mental health service can be most effective. By valuing the skills and insights of all those involved in care planning, ensuring that those workers with lived experience of mental distress play a significant role, every aspect of a person's life can be supported. As services adapt to new ways of working, users and carers may find that their needs are being met in different ways. People's expectations will also change over time, so that, for example, regular out-patient appointments with psychiatrists may no longer be appropriate. Capable teams have a firm belief and understanding of how recovery can be achieved through genuine, open dialogue; by listening to the hopes, dreams, concerns and fears of each individual; and by working together in response to find creative solutions that incorporate real choice. Such teams have truly adopted New Ways of Working.

In summary, NWW is about having the right people in the right place doing the right job at the right time. Let us work together to turn this vision into a reality.

# Foreword by the National Director for Mental Health, Professor Louis Appleby

This report is really important – not just for staff working in mental health services, across health and social care for all ages in England, but also for service users and carers. While the nature of the services available to people suffering from mental health distress and to their families has been transformed since the publication of the National Service Framework for Mental Health in 1999<sup>3</sup> (and as mentioned in my report *Five Years On*<sup>4</sup>), there are still challenges in acute in-patient settings and other community services, in terms of accessing psychology services and enabling staff to take a socially inclusive, culturally diverse perspective in their day-to-day work.

While there have been major strides since 1999 in increasing the *size* of the workforce, numbers alone will not fully deliver the range of services, in the manner required, unless we look at the *way* the staff operate, both as individuals and as teams. It is clear from the way the Ten Essential Shared Capabilities evolved that service users and carers felt that mental health services were not delivering a holistic model of care in the way they wanted; so we all need to seize this opportunity to make the best use of all our staff, particularly given that we anticipate a slower growth in numbers, combined with an ageing workforce.

New Ways of Working (NWW) is a central plank in planning and sustaining the workforce across not only mental health services for people of working age, but also for child and adolescent mental health services and those of older people. The work started in 2003 by the National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists, and described in the NWW Interim Report (2004) and Final Report (2005) has been groundbreaking. It encouraged psychiatrists to review their traditional working practices not only to concentrate on working directly with people with complex needs, but also to spend more time supporting multidisciplinary teams and becoming involved in service improvement, research and clinical governance.

The subsequent work, published in this report, *Mental Health – New Ways of Working for Everyone*, reflects a sustained piece of collaborative work between NIMHE and all the professional bodies. These represent allied health professionals, including occupational therapists, applied psychologists, social workers, the non-professionally qualified workforce,

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3 DH (1999): *Modern Standards and Service Models: Mental Health National Service Framework*, September.

4 Appleby, L. (2004): *The National Service Framework for Mental Health – Five Years On*. Department of Health.

nursing and pharmacy professionals, as well as psychiatrists, who have come together with service users and carers and primary care to address what NWW means for everyone. I have been very impressed and heartened by the enthusiasm and drive exhibited by all those involved.

Essentially, this work, along with the Creating Capable Teams Approach, will help organisations, providers and commissioners, plus service user and carer groups, to engage with clinicians and other practitioners at a local level in reviewing current working practices, in thinking about how roles can be extended and in considering how new people can be brought into the workforce through new roles.

The outcome we should be seeking is the creation of capable, multidisciplinary teams that are focused clearly on meeting the needs of service users and carers by:

- supporting service users towards recovery and self-management, where possible, with the right level and type of worker with the appropriate competences and skills;
- having specialist mental health professionals to support the voluntary sector and primary care by providing assessment, treatment and the care navigator function for those with more complex problems; and
- making the best use of resources.

NWW should be an explicit strategy and direction for the whole of the mental health workforce.

# Section 1. Introduction

**1.1.1** Introducing and implementing New Ways of Working (NWW) cannot happen in a vacuum. It needs to be part of a whole-systems reform that takes account of the wider policy imperatives and that includes the choice agenda and service user values.

The main drivers include:

- Foundation Trusts;
- practice-based commissioning and payment by results;
- the 10 High Impact Changes for Mental Health;
- the review of the social care workforce;
- the White Paper *Our Health, Our Care, Our Say*;
- delivering race equality;
- the Improving Access to Psychological Therapies programme;
- the Care Programme Approach;
- out-of-hours working and the European Working Time Directive;
- the Ten Essential Shared Capabilities;
- social inclusion;
- recovery; and
- values-based practice.

**1.2.1** As part of a coherent approach, NWW helps to deliver these wider policy imperatives. To help put NWW into the national policy context, a brief summary of these issues is set out in Appendix A.

**1.3.1** NWW is now a term in common usage in mental health circles. It has come to mean different things to different people, so right at the outset we should make it clear what we mean:

**1.3.2** Working *with the current workforce*:

- to match the knowledge and skills of practitioners to the needs of the individual service user (the more complex the needs, the more experienced and skilled the worker);



- to think in terms of competence, not profession;
- to think in terms of dispersed leadership;
- to share knowledge, skills and competences across professional and practitioner boundaries; and
- to adopt a team approach to NWW, rather than an individual practice or practitioner focus, thus making better, more effective use of existing resources.

**1.3.3** Extending roles and scope of practice *of existing professions*, including:

- non-medical, independent and supplementary prescribing;
- the proposed Responsible Clinician and Approved Mental Health Professional, as set out in the Mental Health Bill;
- advanced and consultant practitioner roles; and
- delivery of psychological therapies.

**1.3.4** *Brand new assistant and practitioner roles* to bring new people into the workforce, including:

- Support, Time and Recovery workers;
- graduate Primary Care Mental Health Workers;
- case managers (as in the Doncaster Improving Access to Psychological Therapies demonstration site);
- Associate Mental Health Practitioners (Southampton and the Avon and Wiltshire Partnership Mental Health Trust);
- community development workers in black and minority ethnic communities (non-clinical role);
- psychology associates; and
- Peer Supporters.

**1.4.1** Experience and evidence from the implementation of new roles suggests the importance of:

- clarity of role and preparation of the current workforce;
- value to the service user of the relationship with non-professional staff;<sup>5</sup>

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<sup>5</sup> Huxley, P. et al. (2006): 'No Recovery without Time and Support'. STR Evaluation Report.

- effective line management and supervision; and
- education and training tailored to the new role as it is implemented.

**1.5.1** All of the above point to the real need for a whole-systems approach to workforce planning and development. This is the focus of the NWW in Mental Health programme.

**1.6.1** The content of this report is fully endorsed by all the professional bodies, organisations and key stakeholders that have lent their logos to the document, and they include:

Association of Music Therapists	National Institute for Mental Health (England)
British Association of Art Therapists	National Mental Health Partnership
British Association of Dramatherapists	Nursing & Midwifery Council
British Association of Social Workers	Rethink
British Dietetics Association	Royal College of General Practitioners
British Medical Association	Royal College of Nursing
British Psychological Society	Royal College of Psychiatrists
Care Services Improvement Partnership	Royal College of Speech and Language Therapists
Carer representatives	Royal Pharmaceutical Society
Centre for Clinical and Academic Workforce Innovation	Sainsbury Centre for Mental Health
Chartered Society of Physiotherapy	Service user representatives
College of Mental Health Pharmacists	Social Care Institute for Excellence
College of Occupational Therapists	Social Perspectives Network
Department of Health	Together
Mental Health Nursing Association	Unison

**1.7.1** Practitioners at a local level can therefore feel reassured that, when they are testing out and implementing NWW, they will be supported by their professional body or organisation.

## Section 2. Purpose of the Report

- 2.1 The purpose of this report on NWW in Mental Health is to describe what NWW means for everyone, i.e. for all professions and practitioners working with people with mental health problems across all ages, as well as service users and carers. There are issues specific to some professions and practitioners that are highlighted in the individual summary reports – see Section 7, Chapters 2 to 10. What is also clear is that there are many themes that cut across different staff groups, and these, too, are described in the report.
- 2.2 Although there has been specific engagement with a variety of professional groups of staff who work across the full age range of mental health services – such as applied psychologists and allied health professionals, including occupational therapists, nurses, pharmacists, psychiatrists, social workers and the non-professionally affiliated workforce – the direction of travel has been the same for all: how to work flexibly as part of a team.
- 2.3 The Creating Capable Teams Approach is being published as a separate, companion document. It is intended to provide a structured way of helping teams to reflect on their current and future capabilities and skill mix: in other words, how they can implement NWW and the new roles.
- 2.4 This report is for all employing organisations in health and social care; the independent and voluntary sector; practitioners; commissioners; Strategic Health Authorities; Care Services Improvement Partnership (CSIP) regional development centres; service users and carers; and higher education institutions.

# Section 3. New Ways of Working

## What does it mean?

- 3.1.1** This and other related questions often come up, and to help answer them a Frequently Asked Questions section is set out in Appendix B.
- 3.1.2** In essence, NWW is about promoting a model where responsibility is distributed amongst team members rather than delegated by a single professional, such as the consultant. The aim is to achieve a cultural shift in services that enables those with the most experience and skills to work face to face with those with the most complex needs, and to supervise and support other staff to undertake less complex or more routine work. This enables qualified staff to extend their practice, e.g. non-medical prescribing, and provides opportunities for new people to come into the workforce at various levels within the career framework, e.g. Support, Time and Recovery workers, Primary Care Mental Health Workers, and Assistant Practitioners. NWW is about making the best use of the current workforce, providing job satisfaction and career development for staff, and providing services that meet the needs of service users and their carers and make efficient use of resources.
- 3.1.3** This ‘distributed responsibility’ model, across and between teams, represents a challenge – not just about how members of the workforce operate as a team, but also to those individual members of staff who are currently not working to their full potential or capabilities. It may mean some of them having to ‘up their game’ if they are to take their proper place in a more fully functioning team. The Creating Capable Teams Approach, as described later in this report, will provide a valuable tool to help both teams and individuals focus their approach on the needs of service users. It may mean changes in the expectations of their practice to help improve the functioning of the team they work in.
- 3.1.4** NWW is *not* about undermining the role of professionals, nor about ‘dumbing down’ the workforce. It does recognise, though, that with an ageing workforce and population, we need to concentrate on how we develop all our staff, in order to ensure we provide the mix of capabilities required to meet the needs of service users and carers. The solutions will differ across localities, depending on local circumstances, such as vacancies, workforce supply, etc. It encompasses a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce offering a high-quality service.

**3.1.5** Underpinning both NWW and the introduction of new roles is the expectation that all staff, professional and non-professionally affiliated, whether working in health or social care, will know about and adopt the principles set out in the Ten Essential Shared Capabilities<sup>6</sup> and, if appropriate to their role, the recovery approach.<sup>7</sup>

## What is in it for you?

**3.2.1** Of course, the answer to that question depends on who 'you' are. The benefits can be summarised as follows:

- *Service users and carers* – a team response, based on your individual needs and strengths, rather than on clinical symptoms; being clear about the team's responsibilities and scope, offering better continuity and communication, with access to specific specialists as and when necessary.
- *Professionals and practitioners* – doable jobs, with realistic workloads and with team support and personal development based on your needs and strengths, as well as those of the team and service.
- *Trusts and other employer organisations* – an approach that sustains integrated, joint business planning, with a workforce strategy that matches skill mix to need in a cost-effective way and informs learning and development priorities.
- *Commissioners* – a means of understanding and of having dialogue with Trust management and clinicians on the basis of both quality and cost effectiveness which enables revised Service Level Agreements to be drawn up to drive forward NWW in Trusts.
- *Strategic Health Authorities* – a mechanism that supports the full implementation of Foundation Trust status and that refines and tailors commissioning of learning and development.
- *Higher education institutions* – transparency in what is required in the process of learning and development, and closer links with the mental health workforce.
- *Voluntary and independent sectors* – imaginative use of professional and non-professionally qualified staff, and new roles in social care.

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<sup>6</sup> NWP (2004): *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*. DH Publication Ref 40339.

<sup>7</sup> CSIP (2006): *ESC Recovery Training: Learning Materials*. Centre for Clinical and Academic Workforce Innovation.

## How do we make it happen?

**3.3.1** There is no one single route, as the introduction of NWW can come from a variety of sources. NWW should be introduced as part of a strategic approach, underpinned by the principles of person-centred values linked to the Ten Essential Shared Capabilities and staff empowerment. Experience suggests a way forward might be as follows:

- First of all, ensure the Trust Board of Directors (or equivalent in non-NHS organisations) is both aware of the NWW initiative and agrees to support its introduction.
- Brief the Board on NWW reports.
- Identify an NWW lead at Board level and identify key leaders at senior clinical and management levels from all professional backgrounds (see good practice example on page 17).
- Adopt a Board-approved NWW strategy, with clear expectations of clinical staff (based on the Avon and Wiltshire Partnership NHS Trust guidance – see NWW Interim Report), expanded to include other professional staff and practitioners.
- Establish an NWW Steering Group, consisting of service users and carers and key leaders.
- Establish NWW as a project to include management capacity and capability, with milestones to help support the introduction and implementation across team(s) and/or the whole organisation.
- Arrange for an organisation-wide briefing on NWW – including with the participation of trade unions – requesting ideas from teams on what NWW might mean for them and other groups of staff; have this as an ongoing communication process.
- Meet service users and carers and explain what NWW is about, what it means for them, and how they can contribute.
- Bring staff/teams and service users and carers together to agree a common strategy.
- Identify two or three key leaders to undertake an NWW leadership development programme.
- Identify facilitators to undertake regional workshops on the Creating Capable Teams Approach.
- Identify enthusiasts for early/further implementation – for quick(er) wins.
- Use the Creating Capable Teams Approach to facilitate a team approach in implementation areas.
- Meet staff/teams regularly to review progress.

- Identify innovative/best practice examples in the organisation – celebrate and share.
- As part of the communications plan, send regular newsletters to all staff, charting progress, disseminating best practice, providing advice about obstacles overcome, contact points, etc.
- Make regular presentations to the Board to report on progress.
- Collect evidence of outcomes and impact.
- Store evidence of good practice and lessons learnt on the NWW website at [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)
- Expect the process to take five years, but with annual reviews and updates.

### Board-level leadership for NWW

The Board of Avon and Wiltshire Partnership NHS Trust first endorsed its Trust Guidance on the Role of the Consultant Psychiatrist in 2003. In 2006, the Trust decided to underline the importance of New Ways of Working in clinical service and process redesign by making a Board-level appointment of a Director for New Ways of Working. Several other Trusts have appointed leads for New Ways of Working who report to the Medical Director.

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## What does it look like when you have got there?

- 3.4.1** It can be difficult to visualise what NWW might look like and mean for practitioners, so this report contains two different, but linked, pieces of work.
- 3.4.2** First, there is Appendix C that sets out the indicators and outcomes for organisations, teams, staff, learning and development, and service users and carers. These help demonstrate what NWW will look like when it is in place. Discussions are taking place with the Healthcare Commission about how NWW might be incorporated into the standards it uses to measure progress in mental health services.
- 3.4.3** Second, Appendix D has a ‘Diary of a “New Ways of Working” Consultant Psychiatrist’ and helps bring NWW to life. Although it is a statement by a consultant psychiatrist, nevertheless it clearly demonstrates what NWW means for all members of the mental health team.

### Redesign of community services

In Oxleas Foundation NHS Trust, out-patient clinics were audited, analysed and redesigned to produce:

- greater medical staff satisfaction;
- improved access and outcomes for service users through access clinics; and
- enhanced roles for care co-ordinators, nurse prescribers, psychologists, service user consultants and IT and web-design staff working for the Trust.

Specific gains have included:

- reduced caseloads for consultants;
- the introduction of standardised caseload management tools for community mental health teams (CMHTs);
- reduced unnecessary clinical attendance by service users;
- fast-track access clinics for service users who need them;
- recovery and graduation discharge clinics for service users and recovery groups led by service user consultants and psychologists;
- nurse-led memory clinics;
- enhanced care co-ordinator role (for enhanced Care Programme Approach (CPA) service users), especially around physical health reviews;
- electronic information leaflets on conditions on the Trust's intranet; and
- electronic information leaflets on medication on the Trust's intranet.

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### Redcar and Cleveland

A consultant psychiatrist worked with a team for two years to develop NWW. The consultant has now reduced their caseload from 275 to 30 by training the team in formulation skills, cognitive behavioural therapy (CBT) and supplementary prescribing. The team is now fully competent, and this allows the consultant psychiatrist to devote four sessions a week to being clinical director with no extra medical input required.

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### **Derwentside County Durham**

The reorganisation of services has allowed the development of a dedicated in-patient consultant, who frees other colleagues to take on early intervention and other specialist roles.

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Carolyn Hurren at [carolyn.hurren@cddps.northy.nhs.uk](mailto:carolyn.hurren@cddps.northy.nhs.uk)

### **Suffolk Mental Health Partnership NHS Trust – East Suffolk**

As a Care Service Improvement Partnership (CSIP) Eastern Pilot project site, adult mental health services in East Suffolk changed profoundly in June 2005. The previous geographically sectorised model was replaced by a functional specialist one, where consultants worked with one specialist team, either in the community or based in a hospital.

The impact of the changes on the in-patient service was very noticeable from the outset, and there are clear indications of improvement on the community side. The functional specialist model of working has merits that far outweigh the disadvantages. It is certainly a more efficient and more focused way of delivering care than the previous sectorised models, and it offers a better opportunity for training and supervision of junior medical staff.

There is evidence that the service offers patients an improved experience, and that there is greater clarity of the role of the consultant, more focused medical time and expertise, better multidisciplinary team working, an improved skill mix in teams and greater dissemination of clinical skills. The model also provides a high degree of transparency in addressing working practices. It has brought a major culture shift by moving away from a service that fostered dependency to a recovery-focused one with improved access to care.

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## New Ways of Working Interim Report: August 2004<sup>8</sup>

**3.5.1** An exploration of the need and ways to change the traditional role of the consultant psychiatrist was formalised by the creation of a National Steering Group in 2003 to oversee a programme of work that included commissioning pilot projects. By the time of its first (interim) report in 2004, the work was already targeting the development of NWW across care settings and professions. The report examined the current workforce challenges. One of the more significant ones at the time was the difficulty in recruiting consultant psychiatrists, along with their levels of dissatisfaction and burnout. It explored how moving from a traditional 'psychiatrist-centred service' to a more 'consultative partnership' style could benefit those receiving and providing services. It reported on how new approaches were going to be developed in the CSIP/NIMHE regional development centres, and through the evaluation of the pilots it highlighted the central importance of education, training and leadership development. It made links with the Ten Essential Shared Capabilities, which were published at the same time, and gave some guidance on workforce and role redesign.

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## New Ways of Working Final Report: October 2005<sup>9</sup>

**3.6.1** The long title of this report (see footnote) and the expansion of it into four separate documents, showed that by the publication of the 'final' report in October 2005 much encouraging progress had been made:

- NWW was being discussed much more widely, and the language was being increasingly used (the reduction of the name to a three-letter abbreviation being a marker of success!);
- a point-by-point implementation plan was produced, including plans for the development of NWW across staff groups and care settings;
- detailed progress reports were provided for some of the pilot projects, covering areas including NWW for the community mental health team, functionally specialised consultant roles, new roles including the Advanced Practitioner and Psychology Associate, as well as those in the NHS Plan, and extended roles for nurses and allied health professionals;

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8 National Steering Group (2004): *Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context: Interim Report*. DH Publication Ref 40379.

9 DH (2005): *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'*. DH Publication Ref 270394A/B/C.

- details on tools for developing NWW were provided, including project planning, the use of information to inform process redesign and shadowing;
- the model of ‘distributed responsibility’, consulted upon by the Royal College of Psychiatrists, had been accepted by the General Medical Council and was reflected in its updated guidance;
- a model for future leadership development for psychiatrists was proposed; and
- for the first time, guidance on the employment of consultant psychiatrists had been jointly agreed by the Royal College of Psychiatrists and employers. This showed employers and commissioners how to plan on the basis of service need, rather than designing teams around individual doctors or arbitrary units of population.

**3.6.2** A comprehensive Appendix in the Final Report gave details of the work being done at the pilot sites across the country, including tools that could be used by others. The document also had summaries, produced after much careful deliberation, of the traditional expectations, modern aspirations and distinctive contributions of the different staff groups, services users, carers and the voluntary sector. The aim of this was to foster a spirit of joint understanding of each other’s roles and aspirations, to pave the way for the development of new and enhanced roles and NWW that could enhance the experience of service users and carers and use staff in the most effective way.

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**3.6.3** When the NWW Final Report was published, it outlined an implementation plan for 2006/07. The plan has now been implemented, and each project group has been led jointly by a representative of each professional body and a NIMHE National Workforce Programme lead.

**3.6.4** The project groups have been as follows:

- allied health professionals (physiotherapists, dieticians, arts therapists);
- applied psychology (clinical, counselling, health, forensic);
- non-professionally qualified/affiliated staff;
- nursing;
- occupational therapists who have their own mental health strategy;
- pharmacy;
- primary care;

- psychiatrists; and
- social work.

**3.6.5** All project groups have sought to have service user and carer representation and multidisciplinary input, in order to challenge and develop the thinking of the profession. Some groups have also held stakeholder events to consult more widely with clinical staff in services nationally, and also with other clinical, managerial staff and commissioners. The areas of activity that each project group decided to focus on are set out in Section 7, Chapters 2 to 10.

## New Ways of Working – where are we now?

**3.7.1** A survey of English mental health providers (Trusts and Primary Care Trusts) was carried out in the summer of 2006. Over two-thirds (53) replied, and the results show:

Percentage	Finding
81%	were aware of the Joint Guidance on the Employment of Consultant Psychiatrists
78%	said they would not automatically fill a consultant vacancy with a locum. This indicates a shift in thinking from a few years ago, when a locum, often brought in from an agency at vast expense, was the automatic response to a vacancy, creating significant financial difficulties and often resulting in poorer outcomes for service users than more creative use of other members of the team or other teams
77%	looked at the potential for developing NWW when doing their annual job plan reviews
74%	said that the average multidisciplinary team in the Trust would have an idea about what NWW is about
63%	have discussed the Final Report on NWW at Trust Board and executive team level
60%	had current NWW projects
56%	had projects in the planning stage. In 30% of cases, these projects were in partnership with other organisations, such as primary care or the non-statutory sector

55%	had endorsed a vision of the roles and responsibilities of consultant psychiatrists at Board level, stating explicitly that the consultant psychiatrist does not have overall responsibility for the team's activities, or the team caseload. This vision is an important prerequisite for developing teams and distributing responsibility amongst team members
51%	of respondents said they were being asked to make cutbacks in clinical staff in order to achieve or maintain financial balance. NWW was seen as the necessary tool to enable this to happen without adversely affecting service delivery
51%	had done some analysis of what consultant psychiatrists do in their out-patient clinics. These surveys have led psychiatrists themselves to reorganise out-patient care, by demonstrating that the traditional model of routine out-patient appointments, often over many years, is inefficient and insufficiently responsive
36%	had some consultants specialising in acute in-patient care, or in the acute care pathway (in-patient and crisis work)
34%	had an explicit action plan to implement its recommendations, which cover the development of NWW for all professions

### 3.7.2 The narrative responses accompanying the statistics indicated the following.

- NWW is generally finding favour with practitioners. Some reservations – relating to risk, responsibility, status and pay – are expressed about other staff taking on tasks traditionally seen as the doctor's. Where the so-called functional model (separate in-patient and community services) has been introduced, it has been received very favourably, although there are some concerns that need to be addressed regarding continuity of care.
- Changing and enhancing roles still seems to relate almost exclusively to medical and nursing staff.
- Those Trusts that have introduced new roles (Associate and Advanced Practitioners and Support, Time and Recovery workers) gave positive feedback about their value.
- Finding sufficient capacity to support a change management project properly is a problem. Trusts do not feel they have sufficient headroom to adopt an 'invest to save' approach, and Foundation Trust applications, mergers and restructuring are diverting attention from the NWW agenda. The chances of success are related to the resources allocated to projects.

- The great majority value support and information sharing with other Trusts and CSIP, and see this as helping to further NWW in their Trusts.

#### **Example of innovative practice**

In Easington, in Northumberland, a complete turnaround has been achieved through NWW. The previous 'old school' service had one consultant with a caseload of 800 out-patients. This has now changed to a competent team approach with a nurse consultant and Advanced Practitioners delivering both cognitive behavioural therapy and psychosocial interventions, as well as supplementary prescribing. There has been a reduction in out-patient cases to 120 and a second consultant has been recruited. This consultant has no personal cases, and sees patients only at the request of the care co-ordinator.

- 3.7.3** In summary, what this all means is that, although there are some encouraging changes, NWW is still being carried out in only a minority of Trusts, and more work needs to take place at all levels to fully embed NWW across health and social care organisations.

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# Section 4. Cross cutting themes across all staff groups

4.1.1 There are a number of themes that cut across the NWW agenda and all of the staff groups and types:

- workforce planning;
- Creating Capable Teams Approach;
- leadership;
- new and extended roles;
- learning and development;
- career frameworks;
- responsibility and accountability;
- complexity;
- information technology;
- primary care;
- voluntary and independent sectors;
- acute in-patient workforce; and
- evidence base and practice.

## Workforce planning

- 4.2.1** Workforce planning has been an expectation in mental health since the publication of the National Service Framework for Mental Health,<sup>10</sup> where mention was made of the production of a joint, local workforce strategy.
- 4.2.2** The various NWW project groups have all considered what the introduction of NWW means for their particular staff group and how this will need to feed into workforce planning for the future. Put simplistically, up to now workforce planning has perhaps often concentrated on numbers (supply and demand) based on the existing staff groups. In the future, with the emphasis on competences and capabilities, workforce planning will become more complex. For example, it will no longer be appropriate simply to say we have a nurse or occupational therapist staff vacancy, so we should automatically recruit another nurse or occupational therapist. With the move to advertisements based on competences and capabilities, and with the growing use of the Creating Capable Teams Approach (see below) a more service user-led approach will be required. Filling vacancies, for example, may mean having existing staff extend their practice, having a new role introduced – or, indeed, replacing like with like. But this last option should no longer be the *automatic* choice, as it is now perhaps.
- 4.2.3** To help with the workforce planning function, the NIMHE National Workforce Programme developed a Workforce Planning Pilot Programme (WPPP) to explore, in practice, what the issues were and to help test out the Best Practice Guidance published by DH in March 2003.<sup>11</sup> Seven pilot sites were chosen, where the aim was not just to help those particular sites but to disseminate the lessons learnt by way of a report across all the relevant stakeholder organisations.
- 4.2.4** Following an extensive two-year programme of events – including local workshops, site visits, preparation of supporting materials, teleconferences, consideration of local draft reports and plans, etc. – a report on the WPPP was published in May 2006.<sup>12</sup> In essence, the report set out a number of lessons learnt, with 10 key points, as well as a number of resources to support the workforce planning function. As part of the preparation for a local integrated, joint workforce plan, the report also made a link

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10 DH (1999): *Modern Standards and Service Models: Mental Health National Service Framework*, September.

11 DH (2003): *Mental Health Services – Workforce Design and Development: Best Practice Guidance*. DH Publication Ref 31146.

12 NIMHE (2006): *Mental Health Services – Workforce Design and Development: Report on the NIMHE National Workforce Planning Pilot Programme (WPPP) – Best Practice*. DH Publication Ref 274929.



to mainstream health and social care policy by cross-referring to the White Paper *Our Health, Our Care, Our Say*, where, on pages 185–6, it says: ‘Key to closer integration will be joint service and workforce planning. The NHS and local authorities need to integrate workforce planning into corporate and service planning.’

- 4.2.5** It is important that, in taking forward workforce planning, we do not just look at greater numbers of the same type of existing staff. The flexibilities and opportunities offered by NWW and the new roles and functions should form an integral part of the process to recruit and retain a workforce that is fit for purpose in a contemporary mental health service.

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## Creating Capable Teams Approach

- 4.3.1** In considering how NWW and the new roles can be introduced and implemented to best effect, and so contribute to workforce planning at a local level, it is important to ensure that multidisciplinary teams focus on the needs of service users and carers.
- 4.3.2** The Creating Capable Teams Approach (CCTA) is a clear and simple five-step approach with a **defined workforce focus**, developed to support the integration of NWW and the new roles into the structures and practices of a multidisciplinary team, within existing resources. It was designed to be used in all areas of mental health, across health and social care, **for all ages**, in statutory, voluntary and private sectors, including in all staff disciplines.
- 4.3.3** The CCTA is an ‘off the shelf’ product that can be delivered by an experienced facilitator. It requires the participation throughout of service users and carers, as well as the support of an identified senior sponsor, the team leader and the organisation’s Senior Management Team.
- 4.3.4** The process helps a team reflect on their function, the needs of service users and carers, the current workforce structure and the current and required capabilities. The team’s journey is recorded on a team profile and workforce plan, which feeds into the organisation’s workforce planning process.

**4.3.5** The CCTA consists of an information leaflet, senior management briefing, executive summary, a facilitator's handbook and a participant's handbook. The five steps of the CCTA are:

**Step One      Preparation and ownership**

**Step Two      Team function**

**Step Three    Service user and carer needs**

**Step Four    Creating a needs-led workforce**

**Step Five    Implementation and review**

**4.3.6** In order to maximise the benefit and momentum, it is recommended that CCTA should be delivered over a period of no longer than six months. Steps 1 and 5 can be undertaken in existing meetings, while steps 3, 4 and 5 are full-day workshops that require the participation of the whole team.

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## Leadership

**4.4.1** Effective leadership is crucial to delivering and mainstreaming NWW. For NWW to become truly embedded in culture and practice, it needs to be present at all levels of an organisation, not just in senior clinical roles (see also Department of Health, 2005: page 45). There are many challenges in this regard:

- Many of those in leadership positions have not received adequate training for the task, or development while doing it.
- In some areas there is a comparative lack of leadership capacity, as well as capability. Effective leadership takes time. Clinical leaders, in particular, have a range of other responsibilities.
- NWW is about cultural change and developing a new way of thinking. As such, it is not amenable to a quick 'roll-out' and needs consistent champions, with the skills to bring others along with them over a prolonged period.
- Many organisations and their leaders have regarded NWW as an 'add-on' rather than something that is integral to their development, and this has made it easier to become distracted by the welter of other demands on leaders' time.
- Many leaders still do not feel confident in their knowledge base of NWW.

**4.4.2** A leadership sub-group was tasked with looking at leadership for this report. It has examined the challenges and areas, such as definitions, principles, available frameworks, and has set goals and methods for making progress. It is clear that more work needs to be done in 2007/08 and beyond.

## Definitions

Leadership	Delivery through complex systems by engaging partners in the pursuit of major, transformational change. Coping with change (Kotter, 1988).
Management	Transactional, operational processes, controls and problem solving. Ensuring that the performance of the team and the individuals within it matches objectives or requirements. Coping with complexity (Kotter, 1988).
Clinical leadership	No agreed definition. About strategic vision and driving service improvement and effective team working to provide excellence in patient/client care. Further work needs to be done on this.
Professional leadership	No agreed definition. Includes the development of professional identity and standards in a professional group dispersed throughout many different types of team, representing the profession and developing its contribution to the overall objectives of the organisation. Further work needs to be done on this.
Team leader	The person who: <ul style="list-style-type: none"> <li>• draws attention to team process;</li> <li>• is responsible for resolving team conflicts;</li> <li>• is responsible for the team's interface with other teams;</li> <li>• is able to develop an appetite for change and development, and a tolerance of uncertainty, in the team as a whole; and</li> <li>• is able to marshal the efforts of the team in the pursuit of the agreed goals of the team and the organisation.</li> </ul>

## Principles

1. There is a vast literature on leadership, and well-researched leadership strategies and programmes (including effective team working and the leadership programme in mental health) have developed from it. The leadership sub-group will not seek to generate new material. Its job will be to use the published

material to recommend practical ways in which mental health providers can develop leadership at different levels in their organisations.

2. While recognising that there will always be some need for uni-professional leadership development, the overall emphasis of the sub-group's work will be multi-professional, because multidisciplinary teams deliver services to service users and carers, and groups of teams deliver organisational and system goals.
3. Leadership and management development relates to individual needs. However, the focus should be on developing individuals' strengths within a team context, rather than focusing solely on improving an individual's weaknesses.
4. Development should also be taken forward through team-based development opportunities that can provide a powerful approach to tackling real work issues, securing and applying change.
5. Leadership development needs to go hand in hand with the development of effective management and team working. Having effective 'followership' is as important to the success of the team and its enterprise as having effective leadership.
6. The group felt that there were a number of relevant leadership frameworks that could underpin its work, such as the NHS Scotland framework and plan, which can be found on the following website:

Framework: [www.scotland.gov.uk/Publications/2005/06/28112744/27452](http://www.scotland.gov.uk/Publications/2005/06/28112744/27452)

Plan: [www.scotland.gov.uk/Publications/2005/06/27154844/48468](http://www.scotland.gov.uk/Publications/2005/06/27154844/48468)

These are up to date and easy to understand, and they develop many other strands of leadership thinking, much of it NHS related. The domains covered are helpful in building clinical, managerial and technical competences and knowledge and skills, and in developing an individual's personal qualities, the focus for their work to deliver an excellent service.

7. Leadership is not the preserve of a few people at 'the top', although the culture of an organisation is often set by the styles and behaviours of senior managers. Leadership needs to permeate each ward team, community team, functional team, etc. and support frontline leaders in delivering improvements.

### **Supporting leadership development to implement NWW**

**4.4.3** In 2007/08, it will be very important to embed NWW across Mental Health Trusts nationally through a process of focused implementation. The NIMHE National Workforce Programme has developed a joint post with the Royal College of Psychiatrists to support NWW. The College Education and Training Centre and the NWW team will run a series of collaborative learning sets. These are aimed at

executive team members in Trusts (particularly medical, nursing and human resource (HR) directors), and will, through a process of facilitated group learning, enable them to initiate or accelerate the implementation of NWW in their organisations. The benefit of cross-Trust collaboration on the benefits of NWW to promote progress to Foundation Trust status has been brought to the attention of deaneries and Strategic Health Authorities. Although at this time there are no resources to develop further collaborative posts with other professional bodies, cross-professional influence will be assured by the establishment of an executive group under the NWW National Steering Group.

## New and extended roles

### New roles

**4.5.1** A number of new roles have already been introduced into mental health on a national basis, both to help expand the overall workforce across health and social care and to tailor roles to meet the specific needs of service users and carers. These include:

- **Support, Time and Recovery (STR) workers**, who **support** service users by giving them **time** and so help their **recovery**.<sup>13</sup> This has been the object of a national ‘accelerated development’ roll-out programme, and further details will be set out in an STR handbook in due course;
- **Primary Care Mental Health Workers**, who are intended to provide brief psychological interventions, signpost and improve mental health clinical governance in the primary care team for people with common mental health problems in all age groups;<sup>14</sup>
- **Community development workers for black and minority ethnic (BME) communities**, who act at a strategic level as change agents, service developers, capacity builders and access facilitators for the whole of the BME community (Interim Report;<sup>15</sup> education and training;<sup>16</sup> and handbook<sup>17</sup>); and

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13 DH (2003): *Mental Health Policy Implementation Guide: Support, Time and Recovery (STR) Workers*. DH Publication Ref 30742.

14 DH (2003): *Fast Forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers: Best Practice Guidance*. DH Publication Ref 30366.

15 DH (2004): *Mental Health Policy Implementation Guide: Community Development Workers for Black and Minority Ethnic Communities: Interim Guidance*. DH Publication Ref 265796.

16 DH (2005): *Mental Health Policy Implementation Guide: Community Development Workers for Black and Minority Ethnic Communities: Education and Training – Supplementary Guidance*. DH Publication Ref 271259.

17 DH (2006): *Mental Health Policy Implementation Guide: Community Development Workers for Black and Minority Ethnic Communities: Final Handbook*. DH Publication Ref 278271.

- **Carer support workers**,<sup>18</sup> who provide support to carers of people with mental health problems through assessment, provision of care and development of networks.

4.5.2 Other new roles designed to help meet specific skills gaps, as well as to help cover local recruitment needs, have been introduced on a local basis and include:

- **Assistant and Associate Mental Health Practitioners**, who provide a mixture of clinical and other healthcare interventions in various settings, including in-patient care;
- **psychology associates**, who are concerned primarily with offering therapeutic interventions in a specialist field, usually described by protocol;
- **case managers** in the Improving Access to Psychological Therapies Doncaster national demonstration site, to work with people with anxiety and depression within a 'stepped care' model; and
- **Peer Supporters** – people in recovery who support others who are experiencing mental distress within the context of the principles of social inclusion.

### The Psychology Associate Pilot Project in the North of England

Sponsored by NIMHE, this commenced in autumn 2005 with eight trainees, recruited and employed in a range of services, including adult mental health, learning disabilities, older adults, forensic, and children and families. The trainees are registered for a newly designed MSc in Psychology in Healthcare at Northumbria University, with delivery of key foundation module materials provided via the Doctorate in Clinical Psychology training programme at Newcastle University. Early evaluation of the experiences of the trainees and their workplace supervisors suggests that both the training and the emerging role is viewed as making a valuable and sustainable contribution to the delivery of psychological therapies and services in the participating NHS Trusts. The pilot will be completed in September 2007.

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18 DH (2002): *Developing Services for Carers and Families of People with Mental Illness*.  
DH Publication Ref 29778.

### Individual Peer Supporters

Individual Peer Supporters (IPS) are people who have a lived experience of mental distress. The IPS service in Northampton is based in the town centre library, in a space dedicated to well-being. Peer Supporters are trained in, and work within the context of, the recovery approach. People experiencing common mental health problems choose to use the service to access support, information and self-management tools to assist them in their own recovery.

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### Extended roles

4.5.3 **Nationally**, these include:

- **Gateway workers**, who can be employed to work with general practitioners and Primary Care Trusts in a variety of settings, including Accident and Emergency departments, to respond to people who need immediate help;<sup>19</sup>
- **Pharmacy technicians**, who liaise with primary care regarding verification of medication on admission to secondary care, take medication histories, counsel service users and carers about their medication prior to discharge and in out-patient clinics, and develop phlebotomy services;
- the proposed **Responsible Clinician** and the **Approved Mental Health Professional** roles that are under development, as set out below.

### Mental Health Bill

4.5.4 The Mental Health Bill proposes to allow staff with the right skills, competences and experience to carry out key roles, instead of restricting roles automatically to particular professional groups, and supports a competence-based approach to professional practice. The Amending Bill introduces two highly significant extended roles into the mental health workforce:

1. **The Responsible Clinician:** this role replaces the existing role of Responsible Medical Officer. Currently this is only open to doctors, whereas the Responsible Clinician will be open to mental health professionals with the appropriate training and competences, including chartered psychologists, nurses, social workers and occupational therapists, in addition to doctors. A person's Responsible Clinician will have overall responsibility for their care and treatment plan. The role will be carried out with the input of the multidisciplinary team.

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<sup>19</sup> DH (2003): *Fast Forwarding Primary Care Mental Health: 'Gateway' Workers*. DH Publication Ref 29088.

Impact on NWW:

- flexibility regarding the Responsible Clinician role;
- potential to reduce reliance on locum doctors and increase numbers of staff in the Responsible Clinician role;
- improved skill mix at senior clinical/practice levels meeting service user needs;
- cost benefits; and
- improved career pathways for non-medical staff/retention of non-medical senior expertise in frontline practice.

2. **The Approved Mental Health Professional (AMHP):** this role replaces the current Approved Social Worker (ASW). The ASW role will be opened up to a wider group of trained and qualified mental health professionals, including nurses, occupational therapists and chartered psychologists, in addition to social workers. The AMHP role will build on the strengths of the existing system, and the training will be based on the current ASW training. This will prepare AMHPs to bring a social-care perspective and to act independently within the statutory framework.

Impact on NWW:

- flexibility regarding the AMHP role;
- potential to increase the numbers of AMHPs, thus reducing pressure on the existing ASW workforce;
- greater access to AMHPs in rural settings;
- career opportunities for non-social-work professionals – extensive experience in the role of AMHP would assist in satisfying the entry threshold for the Responsible Clinician;
- a greater emphasis on social perspectives for NHS staff; and
- solutions to workforce problems regarding recruitment, retention and age profiles of existing ASW professionals.

**4.5.5** The introduction of such flexibility should provide a catalyst for change in terms of workforce planning and a more appropriate and affordable skill mix.

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## Non-medical prescribing

**4.6.1** Recently, suitably qualified mental health nurses and pharmacist prescribers have moved from being largely limited to prescribing from within the constraints of a treatment plan agreed by a doctor ('supplementary prescribing') to one where they can potentially prescribe independently any medication (with the exception, for the present, of controlled drugs). However, they can only prescribe within their area of competence. Within these limits, service providers can make decisions based on local need about the role and breadth of practice of non-medical prescribers.

**4.6.2** Potential benefits of new ways of non-medical prescribing include:

- allowing service users quicker and more effective access to medication;
- increasing service user choice;
- providing services more cost effectively;
- making better use of the skills and knowledge of nurses and pharmacists; and
- supporting service redesign to allow new ways of working.

**4.6.3** The following are some of the key issues that need addressing to allow implementation of non-medical prescribing in a way that will be best able to develop services successfully:

- clarity of purpose: to be clear why non-medical prescribing is being introduced and to meet what needs; a clear scheme for implementation;
- initial engagement with stakeholders: to ensure professionals, managers, service users and carer representatives understand the rationale, and that any queries are answered;
- identification of resources: to underpin implementation and ensure that policies and practical resources, such as prescription pads, are in place for use on completion of training;
- ensuring suitable clinical governance mechanisms are in place, e.g. supervision, access to learning materials, auditing of safe practice;
- identification of suitable individuals to lead the process: ensuring that they are in a position to exert influence within the organisation;
- continuation of clear communications with stakeholders: to ensure issues and developments can be communicated or responded to in a timely manner; and

- establishment of supportive networks: to allow sharing of issues and knowledge, and to gain support from others in a new role.

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### Good practice example – supplementary prescribing

Les Brooks, a community mental health nurse in South Staffordshire Foundation Trust, is care co-ordinator and supplementary prescriber to a woman who has a long history of being troubled by disturbing voices. She finds that having Les prescribe is helpful, as he is able to respond quickly when required, and he also knows her better than other professionals, as he has worked with her for many years. Les agrees that his long-term knowledge of this individual, her life and her illness makes it easier for him to prescribe sensitively in response to her changing situation, and to combine this with other aspects of care. He is able to seek further advice on prescribing issues from the consultant psychiatrist if required.

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### Good practice example – independent prescribing

Valerie Provan is the nurse consultant for a nurse-led older people's organic assessment unit in Cumbria. Independent prescribing is an important part of her clinical lead role for the unit. She prescribes a range of psychotropic medication whenever required, but if at all possible focuses on identifying non-medication approaches to meeting service users' needs. She works closely with a GP on physical healthcare issues and has support, as required, from consultant psychiatrist and pharmacist colleagues. The Trust has developed a range of approaches to support non-medical prescribing, including prescribing-competence workbooks and ongoing training from pharmacists.

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## Senior clinical roles

Why do we need such roles?

**4.7.1** Senior clinical roles, providing service user-centred and effective care, are an essential component of mental health services. For non-medical staff in the NHS, such roles are typically provided by those working with a primarily clinical focus, employed at Agenda for Change Band 7 and above. Senior clinical roles can provide: clinical leadership within multidisciplinary teams, advanced skills in working with service users, formal and informal education, and supervision of others. They can also 'set the tone' for services by offering a positive role model and can ensure that a clinical/care

view is represented at senior levels within healthcare organisations influencing strategic planning and service development. They are also often essential for meeting legal requirements, e.g. under the Mental Health Act, and can assist in the recruitment and retention of clinical expertise to the workforce.

## New Ways of Working

**4.7.2** NWW challenges existing senior clinical roles to review their practice and work in new and more flexible ways to respond to the needs of service users and carers. NWW also provides an opportunity to introduce entirely new types of senior clinical roles in response to specific local need.

**4.7.3** Many challenges can be experienced either when existing senior roles are developed, e.g. by taking on new activities and skills, or when entirely new roles are introduced. Problems can arise from a range of sources, e.g. if there is a lack of an initial clear-needs assessment, inadequate consultation with others, lack of identified support for the role and lack of clear outcomes to measure progress.

## Principles of good practice

**4.7.4** Where the following processes are in place, organisations are more likely to be able successfully to introduce new senior clinical roles or develop those already in place:

- There is recognition that a new role is an opportunity to do things differently, in order to benefit service users and organisations.
- The need for a new role has been demonstrated by a needs assessment and is highly likely to be of benefit to users and carers.
- The new role has clearly defined essential competences.
- Clear communication has taken place to discuss the development with key stakeholders internally and externally – professionals, managers, service user and carer representatives.
- There is clarity as to the effect on team functioning/roles that will result from the introduction of the new role.
- There is clarity about professional accountability issues.
- There is a ‘champion’ and ‘sign-up’ for the new role at a senior organisational level.
- The relationship between new and existing roles is clear, particularly in multi-professional and cross-organisational contexts.
- The leadership function of the new role has been made explicit, e.g. of whom and in what circumstances.

- The links between the new role and senior management have been made clear.
- Suitable managerial and governance arrangements are in place prior to the introduction of a new role.
- A post-holder in a new role is not left isolated.
- New roles have taken into account the changing context of the NHS and mental healthcare, e.g. Foundation Trusts and legal changes.
- Clear goals/outcomes are established for new roles, and the means of evaluating and evidencing progress towards them are identified.
- New innovative roles may require development of a post-holder during the initial period in post.
- New roles are based on best evidence, for example national guidelines.
- Suitable financial support has been identified to support new roles based on local decisions.
- 'Horizon scanning' has taken place to identify possible long-term changes that may require future changes in the role.
- Continued discussions are planned to take place with stakeholders, such as the professions, service users and carers, after posts have been established, to resolve issues and inform further development.
- The appropriate infrastructure, e.g. accommodation and administrative support, is in place.
- Appropriate attention has been given to succession planning, so that there are career pathways to sustain a role in the future once a particular post-holder moves on.
- Identified lines of accountability and supervision have been formulated in advance of the post-holder's employment.

### Consultant occupational therapist in rehabilitation and recovery services

This innovative senior clinical post is based in Middlesbrough. The role is focused on improving and developing person-centred care, and this includes the training and supervision of staff using a formulary approach, underpinned by values-based practice, within a biopsychosocial framework. This has enabled the multidisciplinary team to share a common language and approach, and to recognise the unique contribution to care of individual team members. To support these changes, multidisciplinary, evidence-based, person-centred integrated care pathways have been developed collaboratively to ensure that the patient gets the right intervention at the right time, delivered by the person with the right level of skills.

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### Introducing new or enhanced roles

The NHS North West has produced a *Good Practice Guidance and Checklist* that covers:

- needs analysis;
- education, training and development;
- management, accountability and supervision;
- communication;
- safety and effectiveness; and
- costs and sustainability.

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## Learning and development

**4.8.1** Learning and development is a key function for the effective implementation of NWW if staff are to extend roles and practice and if organisations are to introduce new roles. Such changes cannot be introduced effectively without the appropriate learning and development taking place in the context of service developments.

**4.8.2** The NIMHE National Workforce Programme has produced a learning and development toolkit<sup>20</sup> that sets out the current learning and development issues and priorities, as well as the forthcoming subjects that Trusts and other organisations need to consider in delivering NWW and policy imperatives.

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<sup>20</sup> DH (2007) A Learning and Development Toolkit for the whole of the mental health workforce across both health and social care. DH Publication Ref 280397.

- 4.8.3 The toolkit outlines the contemporary guidance and the learning materials that are available. These include the Ten Essential Shared Capabilities, Recovery, and other learning and development materials that are coming on stream to include race equality and cultural capability and a Social Inclusion Capability Framework.
- 4.8.4 Not only must these materials inform and, where necessary, underpin pre-qualification or pre-registration training, but they must also help inform and guide continuing professional/personal development in the context of NWW and new roles.
- 4.8.5 Staff and organisations working through the Creating Capable Teams Approach will also identify learning and development requirements to meet the needs of service users and carers more fully. This can link with an organisation-wide education and training strategy, an example of which is included in the Workforce Planning Pilot Programme Report.<sup>21</sup>

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### **The *Journal of Mental Health Workforce Development***

This journal is aimed at managers, practitioners, academics and trainers. It addresses workforce development issues, such as training, education and practice, as well as workforce planning and human resources management.

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## **Career Framework for Health**

### **Introduction**

- 4.9.1 The Career Framework for Health provides a guide for NHS and partner organisations on the implementation of a flexible career and skills escalator concept that enables an individual member of staff with transferable, competence-based skills to progress in a direction that meets workforce, service and individual needs.
- 4.9.2 The Career Framework has nine levels based largely on levels of responsibility. As well as progressing through the levels, there is the opportunity for career movement within each level of the framework, to support staff motivation and retention. It also benefits organisations by supporting service improvement and the delivery of better services for patients by maximising staff skills.

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21 NIMHE (2006): *Mental Health Services – Workforce Design and Development: Report on the NIMHE National Workforce Planning Pilot Programme (WPPP) – Best Practice*. DH Publication Ref 274929.

**4.9.3** A completed Career Framework will have three dimensions:

- population and mapping of roles onto the nine levels of the Career Framework;
- identification of the competences that underpin each role; and
- an Educational and Training Framework (awards, qualifications and other forms of recognised achievement of competences) to support the role and competences associated with it.

**4.9.4** A number of tools have been developed to enable individuals, teams and organisations to benefit from the Career Framework, and these can be accessed from the website [www.skillsforhealth.org.uk/careerframework](http://www.skillsforhealth.org.uk/careerframework)

**4.9.5** A database of roles is currently being developed, and this maps roles against the Career Framework for Health, competence frameworks and the NHS Knowledge and Skills Framework. A number of themes are included in this programme of work, one of which is mental health.

### **Mapping and populating roles in mental health onto the Career Framework**

**4.9.6** A number of roles have been aligned to the Career Framework in Mental Health, and this work is continuing. Examples include traditional roles, such as nursing, psychology, occupational therapy, and NWW roles, such as the Primary Care Mental Health Worker and the Support, Time and Recovery worker. Competence mapping (e.g. mental health National Occupational Standards and Skills for Health competences) to these roles is currently under way. Work has recently commenced on how the Mental Health Career Framework can link into patient pathways and service areas. Two mental health sites (Mental Health and Learning Disability NHS Trusts) have been identified to help progress this piece of work. It is intended that this will benefit the participating organisations in terms of workforce development, i.e. role description and redesign, team and skill mix review. In addition, the Improving Access to Psychological Therapies national programme has identified the need to have a specific Career Framework for practitioners delivering psychological therapies. This is currently under development.

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### **Career Framework for Care**

**4.10.1** Skills for Care and the Children's Workforce Development Council (CWDC) have worked to develop a framework for careers in social care. The project includes the development of a website ([www.skillsforcare.org.uk](http://www.skillsforcare.org.uk)) to support those who wish to develop a career in social care, as well as those already in the sector who are seeking

to identify development opportunities. In addition to the website, an overarching framework has been developed.

**4.10.2** The Career Pathways Framework is for workers and employers. It provides an overview of different types of jobs at different levels, with examples of qualifications. It is similar to (and links with) those already developed in health, children's workforce and other sectors. It supports the Skills for Care Continuing Professional Development (CPD) strategy for all workers in social care.

**4.10.3** The framework includes career pathways diagrams that provide an illustrative overview of the current main jobs and levels in social care. HR specialists will find the examples useful for planning career progression within their organisations and for identifying the links to appropriate qualifications. Workers can use them to get an overview of the range and types of opportunities available to them and the different levels at which they can enter the social care sector.

**4.10.4** The exemplars are based on the understanding that:

- Career pathways are part of an overall HR and CPD strategy to encourage recruitment and retention.
- Pathways should be flexible and go in different directions to support the development of new roles and ways of delivering services.
- Career development includes career breaks and sideways moves – people need to be able to get on and off the pathways and levels for a variety of reasons.
- People will enter the workforce at all levels, from a wide range of backgrounds and into a variety of different jobs. They could enter in support roles, training roles or as professionals or managers in related sectors. They could start from school, as volunteers, service users, carers, or be returning to work after having had a family or a career in a different industry.
- Roles need to be linked to a Qualifications Framework, which starts at 14–19 years of age.
- The exemplars reflect direct care roles, as identified in the National Minimum Dataset, but also other important related non-direct care roles, such as learning and development, commissioning and quality assurance. For example, a person in a senior support role can be working directly with service users, as well as developing as an assessor and supervisor. This could lead them along three different pathways – continuing in direct practice, working as a learning and development specialist, or service management.



- Job roles at higher levels are characterised by greater complexity, expertise, specialisation, responsibility and problem solving. The framework provides illustrations of job roles and qualifications. This is particularly the case from level 4 and above, where it becomes harder to assign job roles and qualifications to levels.
- Progression can involve jumps across levels – for example, a senior care worker may be promoted to a first-line manager, a move from level 3 to level 6 of the framework.
- Career development can include moving sideways into a new role at the same level.

**4.10.5** The exemplars use the Qualifications and Curriculum Authority’s nine-level framework for achievement and the Children’s Workforce Indicative Career Framework role descriptors. This overarching framework should make it easier to compare and move between roles in related sectors.

**4.10.6** Phase 1 of the project has now been completed, with an initial consultation on all of the products. The work will now be linked to a wider UK project for skills for care and development and will be integrated into recruitment and retention tools.

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## Responsibility and accountability

**‘Responsibility’** is defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand of a practitioner.<sup>22</sup>

**‘Accountability’** describes the relationship between that practitioner and others with respect to those responsibilities. In other words, accountability describes the mechanism by which failure to exercise responsibility may produce sanctions such as warnings, disciplining, suspension, criminal prosecution, or deregistration from professional status.<sup>23</sup>

**4.11.1** The Interim and Final NWW reports provided recommendations and information regarding issues of responsibility and accountability, particularly in relation to consultant psychiatrists. This reiterated that they were important members of multidisciplinary teams, but not necessarily ‘in charge’ of them. Responsibility for the care of service

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<sup>22</sup> Taken from the latest draft (February 2007) of ‘Working Psychologically in Teams’, which is based on S. Onyett, *Team Working in Mental Health*, Palgrave, 2003.

<sup>23</sup> *Ibid.*

users is shared with other members of the team. When psychiatrists work directly with a smaller number of service users who have more complex problems, they will not have direct contact with many individuals receiving care from other multidisciplinary team members. However, they will be able to offer advice and support to other members of the team and GP colleagues.

**4.11.2** NWW has accelerated and enabled the extension of roles for other professions, such as psychology, nursing, pharmacy, allied health professionals and social workers. This new work involves a range of new skills and, in some cases, taking on some of the activities traditionally done by doctors, including prescribing and physical examination. Staff can be described as working at assistant, practitioner, advanced and consultant levels in the different professions. The term 'consultant' is no longer synonymous with medical staff only. New ways of working have also produced changing relationships and roles in primary care settings. All these changes have created a range of practical issues that further challenge traditional ideas of professional accountability and responsibility.

**4.11.3** Whatever the professional background, some key principles have been identified that support the successful handling of issues of responsibility and accountability across primary and secondary care. To ensure clear responsibility and accountability there must be:

- a clear statement of the purpose of each service to be delivered, based on the users' and carers' needs;
- guidance produced by each organisation on New Ways of Working (which could be based on the work of Avon and Wiltshire Partnership Trust). Such guidance needs to be clearly operated and supported by the organisation, and agreed and reviewed by the Board annually;
- consideration given to sending each member of staff a letter, on an annual basis, outlining what is expected of them;
- clear job plans and descriptions, with frequent reviews and annual appraisals linked to personal development plans and Agenda for Change processes, where relevant;
- supervision – crucial to support good practice. The time, the organisational support and the necessary training must be provided to enable this;
- the provision of appropriate competences for roles, training and supervision, which are essential to enable people to feel confident to take on and support others in new ways of working;

- clear, agreed human resource policies on NWW. HR and professional leads should work together to have approaches that can resolve accountability and responsibility issues;
- a clear expectation that change is a constant in the work of mental health and other services and should be welcomed;
- formal arrangements that support profession-specific development to enable practitioners to feel confident in working differently; and
- regular updating of advice from professional and regulatory bodies to their members, or registrants, on new ways of working, on responsibility and on accountability.

### A summary of types of responsibility

**Practitioner responsibilities:** professional practitioners within teams are accountable for different responsibilities to different authorities.

**Employee responsibilities** are defined by a contract of employment, which usually includes a job description that describes responsibilities in detail.

**Professional responsibilities** are defined by a duty of care to users, professional codes of conduct and, in some cases, state registration requirements. For staff in training or who have recently qualified, this includes formal accountability to a professional line manager in a clinical supervisory role.

**Legal responsibility** forms part of professional responsibility and describes an obligation to recognise and observe the limits of your training and competence and satisfy yourself that anyone you refer to is also appropriately qualified and competent. Certain members of the team will also have additional legal responsibilities.<sup>24</sup>

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<sup>24</sup> *Ibid.*

## Working party on complexity in mental health: Interim progress report

### Executive summary

**4.12.1** A multidisciplinary working party with service user and carer representation has been considering the issue of complexity in relation to New Ways of Working in Mental Health. The interim conclusions cover definitions, measurement, the Care Programme Approach (CPA), payment by results, and the ratio of self-care to professional care. Following analysis of the results of the national consultation on CPA, which contained questions about complexity, these will be developed further into guidance.

### What do we mean by 'complexity'?

**4.12.2** 'Complexity' is a widely used concept in both government policy documents and general NHS use, but there is no clear, widely accepted definition of what it means or an approach to working with it. There is a whole field of 'complexity theory' that seeks to simplify complex systems, but its usefulness when applied to mental health seems limited.

**4.12.3** In the White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006), complexity is depicted as a key determinant in the ratio of professional care to self-care, and complex healthcare needs are highlighted as requiring greater attention. In the 'stepped care' model recommended by several of the clinical guidance documents published by the National Institute for Health and Clinical Excellence (NICE), the term is used to describe treatment. The guidance for depression (NICE, 2004, page 13), for example, recommends more 'complex psychological interventions' at step 4 for 'treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk'.

**4.12.4** One of the principles of NWW in Mental Health is that the skills of the members of the mental health team are used appropriately, and therefore efficiently and effectively. The level of complexity of need with which service users present is seen to dictate whom they should see, with the most complex needs addressed by more advanced or highly trained professionals, such as consultants (Department of Health, 2005).

### How has the term been used?

**4.12.5** Internationally and across mental health professions, various terms, such as 'difficult', 'problem', 'complex' or even 'bad' or 'unmotivated', have been employed to discuss service users who are seen to pose a particular challenge to service providers. Physical health professionals have similarly described challenging mental health issues in their patients. These terms may once have been seen as useful shorthand for clinicians, but they are highly pejorative, and even the less obviously pejorative, such as 'complex

case', can lead to negative bias; poor expectations of outcome even before a patient is seen for the first time can create a self-fulfilling prophecy (Davies, 2001).

**4.12.6** Although the evidence is not overwhelming, a relatively recent literature review (Davies, 2001) found that patients who are seen to present a challenge to services appear to form a distinct group in terms of:

- having a greater number, and greater severity of, problems;
- being associated with a greater and more negative impact on services and individual clinicians;
- being perceived more negatively by clinicians; and
- receiving a poorer service.

**4.12.7** A controlled study (Davies, 2001) highlights the need to consider issues beyond simply the patient's presentation – such as the clinician's level of experience and training, and the availability of appropriate services – when considering how best to meet the needs of this group.

### How should we define complexity?

**4.12.8** There is a range of options in terms of defining complexity in clinical practice, which includes the following:

- **as a concept:** '...the challenge of clinical practice are often the more *complex cases* which do not fit comfortably into simple case conceptualisations or diagnostic categories' (Tarrier *et al.*, 1999, page xiii);
- **by multiplicity and/or severity of needs, including risk;**
- **by intervention:** a 'complex case' occurs when 'the client's needs (as assessed at screening clinic) appear unlikely to be met by standardized treatment packages or by focussed pieces of psychological treatment' (Elcombe, 1999); and
- **by service:** for example, enhanced rather than standard level of the CPA. The term 'complexity' is not used in CPA guidance, but the characteristics of people on standard and enhanced CPA might correlate with professional and service user notions of differing levels of complexity.

**4.12.9** There is only one standardised measure of complexity, the Pearce Case Complexity Scale (Pearce, 1996), which is designed for mental health services. It records and summates clinical information in six domains: psychopathological co-morbidity, psychosocial problems, legal issues, involvement of other agencies, previously unsuccessful treatment, and degree of disability (Davies, 2001).

## Service provision and complexity

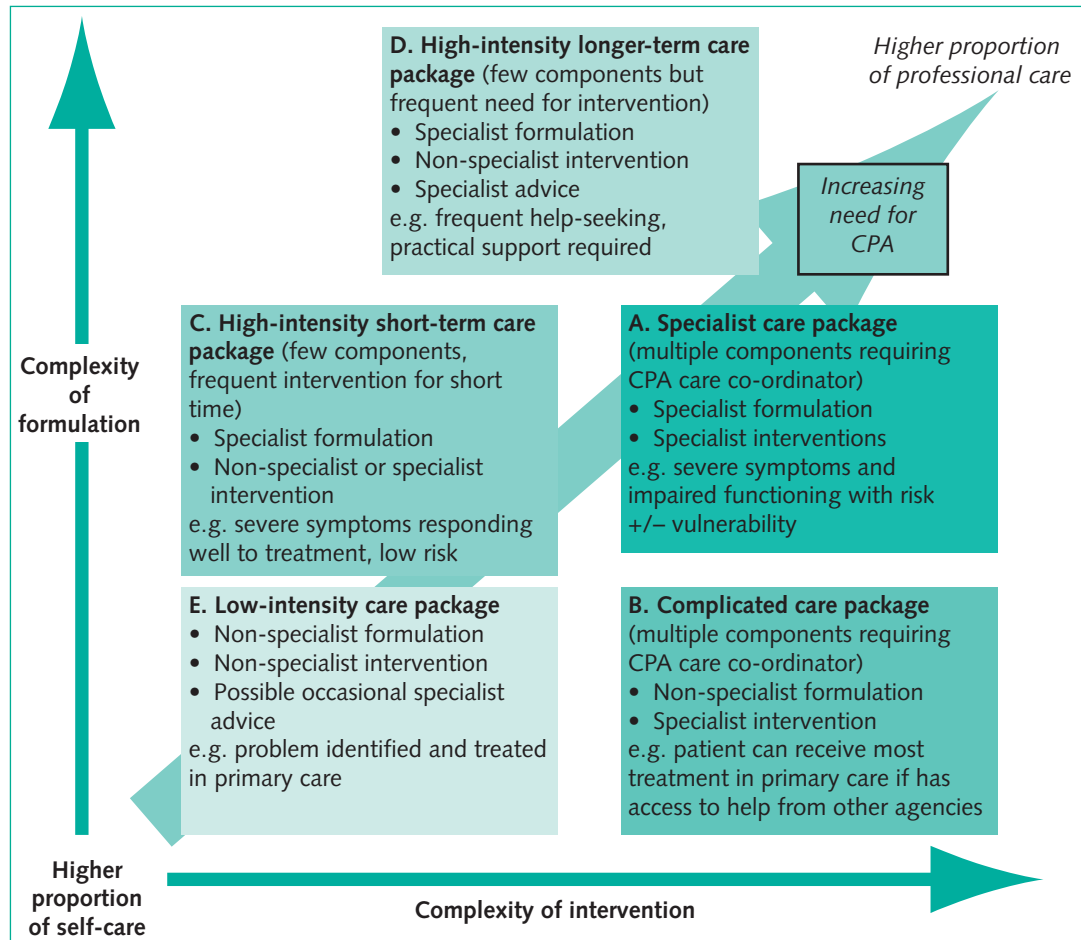
**4.12.10** Expectations of what services should achieve will affect perceptions of complexity.

For example, attempting to achieve a total cure of a patient’s mental health problems or full recovery is likely to increase the complexity of the undertaking, rather than help the patient manage their symptoms more effectively.

## How is the CPA related to complexity?

**4.12.11** The working party’s deliberations thus far have proposed the diagram below (Figure 1) to try and capture the relationship between complexity and the need for the service user’s care to be planned using the CPA. It seeks to integrate the assessment of complexity on two axes: a formulation of the person’s needs, and the service response required to meet those needs. The greater the complexity of both the formulation of the presenting problems and the intervention required, the greater the likelihood that CPA will be required, at the current enhanced level.

**Figure 1: The relationship between complexity of formulation and intervention, and the ratio of self-care to professional care (possible increased need for CPA shown by darker shading of large arrow)**



## Complexity of role in mental health

**4.12.12** The foregoing discussion is entirely concerned with the concept of complexity as it applies to an individual and the services they receive. However, guidance on the use of the term in relation to NWW will also have to consider the use of the term to describe the roles being carried out by different staff. Consultant-level practitioners would be expected to have the skills to deal with complexity of role: they may have several different roles, work with different teams and have to manage interfaces both within the organisation and with a multiplicity of partners. They will need to be flexible and adaptable, and to have a high degree of knowledge and skills in order to provide the best service in terms of individual patient care and contribution to the governance, management and strategy of their organisations.

## Conclusions to date

1. Terms such as 'complex' should only be used with careful consideration of the implications and consequences, both intended and unintended, that they may have. Such consideration should therefore involve joint discussion between providers, service users and carers.
2. As language evolves over time, terms such as 'complex' should be regularly analysed, rather than being set in stone.
3. It should be recognised that judgements of degree of complexity, and the perceived need to make such judgements, may differ not just according to the beholder (service provider, user, carer, etc.), but also according to the time, place and context.
4. Complexity appears to be a concept used primarily by services and clinicians; it does not seem to be particularly helpful for service users or carers. However, if a definition could be developed that linked it with the likelihood of needing CPA, then it could be shared with, and owned by, them. Such a definition would be likely to incorporate both the complexity of the identified needs, and the complexity of the intervention required to meet them.
5. It may be more helpful to focus on variables that might contribute to complexity, rather than seeking to establish a fixed definition. The key variables proposed include:
  - duration, severity and number of problems;
  - level of functioning;
  - level of risk/vulnerability;

- contextual factors (that may affect an individual's ability to make use of traditionally delivered services), e.g. language difficulty, living in a rural area with no transport, or race and culture; and
- the ability of the service and individual clinician to respond appropriately and effectively to the patient's needs, in terms of knowledge, skills, and emotional and physical resources.

It should be noted, though, that high risk and severity, for example, do not necessarily denote high complexity, and vice versa.

6. Poor outcome should not necessarily be viewed as a defining feature of complexity, as it could merely reflect the clinician's sense of 'stuckness' or the inappropriateness of the service offered.
7. Complexity as related to an individual should be regarded as open to change over time and as falling on a continuum, rather than being either present or absent.
8. Research should be undertaken to devise a measure of complexity for use within mental health services that is robust and straightforward to use.
9. All assessment and care planning should take into account that the degree of complexity of need and service response will depend on the outcomes that are being sought. It may be that a service user can manage many aspects of their life that are complex, if assistance is provided to ameliorate or cope with particular problems.
10. Figure 1 should be used to inform discussion about appropriate care packages. For example, complexity can be used as a common language to identify those service users who may require specialist services at different points in time, and to identify when those time-points should facilitate transition into and out of CPA.
11. For those service users within primary care who have high-level or complex needs, it is important to adopt, where appropriate, a case management/care co-ordination, or simply a more intensive approach.
12. Some of the general guidance from complexity theorists is useful – for example, the emphasis on a whole-systems approach, keeping rules minimal, simple and flexible, and good communication through the easy flow of information and the opportunity for continuous feedback.
13. The stepped care model may lead to too great a focus on the primary presenting problem. A holistic, formulation-based approach should be adopted to allow account to be taken of the wider context, which may necessitate more specialist intervention.



14. 'Shared care needs' must be defined more consistently. Do we want the term to be used to mean sharing out the meeting of needs between different services, or between self-care and professional care? In either case, shared care should fall on a continuum of care that people should be able to move along seamlessly.
15. As part of payment by results, service commissioners and providers need to take account of the probability that greater complexity (as perhaps measured by a standardised tool) will be accompanied by a need for greater resources – including time, knowledge, skills and energy – to achieve the outcomes agreed upon by stakeholder consensus (as mentioned above). Services can then be appropriately planned and funded, and this will support clinicians in delivering the services effectively and efficiently, which will in turn benefit service users and carers.
16. It is important that services for people with needs at both ends of the complexity spectrum are not marginalised as being too complex or not sufficiently complex. Regardless of complexity, all have equal rights to access mental health services.
17. Ultimately, the most important way to respond to complexity in mental healthcare is to involve, in a routine and fully integrated manner, service users and their carers in planning, designing, delivering and evaluating services. They are the ones who live with complex needs and so have the wealth of experience to draw upon to help distinguish helpful from unhelpful strategies, sometimes before clinicians reach the same conclusions.

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## Information technology

**4.13.1** Developments in information technology have already contributed to NWW, and the advent of the National Care Records Service (the 'spine'), which allows access to core patient information, together with the new Connecting for Health Clinical Information Systems, will further support innovative working practice and improve the quality of information.

**4.13.2** Mobile technology is particularly important for practitioners caring for service users in a variety of settings. The use of Personal Digital Assistants, BlackBerries, laptops and tablets with remote connectivity enables practitioners to keep in touch and to record and access information whenever they need to, wherever they are. This can also help to reduce travel and estate costs by opening up opportunities for working from home. At a more prosaic level, the use of secure email across the NHS can help to reduce paper, printing and postage costs, and speed up communications, for example between primary and secondary care. It can free up administrative time for more effective use.

**4.13.3** Practitioners, as well as managers, are also taking an increasing interest in developing the use of ‘intelligent information’ – reports generated from the standard data inputs that can be used to measure team performance and the effective use of expensive resources, such as beds. When teams take an interest in measuring their own performance, this inevitably leads to discussion about how to optimise processes to reduce bureaucracy and duplication, and streamline decision making – all of which contributes to a more effective and timely service.

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### **Good practice example – effective use of information technology**

Avon and Wiltshire Mental Health Partnership NHS Trust covers an area of over 2,000 square miles. It wanted to reduce travel to save time and money, and also to contribute to its green agenda. The Trust is therefore installing video-conferencing facilities at key sites across its area. The first use was for the annual meeting, and it is planned to use the facilities for meetings and training events, and to make it easier to involve service users and carers. The Trust has also developed a policy and the technology for occasional home working with access to the Trust network, and is now planning a pilot of a more ambitious home-working project, which could see some staff based at home in the future. The new Trust HQ has been designed on the basis that staff will work from home one day a week.

## **Primary care**

**4.14.1** Working with and within primary care is an ongoing issue both for the professional groups and for cross-cutting theme discussions. Further development of NWW for established professionals will be critical for the provision of mental healthcare closer to home. This imperative is driven by national policies for improving access to psychological treatment and for the development of primary care-led management of long-term conditions. Particularly for those not covered by the remit of the Care Programme Approach, primary care teams and specialist mental health teams will need to work together, sharing responsibilities for recall, review, promoting recovery and responding to crises.

**4.14.2** Key issues in primary care mental health for people across all ages, of all levels of complexity and severity, that have been identified from the examples of best practice include:

- establishing values of recovery and social inclusion in primary care;
- working and learning together;

- timely access to specialists and treatment;
- breaking down the emotional-physical divide; and
- providing proportionate proactive care.

**4.14.3** Section 7, Chapter 8 provides further information and examples, and also some detailed advice on how responsibilities can safely be distributed across organisations. A more comprehensive primary care mental health report for NWW will provide additional examples and guidance on how such far-reaching changes for both roles and functions can be achieved. This complements *Designing Primary Care Mental Health Services* and *Skills for New Workers*. It is anticipated that NWW, the Improving Access to Psychological Therapies and the Care Services Improvement Partnership (CSIP) primary care programmes will work together in the future to support implementation of this agenda.

### **New Ways of Working for Psychiatrists St Albans Pilot Project: The primary care interface**

This project has incorporated several elements. The consultant psychiatrists in St Albans have adopted a functional model. In the community mental health team (CMHT) we have introduced a Joint Assessment Clinic and a system of distributed responsibility. The consultants have located themselves and their teams in the CMHT base. Psychiatrists are seeing fewer follow-up out-patients, but are more available to the team and their primary care colleagues for consultation, advice and emergency assessments. Closer working relationships have been developed with the Crisis and Assessment Team (CAT).

Closely linked to this project has been an Enhanced Mental Health Service project in primary care, which has been associated with a reduction in the number of patients with mild or moderate mental disorder. This is part of a proposal for whole-system redesign.

The results of the first six months of the project show that we have reduced waiting times for non-urgent assessments by 37 days, and that consultants are contributing more time to the CMHT and are more available for advice on complex cases. The team is experiencing greater job satisfaction. Ward admissions and CAT referrals from CMHT have fallen.

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## Voluntary and independent sectors

- 4.15.1** Work in 2006/07 has concentrated on the implications of NWW for professionals working across mental health, but usually in the NHS. This workforce is also employed, however, in the voluntary and independent sectors: in the former often in different roles, and in the latter usually in their traditional roles, but on different terms and conditions. The voluntary sector has a time-honoured reputation for providing person-centred, flexible services. A new role mentioned in this report, namely the Support, Time and Recovery (STR) worker, promotes this approach, and over 30% of STR workers are employed in social and voluntary settings. New roles in social care have also been developed, including some in mental health, where there is an emphasis on employing people with a lived experience of mental ill health.
- 4.15.2** As commissioners seek choice in the providers of services, there is likely to be a shift of traditional professions into the third sector in areas such as improving access to psychological therapies.
- 4.15.3** A pilot site has been funded to test out NWW in the voluntary sector (see below).

### Fit for the Future – New Ways of Working in the Third Sector

The Mental Health Foundation and Mental Health Matters have been funded by the Department of Health to develop a three-year voluntary sector workforce development project called Fit for the Future – New Ways of Working in the Third Sector. Operating in Northamptonshire, the project has two main objectives:

- to develop a third sector workforce capable of delivering services that promote recovery and social inclusion; and
- to improve third sector capacity by promoting new and strengthened networks and partnerships.

Project delivery will include a pilot of the National Social Inclusion Programme Capabilities for Inclusive Practice with local voluntary sector staff; social inclusion training for frontline practitioners; and organisational action learning sets for mental health voluntary and statutory leads. It is anticipated that the project will produce valuable learning for the third sector and commissioning managers in particular, and it will be rolled out nationally.

**Contact:** Louise Lingwood at [llingwood@mhf.org.uk](mailto:llingwood@mhf.org.uk)

## Acute in-patient workforce

**4.16.1** The National Acute Programme and the NIMHE National Workforce Programme have collaborated to identify and address joint priorities relating to acute in-patient workforce issues. One of the major priorities has been the need to provide guidance on the composition, skills, type and numbers of staff and competences needed to achieve an effective and competent acute in-patient workforce.

Two key pieces of joint work were identified:

- to identify and explore different and innovative approaches to staffing levels, skill mix and ward team composition, capability and capacity within acute in-patient care, which can be translated into practical guidance. It was agreed to utilise the CCTA as much as possible; and
- to review and report on current and developing models of NWW for the role of consultant psychiatrists and lead consultants in acute in-patient settings.

**4.16.2** Considerable progress has been made towards the production of a guidance document. The following has taken place.

- A literature review and analysis of staffing levels and skill mix.
- A seminar to present and discuss current skill-mix initiatives, identify key issues and themes to inform the guidance, and look at possible options for pilot work. Those attending agreed to act as a reference group during the consultation process. The key points from the skill-mix seminar, together with the findings of the literature review, have been pulled together to form the basis of the draft guidance framework.
- A workshop, held in November 2006, to identify the key issues regarding multidisciplinary ward team composition and the competences required to meet service user needs. The key findings have been summarised and again will inform the guidance.
- Discussions with three Trusts to implement the CCTA within acute in-patient/ services sites. Implementation began in March/April 2007, and the Trusts will share any early learning. The launch of the CCTA project will take place in April. Facilitator training will be made available to Trusts, with CSIP regional development centres providing a resource to Trusts to review acute ward in-patient workforce competences, skills and composition.
- A scoping exercise, which aims to review the role and working relationships of consultant psychiatrists and the impact this has on ward care and management. It aims to link into the 10 Healthcare Commission sites that are piloting the

assessment framework that will underpin the Healthcare Commission acute in-patient service review. Interviews will be carried out at the individual psychiatrist, ward, unit and Trust level and will also include focus-group meetings with service users. It is hoped that additional useful information will be gathered to add to the recent NWW survey. The first stage of this work has already begun in Mansfield, with the piloting of the questionnaire and focus group by a researcher from the Centre for Clinical and Academic Workforce Innovation.

- 4.16.3** It is planned to have this guidance available and ready for implementation during autumn 2007. For more information, contact Barry Foley (at [mbarryfoley@aol.com](mailto:mbarryfoley@aol.com)) or Yvonne Stoddart (at [ylstoddart@yahoo.co.uk](mailto:ylstoddart@yahoo.co.uk)).

### **East Lancashire Supporting Change Project**

This project commenced in East Lancashire in March 2006 with the aim of supporting implementation of NWW, improving the functioning of multidisciplinary teams (MDTs), providing greater accountability to service users, carers and professionals, and developing specialist skills and specialist team skills.

The new model of 'in-patient/community split' for consultant psychiatrists is now fully established, having initially been implemented in Burnley in spring 2006 and in Blackburn in autumn 2006. The CPA and case review booking systems have been implemented within in-patient wards in Blackburn and Burnley, and traditional ward rounds have been replaced with user/carer-friendly time. This all operates using a clear MDT approach.

Governance arrangements have been established within in-patient services and are operating well, with a Community Governance Group also being set up recently across East Lancashire to replicate the operational governance arrangements of in-patient services. Strategic accountability to users and carers is provided through the Acute Care Forums and the recently established Community Care Forum, while individual accountability now operates through the in-patient CPA and its booking system.

For each community team practice, service and whole-system development is being reviewed and implemented based on evidence gathered from the caseload audit of community teams. This took place in summer 2006. Community services are utilising this evidence to draft Service Development Plans that will be implemented through to autumn 2007. A re-audit is planned after this, in order to measure successful change.

The services have moved from being heavily dependent on line managers for making decisions to being focused on providing a solution at the level of the service and the locality. The governance structures in particular have reinforced and encouraged this approach. The next six months will see further bedding down of the structures and processes that have been established to ensure that they continue after the end of the project in autumn 2007.

**Contact:** Paul Greenwood at paul.greenwood@northwest.csip.org.uk

### NWW in in-patient services

East Suffolk mental health services have been redesigned to have specialised in-patient consultants. There is now evidence of improved patient experience of the service, clarity of the role of the consultant, focused medical time and expertise, improved multidisciplinary team working, improved skill mixes in teams, and greater dissemination of clinical skills. The model also provides a high degree of transparency in addressing working practices. It has brought a major cultural shift by moving away from a service that fostered dependency to one that focuses on recovery. The number of extra-contractual referrals has dropped to zero.

Future plans include ongoing evaluation, development of age-inclusive services, a trust-wide Psychiatric Intensive Care Unit (PICU), an early intervention service, refined pathways both between teams and with primary care, a move to keep all stakeholders involved, provision of trust guidance for consultants, and initiation of a team effectiveness and leadership programme as part of a strategy to build capable teams – an essential component of NWW.

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Kamal Mohammed at kamal.mohammed@smhp.nhs.uk

## Evidence base and practice

**4.17.1** Effective practice requires the confidence of an evidence base. The existing collection of data from Trusts engaged in NWW and their own internal governance structures are mechanisms designed to provide a quality framework underpinning clinical practice. Evaluation studies are under way nationally and locally with Trusts. Implementing evidence-based practice (as identified in NICE guidance) throughout services is the key to improving outcomes for service users and carers. This is as true of psychological therapies as it is of medicines management.

**4.17.2** As practice evolves, an openness to new information needs to be incorporated into emerging clinical work, aligned with new research data. While the rigour of the randomised control trial is the gold standard for any research, much can also be achieved from the collection of clinical stories, and the influence of this in shaping practice should not be underestimated. Much of what is practised in services for people with mental health problems is not evidence-based. Service users and carers commonly describe approaches and interventions that do help them. It is important, therefore, for staff to measure outcomes as a matter of routine and thereby expand knowledge from practice-based evidence.

### Use of 'intelligent information'

Senior clinical staff and IT colleagues in Oxleas NHS Foundation Trust met in a service development forum, and agreed a dataset of 20 items that they found useful in managing their own capacity and improving their own performance.

Reports on in-patient services enable senior doctors and teams to understand demand, flows and outcomes.

CMHT reports enable senior doctors and teams to understand demand, caseload management and outcomes.

The reports are also used to generate data for job planning and appraisal.

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# Section 5. New Ways of Working implementation programme and sustainability

- 5.1** It is clear that NWW is present and acknowledged within mental health services in England. It is referred to repeatedly in clinical and managerial meetings up and down the country. The early results from the national survey indicate that the vast majority of mental health provider Trusts surveyed are fully aware of its importance, and that most of them have a variety of services or developmental plans in place to modernise practice along these lines.
- 5.2** The message has clearly been heard, but will it be sustained? Many Trusts are now engaged in the journey towards foundation status, and the messages of NWW – efficiency, competence and effectiveness – are in complete accord with this strategic direction. It is also a message that will be equally appreciated by Boards of Governors and commissioners alike.
- 5.3** Some Strategic Health Authorities (SHAs) are involved in applying the ‘Toyota lean principles’ method of continuous improvement to their health community, and there is clear alignment with NWW for the workforce to provide an efficient service that the ‘customer’ (read: user and carer) really wants. It may be surprising to some, but there are many parallels between the efficient production of motor vehicles and a person-centred and effective care provision system!
- 5.4** A further challenge for NWW will be to communicate its value to commissioners at the local authority, Primary Care Trust (PCT) and practice level. For NWW to be truly effective, there needs to be clear linkage between the different commissioning arms and an avoidance of piecemeal, disjointed commissioning and perverse measurements of activity.
- 5.5** In order for NWW to be sustained, there must be continued ownership by all the professional bodies: their endorsement and active promotion is essential. Without clear leadership from these agencies, schisms will develop.
- 5.6** Finally and most importantly, it is crucial that service users and carers express their wishes with respect to NWW, and continue to put pressure on Trusts, PCT commissioners and SHAs to develop and implement a system of care that they themselves have asked for and that challenges so much traditional and professional-bound practice.

5.7 In summary, therefore, NWW is entering a new phase. It is already present within the culture, but it needs to be more firmly established as the primary means of delivering mental healthcare. For this to happen, there needs to be support from throughout the healthcare system – from the Department of Health and SHAs to Trusts, commissioners, users and carers. Over the next 12 months, working in conjunction with key national, regional and local stakeholders, the NIMHE National Workforce Programme will support implementation to help roll out NWW effectively.

## Section 6. Next steps

**6.1** This is a progress report. There can be no doubt that substantial progress has been made since our last report in October 2005, as can be seen from the NWW survey and from the individual reports set out in Section 7, Chapters 2 to 10. However, a lot more remains to be done before NWW and the new and extended roles are fully embedded in mental health services.

**6.2** In 2007/08 it is intended that:

- the joint post that has been agreed by the National Institute for Mental Health in England (NIMHE) National Workforce Programme and the Royal College of Psychiatrists to emphasise the importance of NWW nationally will be filled;
- all the products of the work from all the key stakeholders will be placed on the new website that has been established ([www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)). Examples of positive practice will be collected here and local organisations will be encouraged to share and document their work;
- a series of collaborative NWW Implementation Learning Sets, organised through the Royal College of Psychiatrists Centre for Education, will be run in each Care Services Improvement Partnership (CSIP)/NIMHE region for director-level staff within Mental Health Trusts. These learning sets are intended to assist Trusts in taking a strategic approach to NWW;
- organisations will be asked if they are interested in undertaking the Creating Capable Teams Approach (CCTA), and workshops will be run in each CSIP/NIMHE region for identified facilitators. Although it is an 'off the shelf' tool, it is challenging to carry through, and a CCTA network will be established to assist facilitators throughout the year;
- a short NWW Implementation Best Practice Guide will be produced to help organisations focus on the outcomes of NWW;
- specific work will be undertaken, as agreed with the Department of Health, to take forward the implications of NWW for pharmacy; and
- the National Steering Group for NWW will continue its role of guiding, co-ordinating and troubleshooting NWW.

# Section 7. New Ways of Working for individual staff groups

## Chapter 1

### Service user and carer involvement in the New Ways of Working programme

- 7.1.1** It is of real significance – and deliberate intention – that this section, on the involvement of service users and carers in NWW, should head this part of the report. The issue is fundamental to the principles and purpose of the programme, and it underpins the thinking and future practice of each work stream across all age groups (children, working-age adults and older people) in mental health services. Involvement is a constant cross-cutting theme that challenges unacceptable traditional approaches, where the service user was sometimes seen as an ‘add-on’ to the delivery of their own care, the carer was not recognised for their invaluable contribution, and so often both parties were passive recipients of services. NWW is about having the service user and carer at the heart of every aspect of care as equal partners. Accepting that service users and carers should have the right to be involved in decisions that affect their lives, NWW recognises that they have much to contribute through their experience of a particular disability, illness or care service. In particular, they can relate this from their own viewpoint, expressing their fears, joys and feelings, and so contributing to a better understanding for all. Effective involvement leads to service users and carers feeling empowered, confident and valued, thereby making them feel more in control and better able to make choices, and so enhancing the quality of their lives and advancing the potential for a more effective and positive workforce.
- 7.1.2** Feedback from service users and carers suggests a preference for increased multidisciplinary team working as a means to providing more ‘person-centred’ care. The concept of team working presents both challenges and opportunities to the workforce and to the service users and carers. NWW recognises and includes the service users and carers as valued, respected members of the healthcare team, and the Creating Capable Teams Approach (CCTA) is an inclusive, partnership process.
- 7.1.3** As members of the various working parties involved in the NWW, service users and carers have influenced discussions, changed attitudes and affected outcomes. Their voices and opinions have often refocused fixed dialogue and debate that can become too professionally introspective when challenged by change. Mutual respect continues to influence thinking on both sides.

- 7.1.4** Where service users and carers have been integrated into the workforce with genuine encouragement and support, they have used their particular experiences and understanding to great advantage in the care of others. Recent reports into the effectiveness of the new Support, Time and Recovery (STR) role have emphasised the successful impact of the service user and carer on a role built on mutual trust and respect and underpinned by a positive attitude of hope and recovery.
- 7.1.5** A ‘user-friendly’ PowerPoint presentation on the NWW has been devised by the User Involvement Lead with the help and support of a user-carer group in Humber Mental Health Teaching NHS Trust. This has been presented, with good effect, to a number of service user groups and mental health workers. Interest has been aroused and expectations raised. A small working party of service users and carers has devised an appropriate leaflet and poster for national distribution to service user and carer groups and staff. Appropriate information and knowledge is vital to promote inclusion and honest participation.
- 7.1.6** NWW is about a big culture change; it is not about tinkering at the edges of service improvement. Only when all service users and carers are genuinely involved in their care, when real choices based on knowledge can be made, and when service users and carers are truly enabled by services led by their needs to move forward on the long journey towards their recovery, will some of the past, entrenched methods and practices become the exception, and enlightened inclusive care become the rule.
- 7.1.7** Changing individual practice and the values and beliefs of mental health workers, and increasing their knowledge and skill levels to meet more effectively the needs of service users and carers, is only the first part of the challenge. The second part is the difficult trick of changing the way in which services are delivered and the way in which they are organised. To this end, there is great promise in the moves – led so far by so many committed professionals, service users and carers involved in the NIMHE National Workforce Programme and in other areas – to explore and develop new ways of working that will more effectively meet the needs of mental health services customers and the aspirations of mental health services workers. This promise must not falter, but must continue to develop in order to meet future expectations.

**Contact:** Bill Davidson, NIMHE User Involvement Lead, at [sirwillock@aol.com](mailto:sirwillock@aol.com)

## Chapter 2

### New Ways of Working for Allied Health Professionals in mental health

‘Dialectical Behavioural Therapy (DBT) hits the button for me. It is the first treatment I have been offered that directly addresses my destructive behaviours. The team who facilitate this – occupational therapist (OT), psychological and nursing staff – have been helpful and understanding. My primary therapist is an OT.’

Service user, Berkshire Healthcare NHS Trust, February 2007

#### Key recommendations of New Ways of Working (NWW) for Allied Health Professionals (AHPs)

- Service users and carers should be actively involved in the development and delivery of training and education, and as partners in their care (at both individual and service levels).
- AHPs should use the Skills for Health competence-based approach to service delivery ([www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)) and the Creating Capable Teams Approach ([www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)).
- AHPs need to demonstrate to commissioners the cost-effective contribution their specialist skills can make to improving the health and well-being of service users and their carers.
- AHPs should extend links with local authority and other services to ensure clinical protocols and care pathways for service delivery across organisational boundaries are in place.
- AHPs should take advantage of their transferable skills in order to lead service development across mental health services.
- AHPs should make explicit the contribution they can make to improving a person’s quality of life through reducing their reliance on services and by promoting health and well-being.
- The ten essential shared capabilities (underpinning values for all mental health staff, [www.nimhe.csip.org.uk](http://www.nimhe.csip.org.uk)) should be integral to training, induction and the continuous professional development of all AHP professionals and support staff.

## Background

- 7.2.1** AHPs work with individuals from all age groups and within all clinical specialties. Their particular skills and expertise can be the most significant factor in helping people develop and maintain their independence through both physical and mental rehabilitation. AHPs work across many sectors and settings including health, education, social services, primary care, secondary care, the independent and voluntary sectors.
- 7.2.2** There are specific AHPs working in specialist mental health roles. They include art therapists, dietitians, drama therapists, music therapists, occupational therapists, physiotherapists, and speech and language therapists. However, other AHPs also make a valuable contribution to mental health service users via promoting positive mental health. A unique contribution of AHPs is their ability to meet the combined mental and physical health needs of service users.

## New Ways of Working for AHPs

- 7.2.3** NWW represents a cultural change in the delivery of mental health services. The future is a person-centred values-based approach where services and roles are responsive and flexible. The policy context includes the White Paper, *Our Health, Our Care, Our Say* and proposals for improving access to psychological therapies and social inclusion, as well as mental health legislation.
- 7.2.4** One recommendation from *New Ways of Working for Psychiatrists* (Department of Health, 2005) was to take forward NWW for AHPs via the Mental Health Allied Health Professionals Advisory Group (MHAHPAG). Representatives on this group included service users, carers, the AHP Federation, other NWW workstreams, Skills for Health, the National Institute for Mental Health in England and the Department of Health.
- 7.2.5** This chapter is a summary of the full report of NWW for AHPs which can be found at [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk). NWW for AHPs has developed practical guidance illustrating how AHPs can enhance and evolve their practice to meet the needs of working in a modern mental health service and ensure wider social inclusion of service users and carers. It demonstrates and provides examples of how AHPs make the best use of their skills, competence and capacity to work across and between organisations.
- 7.2.6** The MHAHPAG identified four key themes relating to NWW which have been explored through project groups. These were:
- education and training;
  - new roles;
  - system reform (*Our Health, Our Care, Our Say* White Paper); and
  - teamworking.



Common issues, challenges and recommendations of each theme are discussed in the main report.

- 7.2.7 Several cross-cutting themes have emerged both within the project groups and other NWW workstreams, including improving access to psychological therapies, regulation, preceptorship, social inclusion, recovery approaches and complexity. All of these are addressed in the NWW for AHPs full report.
- 7.2.8 Chapter 8 of the final report of the *New Ways of Working for Psychiatrists* (2005) identified actions to be taken in respect of a number of Allied Health Professions to promote NWW. Updates on these are included in the full report.

#### **Innovative practice**

North Central London occupational therapists have developed a training resource pack for senior occupational therapists to deliver training to support staff. The target client/service groups included adult mental health and dementia services. The training is currently being piloted with a view to using it as part of an NVQ course at Middlesex University.

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Vanessa Papas at [vanessa.papas@candi.nhs.uk](mailto:vanessa.papas@candi.nhs.uk)

#### **Innovative practice**

The Adult Mental Health Joint Training and Development Strategy Group in Leicestershire has service user and carer trainers working with professionals/workers to deliver training that models good partnership working and hugely enriches the training experience.

**Contact:** Rebecca Pritchard at [rebecca.pritchard@leicspart.nhs.uk](mailto:rebecca.pritchard@leicspart.nhs.uk)

#### **Innovative practice**

Occupational therapists at the Hartington Unit at Chesterfield Royal Hospital have a new role, working in the Crisis and Home Treatment Team. The occupational therapy team formulated a Crisis Care Pathway and aims to complete intervention and discharge in eight weeks. Benefits include reducing the number of acute mental health hospital admissions and establishing more links with community networks.

**Contact:** Kate Singleton at [kate.singleton@derbyshirecountypct.nhs.uk](mailto:kate.singleton@derbyshirecountypct.nhs.uk)

### Innovative practice

A weight management programme for adult mental health clients in Barnsley helps clients to manage weight gain that is due to a variety of factors, including the side-effects of medication. It is a three-month programme run by a senior physiotherapist and exercise specialist with input from dietitians, pharmacists and psychiatrists, as well as psychology, nursing and leisure centre staff. It has demonstrated that clients taking anti-psychotic medication are able to lose weight if they are prepared to change their exercise and eating habits, and that this results in corresponding improvements in self-esteem. The programme is constantly being modified in response to feedback from clients and staff – for example, a stress management component has recently been added to the programme.

**Contact:** Roderick Newsome at [roderick.newsome@barnsleypct.nhs.uk](mailto:roderick.newsome@barnsleypct.nhs.uk)

### Occupational therapy

‘The activities my son was involved with were going shopping, preparing and cooking light meals, art, constructing wooden models and computer work... He explained how, by being given a choice, he felt he had some empowerment... My son felt the therapists were interested in him as a person, as an ordinary human being.’

### Other useful websites

[www.nhscarers.nhs.uk](http://www.nhscarers.nhs.uk)

[www.dh.gov.uk](http://www.dh.gov.uk)

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

### Reference

DH (2005): *New ways of working for psychiatrists: Enhancing effective, person-centered services through new ways of working in multidisciplinary and multi-agency contexts. Final report 'but not the end of the story'*. DH Publication Ref 270394A/B/C

**Contact:** Wendy Osborn, Professional Head of Therapies, Berkshire Healthcare NHS Trust,

## Chapter 3

### New Ways of Working for Occupational Therapists

#### Introduction

**7.3.1** NWW for Occupational Therapists will ensure that, as a profession, we continue to strive to be at the heart of modern mental health service provision in the 21st century, recovering ordinary lives and delivering what service users want, need and deserve. The NWW for Occupational Therapists sub-group was established in July 2006 and is jointly chaired by Tina Hurley (COT Professional Affairs Officer – Mental Health) and Chris Merchant (National Lead for Workforce Mental Health Bill CSIP). The group includes representatives of the COT, the COT Specialist Section for Mental Health, NWW for AHPs sub-group and a service user representative.

#### Aims and objectives

**7.3.2** The aims, as outlined in *New ways of working for psychiatrists*, were to work towards fulfilling key objectives necessary to raise the profile of the occupational therapists' contribution to mental health services.

The five key objectives in *New ways of working for psychiatrists* (DH, 2005), some of which have already been met, are:

- the development of a strategy for occupational therapists in mental health services;
- exploring the new roles for occupational therapists under Patient Group Directives;
- exploring new roles for occupational therapists under the Mental Health Bill;
- establishing occupational therapy secondment with the Social Inclusion Unit; and
- considering a Career Framework for Occupational Therapists reflecting both the generic and specialist functions of occupational therapists.

#### Progress update

**7.3.3** The COT strategy *Recovering Ordinary Lives* (2006) was launched in December 2006, the programme of secondment to the Social Inclusion Unit is now in its second year, and a Post-Qualifying Development Framework is available to all occupational therapists. NWW is a continuous and ongoing work stream, and the COT will continue to support and promote the implementation of NWW. The NWW for Occupational Therapists sub-group, in its future programme of work, will focus on five priority areas that have emerged from *Recovering Ordinary Lives*. New objectives

have been agreed, and five sub-group leads have been identified to focus and deliver each of these.

### **Programme of work**

**7.3.4** *Recovering Ordinary Lives* closely relates to and complements NWW, and will be implemented from 2007 through a programme of national and regional events. As the profession embraces both programmes, occupational therapists will be enabled to work towards achieving the vision for occupational therapy: 'By 2017, mental health service provision in the United Kingdom will be better for the active role and inspirational leadership provided by the cultural heritage and identity of occupational therapy, which at its core is social in nature and belief and, therefore, will deliver the kind of care that service users want, need and demand' (COT, 2006).

**7.3.5** A national network has been established to seek and explore the concepts, values and beliefs that are currently held within the profession. Stakeholder events will provide an opportunity for areas of innovative practice to be identified. Pilot sites will be established to demonstrate NWW in action. A summary of the current programme of work, highlighting the five priority areas is included below.

### **Valuing occupation and the underlying value base for occupational therapy practice**

**7.3.6** The relationship between occupation, mental health and well-being is evidenced in both the literature review and in the vision *Recovering Ordinary Lives*. Valuing occupation is one of the key themes in this strategy, with associated key messages for practitioners, managers, educators, researchers, COT and commissioners to ultimately improve services. These key messages will form the basis of discussion at stakeholder events and will also be consulted upon through the national network. *Recovering Ordinary Lives* is available at [www.cot.org.uk](http://www.cot.org.uk)

### **Leadership**

**7.3.7** Leadership is being considered in four domains: professional, clinical, managerial and political. A need for occupational therapy champions has been identified to promote leadership opportunities and provide development and support for staff in leadership roles. Consultant occupational therapists are, where they exist, having a significant impact on service delivery, but the paucity of posts makes it difficult to see systemic change or a raised profile.

**7.3.8** Occupational therapists are currently employed in key leadership roles at Board level and as directors of therapy services within some NHS Trusts. However, this is often determined by the individual structure of the organisation and not by any workforce

directive. Where these positions are in place, staff within the organisation feel that occupational therapy is visible and valued.

- 7.3.9** COT will continue to secure representation on government working parties, committees and other groups that develop and influence policy, to promote effective and appropriate leadership in the mental health service for occupational therapists.

## Education and training

- 7.3.10** There are a number of different educational routes to occupational therapy registration, with all pre-registration programmes being subject to approval by the Health Professions Council (HPC, 2005).
- 7.3.11** Most programmes currently undergo voluntary accreditation by the College of Occupational Therapists to ensure their conformity with the *Curriculum Framework for Pre-Registration Education* (COT, 2004a) and the *Standards for Education: Pre-Registration Education Standards* (COT, 2004b). Both of these key COT documents belong ideologically to the occupational therapy profession, and are revised on a five-yearly basis, with interim updates as necessary. Programmes that opt for COT accreditation evidence their responsiveness to local and global issues and agendas that influence the learning requirements of students. In conforming to the Curriculum Framework, they demonstrate that they embrace the philosophical and value base of the profession. Both of these aspects of the pre-registration programmes are vital to ensuring that students and new graduates are aware of the contemporary context of mental health practice while on placement and once in the workforce.
- 7.3.12** There is concern regarding the recent reduction in the number of places being commissioned for occupational therapy training. This will impact upon the existing workforce, its sustainability and capacity to embrace change and new roles in the endeavour to bring quality services to clients.
- 7.3.13** To make the effective transition into new roles, additional training will be required, e.g. Approved Mental Health Professional (AMHP) and Responsible Clinician. COT, with other professional bodies, will contribute to the development of this training, in order to prepare practitioners for new responsibilities as identified in the Mental Health Bill 2006.

## Workforce development

**7.3.14** Occupational therapists recognise that they can use their knowledge, skills and expertise in new roles in a changing and diversifying workplace. Opportunities will arise within new and reconfigured services, and occupational therapists need to recognise the career potential associated with these. Through the implementation of the strategy and the accompanying work on NWW, COT will continue to guide its members and identify opportunities for occupational therapists to work in new practice areas where their skills can be most effectively deployed for the benefit of service users.

**7.3.15** Occupational therapists within the field of mental health frequently work within multidisciplinary teams and actively promote integrated and generic working. However, the unique purpose of our profession, and its specific contribution to the mental health workforce, needs to be clearly stated and owned by occupational therapists, in order to ensure that commissioners of services also recognise the value and contribution of occupational therapy. The debate over specialist versus generic working will continue within the profession, and will be consulted on further via the NWW email network and events.

## Roles

**7.3.16** Occupational therapists have core skills in assessment, planning, intervention, evaluation and occupational performance. These skills, combined with the ability to be flexible, creative and responsive, have enabled practitioners within mental health services to take up the challenge of new roles within a modernising and changing workforce. Occupational therapists are the professionals within the mental health workforce who have the knowledge and experience of issues around occupation and employment to deliver creative solutions to complex problems. As one of the five core professions named within the mental health workforce, they will deliver the new roles and ensure a smooth implementation of policies in accordance with the Mental Health Bill 2006. We will jointly review the new roles for existing and new support staff, e.g. Associate Practitioners and their specific contribution to team working.

### **NWW in action: examples of innovation**

At an NWW sharing event held at the College of Occupational Therapists in September 2006, occupational therapists put forward the following examples of innovative practice:

- a programme for employment and vocational opportunities, with the appointment of vocational specialists and the introduction of specific assessment tools and models;
- in a community mental health team setting, identifying the specific and generic skills of the occupational therapist, to enable more effective and efficient delivery of services to people with complex needs;
- the establishment of joint lecturer/practitioner and researcher/practitioner posts attached to institutes of higher education;
- the identification of occupational therapists as trainers for clinical and managerial roles;
- flexible and out-of-hours working in crisis resolution and home treatment, assertive outreach and early intervention in psychosis teams;
- care co-ordinating and case management;
- partnership working with the voluntary sector, including secondments;
- introduction of new roles, e.g. Support, Time and Recovery workers and Associate Practitioners;
- occupational therapist appointment to Trust-wide service development roles;
- identified service/organisation lead posts for the arts, social inclusion, education and employment;
- joint posts and protocols in outreach services for older people;
- specialist interventions in forensic services – psychiatric intensive care units (PICUs), low and medium secure units, prisons and special hospitals;
- establishment of integrated care pathways approaches across community, day and primary care services;
- involvement and empowerment of service users and carers, including promotion of WRAPs (Wellness Recovery Action Plans); and
- in a primary care setting, demonstrating the unique intervention and contribution to the team that the occupational therapist makes, through interventions that draw upon the knowledge and skills in both physical and mental health that are gained and are core to occupational therapy training.

## Next steps

**7.3.17** The College of Occupational Therapists will implement its new strategy for occupational therapy in mental health services from 2007, and NWW will be fundamental to the process. In order for the vision to be achieved in 2017 and beyond, NWW will have been embraced by the profession and will be embedded in practice. To support this:

- We will review the *Recovering Ordinary Lives* strategy (COT, 2006) regularly to ensure key milestones have been met and that it reflects such things as current and new policy and legislation, NICE guidance, research and the developing evidence base for practice.
- We will promote the implementation of NWW and continue to work in partnerships to facilitate service integration and the introduction of new roles and innovative practice.
- Within the context and overarching NWW programme, we will continue to promote, support and evaluate NWW for occupational therapy staff.
- We will identify what it is that we will need to do, and where and how we will need to do it, in new and innovative ways, to ensure that occupational therapy is recognised and valued for its unique and essential contribution to mental health provision.
- We will continue to contribute to the work being undertaken by other professional NWW sub-groups, and, in partnership, develop the cross-cutting themes that have been identified, with specific reference to leadership, accountability, new roles and team working.
- We will disseminate information regarding NWW for Occupational Therapists within the profession and with other stakeholders through professional briefings, features, articles and updates in a range of professional publications, including the *British Journal of Occupational Therapy*, *Occupational Therapy News*, the COT Specialist Section in the *Mental Health Journal*, and on the COT website, for other stakeholders.
- We will present NWW at national conferences and events.
- We will contribute to research and audit and build the evidence base.

## Summary

**7.3.18** Occupational therapists currently work, and will continue to work, within all areas of mental health service provision and with people of all ages, across service sectors and agencies. NWW will ensure that occupational therapists continue to contribute a



unique professional perspective that focuses on the whole person, embracing the individual's unique lifestyle and preferences. Enabling someone to participate in everyday activities is a central part of occupational therapy; helping them to carry out the activities they need or want to do will enable them to lead healthy and fulfilling lives.

- 7.3.19** The more skilful the intervention the occupational therapist makes, the smaller the 'footprint' they leave. Success in this is demonstrated when service users feel that they have made the intervention themselves. It is therefore vital that occupational therapists are able to articulate and provide evidence of the basis of their therapeutic interventions and treatment at all levels.
- 7.3.20** A service user described one of the many roles of the occupational therapist as: 'Kick starting your mind into recovery and occupation. This involved helping us find our own pathway in life and helping us learn the skills that would allow us to look after ourselves.'
- 7.3.21** Enabling the continued development of occupational therapists to meet the expectations of service users and their carers and the changing needs of organisations is essential to the delivery of effective, high-quality, sustainable care in our changing communities.

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## Chapter 4

### New Ways of Working for Applied Psychologists

#### Introduction

**7.4.1** The applied psychologies include clinical, counselling, health, forensic, educational and child, occupational, sport and exercise psychology and neuropsychology. In order to become a chartered member of the British Psychological Society (BPS), psychologists must first have completed an undergraduate degree in psychology (or equivalent), which entitles them to register as a graduate. Following this first degree, most psychology graduates gain some additional work experience before going on to register for a three-year programme of work and academic experience that leads to chartered membership. Some of these three-year programmes lead to a doctorate-level qualification, and most psychologists are in the process of moving to this level of academic award. All programmes require a mix of work and academic inputs and assessment to ensure the applied psychologists develop the appropriate competences. Finally, to qualify in neuropsychology, one must first be chartered as a clinical or educational psychologist, and must then complete a further programme of academic and work experience. This allows individuals to qualify for practitioner membership of the Division of Neuropsychology.

#### Aims and objectives

**7.4.2** The New Ways of Working for Applied Psychologists sub-group was established in July 2005 and has met every two months since then. The group is jointly chaired by Roslyn Hope (NIMHE, NWP) and Professor Tony Lavender (BPS) and includes representatives of carers and users, from the divisions of applied psychology and other professions, including psychiatry, nursing and the allied health professions. Two stakeholder conferences have been held in Wolverhampton and Edinburgh. The aims of the group have been to address the following seven objectives:

- to review the pre-qualification roles of psychology graduates, including Primary Care Mental Health Workers (PCMHWs), and recommend how they could be developed to contribute to the sustainable delivery of psychological services;
- to review the current training models for applied psychologists, develop and assess alternative models and make recommendations for the future;
- to map the current workforce, identify emerging good practice in new ways of working and develop role descriptions for all levels across the career framework and produce guidance for National Assessors;
- to identify the best models for organising psychological services within Trusts and review the leadership development needs of applied psychologists;

- to identify the best ways that applied psychologists can contribute to the development and work of multidisciplinary teams;
- to identify the way that applied psychologists can improve user access to psychological therapies; and
- to clarify the role, training needs and registration requirements of applied psychologists in implementing the new mental health legislation.

## Progress report

**7.4.3** Seven project groups have been established to meet each of these objectives, and a summary of the work is included below.

- *New pre-qualification roles:*  
The group has reviewed recent developments in graduate roles (including the PCMHWS). The major lessons are that unless i) these roles fit in with clear career frameworks, and ii) are coherent with local service developments, they will not be sustainable. The group is developing a career framework for pre-applied psychology doctorate training that involves the creation of three new levels of worker, which would enhance access to psychological services across specialties. An education framework that builds on previous work about new roles has been developed to improve the competence of those staff.
- *Training models:*  
A review of the training models of applied psychologists (i.e. the current divisions of clinical, counselling, educational and child, forensic, health, occupational, sport and exercise psychology and neuropsychology) has been undertaken. Alternative models that enhance the unification of those models and would encourage the adoption of new and flexible roles have been developed. A preferred way forward will be identified and a consultation process developed. This will be a long- term exercise and will require further strategic analysis and planning by the BPS about the future of the divisions of applied psychology.
- *Career pathways:*  
The current applied psychology workforce has been mapped and examples of good practice in new ways of working across the country have been developed. These examples will be used to provide practising applied psychologists with ideas for developing innovative practice in their local contexts. Throughout the career framework, those roles at the different levels that integrate innovative practice have been identified. Finally, the role of the National Assessors has been reviewed and new guidance produced relevant to all applied psychologists.

- *Organising, leading and managing psychological services:*  
The current organisation of psychological services has been reviewed, and key guiding principles for organising psychological services have been identified. The need for the development within Trusts of Board-level leads in psychological therapies/services has been emphasised. A variety of models of leadership have been reviewed, and a model likely to suit applied psychologists and psychological services has been presented. The leadership roles and training needs of applied psychologists throughout their careers have been reviewed. Ways in which the leadership-development needs of applied psychologists can be met have been identified.
- *Team working:*  
The theoretical and research literature about effective team working has been reviewed. Recommendations have been made about the role of applied psychologists in such key issues as the separation/integration of psychologists in teams, leadership, and the involvement of psychologists in service improvement. The role of applied psychologists working effectively within and for teams is strongly endorsed. Good practice in a number of strategically important services, such as assertive outreach, crisis resolution and acute care teams, have been identified throughout the UK. These should act as examples of how applied psychologists and others can improve the effectiveness of their work for and within teams.
- *Improving Access to Psychological Therapies:*  
The project group has actively liaised with the DH and CSIP programme on Improving Access to Psychological Therapies (IAPT) and in particular the Workforce Group. Issues that have been identified and addressed include defining competences for psychological therapies and CBT in particular, surveying the post-registration training in psychological therapy, developing and defining a Career Framework for Psychological Therapists, and estimating the workforce and training requirements for implementing the phased roll-out of the IAPT programme.
- *Mental health legislation:*  
A small project group has liaised closely with the existing BPS and DH groups addressing the reforms to the Mental Health Act and the Mental Capacity Act. There have been discussions on how to take things forward with the Mental Health Act reform. In particular, there has been identification of the competences required in the roles of Approved Mental Health Professional and Responsible Clinician, the training needs (including probable curricula) and the regulation and registration mechanisms. Finally, strong links have been established with the Royal College of Psychiatrists on issues of implementation.

## Products

- *Development of New Roles:*  
A document outlining the rationale for new pre-qualification roles and a model for developing three pre-qualification-level roles to deliver services in an innovative, cost-effective and sustainable manner.
- *Training Models and the Future:*  
A document providing an overview and critique of existing models of applied psychology training; a set of criteria for evaluating models and a discussion and evaluation of the new models. Clear recommendations about how the conclusions could be taken forward within the BPS will be provided.
- *Map of the current applied psychology workforce alongside examples of innovative practice:*  
A report about the current applied psychology workforce and descriptions of roles at different levels.
- *Guidance for National Assessors:*  
This is a new document outlining the role of National Assessors and giving descriptions of roles at different levels.
- *Organising, Managing and Leading Psychological Services:*  
This document will provide an analysis of the current NHS context and its implications for the organisation of psychological services. An evaluation of leadership styles will be provided, along with recommendations for leadership development and training for applied psychologists.
- *Teamwork and Applied Psychology:*  
A document providing theory and research related to effective team working and examples of good practice. This document will be relevant for a multi-professional audience.
- *Good Practice Guidance for the Deployment of Applied Psychologists in Improving Access to Psychological Therapists.*
- *Guidelines for Applied Psychologists in Implementing the New Mental Health Legislation:*  
A document detailing the role and training requirements of the new mental health legislation and the registration arrangements for psychologists.

## Contribution to the work of other groups

- 7.4.4** Members of the group have contributed to the work undertaken by psychiatrists, pharmacists, AHPs, and primary care, social and nursing workers that is reported elsewhere. The group has identified areas of work it wishes to pursue that have cross-

cutting themes, and members have started to participate in groups working on leadership and accountability.

### Next steps

- Work must be completed on all the documents described under 'Products'.
- The dissemination of the recommendations provided in the documents needs further work within the BPS and with other stakeholders.
- A launch conference has to be organised for July 2007, to present formally the range of work undertaken by the NWW for Applied Psychologists sub-group.
- Funding must be secured for the publication of documents that require more than just being available on the BPS and CSIP/NIMHE websites.
- Senior managers/programme directors in healthcare provider, commissioning and higher education organisations have to be involved in the consultation phase.

### Summary

**7.4.5** Many examples of good practice and new ways of working have been identified. Many ways of improving the contribution of applied psychologists to new and innovative practices have been developed by the group. The implementation of the recommendations and the adoption of positive practice is vital in progressing this work and enhancing the quality, effectiveness, efficiency and sustainability of the NHS.

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## Chapter 5

### New Ways of Working for Non-Professionally Qualified Workers

#### Introduction

**7.5.1** Non-professionally qualified workers (NPQWs) provide an important, substantial and sometimes under-recognised contribution to services for people with mental health problems. Such roles can provide significant benefits to service users and carers, service organisations and other staff. In many areas, such as in-patient care and many community settings, NPQW staff often spend more direct time with service users than staff with traditional professional qualifications.

**7.5.2** A summary of many of the NPQW roles will be available at the NWW website, [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk) NWW provide an important opportunity both to develop new NPQW roles and to change and extend existing roles.

**7.5.3** The term NPQW here refers to:

- those employed without the requirement for a traditional professional qualification; and
- those whose role is to work directly with people with mental health problems.

**7.5.4** NPQW roles are found in both statutory and non-statutory sectors. Those in statutory sectors have traditionally been strongly linked with particular professions – e.g. support workers working to nurses or social workers – while those employed elsewhere have not – e.g. housing support workers.

**7.5.5** A range of factors have influenced the development of NPQW roles, including an identified need for a totally new role, shortages of traditionally trained ‘professionally’ qualified staff, and the drive for better value.

#### New ways of working for established NPQW roles

**7.5.6** A range of existing roles has been extended by increasing training requirements and extending the range of roles, for example pharmacy assistants have taken on new tasks and roles under the supervision of the pharmacist, and healthcare support workers have developed new skills/competences and become Associate Practitioners working with registered nurses.



### Associate Practitioners

In Avon and Wiltshire Mental Healthcare Partnership Trust, Associate Practitioners have been trained, through a University of the West of England course, to work in support of qualified staff and allied healthcare professionals in the assessment, planning, implementation and evaluation of nursing care without the direct supervision of a registered nurse. They work as associate nurses in in-patient areas, ensuring that holistic care is delivered and standards of care are enhanced. They supervise and delegate work to Band 2 and 3 healthcare assistants.

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### New NPQW roles

**7.5.7** Some of the major recent developments in mental healthcare have been supported by the introduction of a range of NPQW roles that have particularly focused on improving access to services or social inclusion. For example, Primary Care Mental Health Workers have been established to provide evidence-based brief psychological interventions, and Support, Time and Recovery (STR) workers provide intensive support to individuals to support recovery.

### An evaluation of a new NPQW role

An evaluation of the impact of the introduction of STR workers showed:

- the effect of the introduction of the role ‘appears overwhelmingly positive’;
- the STR worker role is most effective when clearly linked to the process of recovery and the goals of social inclusion;
- the role generates positive and desired outcomes for service users – particularly through the provision of time, and continuity of support; and
- there is a generally high level of job satisfaction and respect.

**Source:** Huxley, P. *et al.* (2005): ‘*No Recovery without Time and Support*’.

### Challenges to successfully introducing new roles or new ways of working

**7.5.8** Introducing new roles can often be difficult. Problems can arise from a range of sources. New roles may be poorly understood or, occasionally, actively resisted; career structures may not support retention; and appropriate education and supervision may not be available. Many newer roles are not specifically linked to a single existing profession, making assimilation into services more complex.

## Principles of good practice

- 7.5.9** In order to ensure that NPQW roles are able to make the greatest contribution possible to meeting the mental health needs of service users, particularly through NWW, the same general principles apply as to other roles.

### Introducing new or enhanced roles

The North-West Strategic Health Authority has produced a document, *Introducing New or Enhanced Roles*, that provides detailed guidance and checklists to support new workforce developments. Issues covered include: needs analysis, education, costs and sustainability.

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- 7.5.10** However, there are some principles that are particularly important to consider:

- *Recognising that NPQW staff already contribute enormously to services.*  
Service providers can do much to ensure that the good work of existing NPQW staff is highlighted, for example through in-house publications.

### Recognising the contribution

Leicestershire Partnership NHS Trust gives an annual award within its Older People's services to recognise the contribution made by support staff, and their dedication and commitment to older people. Carers and service users are involved in various aspects of the process, including short-listing the nominations and presenting the awards. One recipient, Alison, reported: 'I felt really honoured when I knew a carer had nominated me.'

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- *Challenging the idea that 'professional' is always best.*  
Organisations can actively challenge existing assumptions about traditionally professionally qualified staff always being the 'best' providers for care, where there is no evidence to support such contentions. This may include discussing such issues with service users and carers, who may understandably share such views.
- *Communicating new innovations/roles to existing staff.*  
By engaging with staff groups early on, there is more chance that new roles will be understood and supported. It is important to give clarity about how changes will impact on/fit with existing staff. It is likely that communications will need to be repeated at later times as well, to ensure continued understanding.

- *Ensuring that issues about professional accountability are clear.*  
The introduction of new roles may create new situations that existing models of professional accountability do not clearly cover. Consultation with regulatory bodies may be particularly useful in such circumstances.

### Addressing accountability issues

Avon and Wiltshire Mental Healthcare Partnership Trust set up a large workshop around the introduction of Associate Practitioner roles into the Trust. It invited speakers from professional and regulatory organisations to discuss areas of accountability and responsibility with a large and informed audience.

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- *Ensuring appropriate education/training is in place.*  
In the past, training has been missing for many NPQWs, despite the fact that they play key roles and often spend long periods of time working directly with service users. Widely recognised qualifications add to the ability of post-holders to transfer between organisations and roles, supporting career development.

### An innovative training scheme

Southampton University and Hampshire Partnership have developed an ‘earn as you learn’ two-year postgraduate diploma in Mental Health Practice (MHP) whereby trainees are employed – in the first instance as support workers – while they attend university. Once they qualify, the trainees enter through the Band 5 gateway of Agenda for Change and receive a postgraduate diploma.

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- *Ensuring that appropriate supervision is in place.*  
Supervision can play a vital role in ensuring that standards are maintained, workers continue to learn from their practice and good practice is shared. In the past, NPQWs have sometimes not had the same access to supervision as their professional colleagues.

### Providing appropriate supervision

Within Humber Mental Health NHS Trust, a clearly defined, robust supervision framework has played a major part in the successful implementation and development of the Support, Time and Recovery worker role. Supervision arrangements include peer group supervision every two months, individual clinical/practice supervision, individual STR role-specific supervision and email/telephone supervision outside normal supervision arrangements. Additional specialist supervision is arranged to meet specific needs.

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- *Ensuring that all roles have defined career frameworks.*  
Staff retention is often dependent on staff feeling that they have the opportunity to progress in their careers. Should staff not wish to seek roles with higher levels of responsibility, systems such as the Knowledge and Skills Framework in the NHS provide a means of continuing the identification of learning and development needs.
- *Defining roles and expected outcomes clearly.*  
In order for a role to function well, the aim of the role must be clearly defined and the planned outcomes clearly stated. This provides a benchmark for implementation success.
- *Establishing processes for review.*  
By building in processes and timescales for reviewing new/changed roles, there is the opportunity for all stakeholders to evaluate the contribution made, together with any difficulties. Formal planning in this way may reduce obstructive behaviour, as there is an opportunity to contribute to change.

### Developing and supporting NPQW roles

Pennine Care NHS Trust has established a quarterly forum for Assistant Practitioners. The aim is to bring together post-holders from across all areas of a multi-sited Mental Health Trust to ensure maximum benefits are gained from such roles. Activities in the forum include sharing of experiences from the different service areas, problem solving, transformational thinking and innovation, and operational policy development. The forum has been in place for 12 months, and has been the catalyst for the successful development of two key pieces of work: a preceptorship programme, and a protocol and associated training programme to enable Assistant Practitioners to administer depot medication.

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## Chapter 6

### New Ways of Working for Mental Health Nursing

**7.6.1** Mental health nurses make up the largest professional group in mental health services, with 48,000 registered nurses working in the National Health Service in England. There are also over 30,000 non-professionally qualified staff working with nurses and making a vital contribution (see Section 7, Chapter 5). Nurses work in every area of practice, and are numerically predominant in many areas, such as in-patient settings. In the last few years, a number of new roles have been introduced, for example modern matrons and nurse consultants, and new skills have been developed, for example nurse prescribing and psychosocial interventions. These changes provide opportunities for NWW that can help services become more service-user-centred and effective.

#### **Nurse consultant in primary care mental health**

An innovative nurse consultant role provides a clinical focus for mental health workers and practice nurses working within primary care over a large geographical area (1,000 square miles) in County Durham. The role is to improve access to psychological interventions through training staff in the use of patient-empowering models of care, such as guided self-help and depression case management, and to provide consultation on developing computerised CBT, psycho-education and bibliotherapy services. Advice on the development of new (graduate and gateway workers) and established (practice nurse and community mental health nurse) roles has supported new ways of working within a stepped model of care.

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#### **Nurse-led clinic**

Mary Bentley, a community psychiatric nurse, has set up a lifestyle clinic for service users in Bradford on Avon, Wiltshire. Mary's training as a supplementary prescriber made her more aware of the need to work with service users on issues such as smoking, diet and exercise, and to have discussions about medication and optimising prescribing practice in order to minimise side effects. In the clinic, Mary is able to do basic measurements, including blood tests, and to liaise with colleagues in primary care to manage physical health problems, such as diabetes, collaboratively.

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**7.6.2** *From Values to Action: The Chief Nursing Officer's review of mental health nursing* was published in April 2006<sup>25</sup> and made a series of recommendations supporting NWW by nurses. These were developed in the light of a national consultation, which sought views as to how mental health nurses could best improve the care provided to people with mental health problems. A subsequent publication, *Modernising nursing careers* (October 2006),<sup>26</sup> provides a broad strategy for the future of all kinds of nursing across the United Kingdom. It proposes actions that support many of the concepts of NWW and the recommendations of the Chief Nursing Officer's review.

## Recommendations

**7.6.3** The key recommendations in *From Values to Action* include:

- service providers to review current nursing roles and evaluate whether they make best use of the range of nursing skills – i.e. that nurses focus on working directly with individuals who have higher levels of need and/or support other workers in meeting less complex needs;
- service providers to develop shared roles between in-patient and crisis-home treatment staff;
- service providers to review how non-professionally qualified roles can make a greater contribution to care directly and indirectly, and the developments needed to support this;
- service providers to evaluate the requirements for senior nursing posts, such as nurse consultant roles, as part of a wider review of senior clinical roles, taking into account factors such as:
  - service user needs
  - legal developments
  - shortages of any particular profession/skill; and
- service providers to put in place arrangements to support and implement nurse prescribing, based on local need and taking into account the potential for service redesign and skill mix review.

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25 DH (2006): *From Values to Action: The Chief Nursing Officer's review of mental health nursing*. DH Publication Ref 273612.

26 DH, Welsh Assembly, Scottish Executive and Department of Health, Social Services and Public Safety for Northern Ireland (2006): *Modern nursing careers – setting the direction*.

### Improving physical healthcare for in-patients

Bolton, Salford and Trafford Mental Health NHS Trust has established a physical healthcare team for its in-patient wards, led by a dual-qualified nurse. Over 95% of service users are now receiving an initial physical healthcare screening. The screening includes tests for a range of common conditions, such as asthma, diabetes and cardiac problems, and can also lead on to other services, such as cervical screening and 'well man' and 'well woman' clinics. Smoking cessation support is also provided.

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### Further developments

- 7.6.4** Research looking at the process of implementation and the impact of *From Values to Action* is expected to commence by summer 2007.
- 7.6.5** Following the Chief Nursing Officer's review, three additional nursing-led projects were established to further support NWW for Mental Health Nursing. The projects aim to respond to challenges that commonly arise when implementing new roles and new ways of working.
- 7.6.6** Since the issues covered by the projects are also important for other professions, a range of disciplines were involved in each project, and brief sections describing their findings are included elsewhere in this report:
- *Non-medical prescribing in mental health settings.* There are a number of challenges that arise in trying to implement nurse prescribing (and other non-medical prescribing) in a way that benefits service users and service delivery organisations. Factors supporting successful implementation are briefly described in Section 4.6 of this report. A future electronic publication is planned to consider implementation issues in more detail.
  - *Accountability and new roles.* The creation of new roles, such as Associate Practitioners, has led to challenges for professionals, such as nurses, regarding their professional accountability when working with those in new roles. Accountability and responsibility issues are discussed in Section 4.11 of this report. In relation to nursing, the Nursing and Midwifery Council plans to clarify current guidance on this issue.

- *Senior clinical nursing roles.* *From Values to Action* recognises the importance of clinical leadership in creating and sustaining good practice. Challenges exist in successfully implementing senior clinical roles in an effective way and in ensuring their sustainability. These issues are discussed briefly in Section 4.7 of this report. More detailed guidance will be developed and is planned to be available on the NWW website: [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)

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## Chapter 7

### New Ways of Working in Mental Health Pharmacy

#### Aims of the programme

- To initiate, oversee and provide national programmes of work within and across the mental health pharmacy workforce.
- To promote, support and evaluate new ways of working that deliver improved management of medicines and pharmacy services for people with mental health problems and their carers.

#### Elements of the programme

- 7.7.1 The Spread Programme:** To engage a number of service providers across England in testing, developing and implementing new, changed or extended ways of working in mental health pharmacy that deliver impacts on components of medicines management.
- 7.7.2 The Workforce Survey:** To ascertain the workforce available in mental health pharmacy, in order to deliver new ways of working by pharmacy staff.
- 7.7.3 NWW in Mental Health Pharmacy – The continuing story...:** The current document will describe how NWW in Mental Health Pharmacy can impact on the delivery of medicine-related services to users of mental health services in three ways:
- development of the roles of staff working within pharmacy, so as to release the time of pharmacists and pharmacy technicians to develop improved services to users;
  - development of the roles of pharmacy staff so as to release time of other mental healthcare professionals and improve services to users; and
  - development of other staff to undertake work related to the management of medicines.

#### Progress on NWW in Mental Health Pharmacy

##### 7.7.4 The Spread Programme

- *Phase 1: Northumberland locality of Newcastle, North Tyneside and Northumberland Mental Health Trust*  
A major re-engineering of pharmaceutical services commenced in 2002 as part of a 12-month project supported by the Changing Workforce Programme. The main change centred on reshaping services around the patient at ward level. This required the modification of the roles of staff, creating new roles for existing and

incoming staff, integrating clinical pharmacists and technicians into ward teams, and re-engineering the dispensing functions both within the pharmacy and on the wards.

- *Phase 2: Replication sites*

During 2003, over a nine-month period, 14 sites were engaged, on an individual basis, with the aim of supporting organisations in meeting their obligations to provide improved medicines management to mental health service users by changing the roles of the dispensing assistant, the pharmacy technician and the clinical pharmacist.

Each site was given £10,000 to support change. This 'enabling' money could be used in a variety of ways: project time, audit time and tools, locum costs, training requirements and equipment.

- *Phase 3: Further replication sites and small medicines management innovations*

Although the primary aim of Phase 3 was to improve medicines management in mental health, providers were encouraged to develop alternative ways of working and to introduce small innovations that improved care and demonstrated NWW. The way to achieve this was by engaging with a further 32 service providers across England.

### **7.7.5 The Mental Health and Learning Disabilities Secondary Care Pharmacy Workforce Survey**

In December 2005, the NIMHE NWW for Mental Health Pharmacy (NWWMHP) Sub-Group of the National Steering Group for NWW in Mental Health commissioned researchers at the University of Bath to undertake a survey of the pharmacy services of all Mental Health Trusts (MHTs) in England. The aim of the workforce survey was to ascertain the pharmacy workforce available to provide services to MHTs in England, and the services actually provided.

The final survey received data from 59 of the 79 MHTs (72%). Non-responders were predominantly from PCT providers of mental health services. Only nine specialist MHTs failed to return a completed questionnaire.

### **7.7.6 NWW in Mental Health Pharmacy – The continuing story...**

In line with other professional groups, the final piece of work will be a document that incorporates the lessons from the Spread Programme and the Workforce Surveys.

## Products

### 7.7.7 Products from the Spread Programme:

- *Project Evaluation Report, Changing Workforce Programme, Mental Health – Pharmacy Pilot September 2004*. NHS Modernisation Agency.
- *National Pharmacy Spread Programme Interim Report*, CSIP/NIMHE, February 2006.
- *Individual Project Evaluation for 43 Spread Programme Sites*, CSIP/NIMHE, February 2006.
- *Spread Programme Report* (yet to be completed).

### 7.7.8 Products from the Workforce Surveys:

- *Report on the Mental Health and Learning Disabilities Pharmacy Workforce Survey*, May 2006 (the Bath Report), Taylor, D. and Sutton, J., University of Bath.
- *The UK PPG and CMHP Report of the Mental Health and Learning Disabilities Secondary Care Pharmacy Workforce Survey*, September 2006, Branford, D., Parton, G. and Sutton, J.
- *The UKPPG and CMHP Summary and Key Finds of the report of the Mental health and Learning Disabilities Secondary Care Pharmacy Workforce Survey*, October 2006, Branford, D., Parton, G., Taylor, D. and Sutton, J.

### 7.7.9 Service user and carer leaflet ‘Medicines management – everybody’s business’.

## Key points (lessons learnt)

### 7.7.10 The Spread Programme

All of these programmes and initiatives demonstrated the potential benefits of Pharmacy NWW. However, although significant changes to roles within pharmacy can achieve some improved services to service users, major changes are dependent on the capacity of a pharmacy workforce.

### 7.7.11 Workforce Survey

- *Mental Health Trust Pharmacy Services*  
MHT pharmacy services are very complex. Ascertaining the true extent of the mental health pharmacy workforce proved a larger task than anticipated. For most other groups of staff involved in mental healthcare, information relating to the workforce and services is available from the Durham mapping. Pharmacy services, however, are not.

The dependence of most MHTs on Service Level Agreements (SLAs) with other providers, usually acute Trusts, emphasises the need for a clear framework for SLAs that delivers a satisfactory level of service to the user. This should include the requirement for the personnel to be qualified and competent to work in MHTs. Unless such a framework can be achieved, it is also likely to present an obstacle to bringing about new ways of working.

- *Mental Health Pharmacy Workforce*

For most MHTs, the pharmacy workforce is too small to provide effective medicines-related services to service users and new ways of working. For some MHTs, the pharmacy workforce is too small to provide a safe service to service users.

### **Positive practice from the Spread Programme**

- The introduction of funding from the National Spread Programme project enabled the development of new ways of working for pharmacists, technicians and dispensing assistants in a Crisis Resolution Service (Huddersfield site). Changes to service users' treatment with medicines was just one area of improvement among the many improvements achieved during the time of the project.
- A training package was devised to support medicines error reporting in Pennine Care Trust NHS Trust. The pilot ran for 12 months, and the training package was delivered to many clinical staff.
- At Merseycare NHS Trust they have introduced a medicines management competence-based training package for nursing assistants. The training package was developed using a multidisciplinary approach, and consisted of a PowerPoint presentation, practice-based assessments and a short questionnaire. So far, over 100 nursing assistants have benefited from the training delivered by the three pharmacists and two nurses.
- The purpose of this project was to introduce a pharmacy drug-monitoring service in Leeds Mental Health Trust. Pharmacists led this new service, with pharmacists making referrals for blood tests, pharmacy technicians taking blood, and pharmacists then checking the results and contacting the doctor if any abnormalities were detected.
- The two main areas of change in Derbyshire Mental Health Trust have been:
  - the development of a medication package to be issued to service users at the point of discharge; and
  - counselling was provided to service users during their stay in hospital.

- South West Dorset Primary Care Trust focused on providing and improving information on depression and its treatments directly to service users and their carers in the prison environment.

## Recommendations

**7.7.12** The Spread Programme demonstrated a wide range of potential impacts on service user care and treatment that can be achieved by the various grades of pharmacy staff, as well as the potential impact of NWW. Larger, well-funded projects should be undertaken to evaluate the full worth of those that show the greatest impact.

**7.7.13** Most MHTs need to develop a pharmacy strategy with a clear developmental programme that ensures increased staffing and service provision over a 3–5-year period. Part of that strategy needs to include developmental posts, such as pre-registration pharmacist, student pharmacy technician and trainee pharmacy assistant positions, and to make sure they are safeguarded in times of financial hardship. Local solutions are urgently required to increase the number of pharmacy technicians and develop their role.

## Summary

**7.7.14** NWW initiatives have identified pharmacy staff as being one of the groups of staff that can develop new roles.

**7.7.15** This can occur in three ways:

- development of the roles of staff working within pharmacy so as to release the time of pharmacists and pharmacy technicians to develop improved services to users;
- development of the roles of pharmacy staff so as to release time of other mental healthcare professionals and improve services to users; and
- development of other staff to undertake work related to the management of medicines.

**7.7.16** However, for most MHTs, the pharmacy workforce is too small to provide effective medicines-related services to service users and new ways of working.

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## Chapter 8

### New Ways of Working for Primary Care in Mental Health

- 7.8.1** The primary care sub-group aims to guide commissioners and providers in the redesign of primary care mental health services and roles in the context of an NHS in transformation. This ongoing change provides significant challenges to primary care mental health (PCMH), but also opportunities for developing functions and roles critical to the success of the whole 'primary care-led commissioning' and 'care closer to home' agendas. The sub-group included practitioners and managers from primary and secondary care, and from diverse professional groups. It considered evidence from generalists and specialists across the age range to develop guidance complementing other initiatives – the introduction of Quality and Outcomes Framework indicators for mental health, the increasing access to the psychological therapies work stream and guidance from the primary care mental health programme of NIMHE/CSIP.
- 7.8.2** This summary first re-examines the clinical typologies of people presenting to the primary care workforce and its practitioners, then looks at the critical values for PCMH. It outlines three themes, and provides examples of how excellent primary care mental health can be delivered through new roles in the workforce. It includes practical guidance on how practitioners from primary and specialist care can effectively and safely work together.

#### The scope of mental health problems in primary care

- 7.8.3** Primary care mental health is often characterised as the realm of common mental health problems. It also lies at three critical interfaces: 1) between the lay and medical worlds; 2) between primary care and specialists; and 3) between physical and mental healthcare. Problems presenting as a challenge to the workforce in primary care range in their severity, complexity and co-morbidity and chronicity; and across the lifespan. With this in mind, we propose that the workforce needs the skills, knowledge, attitudes and competences that reflect the following range of clinical typologies:
- **Common mental health problems:** Short-lived distress related to life situation, low-grade ongoing mood and anxiety symptoms, through to diagnosable episodes of depression, anxiety or other psychiatric problems.
  - **Mental health problems associated with physical health:** Health anxiety; distress related to recent physical investigation or diagnosis; medically unexplained physical symptoms; mental health problems resulting from long-term physical health problems.
  - **Long-standing complex non-psychotic mental health problems,** such as recurrent depression, often associated with psychiatric and physical co-morbidity, recurrent self-harm, substance misuse, homelessness and unemployment.

- **People with psychosis:** new and recurrent episodes, ongoing disability, social exclusion and physical illness.
- **Those with cognitive impairment:** dementia, learning difficulties or developmental and organic disorders.

### The essential characteristics of primary care

**7.8.4** The following characteristics are important to understand when considering NWW, as they provide the building blocks on which new systems of care, new roles and new skills are developed:

- **High-volume throughput and rapid point of access to healthcare:**
  - access that is timely, acceptable, and available 24 hours a day;
  - engages, sorts, holds, treats and signposts large numbers.
- **Undifferentiated symptoms and tolerance of diagnostic uncertainty:**
  - early stage of presentation when a diagnosis is uncertain;
  - the problems of the mind and body are intertwined;
  - levels of distress or symptoms that are an understandable response to life events.
- **Continuing care over time:**
  - providing proactive health promotion over decades;
  - chronic disease management for long-term conditions;
  - care for whole families over time.

### Values for primary care mental health

**7.8.5** Primary care and mental health services each have sets of values underpinning care. The following is an amalgam – a set of values embodied in the examples of good practice from around the country:

- **Recovery and social inclusion**  
While promotion of recovery and working towards inclusion in mainstream society (having meaningful work and relationships, and participating in creative activities) are now accepted values for mental health, they are relatively new as explicit aims for primary care practitioners. However, they build on the related values of holistic and patient-centred practice held by many GPs and other primary care staff, and can complement more medically oriented functions of diagnosis and treatment allocation. Generalists in primary care can help people

to understand that distress may be normal and does not imply pathology. They can orient consultations around individuals' strengths and social aspirations.

- **Choice of treatment**

The last ten years have seen an expansion in the range of psychological, social and educational options advocated in primary care for people with mental health problems. As these modalities become mainstream for people of all ages, then working with individuals as partners to choose the most appropriate, accessible and desirable management option will need to be embedded in new systems of care for people with different problems.

- **Care closest to home**

GPs and community nurses have long had a philosophy of caring for people at home. Practice-based commissioning provides incentives for an increased involvement of primary care among those with complex mental health needs within the community. Care closest to home also suggests the critical importance of working with families and other partners in care, as well as with the resources of the individual patient.

- **Working and learning together**

By working together, we will have something to learn from each other: patients and practitioners; specialists and generalists. By welcoming specialists into primary care, generalist practitioners will become more skilled, willing and able to support people with mental health problems to become independent. Conversely, primary care skills can be utilised within a specialist setting. This also includes the critical new notion of working with patients as self-carers and as experts through experience.

### **Three themes to underpin New Ways of Working for the primary care mental health workforce**

**7.8.6** By considering the clinical typologies and the key values set out above, and by building on the essential characteristics of primary care, we developed three themes: ensuring high-volume and rapid access to the most appropriate care; breaking down the mind–body divide; and developing proactive care where it counts.

- **1. Ensuring high-volume and rapid access to the most appropriate level of care**

Timely access to a wide range of psychosocial interventions is possible via the primary healthcare team for a range of conditions and at all ages. This requires both excellent consultation skills and adaptable and resourced care pathways. Generalists require skills to handle the emotional presentation – to help people understand or accept distress, or to discuss possible onward referral. Although



a diagnosis of, for example, depression is valuable to some individuals, others may be set on the path to recovery through acknowledgement of distress and prompt access to non-stigmatising care.

Stepped care provides a framework for allocating the intensity of intervention according to need. By promoting choice and open access, and trusting patients to define their ongoing care needs, LIFT – Least Intervention First Time – embodies a philosophy that builds on strengths and avoids dependence. As well as needing investment in a range of services, stepped care requires new skills and systems of supervision for both generalist and specialist practitioners in primary care. This is particularly important if primary care generalists and specialists are to work together to provide the range of psychosocial interventions required for those with complex, recurrent non-psychotic conditions.

The Improving Access to Psychological Therapies programme incorporates many of these concepts. See the documents *Designing Primary Care Mental Health Services and Skills For New Workers* from the CSIP/NIMHE *Improving Primary Care Mental Health Services – A Practical Guide*, available at [www.csip.org.uk/resources/publications/primary-care.html](http://www.csip.org.uk/resources/publications/primary-care.html). These provide detailed guidance on how to tailor systems and the skill mix to population needs.

**Box 1**

**Walsall Primary Care Mental Health Trust** is moving away from utilising a secondary care model of mental health service delivery towards a robust primary care mental health service, grounded in the strengths of primary care.

Walsall has placed its most senior clinicians within frontline primary care; they have been trained in brief assessment techniques (risk and triage) to enable 20–30-minute initial consultations. Outcomes include:

- increased numbers of people that can be seen;
- reduction in waiting times and in the number of non-attenders;
- faster access for first appointment, in a less stigmatising setting;
- early diagnosis and treatment;
- links with specialist mental health services;
- education and training of the primary care team, e.g. GPs, midwives and health visitors;
- a liaison role between primary and secondary care to discuss cases; and
- assistance for the primary care team with development and maintenance of severe mental illness registers to meet the Quality and Outcomes Framework (QOF).

- **2. Breaking down the mind–body divide**

Increasing importance is being given to the mental health of people with long-term physical problems, understanding the psychological needs of those with medically unexplained symptoms, and ensuring that those with severe and enduring mental health problems receive excellent physical healthcare. Given this trend, primary care remains in an excellent position to promote the integration of care for mind, body and emotion.

Practice-based commissioning provides incentives for **improving psychosocial care for people with long-term physical conditions**. Such initiatives may improve people’s ability to self-manage illnesses, such as diabetes, and may help prevent unscheduled admissions. They will require practice and district nurses to acquire new mental health roles and skills, and will provide opportunities for occupational therapists, with their dual training, to become core members of primary healthcare teams.

**Improving physical care for those with psychosis and other mental health disabilities** has been tackled head on by the Disability Rights Commission

(DRC) and its Doing the Duty campaign. For more information, visit the DRC website: [www.drc-gb.org](http://www.drc-gb.org)

PCTs have a duty to actively prevent ‘diagnostic overshadowing’ and to ensure that those disabled by mental health problems and learning disability have their physical health needs met. This will require closer co-operation and better communication between generalist and specialist teams, particularly around the QOF and CPA systems.

### Box 2

**Devon PCT: Wellness Recovery Action Planning (WRAP)** is a preventative approach for managing stress and maintaining well-being which can be used as an advance directive. This approach is embedded throughout the mental health voluntary and statutory sectors in Devon, and a version more suitable for use in primary care has been developed. Training courses for primary care staff have begun to address how WRAP can support self-management for people with long-term physical health conditions, and promote mental health recovery approaches in primary care.

**Plymouth PCT: A Well-being Network** to enhance opportunities for people with long-term mental health problems has been established in North West Plymouth. It aims to improve well-being with one-off events and increased signposting to existing opportunities for increased exercise, healthy eating, creative leisure and smoking cessation. Patients involved with three voluntary organisations, two primary care liaison teams and local general practices are involved. The main changes for service users include: experiencing new forms of exercise, eating new foods, being invited to attend new groups, contributing to mutual help, being involved in planning and evaluation, and having practice nurses do physical checks in the community settings.

**People with medically unexplained symptoms** are over-represented in out-patient clinics and on investigation waiting lists. Best practice requires GPs and specialist physicians to:

- attend to people’s concerns, beliefs and expectations;
- act consistently; and
- engage with individuals’ psychosocial worlds.

Mental health specialists can help the most difficult cases.

- **3. Developing proactive care for long-term mental health conditions in primary care**

While general practice has a long tradition of providing ongoing care, the inputs have often been reactive rather than proactive in nature. Practice-based commissioning and payment by results will provide the incentives for bringing care closer to home for people with dementia, long-term physical conditions, psychosis, learning difficulties, and also the heterogeneous group of people with severe and enduring mental health problems caused by recurrent depression, ongoing anxiety and other co-morbidities. The QOF in general practice provides a foundation of incentives for all but the last of these groups. However, there is relatively little specificity within these mental health domains of the new contract; the emphasis is primarily on medical care, and values such as recovery and promoting social inclusion are not addressed.

Practice-based commissioning will encourage practices to extend systems of chronic disease management. Systems of recall and review, specialist liaison and information for patients will be developed. Initially, until proved cost effective, models of care (such as WRAP) that build on strengths and promote recovery will need to be promoted locally through service user influence, local contracting strategies and professional pride in best practice.

It is this last area of proactive care where specialists and generalists will have to start working together most effectively. The previous New Ways of Working Report outlined a series of mechanisms for joint working, many of which involved working and learning together through discussing cases and designing the detail of local services alongside user experts.

**Box 3**

**Northampton:** Proactive interface working for perinatal mental health.

An integrated care pathway for perinatal mental health provides a proactive structure and support for the early intervention required to predict and detect mental disorder and/or mental distress. For perinatal mental health, the delivery of a stepped-care approach in primary care involves the initial engagement of new cases and mothers at high risk by well-established, skilled primary care workers (health visitors, community nurses, GPs and midwives) with a generic set of competences that allows them to deliver low-intensity psychological treatments. The more severe cases are referred on to specialists, who share care and offer support, training and advice to primary care workers.

To support new ways of working in primary care, some important practical issues need to be considered, and the next section begins to explore these.

## Practical guidance on roles and responsibilities at the interface

**7.8.7** This section provides a summary of the guidance available to support those professionals who are being asked to carry out new roles at the interface, and enable them to complete these roles in a high-quality, safe and defensible way. The sub-group responsible for this piece of work included representation from different professions, unions, defence bodies, the Department of Health and Royal Colleges. As traditional boundaries between professionals, and between primary and specialist care, are broken down, the notion of **medical responsibility** is transformed into **sharing responsibilities between practitioners and patients or service users**.

- **Providing advice about a patient or service user you have not seen.** This occurs frequently when primary care clinicians ask for advice from specialists, and occasionally it happens in reverse. The following principles should be adhered to.
  - The person giving advice should ask for sufficient information about the clinical case and record this. A record should be kept of the problem and the advice given, including the date and a patient identifier as an absolute minimum for defensible practice.
  - Best practice would indicate that, for telephone advice, the information should be provided in writing, so that it can be incorporated into primary care or other records.
  - Email advice provides a useful audit trail, but needs to be incorporated into primary care records.
- **Advice for clinicians working within another team.** Increasingly, clinicians are appropriately asked to work alongside other teams in order to provide co-ordinated and multidisciplinary care. For example, community psychiatric nurses, social workers and occupational therapists may be asked to take on the role of a link worker and provide advice and shared care for people with long-term problems. The following principles and guidance have been developed.
  - It is good practice for clinicians working for other organisations to provide care within a primary care setting.
  - Responsibilities for the care being provided should be documented in an agreement between the two teams.

- It is considered good practice for linked workers, doing assessments or engaged in shared care, to make the principal recording of records into the notes of the team they are working with, rather than their own team's notes. Some may wish to keep supplementary records or copies of records for their own or for their organisation's use. This was not considered essential practice.
- Agreement for retrieval of records made by practitioners outside the organisation they are working in should not be a problem, as medical records are NHS property rather than belonging to primary care or the specialist Trust.
- **Chronic disease management and shared care.** The co-ordinating function for chronic disease management may well be located within primary care and might be the joint responsibility of administrators in primary care and clinicians either from primary care or from linked organisations.
  - It is essential to record the responsibilities for components of care in terms of which team and which professional are responsible for carrying these out. This is particularly critical for the various sub-components of care with respect to lithium, depot injections and clozapine treatment.
  - In shared care, both primary and secondary care records should include all oral/parenteral medication (not just psychotropic) and significant diagnoses in order to prevent interaction errors and prescribing against contraindications.

Joint working within CPA and other care navigator functions (e.g. QOF) should ensure proportionate engagement of all involved in the care of individuals with complex needs. Invitations to attend lengthy CPA meetings or case conferences may not be the most appropriate way of engaging others. Alternative mechanisms, such as requesting key information to be sent to care co-ordinators or having verbal discussions prior to CPA meetings, is considered best practice when liaising with those unlikely to attend.

While the contents of this chapter are in many ways aspirational, and we recognise the very real problems for commissioners, managers and practitioners, the examples are from real services. Further explanation and examples will be given in a more detailed report to be produced by the primary care sub-group, which will be available in summer 2007. It is anticipated that NWW, the IAPT and CSIP primary care programmes will work together in the future to support implementation of this agenda.

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## Chapter 9

### New Ways of Working for Psychiatry

#### Aims and objectives

**7.9.1** The NWW for Psychiatrists sub-group has continued to meet every two months since the publication of the Final Report in 2005. It is an advisory group with multidisciplinary and service user and carer representation, co-chaired by Professor Richard Williams (Royal College of Psychiatrists), Dr Christine Vize and Dr Steve Humphries, Associate Directors for NWW.

**7.9.2** The objectives of the group through 2006 have been:

- to promote wider awareness of NWW nationally;
- to gather data on the extent of uptake of NWW;
- to widen the consideration of NWW, which had been mostly concentrated on adult services and consultants;
- to undertake particular pieces of work with a view to producing guidance and advice;
- to contribute to the work of other groups, including the identification of common emerging themes to form the basis of the next phase of multidisciplinary work; and
- to make the appropriate links with other agencies and work streams.

#### Promoting awareness of NWW

**7.9.3** Members of the group have participated in, led and organised a variety of events across the country, with regions, Royal College divisions and individual Trusts. These have raised awareness of the principles of NWW and provided opportunities to explore local examples, progress and difficulties, and have also fostered links between teams developing the same approaches in different areas of the country. They have contributed to a DVD about NWW, and a presentation template and supporting material have been produced, with a version aimed at service users and carers to inform them about what NWW means for them. The chairs of the group have met with Louis Appleby, National Director for Mental Health; Hugh Griffiths, Deputy National Director for Mental Health; and the President and Dean of the Royal College of Psychiatrists. The chairs have responded to a wide range of requests for information, articles, etc., and are involved in developing the NWW website.

## Gathering data on NWW

**7.9.4** The group contributed to the development of a questionnaire that has been sent to all Trusts in England, asking questions about NWW in general and in relation to psychiatrists. The results are reported elsewhere. In addition, the CSIP development centre workforce leads and lead psychiatrists have reported back on work in their regions and organisations. Common difficulties that have emerged have informed the development of specific projects. The chairs have linked with the workforce leads in the NIMHE regions to monitor progress.

### Practice example

An NWW peer review was undertaken at the request of Suffolk Partnership Trust. This involved one of the Associate Directors for NWW, the regional workforce lead, a service user representative, and a senior clinical leader from a neighbouring Trust undertaking a day-long visit to the Trust and meeting staff, service users and managers. It culminated in a feedback session for executive and senior staff and the production of a report.

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## Widening the scope of NWW

**7.9.5** The principles of NWW apply to all services, but many well-known examples have come from adult services. The group has, therefore, discussed the particular relevance of NWW to old age, child and adolescent and forensic psychiatry.

**7.9.6** A briefing paper was produced after discussion with the College Trainees Committee about NWW for trainees, both in their training and as the consultants of the future. There is concern among trainees about two main issues: whether their training, both before and after the introduction of Modernising Medical Careers, equips them to be an NWW consultant, and the potential for erosion of their service role while training, due to the advent of enhanced roles for other professions, which can now undertake many of the psychiatric trainees' 'traditional' tasks. The Trainees Committee now has a representative on the group and is developing the agenda for NWW for trainees, and its concerns are being listened to by the Royal College of Psychiatrists.



**Practice example**

Chris Ball, a consultant in old age psychiatry, gave a presentation to the group on an NWW project in Lewisham, South London, where he has developed an in-patient consultant role for an older adult ward. The results are very encouraging, similar in many ways to the gains seen in adult units that have adopted this model and have been reported previously. However, of particular note is that the number of slips, trips and falls fell significantly, indicating that better team working was resulting in better assessment of risk and implementation of preventative measures. Sickness levels among staff also fell, indicating a benefit for staff morale.

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**New Ways of Working and psychiatric trainees**

**7.9.7** The structure and content of postgraduate psychiatric training is undergoing a complete overhaul, with the implementation of Modernising Medical Careers (MMC) and the Royal College of Psychiatrists' new Postgraduate Medical Education and Training Board (PMETB)-approved competence-based curriculum. Trainees' overall clinical experience has also recently changed, following the reduction in working hours to comply with the European Working Time Directive and the introduction of specialist teams via the National Service Framework. Independently, but simultaneously, the working practices of consultant psychiatrists are being reviewed under the aegis of the NWW initiative. The concurrent nature of these two separate changes presents all those charged with development of medical practices within psychiatry with a distinctive opportunity to work together to develop a seamless system that trains new MMC/PMETB trainees today to be 'fit-for-purpose' NWW consultants tomorrow.

**7.9.8** The implementation of NWW for consultants has two major implications for trainees. Firstly, the role for which trainees are training will be different in the future. This will require a regular review of the new curriculum to ensure that training is in line with service, particularly in areas such as management, leadership and supervision of colleagues. Secondly, as we move away from the traditional consultant role, we need to consider mechanisms to retain the broad range of experience required by trainees in order for them to become NWW consultant psychiatrists competent in dealing with the most difficult and complex cases and providing supervision to other multidisciplinary colleagues.

**7.9.9** The role of trainees within a team should be clearly defined alongside the evolving role of the consultant psychiatrist at the time of local service reorganisation. This

process should involve all stakeholders, including the consultant, the college tutor, trainees and other team members, and the following should be considered:

- Working in partnership with service users, carers and other professionals should be emphasised throughout training.
- At a junior level of training, 'routine work' is a necessary part of the training experience. Without learning how to assess, formulate, investigate and manage 'simple' cases, it is impossible to learn how to manage 'complex' ones.
- Trainees should be more involved in more multidisciplinary assessments and follow-up, with an increasing supervisory role as their level of experience increases. Frontline assessment and supervisory management of out-of-hours/emergency clinical presentations should be encouraged, depending on the trainee's level of experience.
- As other members of the team take on some of the tasks traditionally performed by consultants, some of the NWW consultant's time should be utilised to revive and promote the traditional apprentice model, with emphasis on both the management of complex clinical cases and the supervision of multidisciplinary colleagues in managing such cases.
- Individual training posts should be allocated to trainees to ensure that, upon completion of training, they have gained the necessary clinical and technical skills to work as a consultant psychiatrist.
- Taking on the role of the care co-ordinator would be a valuable training experience at a higher level of training (ST4–6).

**7.9.10** The Psychiatric Trainees Committee of the Royal College of Psychiatrists will:

- take a lead in raising awareness of NWW with trainees and trainers;
- work with the National Steering Group to integrate trainees' issues more fully with the entire NWW agenda; and
- work with the associate directors for NWW and the college to develop the training curriculum.

**Contact:** Amit Malik, Chair, Psychiatric Trainees Committee, at [doctmalik@hotmail.com](mailto:doctmalik@hotmail.com)

## Products

- Guidance on the management of medical vacancies and the use of locums has been produced in collaboration with the Medical Directors network.

- The group advised on the development of a successful bid for two Trusts to become pilots for ‘Team Working Handover and Escalation – Working Time Directive 2009’, and these projects are now under way.
- A paper on the use of Section 5(2) was submitted to the Mental Health Bill team, and its conclusions accepted, resulting in a proposal to allow Responsible Clinicians to use Section 5(2).
- An evaluation of the proposed new psychiatric training curriculum with respect to NWW has been produced and submitted to the Dean of the Royal College of Psychiatrists.
- A paper was produced identifying where the requirements for data collection were at odds with NWW and distributed responsibility, and anomalies are being rectified.
- Reference to NWW has been incorporated into the Care Programme Approach (CPA) review consultation document. A paper on CPA-related issues has been produced and submitted for the consultation.
- Guidance has been produced on working with the coroner. Some collaboration with coroners has been achieved over this. Thus far, it has fallen short of a joint document, but further work with the Coroners Society for England and Wales will be pursued in relation to new roles proposed in the Mental Health Bill.
- A working party on complexity has been established, chaired jointly by Dr Christine Vize and Felix Davies, representing the British Psychological Society.
- The group has debated and responded to the national consultation on the CPA.
- Work has been carried out with the Healthcare Commission to incorporate questions about NWW into the staff survey for 2008.
- Vignettes have been produced about psychiatrists developing NWW, as well as a ‘diary of a modern psychiatrist’.
- A ‘Frequently Asked Questions’ document has been created.
- An NWW-friendly version of the diary has been used in consultant job planning.

### **Contribution to the work of other groups**

**7.9.11** Members of the group have contributed to the work undertaken by psychologists, pharmacists, primary care, nursing, and the acute in-patient project group, which is reported elsewhere. The group has identified areas of work it wishes to pursue that have cross-cutting themes, elaborated elsewhere, and members have started to participate in groups working on leadership and non-medical prescribing.

## Joining up the NWW agenda

**7.9.12** The chairs of the group have met with Department of Health and CSIP partners about:

- payment by results in mental health;
- productive time;
- mental health Foundation Trusts;
- the Mental Health Bill; and
- homicide inquiries.

The chairs have been co-opted onto the executive of the newly established Royal College of Psychiatrists Medical Directors network, the CPA review Steering Group, and the Department of Health-funded national evaluation of NWW that is being undertaken by Newcastle University.

## Key conclusions from the work of the group

- We have many examples of successful NWW across the country. However, development is still patchy both within organisations and across Strategic Health Authorities. NWW is about cultural and attitudinal change, not about endorsing a particular service model, and as such it will take time to achieve.
- There must be a way for organisations and individuals to access, and contribute to, the growing data base on NWW. NWW is about using skills to maximum effect; reinventing wheels does not do that.
- Moving towards Foundation Trust status and sustaining financial balance are likely to be the top priorities for most Mental Health Trusts in 2007. It is essential that NWW is seen as part of these agendas, not a distraction from them. Foundation Trust status offers a wealth of creative opportunities for new partnerships and ways of working.
- We need to involve commissioners more in understanding and developing NWW.
- Education and training are vital in producing a skilled and adaptable workforce that can work for the benefit of the 21st-century service user and carer, and the resources to provide them must be protected.

## Next steps

- Members of the group will work with colleagues to develop the cross-cutting themes that the professional groups have identified as needing further work.
- Working with Medical Directors to develop their role as champions for NWW in their organisations, linking the NWW agenda with the strategic direction and objectives of their Trusts.
- Continuing work at all levels to increase knowledge about NWW and empower staff to work in collaboration with service users and carers to achieve it. The NWW website will be an important tool in this regard.
- Work with the Royal College on NWW for trainees, and equipping them for NWW consultant roles.
- Getting NWW principles emphasised in the revised policy and guidance for the CPA following the national consultation.

### **Contact details for chairs of the NWW for Psychiatrists sub-group:**

Professor Richard Williams at [Rjwilli@glam.ac.uk](mailto:Rjwilli@glam.ac.uk)

Dr Christine Vize at [christine.vize@awp.nhs.uk](mailto:christine.vize@awp.nhs.uk)

Dr Steve Humphries at [stephen.humphries@tney.northy.nhs.uk](mailto:stephen.humphries@tney.northy.nhs.uk)

## Chapter 10

### New Ways of Working for Social Workers (NWW4SW)

#### Aim of the programme

**7.10.1** The aim of this programme is to take forward the ‘Continuing Story’, as set out on page 56 of the NWW Final Report of October 2005 – i.e. ‘To raise the profile of the future contribution of social workers to mental health services’ by:

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

#### Progress on the ‘Continuing Story’

**7.10.2** All four objectives set out in the ‘Continuing Story’ have been met. A discussion paper was produced and distributed in November 2005; regional and local events subsequently took place to help formulate responses; a report on the 103 responses was produced in March 2006; a national conference, comprising 176 delegates, was held in April 2006; and a programme of work was established in May 2006.

#### Programme of work

**7.10.3** Following both the discussion paper and the national conference, four key areas for development emerged around **social work identity**; **social work research**; **career pathway/progression**; and **leadership** to include education and training. A summary of the progress on each of these elements is set out below. Further details and information are available in the NWW4SW Portfolio of Evidence, located on the Social Perspectives Network (SPN) website at [www.spn.org.uk](http://www.spn.org.uk)

#### Social work identity

**7.10.4** On pages 87–91 of the Appendices to the NWW Final Report of October 2005, there is a statement about the traditional expectations, modern aspirations and distinctive contributions of the Mental Health Social Worker and Approved Social Worker (ASW). Essentially, this says that the traditional expectations have been to empower service users and carers through a range of value-based and evidence-based interventions within a social model and understanding of mental distress, emphasising choice, human dignity and worth, equality, respect and social justice, grounded in anti-oppressive practice. A copy of the full statement can be found at [www.spn.org.uk](http://www.spn.org.uk)

**7.10.5** The NWW4SW consultation process has further raised the identity of social workers as a key issue, particularly in respect of those who are employed or seconded to NHS Trusts. Although they may be part of a particular mental health team, they often feel that they are professionally isolated, that their contribution is not valued, that they are not receiving effective, professional supervision, and that they are under enormous pressure, etc.

**7.10.6** The lack of job satisfaction, a feeling of not being valued and of 'burnout', was highlighted in research undertaken by Peter Huxley *et al.* and reported in the *Journal of Psychiatry* in 2006. A copy of the article can be found at [www.spn.org.uk](http://www.spn.org.uk)

**7.10.7** In an attempt to address this feeling of isolation, an article was placed in *Community Care* magazine in July 2006 that said:

'social work brings something distinctive to mental health. Articulating it is more difficult. It is a constellation of values, commitment to social justice and partnership with users and carers. Social workers practised social inclusion before the term had been invented. Above all in mental health, it challenges the traditional medical model which does not fully acknowledge the patient or client as best informed about their needs.'

A copy of both the text that was published and the longer draft submitted for publication can be found at [www.spn.org.uk](http://www.spn.org.uk)

**7.10.8** In addition, the NWW4SW programme has now produced a one-page statement, aimed primarily at NHS staff, that clearly articulates the role and values of a social worker and the unique contribution social workers can make to the delivery of mental health services. A copy of the statement can be found at [www.spn.org.uk](http://www.spn.org.uk) This will need to be reviewed in the light of the work being led by the General Social Care Council (GSCC) to describe the roles and tasks of social work as part of the Options for Excellence review.<sup>27</sup>

**7.10.9** In terms of social work identity, one of the future challenges is around the proposed introduction of the Approved Mental Health Professional (AMHP) under the Mental Health Bill. Although the formal designation of the ASW will be replaced, social workers will have a critical influence in ensuring that the practice competence of AMHPs embraces and actively promotes the independent nature of the role.

**7.10.10** Social workers are also well placed to function as Responsible Clinicians, particularly given their current experiences in the role of social supervisor. Social workers will need to be proactive in seeking opportunities to train and practise in this new role.

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<sup>27</sup> DH/DfES (2006): *Options for Excellence – Building the Social Care Workforce of the Future*.

## Social work research

**7.10.11** Although this element of the NWW4SW programme did not feature in the discussion paper, it emerged strongly at the April 2006 conference. Delegates felt that, unlike other professions, such as doctors, there was neither the expectation that social workers should conduct research nor was there any specific mention of this in job descriptions, so no time was set aside for social workers to undertake research. In addition, where there is a very clear steer for the NHS to focus on evidence-based practice, underpinned by effective research, there was no parallel in the social care/work field.

- The Social Care Institute for Excellence (SCIE) and the NWW sub-group have jointly commissioned a research briefing on the evidence base of mental health social work, which is available at [www.scie.org.uk](http://www.scie.org.uk)
- In 2006, SCIE carried out a consultation exercise about strengthening social care research. The key findings were that each country in the UK should develop its own structures, supported by a UK-wide co-ordinating body with the role of ensuring that research priorities are complementary and of addressing generic infrastructure issues. Further information can be found at [www.spn.org.uk](http://www.spn.org.uk)
- Work is taking place to ensure that social work/social care links into the Department of Health strategy *Best Research for Best Health* and the new National Institute for Health Research.
- SPN/NIMHE/SCIE have published guidance on *Values and Methodologies for Social Research in Mental Health* that sets out a foundation for social research, ensuring that it fits better with their values, aspirations and concerns. This has been widely disseminated across the social care community and is available from [www.spn.org.uk/publications](http://www.spn.org.uk/publications)
- In partnership with the NWW for primary care, the NWW4SW sub-group is leading on piloting and evaluating a new role of Individual Peer Supporters. The Peer Supporters are people in recovery who, within the context of the principles of social inclusion, support others who are experiencing mental distress. The report of the outcomes of this project can be found at [www.spn.org.uk](http://www.spn.org.uk)

## Career pathway/progression to include education and training

**7.10.12** Unlike some other professions, there is no nationally agreed career progression or pathway for social workers, although the Post-Qualifying (PQ) Framework goes some way to provide a structure. Whether and how social workers move along their pay band depends upon their qualifications, experience and applications for specific posts. Some social workers are regarded as 'senior social workers' but there are no agreed criteria for this or specific timescales. The most common form of career progression is for social workers to become ASWs under the Mental Health Act 1983,



which attracts a higher status and salary/increments, or to move into a team leader/management role. A move into management is not a bad thing by itself, of course, as NHS Trusts should have a mix of health and social care practitioners at senior level.

**7.10.13** Following on from the responses to the discussion paper, a potential career pathway has emerged, specifically: Social Worker; Senior Social Work Practitioner/Professional Lead; Team Manager; Social Care Lead or Locality Manager; and Head of Social Work/Social Work Consultant. (The job titles can vary from locality to locality, but the purpose and duties may be broadly similar.) Social workers would like more flexibility to combine roles, such as joint appointments, that retain a practice element but that also include, for example, lecturing, research and professional development. Further details, including local Trust contact points, can be found at [www.spn.org.uk](http://www.spn.org.uk)

**7.10.14** For those social workers who are employed by NHS Trusts and are subject to the Agenda for Change process, national profiles exist, showing social workers to be in Band 6; social worker specialists in Band 7; and social work locality/service managers in Band 8. Further details are available at [www.nhsemployers.org/pay-conditions/pay-conditions-1993.cfm](http://www.nhsemployers.org/pay-conditions/pay-conditions-1993.cfm)

**7.10.15** Skills for Care is developing a Career Framework for Social Care to apply across the whole of social care, not just social workers. The current position is described earlier.

**Contact:** Amanda Hatton at [amanda.hatton@skillsforcare.org.uk](mailto:amanda.hatton@skillsforcare.org.uk)

**7.10.16** Mental health is one of the compulsory elements in the three-year social work degree. It is recommended that further work be undertaken by NWW4SW in conjunction with CSIP/SCIE/Department of Health/GSCC to determine what level of knowledge and skills is actually being delivered within the mental health component of the social work degree and how this is being applied in the workplace.

## Leadership

**7.10.17** It is clear from both the discussion paper and the April 2006 conference that there is a lack of clarity about the leadership expectations and/or requirements of social workers. Leadership needs to be sustained and developed in order to deliver the priority outcomes of social care within mental health services and to support the development of a confident, competent and integrated social care workforce. The following actions have been taken to help with this process:

- The disparate representation and leadership of social work/care has been highlighted: there has been a variety of organisations working in this field, but no single voice or forum. Accordingly, the NWW4SW programme has set up

a Social Work and Social Care Forum, whose first meeting was held on 18 January 2007. The aim was to provide an opportunity for the main social care organisations to discuss areas of common interest and for this meeting, to hear about the NWW4SW programme. The key conclusions were that a Forum would be established to include social work and social care that would continue to promote ASW/AMHP values based on effective learning and development as a form of Advanced Practitioner role that would also embrace the proposed new role of Responsible Clinician. In the future, the Forum would discuss the recommendations made by the NWW4SW sub-group thus helping to support this work and it might also help to influence the development of a research capacity in social work where there is little support and funds at present. The draft terms of reference for the forum can be found at [www.spn.org.uk](http://www.spn.org.uk)

- The GSCC has set out its PQ Framework at three levels – specialist, higher specialist and advanced. This can be found at [www.gsc.org.uk](http://www.gsc.org.uk) With the exception of programmes for managers of registered services offered at specialist level, leadership and management programmes must meet all the requirements for the higher specialist or advanced levels of the PQ Framework. It is recommended that all social workers in a management or leadership role undertake training to meet the requirement of the higher specialist or advanced levels of the PQ Framework.
- The Eastern Development Centre for CSIP co-ordinated a survey of the views of social care leaders working in one-third (25) of the mental health and social care Trusts throughout England. The survey asked two overarching questions:
  - What are the main roles and structures within integrated services to support social care and social work?
  - What might constitute best practice in relation to delivering social care outcomes, supporting social workers, and bringing the best social care leadership practice and culture to enhanced, integrated services?

Having analysed the findings of the survey, it was felt that the following recommendations should be made:

- **explicit representation of social care interests** in decision-making processes throughout the organisation, up to board level;
- **strong, ongoing local authority engagement** in mental health issues where the Trust is leading on delivery of social care;
- **proper resourcing of the social care management and leadership tasks** that are required to deliver integrated social care outcomes and support social work and social care staff;

- **enabling social work and social care staff** to prepare for, take on and sustain diverse leadership roles throughout trusts;
- **enabling social care staff** to influence positively the culture and value bases of Trusts;
- **ensure excellent ongoing leadership of the technicalities of integration;** e.g. HR, IT, finance, performance, learning and development; and
- **develop a confident social care workforce** that can deliver and promote social care and social inclusion outcomes.

Full details of the survey can be found at [www.spn.org.uk](http://www.spn.org.uk) and on the Eastern CSIP website at [www.eastern.csip.org.uk](http://www.eastern.csip.org.uk)

- TOPSS England (Training Organisation for Personal Social Services) produced a leadership and management pack that includes a main strategy report, supported by a number of products including a ‘whole-systems’ model, a set of standards, signposting links, continuing professional development and organisational evaluation. A copy of the pack is available from SCIE.
- SCIE and the National Social Inclusion Programme held a symposium on Social Care Leadership in Mental Health Trusts in March 2007. The key theme focused on improving the ways in which local authorities and Mental Health Trusts link to lead the delivery of socially inclusive outcomes for mental health service users. A full report on the outcomes of the conference can be found at [www.scie.org.uk](http://www.scie.org.uk)

## Summary

**7.10.18** Social work and social workers are important. Social work makes an important contribution to mental health services and is a crucial component in their development. Social work values, skills and knowledge already encompass the approach set out in current government policy documents. These all emphasise the need for service users to participate actively in their care. Social workers have historically sought to work together with service users and their carers in partnership. More than any other profession, their value base is most closely aligned to this approach.

**7.10.19** However, like any other profession, social workers cannot afford to rest on their laurels and stand still. If they do, they will get left behind. In an increasingly rapidly changing world of new demands and pressures, where there is a need for a more flexible and well-trained workforce, it is vital that social workers fully embrace this culture shift and seize fresh opportunities, including NWW. This does not mean they should abandon their highly prized and well-recognised value base – far from it. They should continue to champion both their approach and their cause, but should do so in a positive and outward-looking way.

**7.1020** This report from the NWW4SW sub-group, taken together with the Portfolio of Evidence, clearly sets out the need:

- to maintain and nurture the **social work identity** to help with recruitment;
- to promote the **leadership expectations** of social workers;
- to encourage the expectation among both staff and employers that **research** will form an integral part of future employment arrangements for social workers;
- For employers to put in place a **career pathway or progression** not only to help raise the profile of the social worker profession, but also to help with retention; and
- to actively embrace new opportunities.

**Contact details for chairs of the NWW4SW sub-group:** Jane Shears at [jane.shears@nht.northants.nhs.uk](mailto:jane.shears@nht.northants.nhs.uk) and Terry Bamford at [terry.bamford@scie.org.uk](mailto:terry.bamford@scie.org.uk)

# New Ways of Working for Mental Health Services

## Chapter 11

### New Ways of Working for Child and Adolescent Mental Health Services (CAMHS)

#### Introduction

**7.11.1** Modernising and strengthening the workforce is a central feature in the National Service Framework for Children and *Every Child Matters: Change for Children*. Child mental health problems are common, with 10% of children aged 5–15 years having had a mental disorder. This results in the significant use of a range of health, education and social services (ONS, 2004). The specialist workforce for this group has increased by over 10% every year (DH, 2006) but the absolute number of workers still does not meet the need or demand for services. A range of workforce strategies is, therefore, needed to meet the needs of young people, while making best use of limited resources.

**7.11.2** The National Workforce Programme (NWP), supported by the national CAMHS workforce sub-group, commissioned a project to look at NWW in CAMHS. This builds on previous work within professional groups, but principally on NWW for psychiatrists. The focus of the CAMHS work stream was to look across a range of professional disciplines working with young people, rather than focusing on single-discipline working. Specialist CAMHS provision is often organised on a multidisciplinary, multi-agency basis, and therefore early implementer projects were identified that could build on this structure and help develop working strategies that look to future needs.

#### Aims

**7.11.3** The aims of the project were primarily to promote, support and evaluate NWW within the CAMHS workforce. It was also envisaged that any developments needed a systemic perspective, integrating and linking with other work streams to encourage sustainability.

## Key workforce themes

**7.11.4** A review of workforce issues (Nixon, 2005) identified six key themes for the CAMHS workforce, now incorporated in the recent report on the implementation of standard 9 of the National Service Framework (2006) as a means of ‘Delivering good practice’:

- Commissioners and providing organisations should root workforce design and planning in local service planning and delivery.
- Teams should identify and use creative means to recruit and retain people in the workforce.
- Commissioners and providers should promote NWW across professional boundaries.
- Services should create new roles to tap into a new recruitment pool and so complement existing staff types.
- The workforce should be developed, with up-to-date education and training at both pre- and post-qualification levels.
- Managers should be supported to develop their leadership and change management skills.

## Objectives

1. Develop NWW within an overall workforce strategy.
2. Develop workforce strategies that help deliver CAMHS Public Service Agreement targets, including 24-hour access, services for children and young people with learning disabilities, and adolescent services.
3. NWW to be disseminated to other services and provide appropriate models for a range of services to implement and sustain.

## Work programme

**7.11.5** Expressions of interest were sought across agencies working with child mental health. Forty-six completed applications were received, demonstrating the range of services provided and highlighting the interest in developing different models of working. Ten sites were selected that best met the key objectives, and other projects were offered support through CAMHS regional development workers. The overall work programme cuts across a number of themes. Each project site identified a lead theme.

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Oxford	Common Assessment Framework link to Care Programme Approach
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St Helens	CAMHS learning disability skills for Tier 3 generic CAMHS
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Lincolnshire	CAMHS learning disability Tier 4 service development
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Sussex	Stepped care within Tier 4 in-patient unit, with extended nursing roles
Lancashire	Out-of-hours emergency service and extended opening hours '8 until 8'
Southampton	Attention Deficit Hyperactivity Disorder (ADHD) roles, including nurse prescribing
Derbyshire	Functional teams within workforce remodelling
Staffordshire	Job plans, team roles and team management structures
Stockton	Capacity and demand planning in context of specific role
Surrey	User and carer in service capacity and demand management change

**7.11.6** The programme recognises that many examples of NWW in CAMHS already exist, with many services incorporating the findings identified within the previous reports.

### Next steps

- Distribute detailed information about individual projects to interested parties, as part of a growing database of effective strategies to develop and deliver modern CAMHS services.
- Identify how far NWW have been introduced into CAMHS nationally, and evaluate work done so that changes can be considered in response to further developments – particularly how to move on from an 'early implementer' stage to long-term sustainability, and identify any barriers to implementation.
- Identify what impact NWW could or is having on other areas of universal CAMHS, as part of whole-systems change.

### Avon and Wiltshire Mental Health Partnership Trust

The Trust has produced a summary document that sets out the impact of NWW on CAMHS under a series of headings:

- key documents;
- key elements of NWW (service delivery, improving working lives, clinical governance and sustainability);
- changes needed to deliver NWW (people, systems and processes);
- progress to date and future changes around a number of factors (new role, enhanced role, changed role, new service models, better information and communications, increased flexibility, reduced duplication, developing a vision, strategy and plan, cultural change, structural change, technological change, and leadership); and
- possible tools.

**Contact:** Shirley Gracias at [shirley.gracias@awp.nhs.uk](mailto:shirley.gracias@awp.nhs.uk)

### Summary

**7.11.7** NWW has been a major initiative since 2003. It is acknowledged that many CAMHS services already employ a number of the findings identified within the previous reports.

**7.11.8** NWW is intended to enable those with the most experience and skills to work with children, young people and families and support universal services. We envisage that this will allow experienced staff to extend their practice, providing opportunities for new people to come into the workforce at various levels. NWW is about making the best use of the current workforce, enhancing job satisfaction, providing career development for the services' most important asset – the staff – and ensuring services meet the needs of children, young people and families/carers. NWW in CAMHS recognises that we need to concentrate on how we develop our staff to ensure that we provide the mix of skill and capabilities required to meet identified needs. Depending on local circumstances, the solutions will vary across localities.

**7.11.9** If we are to truly move towards the development of comprehensive CAMHS services, there will be an ongoing need to explore NWW as part of a modern workforce.

**Contact:** Dr Tim Morris, NWW CAMHS Project Lead, at [timothy.morris@elht.nhs.uk](mailto:timothy.morris@elht.nhs.uk) and Barry Nixon, National Workforce Lead – CAMHS, at [helen.dickson@wwl.nhs.uk](mailto:helen.dickson@wwl.nhs.uk)



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## Chapter 12

### New Ways of Working for Older People's Mental Health

#### Introduction

**7.12.1** There can be few areas where the individual qualities, competences and skills of the workforce matter more than in the care of an older person with mental health problems. Often presenting with complex co-morbidity, vulnerability and a diverse range of needs, older people and their carers require support and care from a whole range of agencies and within many different settings. It should be noted that some conditions associated with old age (specifically those causing dementia) are also prevalent in adults of working age. Importantly, at any one time, there are as many as four times the number of older people with mental health needs in generic care settings as there are receiving specialist mental healthcare services.<sup>28</sup>

**7.12.2** The role of specialist mental health services in mainstreaming knowledge into generic care and the pressing need to ensure age equality across specialist mental health services present significant opportunities (and challenges) for workforce development and implementation of NWW.

#### Policy and legislative context

**7.12.3** A number of policy imperatives underpin the importance of applying the principles of NWW to the care and support of older people with mental health needs and their carers. The National Service Frameworks for Older People (2001)<sup>29</sup> and Mental Health (1999),<sup>30</sup> and the service development guide *Everybody's Business: Integrated mental health services for older adults* (2005)<sup>31</sup> make specific reference to the workforce and the need to embrace different roles. The implementation of the Mental Capacity Act 2005 and implications arising from the Bournemouth Ruling (2004), in addition to those associated with implementation of the Mental Health Bill, necessitate new roles for the assessment and support of those who lack capacity. The models of service outlined in *Our Health, Our Care, Our Say* (2006)<sup>32</sup> point to the ever-increasing role of the workforce in prevention strategies and support for self-care.

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28 Royal College of Psychiatrists (2005): *Who Cares Wins – Improving the outcome for older people admitted to the general hospital: Guidelines for the development of Liaison Mental Health Services for older people*. (Endorsed by the Alzheimer's Society, the British Geriatrics Society and the Royal College of Nursing.)

29 DH (2001): *National service framework for older people*. DH Publication Ref 23633.

30 DH (1999): *National service framework for mental health: modern standards and service models*.

31 DH and CSIP (2003): *Everybody's Business: Integrated mental health services for older adults: a service development guide*. DH Gateway Ref 5637.

32 DH (2006): *Our Health, Our Care, Our Say: A New Direction for Community Services*. (Cm 6737). London: The Stationery Office.

**7.12.4** All of the above, combined with the diverse range of settings in which input is required, means that the minimum requirement is for an integrated approach to workforce strategy across health, social care and the third sector as part of local area agreements and local delivery plans.

## Implementation of NWW

**7.12.5** Ensuring a focus on older people's mental health and NWW has, to date, largely consisted of encouraging NWW sub-groups (for example, psychiatrists and applied psychologists and the review of mental health nursing) to embrace an age-inclusive approach. Additionally, some areas have appointed workers in newer roles, with a remit to develop a more specific knowledge base in relation to the needs of older people. Professional development initiatives, including the Ten Essential Shared Capabilities framework, have been evaluated in relation to the workforce employed in the care of older people with mental health needs and of younger people with dementia.

### Community development workers (CDWs)

- People working in this role are expected to work across the age range. The Competence Framework for CDWs contains comprehensive information on the skills and knowledge needed to work successfully with the elderly from black and minority ethnic (BME) communities.
- Additionally, in some localities, CDWs have been appointed with a specific remit to work with elders and their families, and it is hoped that such detailed experience will augment our understanding of working with these particular client groups for roll-out across other localities in the future.
- Concepts of ageing and mental health vary widely across the multitude of cultures that contribute to the fabric of contemporary society, and there is increasing evidence that stereotypical attitudes towards the care and support of elders within and by BME communities can often be unhelpful and misleading.
- Strategies to engage communities **must** be cognisant of the realities that individuals and carers *actually face*.

**7.12.6** In Leeds, for example, the CDW employed by Touchstone as part of the Partnerships in Older People's Projects (POPPs) initiative has been cultivating links with a number of local voluntary and service user groups for elders within BME communities. *The specific focus of this work is that service users and carers from particular cultural groups actively influence workforce training and service delivery.*

**Contacts:** Penny Redwood at penny.redwood@leeds.gov.uk (CDWs with a specific remit for older people are also employed in Bradford, Rotherham and other areas of the country); and Colin Warren at colin.warren@eastmidlands.csip.nhs.uk

### Support, Time and Recovery (STR) workers<sup>33</sup>

- 7.12.7 The philosophy and remit underpinning the creation of STR workers is equally applicable to older people with mental health needs, since they are focused on:
- providing holistic care across all traditional barriers as part of a team;
  - offering practical help, empowering service users to live ‘ordinary lives’; and
  - developing skills and competences associated with this role.
- 7.12.8 Approximately 3% of STR workers are currently employed within services described as addressing the specific requirements of older people with mental health needs.
- 7.12.9 The stereotypical view (principally relating to dementia) that older people’s mental health needs are not receptive to a recovery model means that there is some resistance to the adoption of this role. The term ‘recovery’ needs to be understood and used in the broadest sense. User-led definitions of ‘**recovery**’ do not equate to ‘**cure**’, but rather to what extent an individual feels their need to live a fulfilling and growth-enhancing existence is met. Mental health needs – including the need for mental health promotion and preventative strategies – are no less great among older people or younger people with dementia than they are among the rest of the population.
- 7.12.10 A number of sites can provide insightful observations in relation to the benefits and challenges associated with adopting the STR role to meet the mental health needs of this client group.

**Contacts:** Irene Rigg, STR Project Manager, at [irene.rigg@dh.gsi.gov.uk](mailto:irene.rigg@dh.gsi.gov.uk)  
Steve Metcalfe at [steve.metcalfe@eastsussexcounty.nhs.uk](mailto:steve.metcalfe@eastsussexcounty.nhs.uk)  
Wayne Goddard at [wayne.goddard@dsh.nhs.uk](mailto:wayne.goddard@dsh.nhs.uk)

### Next steps and work during 2007/08

- 7.12.11 NWW will effectively underpin the strategy for the workforce in relation to older people’s mental health during the coming year and beyond. Resources will be made available to ensure that we network and learn from the experience of those individuals and organisations operating newer roles and practices in relation to older people with mental health needs. The voluntary annual mental health service mapping was extended to cover older people’s services in 2005. This will augment our understanding of workforce investment and development in older people’s mental health as the workforce strategy is implemented.

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<sup>33</sup> CSIP (2007): *STR Evaluation – Final Report*.

**7.12.12** There are already a number of networks, collaboratives and related forums as part of the National Older People's Mental Health programme. NWW and workforce issues will remain an integral part of all of these service redesign and improvement initiatives.

# New Ways of Working Case Studies

## Chapter 13

### New Ways of Working Positive Practice Awards

**7.13.1** The NIMHE National Workforce Programme took part in the NIMHE Positive Practice Awards ceremony in November 2006. There were 38 applicants, of whom eight were short-listed. A panel from the NWW National Steering Group chose three teams as follows:

- The winner, receiving £5,000, was Easington Mental Health, for the development of an exciting and innovative community team with working practice, offering further advancement of the principles of NWW in a deprived area in the north east of England.
- A further two schemes received special mention:
  - the **Croydon Memory Service**, a team set up using NWW principles in services for older people. Its notably flexible, inter-professional working challenges traditional boundaries; and
  - the **Stockport Adolescent Services'** use of novel forms of clinical communication, through the development of a website called Cooth.com, which was successful in encouraging young people to link with mental health services using IT messaging.

**7.13.2** Apart from the three finalists, there were many other good ideas generated by the competition. For example:

#### **CAMHS**

Crisis Liaison Crisis service, Colchester, Essex

Contact: [elizabeth.went@nemhpt.nhs.uk](mailto:elizabeth.went@nemhpt.nhs.uk)

Cultural Liaison, Hackney CAMHS – liaison for the Turkish/Kurdish community

Contact: [begum.maitra@elcmht.nhs.uk](mailto:begum.maitra@elcmht.nhs.uk)

### **Graduate Mental Health Workers**

North East Leeds for providing the FLASH (Focused Learning and Self-Help) clinic – open access and self-help service

Contact: [charlotte.hanson@nhs.net](mailto:charlotte.hanson@nhs.net)

First Steps, Redhill, Surrey – workers' advice and support service

Contact: [toby.chelm@eastsurrey-pct.nhs.uk](mailto:toby.chelm@eastsurrey-pct.nhs.uk)

Bury, Lancashire for providing brief cognitive behavioural therapy to a range of older adults with chronic physical and mental health problems in primary care

Contact: [claire.maguire@nhs.net](mailto:claire.maguire@nhs.net)

### **Primary care initiatives**

Triaging in primary care in Sturminster, North Devon, using social workers, occupational therapists and nurses in two practices

Contact: [silvia.hardisty@nhs.net](mailto:silvia.hardisty@nhs.net)

Durham Dales PCT, with practice nurses offering mood management clinics

Contact: [pat.rich@durhamdalespct.nhs.uk](mailto:pat.rich@durhamdalespct.nhs.uk)

Support and Signposting, Gillingham Primary Care signposting service

Contact: [netty.swinburne@nhs.net](mailto:netty.swinburne@nhs.net)

### **Recovery**

Diverse Culture Community Support, Bedford – recovery service for BME users

Contact: [simran.khinder@blpt.nhs.uk](mailto:simran.khinder@blpt.nhs.uk)

### **Service user involvement**

The RISE (Recovery and Improving Service Experience) project in Lincoln – service user and carer involvement in service redesign of psychological therapy services

Contact: [rebecca.morland@lpt.nhs.uk](mailto:rebecca.morland@lpt.nhs.uk)

The Carers Telephone Assessment and Support Team in Chelmsford Essex

Contact: [lynda.hampel@essexcc.gov.uk](mailto:lynda.hampel@essexcc.gov.uk)

### **STR workers**

CREST home treatment team, using STR workers in Southwark to support delivery of services

Contact: [cha.power@slam.nhs.uk](mailto:cha.power@slam.nhs.uk)

### **Other projects**

Bipolar Affective Disorder service, Hadrian Clinic, Newcastle upon Tyne –  
psycho-educational groups for bipolar disorder  
Contact: dipty.reavley@nmht.nhs.uk

Bromley community and social inclusion psychology was developed in Oxleas  
Foundation Trust – collaboration between social inclusion workers and psychologists  
in support of CMHTs  
Contact: fabian.davies@oxleas.nhs.uk

Cerebrus Associates, Basingstoke – service user-led training for trainers  
Contact: tracey@cerebrusassociates.org.uk

Changing roles of psychiatrists, Ipswich – functional teams in mental health  
Contacts: kamal.mohammed@smhp.nhs.uk and albert.caracciolo@smhp.nhs.uk

Clinical Pharmacy, St Georges Hospital, Morpeth, Northumberland – ward-based  
working-practice change in medicines management  
Contact: barry.corkhill@nmht.nhs.uk

Positive Futures, Colchester – support and advice to drug-using parents during and  
after pregnancy  
Contact: jean.gordon@nemhpt.nhs.uk

Prescription for Healthy Living, Leicester – PCT initiative to deliver information  
to over-20 age group who are depressed  
Contact: psouth@nextstep-leics.org.uk

The Circle, Worksop, Nottinghamshire – performance, education and therapeutic arts  
Contact: info@circlearts.co.uk

Weight Wise, Peterborough – nutrition and dietetics advice in primary care  
Contact: rachael.cooke@peterboroughpct.nhs.uk

Youth Voice Peer Power, Brighton – peer group support to help with emotional distress  
Contact: epiper.tsa@ntlworld.com



# Appendix A

## New Ways of Working – National Policy Context

### Wider policy imperatives

A significant number of organisational changes are taking place – particularly, but not exclusively, in the NHS. These may affect the ability of very busy managers, staff and clinicians to turn their attention to introducing NWW. These changes include the reorganisation (and staffing) of Primary Care Trusts, specialist Trusts and Strategic Health Authority boundaries, as well as the introduction of Foundation Trusts. NWW, however, can assist in all these changes.

### Foundation Trusts

These have grown out of the wider public service reform programme and offer greater autonomy and freedom for local communities within a national regulatory framework of standards and inspection. The underlying ethos of Foundation Trusts is that accountability should be devolved to local stakeholders, including service users and staff, and opportunities should be offered to influence the strategic development of the Trust. As this report makes clear, the expectation of service users and carers is that NWW will be introduced across the board in all localities; they should, therefore, use their influence to take a strategic approach to implementing NWW in the Trust.

Furthermore, Foundation Trusts will need to demonstrate that they are ‘lean’ organisations, and will therefore need to understand and plan for their workforce as part of their integrated business plan.

### Practice-based commissioning and payment by results

These initiatives underpin the wider organisational changes, and are aimed at securing a more effective and efficient service that provides value for money for the taxpayer. In future, practice-based commissioning will be much more specific about what a proposed service should deliver, and this will enable providers to think more carefully about the nature or type of service that is required and to think ‘outside the box’, rather than just in terms of traditional services or existing staff groups. Chapter 8 provides illustrations of how responsibilities can be safely distributed across the primary–specialist interface. Payment by results will drive forward a more cost-effective/cost-conscious service.

## 10 High Impact Changes for mental health<sup>34</sup>

These were produced by the Care Services Improvement Partnership (CSIP) in June 2006. They are framed mainly around the provision of services to include access, user pathways, and discharge, as well as redesigning and extending roles. The 10 High Impact Changes set out a 'balanced scorecard' of benefits that includes the impact on staff, e.g. role development and 10 separate case studies.

## Review of the social care workforce

This review<sup>35</sup> is a generic piece of work covering the entire social care workforce, of which mental health is but one part. The *Options for Excellence* document includes a chapter on NWW and the need to define the role of social workers, where there is a strong link to the work of the mental health NWW for Social Workers sub-group as set out in Chapter 10 of this report.

## White Paper *Our Health, Our Care, Our Say*

The White Paper<sup>36</sup> recognises the importance of the workforce. In particular, paragraph 1.47 reads:

'We need strategies for workforce development that support radical shifts in service delivery and equip staff with the skills and confidence to deliver excellent services, often in new settings. Staff will increasingly need to bridge hospital and community settings in their work.'

An important theme of the White Paper is meeting the whole of people's needs and supporting their well-being and health. This means changing the culture of the workforce to introduce new roles and extend practice so as to focus on prevention and provide support for self-care. As part of the delivery, there needs to be integrated workforce planning across health and local authorities. It states that, in achieving delivery of the workforce aspects of the White Paper, employers will increasingly plan around skills and competences, rather than professional groups, and through local area agreements and local delivery plans. NWW in mental health will therefore be a major part of the delivery of the White Paper.

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34 CSIP (2006): *10 High Impact Changes for Mental Health Services*. CSIP Publication Ref 6583.

35 DH (2006): *Options for Excellence: Building the Social Care Workforce of the Future*. DH Publication Ref 7231.

36 DH (2006): *Our Health, Our Care, Our Say: A New Direction for Community Services* (Cm 6737). London: The Stationery Office.

## Delivering Race Equality

The Delivering Race Equality (DRE) initiative is a five-year action plan, designed to reduce the acknowledged discrimination in the planning and delivery of mental health services for black and minority ethnic (BME) service users and communities. The action plan forms a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users. DRE sets out 78 specific actions based around three main building blocks:

- more appropriate and responsive services;
- community engagement; and
- better information.

DRE also sets out 12 characteristics of a reformed service that, if successful, could be in place by 2010. Since it was published in January 2005, several key components of the five-year action plan have already begun operating, such as:

- the first annual 'Count Me In' census of mental health in-patients and ethnicity;
- 17 focused implementation sites for DRE to identify and disseminate good practice;
- 40 community engagement projects, with 40 more to follow;
- the recruitment of 500 new community development workers to help bridge gaps between BME communities and services;
- BME components in new programmes on older people's mental health and CAMHS; and
- the publication of new guidance on mental health services for asylum seekers and refugees.

**Contact:** Jim Fowles at [jim.fowles@dh.gsi.gov.uk](mailto:jim.fowles@dh.gsi.gov.uk)

## Improving Access to Psychological Therapies

The key aim of the Improving Access to Psychological Therapies (IAPT) programme is to improve the health and well-being of the six million people who suffer from depression and anxiety disorders. Part of the strategy involves helping people to look after their mental health and providing more services for people with mild to moderate mental health issues.

The programme presents major challenges regarding workforce and service redesign. If access is to be significantly improved, and mental health users are to be offered a

choice of evidence-based therapies, both the size and configuration of the existing psychological therapies workforce will require significant development. This will mean NWW for mental health staff, with an extension of roles and scope of practice, as well as the introduction of new roles.

The Workforce Group of the IAPT programme, working in close collaboration with various NWW project groups, has focused on drawing up the specific cognitive behavioural therapy (CBT) competences required to deliver therapy within a stepped care model. At the same time, work is also taking place to scope a broader competence framework that targets a wider range of psychological therapies. It is hoped that this scoping exercise will inform the production of National Occupational Standards for psychological therapies and also help progress statutory regulation within this area. At the same time, work is ongoing to develop a Career Framework for Psychological Therapists.

With regard to the skill mix of new and existing psychological therapies services, the Workforce Group has developed a provisional workforce plan. It describes a complementary mix of highly trained therapists, capable of delivering high-intensity interventions within a stepped care model, together with less qualified practitioners who might provide low-intensity assistance in the form of case management, employment coaching, CBT and supported self-help. With regard to education and training, a survey has been conducted to examine the capacity and availability of training.

**Contact:** Graham Turpin at [g.turpin@sheffield.ac.uk](mailto:g.turpin@sheffield.ac.uk)

## Care Programme Approach

The Department of Health, through the CSIP, has launched a consultation on policy and practice around the Care Programme Approach (CPA). The review aims to encourage better support for individual service users with the highest needs and the highest risk by clarifying the CPA's focus, cutting down on bureaucracy, and supporting and training staff to undertake this work. The consultation document<sup>37</sup> explores concepts surrounding the definition and characteristics of the term 'complexity' and its relationship to the CPA. This builds on discussions on the deployment of different levels of professional skills in accordance with NWW.

The document proposes identifying national competences for care co-ordinators, linked to national skills frameworks, and considering what the subsequent training requirements might be. The review also explores how risk assessment and

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37 DH (2006): *Reviewing the Care Programme Approach 2006 – A consultation document*.  
DH Publication Ref 7274.

management can be better integrated into CPA processes, and what further support professionals need to enable them to make better decisions around risk management. It heralds the development of a national framework on the effectiveness of risk assessment tools to help with this.

**Contact:** Janet Davies at [janet.davies@londondevelopmentcentre.org](mailto:janet.davies@londondevelopmentcentre.org)

## **Out-of-hours working and the European Working Time Directive**

In mental health, out-of-hours working presents NWW with a practical challenge, as more often than not services provided out of hours have relied upon a more single-discipline approach to care than during normal working hours. This is particularly marked in the in-patient setting, where a whole range of tasks have characteristically been delegated to the junior doctor on call, who is often tired, overworked and under-experienced.

In order to offset this, the European Working Time Directive (EWTD) is being implemented in a series of stages up to 2009, reducing the permitted hours of work to a maximum of 48 hours a week. This is leading to a complete rethink in the way out-of-hours services are provided, often including complicated shift systems that may fail to provide adequate experience or training for junior doctors.

The NWW in Mental Health Team has, together with two provider Trusts, been successful in securing funding for two 'Hospital at Night' pilot projects aimed at defining the tasks characteristically taken on by a junior doctor at night and then developing a competent team approach to out-of-hours care. The vision is to construct a multidisciplinary team, with a broad skill base that includes independent prescribing, physical examination and emergency rapid tranquillisation to replace dependency on medical input. Such a team would provide all the skills required out of hours, but would not be limited to one profession. It would draw predominantly on nursing, pharmacy and social work, as well as on the medical services rostered in for such provision.

A major step forward was achieved when provision for the implementation of Section 5(2) under the old 1983 Mental Health Act was accepted as a proposed amendment to the amended Bill allowing holding powers to be extended to the Approved Clinician or their nominated deputy. In practice, this will allow the most appropriately competent individual, regardless of profession, to use such powers, thus avoiding the necessity of calling a junior doctor out of bed to detain a patient on a ward. Other issues that have typically led to the exclusive calling of a junior doctor have included certification of death and attendance at seclusion. Both of these issues

are being addressed in the two pilot projects, and it is anticipated that they will be resolved shortly.

The pilots, which are funded by the NHS National Workforce Project, will be completed by 2007, and the wealth of data and experience that is being collected will be usefully disseminated throughout the NIMHE development centre network to individual trusts.

**Contact:** Stephen Humphries at [stephen.humphries@tney.northy.nhs.uk](mailto:stephen.humphries@tney.northy.nhs.uk)

## Choice agenda and service user values

### The Ten Essential Shared Capabilities

The Ten Essential Shared Capabilities (ESC), published in August 2004,<sup>38</sup> reflect the concerns expressed by many people who had used mental health services and by their carers. These included that staff did not value the contribution that service users could make to the delivery of services if they are treated as equal partners, and nor did they reflect service user values. The Ten ESC set out these values as part of a clear statement of the essential capabilities that all staff working in health and social care should aspire to as part of their learning and development.

### Social inclusion

The Social Exclusion Unit report<sup>39</sup> showed that many people with mental health problems have experienced exclusion. This means that they do not have access to a wide variety of opportunities in modern society, including paid employment and volunteering, housing, lifelong learning, financial services, access to civil rights, and social participation. Denial of these opportunities is unjust and it makes life harder for people, lowers self-esteem and weakens the rest of society. Another key finding was that the low expectations of staff, including specialist mental health staff, is a major contributory factor to the individual remaining excluded. The advice, support and treatment that people with mental health problems receive from health and social care staff can affect the course of their experience of mental distress and have an impact on their lives. Building on the Ten ESC, NWW is an opportunity for staff to reflect on, review and refresh practice. The aim is to find better ways of delivering improved opportunities for inclusion, enhancing recovery, bringing hope to relatives and ultimately reducing dependence on the state, as people make a positive contribution to society, find some of their personal support through informal social networks, and make less use of hospital and community services. In terms of NWW, these drivers

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38 NWP (2004): *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*. DH Publication Ref 40339.

39 Office of the Deputy Prime Minister (June 2004): *Mental Health and Social Exclusion*.

should help shape the roles and functions that new and established staff and teams work towards.

**Contact:** Naomi Hankinson at [naomi.hankinson@londondevelopmentcentre.org](mailto:naomi.hankinson@londondevelopmentcentre.org)

## Recovery

The NIMHE *Guiding Statement on Recovery* (2005) states: 'Recovery is a concept that has been introduced primarily by people who have recovered from mental health experiences.' The guidance states a commitment to developing 'recovery orientated services'. It is important to note from a policy context that a consistent broad definition of 'recovery' needs to be more fully understood. There is no doubt that the ethos of the 'recovery approach' is being promulgated throughout statutory and non-statutory mental health services, not just in England but throughout the UK.

This consensus is being developed by service user and carer involvement, together with the NIMHE *Guiding Statement* and the recently published recovery training materials *Creating and Inspiring Hope*, developed by NIMHE and available through the Centre for Clinical and Academic Workforce Innovation at the University of Lincoln.

The promotion of recovery approaches, when appropriately delivered, can focus attention on partnership and empowerment issues that are central to NWW in mental health. Recovery is entirely consistent with the values expressed in the Ten Essential Shared Capabilities and the provision of service user-centred care. Additionally, the approaches to 'recovery' are consistent with NHS wider policy on social inclusion, choice, self-managed care and the promotion of independence.

**Contact:** Ian McGonagle at [imcgonagle@lincoln.ac.uk](mailto:imcgonagle@lincoln.ac.uk)

## Values-based practice

Values-based practice (VBP) is a new approach to working with complex and conflicting values that builds on trainable clinical skills within an appropriate service delivery framework.

The NIMHE Framework of Values, which was produced by the NIMHE Values Project Group and represented a number of NIMHE's key work streams (including recovery, social inclusion and user-centred practice) is explicitly based on VBP. It underpins all NIMHE's work and a number of CSIP projects. These include Delivering Race Equality, the Mental Capacity Act, training and other contributions to the Code of Practice and implementation programme for the Amending Bill to the Mental Health Act 1983, and a recently launched review of comprehensive assessment.

VBP is central to key aspects of NWW, notably to providing services that are genuinely user centred, and to effective multidisciplinary and multi-agency working. The Ten Essential Shared Capabilities are explicitly built on the twin resources of evidence-based and values-based practice. The training resources to support the Ten Essential Shared Capabilities include a module on VBP. This module in turn builds on a wide range of training developments based on the training manual *Whose Values?*, developed jointly by the Sainsbury Centre for Mental Health, Warwick University Medical School and NIMHE, which was launched by the Minister, Rosie Winterton, at a joint conference in London in 2004.

**Contact:** Bill Fulford at [k.w.m.fulford@warwick.ac.uk](mailto:k.w.m.fulford@warwick.ac.uk)



# Appendix B

## Frequently Asked Questions

### New Ways of Working – what is it all about?

#### 1. What is New Ways of Working?

New Ways of Working (NWW) is about developing new, enhanced and changed roles for mental health staff, and redesigning systems and processes to support staff in delivering effective, person-centred care in a way that is personally, financially and organisationally sustainable.

Examples of new roles include Support, Time and Recovery workers, community development workers, graduate mental health workers, and a variety of Assistant Practitioner and mental health worker roles. Professionals from a variety of backgrounds are training to enhance their skills, for example in non-medical prescribing, physical health assessment and psychological therapies, and they are also changing the way they work to ensure it provides the most benefit to service users and carers – for example, consultant psychiatrists seeing people when needed, rather than routinely, and working directly with a smaller number of the most complex cases while providing advice and consultancy support to team members, primary care and other partners on a larger scale.

NWW is a cultural shift – it involves rethinking values, ways of working and roles to deliver person-centred care.

#### 2. Is it really 'new' at all?

There have always been organisations that have developed new roles, staff who have sought additional training, and team members who have worked together to optimise their functioning individually and as a unit in the service of their clients. However, it is equally true that, in many places, outdated models of service delivery persist that do not match service user and carer needs or organisational expectations. NWW is a way of systematising and mainstreaming innovative and forward-looking approaches, and of disseminating and developing good practice that has come from the bottom up, from practitioners who have seen opportunities to improve the service they provide.

#### 3. Where has NWW come from?

NWW has been around for some years, but it received particular impetus in mental health in 2003, when two national conferences for consultant psychiatrists

summarised the problems in the profession – significant difficulties recruiting and retaining psychiatrists because of the increasing demands of the role, increasing degrees of burnout among consultants, unsustainably high caseloads and crippling expenditure on agency locum doctors to try and plug the gaps. When these problems were examined, it quickly became apparent that, as consultant psychiatrists were part of a system, and other parts of that system were demonstrating the same stresses (revealed, for example, in a study of social workers), all the parts of that system needed to be considered in order to effect change and produce sustainable jobs for all.

#### **4. Who is NWW for?**

People working in mental health, in whatever care setting they are based, and the service users and carers they work with. Over the past year, national groups representing all professions, and non-professionally affiliated workers, have been addressing their own particular NWW issues, with support from colleagues in other disciplines and from service users and carers. This work has now resulted in a set of common themes, which all groups want to take forward in a multidisciplinary forum; these themes are described in Section 4 of this document.

#### **5. Why is NWW necessary?**

Back in 2003, NWW was necessary to help tackle the difficulties being faced by the psychiatrists. Together with other levers for change, including the new consultant contract, NWW has contributed to a significant improvement in vacancy rates and the development of fulfilling, sustainable jobs providing effective care. However, reform and regulation, the drive towards Foundation Trust status, and the rising expectations of service users, carers and the general public have all focused larger lenses on mental health services now than ever before, and have demonstrated that, in order to be sustainable, services need to be more flexible and person centred, at the same time as providing demonstrable value for money. This requires organisations to analyse what skills they need in their teams and to create capable teams with effective leadership supported by efficient processes and infrastructure. NWW aims to provide tools to help achieve this and the communication necessary to disseminate learning about new approaches.

#### **6. Where is NWW happening and how can I find out about it?**

Reading this report will help to bring you up to date, and the Final Report on New Ways of Working (2005) also provides a wealth of information, including NWW examples in the appendices. We are launching a website this year, and all the organisations that have supported the initiative from the beginning will be able to give details pertaining to their particular interest in it. The workforce leads in the regional development centres of the Care Services Improvement Partnership (CSIP)

also have a good overview of the state of NWW in their areas; some have commissioned regular progress reports, which are available. Medical Directors are linked in to the national programme via the Royal College of Psychiatrists Medical Directors network, as many have the role of board champion for NWW in their Trusts, on behalf of all staff.

## **Where does the support for New Ways of Working come from?**

### **7. Is NWW a government policy or target, and will it be replaced by some other initiative soon?**

The strength of NWW is that it has been developed by practitioners, by those working at the coal face, who saw that roles, systems and processes needed to change to be able to cope with the expectations of today and of tomorrow. Bottom-up innovation has been supported throughout by top-down strategy, as evidenced by the support for projects from the Modernisation Agency and the Changing Workforce Programme, and then the National Workforce Programme. It may be that, in the future, mental health providers will have to achieve targets that relate to their development of NWW; but these targets will have been shaped by those bottom-up achievements and will be a reflection of NWW having made it into the mainstream of mental health thinking.

NWW is about cultural change, about considering ways of working from a person-centred, values-based standpoint, and about developing services, and roles within them, that are flexible and responsive. NWW isn't complicated, much of it is common sense, and many 'NWW' changes can be easily and simply made. As such, it should just become the accepted approach to doing things because it makes sense, and a way of thinking can't be replaced in the same way as a policy.

### **8. Is NWW supported by my professional body/trade union?**

The National Steering Group on NWW and the work it has commissioned, including all its reports, have been supported by the professional bodies and trade unions that represent workers in the mental health field. NWW is also aligned with the objectives of the regulatory bodies.

### **9. Is NWW supported by my Trust?**

If you are not sure about the answer to this question, ask them! Our data gathered from Trusts in England, summarised at 3.7.1 in this document, indicates that the majority have discussed the Final Report on New Ways of Working (2005) at a senior level, and that their 'average team member' will have heard about NWW. However, actual NWW initiatives can be patchily distributed within organisations, and we are

not yet at the stage where any could say that they have comprehensively introduced NWW throughout the organisation – so there is still plenty of work to do.

#### **10. How is NWW being taken forward nationally?**

Nationally, the New Ways of Working Programme has been co-ordinated by the NIMHE National Workforce Programme, now part of the CSIP. The National Steering Group, co-chaired by the Director of NIMHE and the President of the Royal College of Psychiatrists, will continue to meet, and work will continue on the common themes identified by the sub-groups. Members of the small national team will continue to work with provider organisations, including primary care and the third sector, to mainstream NWW, and to work with the Department of Health, the Healthcare Commission, Monitor, professional organisations and service users and carers to ensure that the principles of NWW are enshrined in national policy, guidance and regulation of mental health. Part of that work involves linking together a multiplicity of different influences on the development of the mental health workforce.

### **Concerns about New Ways of Working**

#### **11. Is NWW about cutting costs or dumbing down?**

No, it is about using people's skills to the greatest effect, where and when they are needed. It is about working supportively in teams. Cost and skill-mix reviews have been a fact of life for a long time, and will continue to be so; NWW offers opportunities not only for surviving such reviews, but for making positive changes in practice to develop a more efficient service.

#### **12. Is New Ways of Working about having specialist in-patient consultant psychiatrists, or cutting the number of consultant psychiatrists?**

There is no one way to develop NWW. Specialist in-patient consultant psychiatrists, or consultant psychiatrists working across the acute care pathway in crisis and in-patient work, are one example of NWW, and just over a third of Trusts have developed these roles – the so-called 'functional model' – in at least part of their area. Where they have been implemented, they have been very successful, with demonstrable improvements in the in-patient experience for service users, carers and staff. The trick is then to ensure continuity with community services, which will always provide the bulk of care for individuals.

NWW is not about cutting the number of consultant psychiatrists. However, there has been a large expansion in the number of consultant psychiatrist posts in recent years, and this is unlikely to continue. Therefore alternative ways of meeting the

continuing rise in expectations and demand have to be developed, and these involve NWW. In addition, there is more pressure on costs, and staff therefore have to be used most effectively to provide value for money. Consultant psychiatrists and their trainees, alongside other staff, will have to prove they are worth the investment made in them, and they will need to be flexible and adaptable in their roles in order to achieve this.

## **How am I affected by NWW, and how can I help it develop?**

### **13. How does NWW affect me as a service user and as a carer?**

If NWW is embedded in the team(s) you link with, you should find that they are flexible and responsive to your needs. It should be clear to you that the team has a recovery focus. It will be always looking for ways to improve, and will involve service users and carers in that process. Your experience of services may change – for example, you may find that your needs can be met by fewer people, because some staff in the team have acquired additional skills, e.g. in prescribing. You should find it easy to get access to those with the appropriate skills to help you if you become more unwell. You should find yourself reassured and informed, and fully part of, not intimidated by, the care planning process. The team will communicate well with you, perhaps offering a variety of methods, and with your GP; they will be open about sharing information and will collect it appropriately. You may find that some aspects of your care can be provided in a primary care setting. If you need to go into hospital, you should find that, although different people may care for you, your care co-ordinator ensures continuity and plans with you and your ward team for your discharge from the point of admission, involving your carers at each step.

If the providers of your services have embraced NWW, there should be some information about it; nationally, leaflets will be produced to highlight the main features and indicate how to get local information.

### **14. How does NWW affect me as a practitioner?**

NWW emphasises the collaboration of all practitioners within teams to achieve person-centred care for service users and carers. However, within this, as an individual practitioner, you will want to review the way you work, to ensure that it is efficient and uses your skills appropriately. You will also have ideas about how the whole team can improve, and it is this bottom-up innovation that will enable your team to develop NWW effectively.

**15. How does NWW affect us as a team? What can I do about it as a team manager?**

The first step is to look at how the team is organised: is there a model of distributed responsibility, with all members taking responsibility for the care they provide? If you are a community mental health team, for any age group, have you moved away from any notion of the consultant psychiatrist being ‘in charge’ of all the ‘cases’? If you are a ward team, are ward reviews truly multidisciplinary, with contributions from all equally valued? What can you do about your team processes to make them more efficient and reduce duplication and wasted time? Have you looked at the roles of everyone in the team, to ensure that their skills are being used to best effect? What do your service users and carers think? Can you put forward team members for additional training, with a clear idea of how you will all utilise the new skills they will bring? Does the team look at its own performance data? You will want to read the sister document to this report – the *Creating Capable Teams Approach* – to help you develop a team competence model.

**16. As a director, what can I do about NWW?**

Help to ensure that your organisation can affirmatively answer questions like the following:

- Does your workforce strategy consider the potential for developing or expanding new types of role in your workforce, and is there a plan for delivering this?
- Is there a strategic approach to developing enhanced skills in the workforce, so that the right people are trained, and their roles, and those of the teams they work with, are then adapted to allow them to use their new skills?
- Is NWW discussed in your integrated business plan and do your commissioners understand its potential?
- Do you have assurance that you are using your workforce, particularly the most expensive elements of it, in the most effective and efficient manner? How prevalent is job planning and appraisal, and do they consider the person in the context of their team?
- Do you know which teams are having the most difficulty managing their workloads, and is the organisation doing something about it?
- Is there a strategy for dealing with a consultant psychiatrist vacancy that involves more than automatic recruitment of a locum and then a straight replacement?
- How efficient are your clinical and administrative processes? Can you demonstrate that you are achieving the 10 High Impact Changes for Mental Health?

- Are there mechanisms for involving service users and carers and frontline staff in generating ideas for improvement and, if so, is the infrastructure there to support implementation?

#### **17. As a commissioner, what do I need to know about NWW?**

The core of a mental health service is its staff, and those staff can be developed in three ways: existing staff can work differently, existing staff can be trained in additional skills, and different roles can be developed to bring new people into the workforce. These staff can then form capable teams, if they are deployed within a service model attuned to the needs of its users, supported by good systems (particularly information systems) and adequate resources, and embedded within a values-driven organisational culture with leadership and effective team working modelled at all levels. As a commissioner, you will want to know that all these elements of NWW are being developed in the organisations that provide your services, because they are at the core of a sustainable enterprise that provides quality, value for money and choice for your population.

#### **18. Do others, for example the public, GPs and coroners, know about NWW?**

The amount of knowledge is variable, and it behoves us all to seek to explain the concepts and therefore increase it. People are perhaps more used to NWW in other branches of the health service, such as emergency care practitioners, new roles in primary care, chronic disease management – even surgery; so it just needs explaining that things are changing in mental health, too. The primary care sub-group of the National Steering Group on NWW is actively promoting NWW in mental health across care settings, and helping to raise awareness. We are seeking to develop a guidance document with the Coroners' Society for England and Wales to explain what the changes might mean for them and their work.

### **New Ways of Working and national context**

#### **19. Is there a link between NWW and Foundation Trust status?**

All Mental Health Trusts in England are established or aspiring Foundation Trusts, and as such they must demonstrate not only that they can break even, but that they are sustainable organisations that can generate surpluses. Since most spend about 70% of their resources on staff, creating a sustainable workforce is a key component of their integrated business plans. New Ways of Working can help them achieve a balanced, effective, sustainable workforce that offers the care and treatment that service users and carers are asking for. Foundation Trusts have Boards of Governors elected by their members, and there are thus real opportunities for service users,

carers, staff and other key stakeholders in the local community to influence the development of their local Trust.

**20. How does NWW link with other developments, like payment by results?**

The National Workforce Programme is working closely with the Department of Health and has links with the pilot projects for payment by results in mental health. There is a good understanding of the need for any mental health tariff to take account of new working practices. The National Workforce Programme is also making links with Connecting for Health to ensure that the new clinical information systems are not based on outmoded assumptions about who does what and where.



# Appendix C

## Indicators and Outcomes

### That Help Demonstrate What NWW Will Look Like When it is in Place

Indicators	Outcomes
<i>Organisation</i>	
<ul style="list-style-type: none"> <li>• Board has discussed both the Final Report (2005) and this report (2007) and has an NWW action plan</li> <li>• Board policies on roles, responsibilities and accountability of clinical and non-professionally affiliated staff are in place</li> <li>• Nominated NWW lead at Board level</li> <li>• Joint guidance in employment of consultant psychiatrists embedded in Trust HR policy</li> <li>• NWW covered explicitly in annual reports, business plans and minutes of Board meetings</li> <li>• Robust workforce strategy for the organisation in place, citing skills and competences required, rather than gaps expressed in (traditional) staff numbers</li> <li>• Training strategy explicitly linked to workforce strategy</li> <li>• Serious untoward incident data</li> <li>• Policy on risk includes positive risk taking</li> <li>• General rather than professional management arrangements in place</li> <li>• Senior clinical staff of all professions involved in policy development</li> <li>• Staff turnover</li> </ul>	<ul style="list-style-type: none"> <li>• Organisation workforce budget is in balance</li> <li>• Minimal or no use of agency staff</li> <li>• Use of internal bank staff in place and utilisation of NHS Professionals where external agencies required</li> <li>• Vacancies are used as an opportunity for role and system redesign</li> <li>• Reduced levels of serious incidents; reduced recommendations relating to skills and competences</li> <li>• Annual improvements in ratings in staff survey</li> </ul>

- Number of agency locum consultants employed
- Audits of working practice completed, e.g. use of consultant out-patient clinics
- Sickness rates
- Chief Nursing Officer's Review of Mental Health Nursing disseminated, assessed and implemented
- IT available to support flexible working – computers, BlackBerries, laptops, video conferencing
- Improved recruitment and retention year on year
- Minimal or no use of locum staff
- Lower sickness levels year on year

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*Teams*

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- Teams within the organisation have individual workforce plan
- Creating Capable Teams Approach in regular use for team workforce and learning and development review
- Teams describe skill mix in terms of competences and capabilities
- Teams have a range of new or extended roles, including STR workers, non-medical prescribers, etc.
- Multidisciplinary teams led by a variety of practitioners
- Pharmacist(s) as part of multidisciplinary teams
- Teams use own data to improve performance
- Teams have devolved, balanced budgets
- Creative solutions to meeting service user and carer needs (whole-systems approach)
- High service user and carer satisfaction rates with service
- Reducing levels of drug errors
- Improving levels of complaints
- No waiting lists for treatment

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*Staff*

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- Staff are clear about and confident of their roles, responsibilities and accountability as part of a distributed responsibility model
- Staffing profile shows a balanced skill mix profile (Christmas tree)
- All professions are described as having a role in relation to clinical leadership
- Positive response to staff surveys
- Clear sign-up by staff to service user and carer-centred values
- Job adverts described in terms of competence/capabilities, not profession
- All consultant staff with smaller caseloads

- Clear career framework – staff encouraged to change or extend roles
- Internal promotion within and between professions
- Annual appraisals address NWW and the Ten Essential Shared Capabilities
- Staff can explain NWW
- New practitioner roles in place and integrated within teams
- NWW is a criterion for clinical excellence awards for psychiatry
- Staff routinely collect outcomes data on clinical work
- Coroners not automatically asking for/insisting consultant psychiatrist attends court hearings in every case
- Psychiatrists no longer doing routine out-patient clinics

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### *Learning and Development*

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- Learning and development plans explicit in appraisals
- Learning and development linked to multidisciplinary working
- Organisation's learning and development priorities underpinned by the Ten Essential Shared Capabilities for all staff
- Continuing professional/personal development focuses on extended practice
- Quality of learning and development and continuing professional/personal development improved
- Costs of learning and development and continuing professional/personal development reduced
- Clear evidence to show that service users and carers are involved in learning and development, e.g. planning, delivery, evaluation

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### *Service users and carers*

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- Service users and carers are represented at all levels of the organisation
- Service users and carers employed in organisation
- Funding is allocated to support user and carer involvement
- Care plans reflect whole person needs
- Care pathways designed on service user and carer needs and linked to staff skills
- Service user and carer experience more focused, co-ordinated and appropriate service to their needs
- Care Programme Approach care plans show continuing positive outcomes
- Positive response to service user and carer surveys
- Evidence of local gathering of data on service user and carer satisfaction

# Appendix D

## Diary of a 'New Ways of Working' Consultant Psychiatrist

**Sunday, 4 November 2007**

Bonfire night tomorrow, although from the flashes and bangs I can hear and see through the bathroom window it appears to have arrived a day early. The dog doesn't appreciate the noise and is attempting to insert herself into the 3-inch space beneath one of the beds.

This is really quite a good time for reflection; as it is now a year since my job changed radically in line with the principles of New Ways of Working. Last year I began working in a completely different way, with a sense of trepidation and excitement, wondering whether this big experiment would be a gloriously exploding pyrotechnic display or a complete damp squib.

Things have certainly changed from the days when I would feel a knot of tension in my stomach on a Sunday evening, as my attempts to block anxiety about what faced me the following day failed rapidly. I used to have a big caseload of about 300 patients that I prided myself on seeing as 'regularly as possible'. Given how tremendously busy I was, I used to compare myself to my colleagues, and we used to compete to see who could carry the largest burden of responsibility. I used to constantly look over my shoulder for fear that someone in the team would do something that reflected badly on me. After all, I did have overall responsibility; whatever that meant!

It was quite a relief as the rich web of myth and inaccuracy surrounding my role and responsibility began to be unpicked. The ideas developed with the backing of the General Medical Council, the British Medical Association and the Royal College of Psychiatrists around personal and distributed clinical responsibility came to me as quite a relief. I remember sitting down with my team members and feeling a sense of comradeship as we discussed the implications within the team. As I pointed out to them, it was now clear to me that, although I was personally responsible for the cases I was seeing, for the advice I gave to team members and had a leadership role within the team (part of which was to ensure the effectiveness and competence of its members), I did not have personal responsibility for whatever clinical actions they took. There was a collective sharp intake of breath as we discussed this, but a sense over the following months of working together for a common aim started to develop. The long lines of worried Community Psychiatric Nurses (CPNs) standing outside my office began to dwindle away as a sense of confidence developed in the close-knit and increasingly well-oiled workings of a more effective team.

They had quite a shock, and so did I, as caseloads began to transform! We set ourselves the surprisingly modest target of analysing just who was in the service, and were truly amazed by the results. We found people on caseloads who were long deceased but had never been removed from the system. We found people being seen because they were 'nice' – who we as clinicians enjoyed seeing, but who were really so well that they didn't even need to be managed in primary care. We found a whole host of people who had been ill (often very ill), who were now quite stable, but were being seen every 2–3 months in my clinic for a bit of a chat and the monitoring of their physical symptoms and medication. I had to ask myself 'did I personally need to see them all the time?' It was fairly easy to set up a team to support these individuals, many of whom, over time, have gradually moved back into primary care. Many are still seen, and when they become unwell I can trust the CPN and social worker to know when they should be reviewed by me.

My caseload has fallen so dramatically that one of the CPNs was joking with me the other day that my list is the shortest in the team. How things have changed!

As I lie here, reflecting, hoping not to drop this Dictaphone into the increasingly cooling waters of the bath, I am aware that I am not anxious about going to work tomorrow. I don't expect to walk in and find a service anxiously waiting for me to turn up. I do expect to find a team with a sense of identity and common purpose, increasingly proud of its effectiveness, that sees me as a valued specialist member.

### **Monday, 5 November 2007**

Time to switch on the BlackBerry and load the emails onto the system. I try to be disciplined and not read my correspondence over the weekend, although sometimes I am tempted. I have found the electronic PDA – which doesn't stand for Pester Doctor Again, as I was advised by a colleague, but Personal Digital Assistant or BlackBerry – to be a useful tool; it helps me work in a more modern way. It makes me accessible, but is less intrusive than a phone call. Team members know that they can email me at any time and I will respond. I can click over onto my electronic diary, which my secretary co-ordinates, and I know at all times what I have to do during the day. Trusting other people to co-ordinate my diary was a bit of a step for me but has proved extremely useful and effective. No more double bookings! Team members now know they can fit in people to see me and they know when time is available. They know that they can attach documents to my emails, bringing me up to date quickly with any developments. Crucially, they trust that I trust them to make those judgements.

The working week starts with a team meeting and this has become the centre of the working week. All communication comes to the team manager; all referrals enter through their structure, and, no, the GPs aren't jumping up and down! They were a little challenged at first, but once they realised their patients would be seen effectively and efficiently by the

most appropriate professional, they were very happy. The team has become proud of its abilities and its developing skill base. We now have an Advanced Practitioner and two nurse practitioners within the team. They have been trained in supplementary and now independent prescribing, and I have trained them in that mysterious skill of clinical formulation. I now work with colleagues who are able to interview, assess and formulate cases in which they sometimes initiate pharmacological treatments and monitor their effects. Other colleagues who work in such ways agree with me that it has revolutionised the dynamics of the team. I have a pharmacist working in the team with a clearly defined medicines management role. Yes, this can sometimes cause conflict, but it provides a useful scientific backdrop or framework and helps to balance the team. It helps keep governance and innovation in balance. The pharmacist works with the team in a number of interesting ways: occasionally, we hold a joint case conference with myself, the pharmacist, users and carers and care co-ordinator to look at particularly knotty decisions about choice of medication. It's a long way from a quick flick through 3 volumes of notes at a busy out-patient clinic to find 'an antidepressant you haven't been on yet!'

Sometimes I refer to the pharmacist for advice for a detailed report and discussion on medication choice. He will supply me with a review and references to the evidence base backing that up. Some colleagues have grimaced at this process, wondering why, as a consultant, I should be seeking advice in this way. I really don't think I need to answer their criticisms, as such, having seen too many of the same colleagues hit problems by not communicating and not seeking opinions. Let's be honest, the average senior pharmacist has a much more detailed knowledge of pharmacology and pharmacokinetics, and a better scientific background to medication, than the average consultant psychiatrist, who, granted, is the acknowledged expert in the application of that knowledge in a clinical setup. Another example of where a team approach is the optional delivery format, and one in which trust and respect for colleagues in other disciplines is called for.

Our pharmacist makes a great show of criticising the previous approach of his profession: hiding behind lab coats, occasionally peering out from behind the dispensing counter, avoiding patient contact, counting pills and tutting at prescription errors by doctors. He is aware that, just like all other professions, pharmacy needs to optimise and align its skill base for the better good of our users and carers.

I am developing a love of doing things differently and of confronting tradition and prejudice. I have a colleague who is a Staff Grade, who has for years worked in a very holistic manner. She has taken the unusual step of wanting to be a care co-ordinator and is learning many of the skills that traditionally would have been owned by a nurse or social worker. With her extensive range of physical medical skills, she is probably going to become the first proper care co-ordinator from a medical background within the Trust, maybe even nationally.

What we are trying to create is a team with a much broader generic skill base, which, on a day-to-day basis, allows me to occupy a more specialist position as consultant advisor to the team and chief practitioner for the most highly complex and difficult cases. I now spend much more of my time concentrating on the top end of the scale, grappling with the difficult-to-engage, highly complex cases with co-morbid physical illness, instability and high risk. As this is now my clinical focus and I am not cluttered up with lots and lots of maintenance and routine monitoring, I enjoy it so much more. The team see me now as a highly specialist resource, which is now more accessible, as opposed to someone they had to hunt down and corner. I used to feel like an animal pursued by a pack at one time.

I no longer do out-patient clinics, and see all of my patients at the request of the team. Hence the need for access to my electronic diary. People treat that privilege with so much respect, they can see now what I have to do and adjust accordingly.

So the morning is spent discussing the referrals and the management of recent cases. I feel quite secure in my specialist role – to the extent that we have even begun discussions on the importance of team leadership not just being a function occupied by the consultant psychiatrist. I think we are going to experiment with rotating the team leadership and team development role between some of the professions. Sometimes being brave like that, I believe, can enhance status, respect and position within a team.

The afternoon is spent seeing patients.

I don't do a clinic. I won't see anyone unless they are accompanied by their care co-ordinator at the very least, and often I see them with several key people, including their carers. I may see them at the team base or I may see them at home. It is very interesting, it's very varied, and it means that I have enough time to do things I need to do. The team know when I am available, they fit people in for me to see and they make sure that all the information I need is available. They also know that I will not routinely follow up these patients, but at the end of my intervention I will effectively hand the case back to the care co-ordinator and trust them to monitor the situation and bring it back to me as appropriate. This system is working spectacularly well, although the patients needed to be reassured at the start that they would see me when they needed to, not just when I wanted to see them.

Seems obvious now, but why should contact with a psychiatrist be based on my needs rather than theirs? I am told it is called 'person centredness'.

### **Tuesday, 6 November 2007**

Tuesday is my 'complex morning', when although I don't do clinics as such, I put aside time to work on my most demanding cases. They often have co-morbid neurological problems

and I often need to set up case conference-type facilities to pull together the mass of information required to really get to grips with these problems. Although I don't interview the patient in the presence of a mass of people, the meetings often become a teaching and learning experience for everybody. They are becoming very popular with all types of clinicians in training. I leave myself time at the end of the morning and throughout the afternoon in case there are any emergency assessments, but to be honest the team is now so competent that they will respond without informing me and have developed a style which suits me well. In effect, they go away, assess a situation, come up with some initial solutions and then present me with the information in a useable form. It used to stress me enormously when people from the team, in a helpless and inefficient way, would present crises to me to be solved. Now they do most of the solving themselves and present me with usually an almost fully worked-out solution. This then allows me to be much more effective in taking the clinical resolution to the next stage.

The afternoon is really quite a joy: as I am not burdened with hundreds of routine out-patients, I have been able to set aside time for teaching and training. I insist that the training forum is multidisciplinary, as I am trying to bring up the junior doctors in a culture of team-working experience. They do almost no uni-disciplinary training nowadays with me, as I believe that the young doctors of the future will be expected to deliver their care almost exclusively in a multidisciplinary setting. The teaching session this afternoon concerns the integration of formulation skills with prescribing effectiveness and the delivery of physical forms of treatment as an adjunct to psychological therapies. We all regard this as a highly effective and truly 'joined-up' way of delivering mental healthcare.

### **Wednesday, 7 November 2007**

The morning is spent in liaison with the in-patient service. Since I gave up in-patients and handed over their care to a colleague who specialises in that environment, there have been massive changes. It helps that I trust my consultant psychiatrist colleague and that we work as a team. It would be dreadful to hand over a well-known patient in crisis for there to be a complete change of care plan, which I would then want to change once they're discharged. We have overcome these difficulties by developing a close working relationship. The care co-ordinators and myself regularly visit our patients on the wards and have input into the care planning meetings. There are no ward rounds anymore; only timetabled sessions when the in-patients are discussed. A note of which I get in my electronic diary. My colleague is a bit of a technology freak and insists on interviewing his patients by video link for the rest of the team, to avoid the old horror of the in-patient being marched into a room of 15 people, few of whom they would know. Generally speaking, I have found that, so long as there is clear communication between the different parts of the functionalised service, there is less room for dispute and poor co-ordination. People don't seem to fall down the gap nowadays, like they used to, and there is a developing sense of handover in crisis – or, perhaps more



accurately, loaning to another part of the service – knowing that you will be given them back again in a form which is not alien.

In the afternoon I spend my time on service development with the clinical director and the general manager. This is a rare treat, as, at one time, I had my head down so far that I had no idea what strategy meant.

The presence of the in-patient continuity team has also greatly increased the physical healthcare to the in-patient environment. Apart from the fact that my Medical Director tells me that we now no longer live in fear of falling foul of the European Working Time Directive and New Deal and its punitive banding structure, we now have a team of competent individuals from different professions, all trained in physical examination and rapid tranquillisation, who are co-ordinated to respond to the wards. The junior doctors play their part in this, but sometimes it is the nurse practitioner who comes to see a patient, initiates treatment and reports back to a centrally co-ordinated service. The days of chasing the junior doctor, who is off site, not answering his bleep or had swapped with a colleague are now long since gone.

Another crucial intervention has been the realignment of our nurse consultants. They used to have really quite poorly defined professional identities. Nobody knew exactly what they were supposed to be doing, and even they themselves were aware of the limited impact on services. Since they have been realigned into a clear role of operational service modernisers they deliver much more benefit. In effect, within our Trust now they operationalise NWW in the clinical environment and have links with our strategic modernisation committee.

It has been an enlightening experience to be involved in such work, developing services within the directorate and being aware of the financial implications. What is fascinating is observing the culture shift that has occurred. The in-patient unit is now a very different place. Sure, it is more disturbed, in that we are only admitting the most severely ill people; but with a dedicated in-patient consultant there is now a sense of owned culture within the ward, with some interesting knock-on effects. The general manager was showing me the reduction in sickness absence over the last 12 months, and I believe that can be directly related to the sense of ownership and to a coherent identity developing within the services.

#### **Thursday, 8 November 2007**

The morning was pretty much the same stuff – seeing patients with some team members and a home visit. It was relatively quiet, so I was able to catch up with a bit of administration, checking my emails and making sure that all communications were up to scratch. Over lunch I had an interesting meeting with the clinical director and some of the new commissioners. To be honest, a year ago I didn't really know what commissioners were, but in this new environment they are very anxious to liaise with the clinicians providing

frontline care. As our Chief Executive explained, we are in the business of providing a service to our users and carers and to our commissioners – a service that needs to be marketable. If we are going to achieve income as a Foundation Trust, as we now are, we have to produce the products that the commissioners want to buy and that are acceptable to our users and carers. In order for the commissioners to join up the pieces they need to know what sort of services are available and effective. I have to say, they are very impressed with our approach and with the fact that they can now walk into a meeting with a psychiatrist who is not simply complaining about lack of resources, who is overworked, overstressed and complaining about being told what to do by management. In effect, the team ethos has spread from the clinical setting into the managerial setting.

I spend the early part of the afternoon supervising one of our nurse-led clinics. The nurses are pretty competent and don't require much input, but they want to discuss several cases, particularly issues related to physical health and medication. I run this supervision service jointly with the pharmacist, who sometimes disapproves of my prescribing practice; but generally speaking we have learned to get on and he is enjoying the benefits of working at the clinical interface, as opposed to just putting pills in bottles.

Towards the end of the afternoon, I had a telephone conversation with a local coroner. I think that the legal profession is finding it hard that the mental health services are undergoing a considerable change. Coroners have the tendency to always assume that, if they require any information on an unexpected death, it comes from the medical practitioner. I was able to explain that, in many cases, this would be the person they would want to speak to or receive a report from. However, nowadays, with the enhancement of the role of care co-ordinator, it might be equally feasible for them to just seek evidence from such an individual. I think it is going to be a long slog with the legal eagles, as they tend to be quite conservative by nature. But at least the coroner agreed to a face-to-face meeting in a couple of weeks' time.

### **Friday, 9 November 2007**

Friday is usually my tidying up day for the weekend, although on this occasion I spent the day at a national conference. My working week has become much more flexible and the community team is now so competent that they are quite happy when I disappear off to other parts of the country. They do have a point of contact in one of my colleague psychiatrists, but they rarely call. They resolve things themselves and tell me about it later. In fact, they often email me when I am away, just to say what they are doing. I find myself answering the odd message on the BlackBerry sometimes in the back of a taxi or on the train. This flexibility of working and availability at distance works well for me and the team, although it does require them to know that you will respond if necessary – and speedily.

The conference? Well that was about NWW, and I was presenting my experiences of the first year of practising in this way. I met some hostility and it never ceases to amaze me just how inhibited some people can be. I was faced with two or three consultant colleagues from different parts of the country who were telling me that it was not possible to work in this way. I had the perfect answer, of course: that me and my team were living examples of just how effective it could be! Some colleagues seem to find it difficult that caseloads can be reduced and that patients will survive without seeing a psychiatrist every three months for five minutes. Some find it difficult to believe the other professions can be effectively trained in what were traditionally medical roles. Some other professions don't want to enhance their clinical skill base and don't want to feel like 'mini doctors'.

To me it all seems fairly clear. The central point of future mental health clinical teams will be the care co-ordinator. They will have a broad clinical skill base and be responsible for guiding the patient around the care pathway. The future role of the consultant psychiatrist is as a highly specialised clinician, positioning him or herself at a different point on the care pathway and being an accessible and flexible resource with a skill base oriented towards complex cases, some of whom they will treat clinically and a larger number of whom they will provide consultancy services for. This will allow them to further enhance their leadership skills and strategic management capacity in the developing services.

As I say to some of my colleagues, 'in order to climb a ladder you also need to let go one hand at a time'. Some of the colleagues that I see are still gripping tightly to the rung they were stuck on several years ago.

I came home from the conference, had a nice glass of Pinot Grigio and switched off my BlackBerry. I might have a peek at it later on if my wife's not looking!

# Appendix E

## Membership of the NWW National Steering Group

<b>Name</b>	<b>Representing</b>
John Allcock	Associate Director, NIMHE NWP
Dr Robin Arnold	Consultant Rehabilitation Psychiatrist representing the Central Consultants Committee of the British Medical Association
Peter Atkinson	Vice Chair, Unison National Nursing Committee
Ian Baguley	Centre for Clinical and Academic Workforce Innovation
Neil Brimblecombe	Director of Mental Health Nursing, Department of Health
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# Appendix F

## NWW National Steering Group (NSG) Terms of Reference

### Overarching purpose

To initiate, oversee and provide strategic direction for national programmes of work within and across the mental health workforce to promote, support and evaluate NWW in services for people with mental health problems and their carers.

### Functions

1. To develop and share new ideas and practice on NWW
2. To set up or commission future programmes of work
3. To facilitate inter-professional dialogue and provide a mechanism for professional body inclusion and sign-off
4. To act as a reference group for multidisciplinary practice
5. To ensure that the NSG programme of work (published in the NSG Final Report) is monitored and delivered.

### Current programmes of associated work

#### Practice

1. NWW:
  - Psychiatrists
  - Applied Psychologists
  - Mental Health Nursing
  - Social work
  - Allied Health Professions (Occupational Therapists, Physiotherapists, Dieticians, Arts Therapists, Speech and Language Therapists)
  - Pharmacists
  - Primary Care
  - Non-professionally affiliated workforce
2. Professional development:
  - Implementation of Ten Essential Shared Capabilities
  - Service user and carer-centred multidisciplinary working

3. Policy and legislation: – Workforce and training implications of mental health legislation
4. Publications: – National Steering Group final report dissemination and feedback  
– Conferences
5. Liaison with: – Mental Health Trusts, Human Resource Directors through SHRINE, Primary Care Trusts and Strategic Health Authorities
6. Liaison with: – Non-statutory sector service providers

### Governance

Accountable to:

1. CSIP/NIMHE through the National Workforce Programme
2. Respective professional organisations, via members.

Reporting to:

1. Department of Health (DH) Mental Health Programme Delivery Board via the National Workforce Programme.
  - Circulation of minutes to:
  - NWP members
  - Mental Health Forum (Sector Skills Councils via Skills for Health)
  - Workforce Leads – Regional Development Centres
  - Debbie Mellor, DH Workforce Capacity Branch
  - Louis Appleby, National Director for Mental Health
  - Ensure that all reps send out to own networks.

### Method of work (for all projects)

- Co-Chairs
- Focus across disciplines/non-professionally affiliated workforce
- Service user/carer involvement.

# Appendix G

## Abbreviations

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Health Professional/s
AMHP	Approved Mental Health Professional
AOT	Assertive Outreach Team
APMT	Association of Professional Music Therapists
ASW	Approved Social Worker
BAAT	British Association of Art Therapists
BADth	British Association of Dramatherapists
BASW	British Association of Social Workers
BDA	British Dietetic Association
BMA	British Medical Association
BME	Black and Minority Ethnic
BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CAT	Crisis and Assessment Team
CBT	Cognitive Behavioural Therapy
CCAWI	Centre for Clinical and Academic Workforce Innovation
CCTA	Creating Capable Teams Approach
CDW	Community Development Workers
CMHT	Community Mental Health Team
CNO	Chief Nursing Officer
COT	College of Occupational Therapy
CPA	Care Programme Approach
CPD	Continuing Professional/Personal Development
CPMH	Chartered Physiotherapists in Mental Healthcare
CPN	Community Psychiatric Nurse
CSEW	Coroners' Society for England and Wales
CSIP	Care Services Improvement Partnership
CSP	Chartered Society of Physiotherapy
CWDC	Children's Workforce Development Council
CWP	Changing Workforce Programme
DBT	Dialectical Behavioural Therapy
DCs	Development Centres
DH	Department of Health
DNA	Did Not Attend
DRC	Disability Rights Commission



DRE	Delivering Race Equality
ESC	Essential Shared Capabilities
E&T	Education and Training
FIS	Focused Implementation Sites
GMC	General Medical Council
GP	General Practice/Practitioner
GSCC	General Social Care Council
HCC	Healthcare Commission
HEI	Higher Education Institutions
HIC	High Impact Changes
HMP	Her Majesty's Prison
HPC	Health Professions Council
HR	Human Resources
HWB	Health and Well-Being
IAPT	Improving Access to Psychological Therapies
IPS	Individual Peer Supporters
KSF	Knowledge and Skills Framework
LA	Local Authority
LAA	Local Area Agreement
LDP	Local Delivery Plan
LIFT	Least Intervention First Time
MHAHPAG	Mental Health Allied Health Professionals Advisory Group
MDT	Multidisciplinary Team
MH	Mental Health
MHP	Mental Health Practice
MHT	Mental Health Trust
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NMDS	National Minimum Data Set
NMHP	National Mental Health Partnership
NOS	National Occupational Standards
NPA	Non-Professionally Affiliated
NPQW	Non-Professionally Qualified Worker
NR	New Roles
NSF	National Service Framework
NSG	National Steering Group
NWP	National Workforce Programme
NWW	New Ways of Working
NWWMHP	New Ways of Working for Mental Health Pharmacy
NWW4SW	New Ways of Working for Social Workers

ONS	Office for National Statistics
OT	Occupational Therapist
OT	Occupational Therapy
PBC	Practice-Based Commissioning
PbR	Payment by Results
PCGW	Primary Care Graduate Workers
PCMH	Primary Care Mental Health
PCMHW	Primary Care Mental Health Workers
PCT	Primary Care Trust
PDP	Personal Development Plan
PICU	Psychiatric Intensive Care Units
PQ	Post-Qualifying
QCA	Qualifications and Curriculum Authority
QOF	Quality Outcomes Framework
RC	Responsible Clinician
RCP	Royal College of Psychiatrists
RCSLT	Royal College of Speech and Language Therapists
SCIE	Social Care Institute for Excellence
SCMH	Sainsbury Centre for Mental Health
SfH	Skills for Health
SHA	Strategic Health Authority
SLA	Service Level Agreement
SLT	Speech and Language Therapists
SMI	Severe Mental Illness
SMT	Senior Management Team
SPN	Social Perspectives Network
STR	Support, Time and Recovery
TOPSS	Training Organisation for Personal Social Services
UK	United Kingdom
VBP	Values-Based Practice
VFM	Value For Money
WHO	World Health Organization
WPPP	Workforce Planning Pilot Programme
WRAP	Wellness Recovery Action Planning
WTD	Working Time Directive
YOI	Youth Offenders Institution





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