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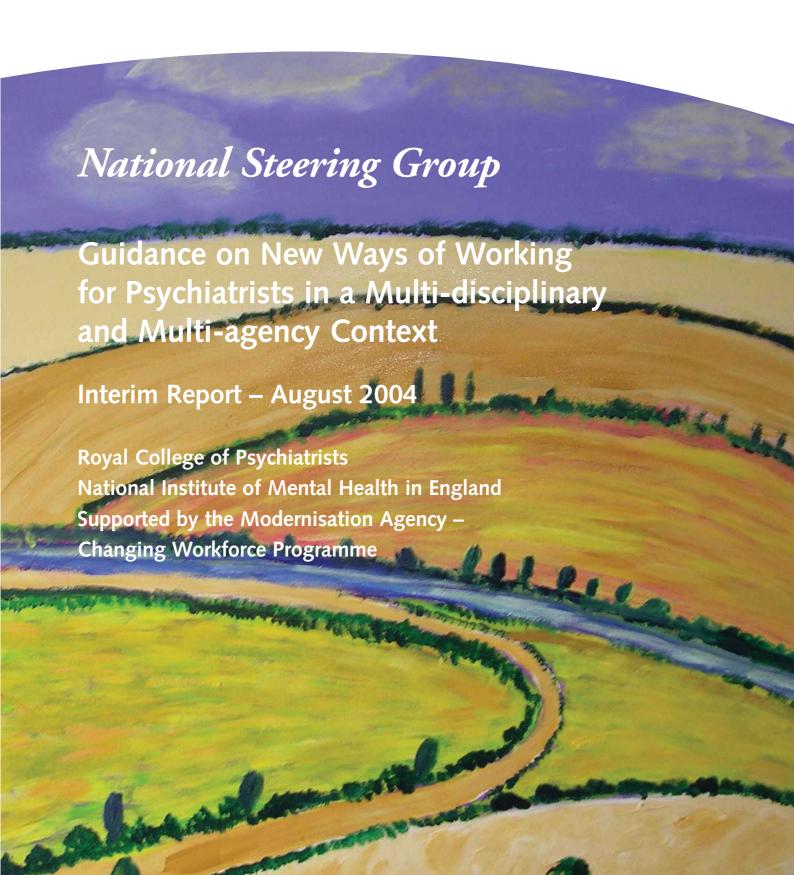
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40379 *National Steering Group – Interim Report* is available on the department's website at: www.dh.gov.uk/





This guidance has been produced to:

Ensure that all staff active in Mental Health and Social Care are working most effectively, through implementing evidence and values based practice, to improve the quality of life and the service experience of people using mental health services, their families and supporters.





National Steering Group

Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context

Interim Report - August 2004

Royal College of Psychiatrists

National Institute of Mental Health in England

Supported by the Modernisation Agency –

Changing Workforce Programme

READER INFORMATION

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Foreword

The vision and the service imperatives encompassed in the Mental Health National Service Framework (MHNSF) and the NHS Plan, in the Older Persons' and Children's National Service Frameworks (NSF) all reflect the need for staff to review their current practice. We must ensure that we are delivering services that make a difference to the people who use them and to their families.

We are making great strides to train more doctors, nurses and allied health professionals, to recruit internationally and to retain staff through Improving Working Lives. We cannot be complacent however. Demographic factors including an ageing population, fewer school leavers and a healthy economy all indicate that we need to be more imaginative in how we expand our workforce. In mental health, whilst training more psychiatrists, nurses, social workers, clinical psychologists, occupational therapists and other professions is critical, we recognise there will still be difficulties in producing the numbers we need to staff services.

The challenge then is to use our highly trained professionals, both currently and in the future, to maximise the positive impact they have on the service user experience. Key, within this context, is the psychiatrist and I am pleased that the Royal College of Psychiatrists (RCPsych) has been proactive in addressing this challenge. Indeed, a key factor in setting up the National Steering Group (NSG) on New Ways of Working (NWW) of the Psychiatrist in a multi-disciplinary and multi-agency context, was a letter written by the President of the RCPsych to the (then) Secretary of State requesting a joint approach to address the shortage of psychiatrists.

I am delighted that the National Institute of Mental Health in England (NIMHE) has entered into partnership with the RCPsych to lead this work in collaboration with the Changing Workforce Programme (CWP), other professional bodies and mental health organisations.

The content and implications of this Interim Report are important and far-reaching. It will be essential to place them in the context of Agenda for Change, consultant contract development and other recruitment and retention initiatives. Further work is being undertaken and this, together with feedback from the field, will inform the final report to be published in Spring.

It is vital that Mental Health Trusts, Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and their Workforce Development Confederations (WDCs), Deaneries and Local Authorities (LAs) address the themes raised in this report in their own services. Local input to and feedback on the current and planned action will be essential to ensuring the success of implementing changes in the workforce at a local level.

I would like to commend this report to you.

Rosie Winterton Minister of Health

1 Background

- 1.1 The Planning and Priorities Framework (PPF) 2003-6 has created new challenges for the workforce by transforming the demand and supply of mental health care. The limited supply of staff in all professional groups means that a review of their roles, responsibilities and working practices across the role boundaries between the professions the workforce is essential.
- 1.2 A groundswell of opinion at the RCPsych, the Department of Health (DoH), British Medical Association (BMA) and from the work of the CWP, has led to an exploration of the need for new and changing roles of consultant psychiatrists, and other professionals engaged in mental healthcare across the United Kingdom (UK). Through a partnership between NIMHE and RCPsych, this led to a review of the role of psychiatrists and their interface with other professionals who provide mental healthcare.
- 1.3 A NSG with two sub-groups was established. The NSG comprises representation of all the key professions and related staff groups involved in mental healthcare. Membership, subgroups and process are described in Appendices 1 and 2.
- 1.4 The aims of the NSG were to:
 - Review the current roles of psychiatrists and produce recommendations for more effective and satisfactory modern roles and career paths;
 - Explore the professional role of psychiatrists in the context of multi-disciplinary working including all groups working in mental health care;
 - Commission projects to identify challenges and solutions, test new ways of working and support dissemination; and
 - Oversee an initial first year's programme of work.

2 Purpose of Guidance

This guidance has been produced to:

- 2.1 Ensure that all staff active in mental health and social care, which covers those working in both the statutory and non-statutory sectors, are working most effectively, through implementing evidence and values based practice, to improve the quality of life and the service experience of people using mental health services, their families and supporters.
- 2.2 Influence and encourage innovative and new and changing ways of practice in the field.
- 2.3 Encourage and support new and effective roles in response to the needs of users and carers. This should enable discussion, development, evaluation and adoption of new ways of working.
- 2.4 Set up a process that influences and engages professional bodies and related organisations to agree and implement the guidance that will be contained in the final report.
- 2.5 Provide Trust Clinical Governance teams with guidance across a range of key role and workforce issues.
- 2.6 Advise regulatory and professional bodies how to reinforce desirable service and workforce change.

3 Parameters

- 3.1 This guidance has been developed for services for people of all ages and diverse backgrounds with mental health needs.
- 3.2 It has been developed with a whole system/mixed economy approach and should be of use to both health and social care.
- 3.3 The primary objective is to develop guidance for England but it is recognised that many Colleges and professional bodies operate across the UK. Every opportunity has been made to involve Wales and Scotland, and it is hoped that the guidance will be of use to Northern Ireland.

4 Values and Vision

- 4.1 Values influence what we do as individuals and as practitioners, whether we are aware of them or not. It is of critical importance that we are aware of the diversity of the values we all hold in order to work successfully together to meet the needs of service users and their families and to address their rights under the Human Rights Act.
- 4.2 The overall purpose of the Mental Health Workforce Strategy for England, led by NIMHE and supported by all partners, including the RCPsych, is to ensure that services reflect the needs and preferences of the population they serve, are delivered by sufficient numbers of well-trained staff who have the appropriate capabilities and are well led and effectively managed. Services of this kind will meet the needs and wishes of the people who use them and their families and supporters.
- 4.3 One in four people experience mental health problems and disorders, of varying degrees of complexity and severity. People who experience mental health problems have the same shared needs as others in society. All citizens in a civil society¹ need a home, education, employment opportunities and an income. Family relationships and friendships, personal relationships, leisure and retirement opportunities and health and social care, when required, are also important to everybody. Every member of society has his or her own unique and individual needs, aspirations and abilities irrespective of age or background but shares wishes and needs that are common to all.
- 4.4 The overarching purpose of modern mental health and social care services is to respond to the people who have need of those services and to their relatives, carers and others close to them. The intention is that services should assist their users to maximise their opportunities and that they should meet their aspirations for independence so far as is possible.
- 4.5 The MHNSF and the Older Peoples' NSF recommend that services "promote mental health for all"; in other words, mental health is everybody's business, whether we use mental health services, care for a relative or friend, or work within the health and social care arena. In partnership, we must all strive to challenge stigma and correct misunderstandings that some people attach to mental health problems. Child and adolescent mental health services and the forthcoming NSF for Children express a similar ethic.

¹ Longley M., Williams R., Furnish S. & Warner M (2001). Promoting Mental Health in a Civil Society: Towards a strategic approach. London: The Nuffield Trust.

- 4.6 Services, including, importantly, primary care services, must be available to help people to understand what they might be going through and how they might be helped, including how to help themselves. Staff should be competent in their particular areas of professional expertise and confident in working with others to address problems that are not just physical in nature. Schools, colleges, workplaces, housing departments, community facilities and residential settings should have information and their staff should have adequate awareness of mental health matters.
- 4.7 Where people have need for more specialist interventions and are referred to secondary and tertiary mental health services, those staff must retain the perspective of the whole person through individual assessment and care planning.
- 4.8 This perspective should be underpinned by a positive attitude of hope and recovery in the belief that each person may continue to lead a self-defined life, reflecting their hopes and ambitions². Where this is not possible, each person and their families should be fully involved in decisions about their future and treated with dignity and respect at all times.
- 4.9 In aiming to develop a workforce with the capabilities to provide developmentally orientated person-centred, socially inclusive and recovery-oriented services, primarily operating in multi-disciplinary settings, the Workforce Strategy reflects the values of the Working Age and Older Adult [and impending Children's] NSF's and NHS Plan as expressed in the NIMHE Values Framework³.
- 4.10 There are differences of language and approach that are necessary and appropriate to services for younger people, working age adults and older people. Nevertheless, all three groups of people and services for them share certain matters. There are linkages of risk and the opportunities for mental health promotion and prevention that exist across the age spectrum⁴. Provision of good services for people of one age can offer the enormous benefits of prevention and early intervention for the same people as they mature.
- 4.11 There are many facets to people's lives; seeing them too narrowly can not only risk failure to meet their needs but can also cause them and their families damage. For instance, it is recognised that many people, who use adult mental health services, are also parents and that some of their children are at vulnerable developmental ages. The importance of

Allott P, et al (2002 in press). Discovering Hope for Recovery from a British Perspective: A Review of a Selection of Recovery Literature, Implications for Practice and System Change. In Lunes et al 'Innovations in Community Mental Health'. Canadian Journal of Community Mental Health.

³ www.connects.org.uk/conference

⁴ Royal College of Psychiatrists (2002). Council Report CR104 Prevention. London: Royal College of Psychiatrists

providing good input to support adults in parenting their children effectively is well established. Not only is this an important matter for the recovery of the adults concerned but the benefits to their children and the risks of not doing so are also clear⁵. Equally, service users can be carers of older people, with similar implications.

- 4.12 These values have significant implications for everyone involved in delivering mental health services; the commissioners of services and of education and training; employers; professional bodies; and professionals themselves.
- 4.13 Recognising the importance of this strategic direction, the RC Psych has set up its own Scoping Group on the Roles and Values of Psychiatrists led by Richard Williams and Bill Fulford and it is expected that it will report in the summer of 2004.
- 4.14 NIMHE has employed a Fellow in Values-based Practice, published the NIMHE Values Framework and developed a set of 10 Essential Shared Capabilities for the whole mental health workforce. [published July and August respectively]
- 4.15 Together these initiatives illustrate the commitments of a number of key organisations to work collaboratively and to share work done separately to better explore, develop and implement this important aspect of new ways of working.

⁵ Royal College of Psychiatrists (2002). CR105 Patients as parents. Addressing the needs, including the safety of children whose parents have mental illness. London: Royal College of Psychiatrists.

5 Workforce Challenges

- 5.1 The NSFs and the PPF pose a serious challenge to create a workforce of sufficient numbers with the right capabilities across all professional and non-professionally affiliated groups.
- 5.2 For the NHS, in England alone, the staffing consequences of PPF targets require tens of thousands of additional staff by 2008. Furthermore, a modest 3% growth per annum in workforce would produce demand for 305,000 new staff. This needs to be seen within the context of the overall national workforce. There are record employment levels (27.9m in April 2003) and by 2010, there will be 700,000 fewer people of working age. Vacancies in the NHS are running at a very high level and legislation, such as the European Working Time Directive, adds additional pressure to reduce hours and recruit more staff to compensate. [Standing Conference of WDC's]
- 5.3 It is vital that we recognise that the mental health workforce spans the health and social care sectors, including the voluntary and independent sectors. To date, workforce planning processes have been separate for each sector. For the NHS, based on new service models and the impact of the Mental Health Bill, a modest estimate of staffing demand, submitted to the Workforce Numbers Advisory Board (WNAB) in 2003, indicated the need for increases by 2006 of 500 psychiatrists, 3,000 nurses, 1200 social workers and 600 occupational therapists for employment in mental health services and a 15% annual increase in clinical psychology training places. Additional capacity is also required for other groups, including pharmacists, physiotherapists, art therapists and dieticians.
- 5.4 Training more professional staff is a high priority, as is the retention of existing staff and recruiting internationally. It is clear, however, that these initiatives will not be sufficient to meet demand. It is essential, therefore, to make best use of our highly trained professionals and, hence, to support them to work most effectively and efficiently. This requires existing and new staff to be flexible in reviewing and changing their roles.
- 5.5 Furthermore, we should seek to recruit from a wider pool of the population into health and social care. We should draw on people without the present minimum GCSE qualifications and graduates in health and social sciences (for example, 13,000 psychology graduates are trained each year), who may not want to train in the traditional professions. In order to attract these people into the workforce and create career pathways, we must explore new roles to complement new service configurations.

5.6 Two national conferences were held in the spring of 2003 and the BMA published a report from the cross-agency NSG n New Roles for Psychiatrists in February 2004⁶. It highlights three key areas of concern in relation to the role of the psychiatrists.

These are:

- Issues concerning responsibility, power and accountability;
- Training in leadership and management skills; and
- Concerns about ensuring continuity of care.
- 5.7 History and ambiguous guidance has led to the widespread expectation that consultant psychiatrists carry 'medical responsibility' for all people who are referred to secondary care services. The Responsible Medical Officer role is a legal requirement under the Mental Health Act it does not apply to informal patients; yet this has been extrapolated to other service users. In turn, consultants have developed unmanageable workloads, whilst Trusts, and indeed the general public, have developed unrealistic expectations of consultants.
- 5.8 Similarly, assumptions that consultant psychiatrists should automatically be team leaders has led to role confusion in some areas, to stress for consultants and to irritation from other professionals. This has been compounded by lack of clarity between the functions of leadership and management.
- 5.9 In general psychiatry, there has been a conflict, in some areas, between the implementation of the Care Programme Approach/ Care Co-ordination by teams and the work of general adult psychiatrists in outpatient clinics. Many psychiatrists recognise that this situation is undesirable. There is now a real opportunity to create services without traditional outpatient services, based more flexibly on the needs of service users.
- 5.10 Some research supports this review. In 2003, a study, inspired by the Dean of the RCPsych and carried out by a group from the College Research Unit, measured the effect of different consultant roles on their level of stress⁷. It showed that an alarming proportion of consultants exceeded clinically significant scores on well-validated questionnaires. A key finding was that those consultants who had adopted 'new' ways of working were significantly less stressed than those practising more traditionally.

⁶ National Working Group on New Roles for Psychiatrists (2004). New roles for psychiatrists. London: British Medical Association.

Pajak S, Mears A, Kendall T, Katona C, Medina J, (2003). Workload and Working Patterns in Consultant Psychiatrists. An investigation into occupational pressures and burdens. London: College Research Unit of the Royal College of Psychiatrists. http://www.rcpsych.ac.uk/cru/hsrp/workloadreport.pdf.

- 5.11 It is sobering to learn that parallel research on social workers, carried out by Peter Huxley, illustrated that the stress levels of social workers were, overall, even higher than of those of psychiatrists.
- 5.12 One component of the work done by the Scoping Group, set up by the RCPsych, has been to take further the work done originally by Peter Kennedy and Hugh Griffiths on consultant responsibility⁸. That work was a key part of workshops run by them at the two conferences conducted in 2003. The College Scoping Group drew up a consultation paper, which it published on the College website late in 2003 and in the Psychiatric Bulletin in early 2004⁸. Views were sought of respondents on three hypothetical illustrative options for new roles for psychiatrists and other mental health professionals and on how work, roles and responsibility might be distributed between them. The intention was not to promote any one of those options but to use them to gauge the spread of opinion on the issues that they described.
- 5.13 Appendix 3 to this report summarises the options on which the Scoping Group consulted. At the time of publishing this report, the responses indicate that Option One (no change) is not popular while the majority favour Option Three and a sizeable minority saw Option Two as either more easily attained or preferable. Further analysis will be carried out, but it does appear clear that a majority of those who responded wish to see changes in their roles and responsibilities.

The NSG and its sub-groups have been reviewing documents, hearing evidence from across the spectrum of mental health care and identifying good practice. The following themes are emerging:

⁸ Kennedy P, Griffiths H, (2002). What Does 'Responsible Medical Officer' mean in a modern mental Health service? Psychiatric Bulletin, 26, 205-208.

⁹ Royal College of Psychiatrists' Scoping Group on the Roles and Values of Psychiatrists (2004). Remedies for work overload of consultant psychiatrists: Consultant psychiatrists and specialist registrars – your views are invited. Psychiatr. Bull., 28: 24 – 27.

6 Initial Themes

- 6.1 Any change in roles and practice must lead to more choice and better information and higher quality for service users and carers and to a more satisfied workforce.
- 6.2. The need for new roles and new ways of working is supported by representatives from across the workforce and professions and by users and carers.
- 6.3 Research indicates that moving from the more traditional 'psychiatrist centred service' approach to a more 'consultative partnership' style (Kennedy and Griffiths) can lead to jobs that reduce the stress, burnout and actual working hours of psychiatrists and create more opportunities for other disciplines.
- 6.4. In such a style of approach, psychiatrists operate as 'consultant advisers' to team(s). When working in this way, consultant psychiatrists advise or consult with the other professionals. In these instances, consultants are responsible for the quality and content of the advice they offer but do not adopt continuing responsibility for the care of the service users or for the care plan. Service users' care is managed through Care Co-ordination and other professionals retain clinical responsibility for their practice. This enables psychiatrists and other senior professionals to have reduced caseloads concentrating on the care of people with high levels of severity and complexity of problems. The success of approaches of this kind relies on comprehensive assessments of the needs, strengths and the preferences of individual service users.
- 6.5 Success in using senior staff in these, more strategic, ways requires clarification about accountability, supervision and leadership in mental health care. This poses questions of service accountability for local resolution and, at national level, questions about legal and professional accountability that need to be addressed.
- 6.6 Models that are in current use in some services for adults, older people and children and adolescents (e.g. single management systems, single point of entry, integrated care pathway, workload management, team-working and modern models of leadership), have shown considerable improvements in service users' pathways through services.
- 6.7 There is a need to carry out a review of the RCPsych guidance on job descriptions and the appointments of consultant psychiatrists, including job profiles and recommended norms for numbers of psychiatrists in a service.

- 6.8 This need has been accelerated by new job contracts for consultants in the UK, which are based on local job planning. This process has highlighted the hours worked by and pressures on psychiatrists in pilot Trusts and it provides opportunities for better management of consultants' workloads.
- 6.9 The over-dependence on locum psychiatrists is a problem that is intended to be addressed by new ways of working. Meanwhile, a review of the use and terms of employment of locums is necessary to determine the implications for good practice, recruitment and retention.
- 6.10 The roles and responsibilities of all staff groups will change as a consequence of psychiatrists adopting new roles and as a consequence of other factors such as new technology and service redesign. New models of working for the whole workforce are required to achieve the most effective systems of care.
- 6.11 There is a need to develop further roles at advanced and consultant levels across many professional groups and to design new roles at assistant and associate level to facilitate clinical career progression.
- 6.12 New roles for support and administrative staff have been identified as key to enabling professionals to achieve greater efficiency and effectiveness in their work.
- 6.13 Providing leadership development for psychiatrists and the other professions is vital. Leadership development must recognise the specialist and generic roles of the various staff groups, and the importance of team effectiveness.
- 6.14 Combating the stigma of working in mental health services and creating a positive view of a career in mental health services is essential if we are to achieve a competent and motivated workforce.
- 6.15 We must acknowledge the diverse and changing needs of service users and ensure that staff are equipped to meet those needs.
- 6.16 A key factor in creating and sustaining change is the nature of the organisation within which practitioners work and much greater emphasis on healthy working environments is required.
- 6.17 Current training, education and continuing professional development do not yet sufficiently support flexible, multi-disciplinary, user-focussed practice. Examples of service user and carer involvement in education and training are expanding.

7 Current and Planned Action

- 7.1 The legal and professional responsibilities of Consultant Psychiatrists are being actively discussed by the RCPsych, the BMA and the General Medical Council (GMC), in order to provide greater clarity and flexibility nationally.
- 7.2 In the meantime, the Avon and Wiltshire Partnership Trust pilot site has produced a local framework, which has been agreed with its lawyers and Clinical Negligence Support for Trusts. It has been approved by the Trust Board. This pilot site will continue to develop this document as part of its programme of change. (See Appendix 9) Trusts should consider how this framework could be used locally.
- 7.3 Although the main focus of the NSG has been on consultant psychiatrists, mental health services are delivered by teams of multi-disciplinary staff, who jointly offer comprehensive care. No individual discipline can be expected to possess all the capabilities, knowledge, skills and values required. Equally, the vital role of primary care in dealing with the large majority of mental health problems will be addressed in the next six months.
- 7.4 Defining what only one profession can do in a multidisciplinary team is [and has been] fraught with problems. The challenge is to map capabilities that meet the needs and preferences of service users. A matrix will be produced to illustrate the model for use by services when they review their workforce requirements and their skill mix options.
- 7.5 The CWP is supporting two sites which are working through some of the complex change issues and are currently developing and testing new ways of working. They are:
 - Newcastle, North Tyneside and Northumberland Trust, which is moving from generalist to specialist consultant roles in acute inpatient and crisis services and its community-based teams for working age adults. Work is also under in Hull and Doncaster NHS Trusts. [North East, York & Humber NIMHE Development centre (DC)]
 - Avon and Wiltshire Partnership Trust, which is redesigning its care pathway with the intention of supporting primary care services more effectively and enabling more appropriate access to specialist services [NIMHE South West]

In addition, the CWP has secured funding to support a pilot site in each of the remaining six NIMHE DC areas to ensure that there are eight pilots underway and that reports are received in 2004-2005. NIMHE centres and CWP have begun discussions and early indications are that:

- South East NIMHE will follow up the outcome of a workshop on consultant roles held recently to explore next steps
- West Midlands NIMHE has held meetings with two NHS Trusts and further developments are underway
- Eastern NIMHE held a workshop in March 2004 and has agreed an Action Plan for 2004/5
- East Midlands NIMHE held a local conference in early 2004 and is looking for a pilot site in respect of people of working age
- Discussions are taking place in London NIMHE and North West NIMHE
- 7.6 Working Groups have been or are being established with the British Psychological Society, the College of Occupational Therapists, the College of Pharmacists, Nursing Groups and Social Work as well as with NHS Trust Chief Executives to develop new ways of working and new roles, supported by the CWP and NIMHE.
- 7.7 The NIMHE/Sainsbury Centre for Mental Health Joint Workforce Support Unit has undertaken a national survey of the use of locums and the reasons for their use, which was completed in June 2004.
- 7.8 A Working Group of representatives of the RCPsych, Chief Executives of NHS Trusts, CWP and NIMHE has been set up to review and revise the guidance offered by the RCPsych on appointing consultant psychiatrists. This will consider job descriptions and the norms for the numbers of psychiatrists in a service.
- 7.9 The Joint Workforce Support Unit will undertake a survey of innovative practice across England by October 2004.
- 7.10 'Capable Organisations' rely on good systems, structures and characteristics, which affect the functioning of staff. Good practice examples will be sought as part of the survey of innovative practice by October 2004.
- 7.11 A Joint Action Plan on recruitment and retention of psychiatrists has been drawn up by the RCPsych and DoH and is now available on the DOH website for implementation.

- 7.12 Education and Training (E&T) and Continuing Professional Development are of major importance to change the attitudes, expectations and skills of all professionals. Work has taken place to design values-based as well as evidence-based practice principles and was published in July 2004 In addition, work has taken place to develope a set of Shared Capabilities for the staff workforce in Mental Health Services, the Ten Essential Shared Capabilities and is being published in August 2004.
- 7.13 Good practice guidance on user and carer involvement in E&T for use by commissioners and providers of education and training will be available in summer 2004.
- 7.14 'Modernising Medical Careers' will stimulate rapid and beneficial change. The RCPsych, postgraduate Deaneries and employers will ensure that there is active engagement in this process by summer 2004.
- 7.15 The provision of leadership development for all professionals, with a preliminary focus on psychiatrists should be accelerated. The Team Effectiveness Leadership Programme, currently being rolled out through NIMHE, will be used as an opportunity to facilitate this process. The Leadership Centre will support exploratory initiatives such as psychiatrists' leadership development programmes.
- 7.16 Service redesign is well established in Trusts, PCTs and SHAs. It is a major programme within NIMHE. Role redesign, facilitated by CWP, should be actively explored to support change management.
- 7.17 Changing practice towards reduced caseloads needs to be recognised in activity returns for performance management by commissioners and the DoH to avoid building in perverse incentives as does definitions of waiting times.
- 7.18 Evaluations of new ways of working, particularly from early pilot sites, will be fed in to new sites as they become available.

8 Next Steps

- 8.1 This interim report provides an update on progress and a summary of the direction of implementation of 'New Ways of Working in Mental Health'.
- 8.2 The Psychiatrist Subgroup will be reconstituted to support the work of the pilot sites.
- 8.3 The Cross Boundary Subgroup will complete the development of the matrix and will address the interface between primary and secondary care.
- 8.4 Research will be carried out and feedback sought from the field on the Interim Report and on local experience.
- 8.5 A draft final report will be produced by December 2004 and the agreed final report will be published by Spring 2005 to include recommendations.
- 8.6 Dissemination of key action points will begin as soon as possible. They include:
 - Delivering an extensive programme of national and regional conferences and workshops in order to consult and inform the workforce, led by the NIMHE National Workforce Programme, NIMHE DCs, the RCPsych and the other professional bodies;
 - Agreeing with the DOH and other associated organisations, such as NHSU, Skills for Health and TOPSS, the strategic development of new roles, E&T programmes and the resource implications;
 - Consulting on the guidance with the relevant professional bodies;
 - Ensuring the Mental Health Care Group Workforce Team supports the delivery of the workforce and education and training implications;
 - Agreeing with SHA, WDCs and postgraduate Deaneries how planning and commissioning of E & T for the existing and new workforce will be taken forward;
 - Indicating to SHAs, PCTs and LAs what are the implications for commissioning services;

- Supporting the pilot sites and disseminating good practice through NIMHE and the DCs;
- Working with the Higher Education Institutions and NHSU to develop new curricula and to train the trainer programmes; and
- Working with the Leadership Centre, NIMHE and professional bodies to develop further leadership and team working capabilities.
- 8.7 A review of progress and a decision on further action that is required will be made in early 2005. We recommend that a meeting is organised and jointly chaired by NIMHE and the then President of the RCPsych, or his/her nominee to involve all of the key stakeholders.

Appendix 1 Background to setting up of National Steering Group

The NSFs, the NHS Plan and changes in populations of the countries that comprise the UK, and the western world together with the European Working Time Directive have created new challenges for the workforce by transforming the demand and supply of mental health care. Furthermore, challenges set by the Wanless Report in England and Wales, which stress community services and emphasise health promotion, are going to have fundamental effects on the pattern of statutory sector funded services in the UK. Service users, in secondary care, are cared for by specialist teams and other new type of services, thereby creating greater expectations and the need for new ways of working. The limited supply of staff in all professional groups means that a review of their roles, responsibilities and working practices across the role boundaries between the professions is essential.

Several contemporary pieces of work put in hand by different bodies identified similar requirements for a wider UK-wide review. These include the Northern Centre for Mental Health thaat undertook an initial role analysis; the BMA's Central Consultant Specialist Committee had established a sub-group to look at the role of consultant psychiatrists in multi-disciplinary teams; the RCPsych had established its scoping group on the roles and values of psychiatrists. Several other groups at the RCPsych and the DoH had begun to explore the need for new and changing roles for consultant psychiatrists and other professionals engaged in mental healthcare. The latter included work that is being undertaken in the Modernisation Agency's Changing Workforce Pilots in Newcastle, Northumberland and Tyneside and North Cumbria. A project, to learn more about what consultants do and the pressures on them, by shadowing consultant psychiatrists, gave particular insights, which reinforced the need for new ways of working. Finally, two national conferences, held in the spring of 2003, as a joint initiative involving the NIMHE, BMA, RCPsych and GMC, were attended by a large number of psychiatrists and, again, their responses provided strong support for the urgency of a review.

In parallel, a letter to Jacqui Smith MP, to the then Minister responsible for Mental Health, from Dr Mike Shooter, President of the RCPsych and supported by the National Director of Mental Health, Professor Louis Appleby, led to a review of the role of psychiatrists and their interface with other professionals who provide mental healthcare.

As a consequence, a NSG with two sub-groups was established. Dr Shooter and Professor Sheehan (then Chief Executive of NIMHE) jointly chaired the NSG. This group comprised representation of all the key professions and related staff groups involved in mental healthcare, together with service users and carers.

The NSG met for the first time at the end of February 2003. Beforehand, Professor Anthony Sheehan contacted the relevant presidents, heads of other organisations or colleges and lead officers

to seek their advice, support and nominations for the National Steering Group. As a result, the group has a wide membership. [Appendix 2.]

The aims of the NSG are to:

- Review the current roles of psychiatrists and produce recommendations for more effective and satisfactory modern roles and career paths;
- Explore the professional role of psychiatrists in the context of multi-disciplinary working including all groups working in mental health care;
- Commission projects to identify challenges and solutions, test new ways of working and support dissemination; and
- Oversee an initial first year's programme of work.

Two two sub-groups were formed to undertake the work needed.

The Psychiatrist Sub-group

This group, looking specifically at the role of consultant psychiatrist, has adopted a focus on workforce design. It has examined, reviewed and recommended an action plan for the emerging new and changing roles of psychiatrists.

This group is jointly chaired by Professor Richard Williams, from the RCPsych, and Barry Foley, Mental Health Lead from the CWP. It has a wide membership ranging from professionals, organisations and users of mental health services. See membership. [Appendix 2.]

Cross Boundary Sub-group

This group, looking at the existing roles of all professions and non-professionally affiliated staff, is exploring the flexibility of roles and responsibilities and the potential for multi-disciplinary working in new and changing models of mental healthcare.

It is jointly chaired by Dr Matt Muijen, (the then Director of the Sainsbury Centre for Mental Health) and Roslyn Hope, (Director of National Workforce Programme for NIMHE). Its membership is representative of organisations and involves service users and carers. [Appendix 2]

Appendix 2 Membership of Groups

National Steering Group

John Allcock Janice Miles

NIMHE National Workforce Programme NHS Confederation

Dr Robin Arnold Rachel Munton

British Medical Association Department of Health
Director of MH Nursing

Ian Baguley Joe Nichols

Trent NHS WDC Nursing & Midwifery Council

National Mental Health Lead Professional Advisor

Richard Brook Dr Sally Pidd

MIND Deputy Registrar-Workforce

Chief Executive Royal College of Psychiatrists

Professor CA Butterworth Catherine Pope

South Trent Workforce Development Chartered Society of Physiotherapy

Confederation

NIMHE Fellow in Values Based Practice

WDC/Lead MH

Professor/Chief Executive of Trent

Judi Egerton Professor Shula Ramon

Clinical Nurse APU
Changing Workforce Programme BASW

Barry Foley Anne Richardson
Joint Chair, Psychiatrists Subgroup Department of Health

Workforce Designer /MH Lead CWP Branch Head-Mental Health

Professor Bill Fulford Brian Rogers

Warwick University Professional Officer/MH Nurses

Peter Gilbert Jane Shears

NIMHE Social Care Fellow British Association of Social Workers

Angela Greatley

Sainsbury Centre for Mental Health

Acting Chief Executive

Professor Antony Sheehan

Joint Chair - NSG

NIMHE Chief Executive

Roslyn Hope

Joint Chair-Cross Boundary Subgroup

Director, NIMHE National Workforce

Programme

Dr Mike Shooter

Joint Chair - NSG

Royal College of Psychiatrists

Dr. Bob Jezzard

Doh CAMHS Advisor

David Tombs Service User

Dr. Peter Kinderman

British Psychological Society

University of Liverpool

Carol Walker

College of Occupational Therapy

Sue McQuire

Senior Dietitcian

College of Dieticians

Professor Michael Wang British Psychological Society,

The University of Hull

Sheila Merriman

Head of Nutrition & Dietetic Service

St Andrew's Hospital

Professor Richard Williams

Joint Chair Psychiatrist Sub-group

Royal College of Psychiatrists

Consultant Psychiatrist Sub-group

Barry Foley

CWP Mental Health Lead

Joint Chair

Dr Peter Kinderman

British Psychological Society/

Reader of Clinical Psychology

The University of Liverpool

Professor Richard Williams

Royal College of Psychiatrists -

Joint Chair

Dr Matt Muijen

Sainsbury Centre for Mental Health

Chief Executive

Dr Anna Higgitt

Chief Nursing Officers Directorate,

DoH Senior Policy Advisor

Dr. Peter Kennedy

Northern Centre for Mental Health

Brian Rogers

Mental Health Nurses Association,

Professional Officer

Professor Bill Fulford Dept. of Philosophy University of Warwick

Professor

Dame Lesley Southgate

Royal College of General Practitioners,

President

Dr. David Prosser

Adult Mental Health Services

The Carleton Clinic Consultant Psychiatrist

David Tombs Service User

Dr. Hugh Griffiths

NHS Clinical Governance Support Team, Director of Policy Innovation and Knowledge

Management

Ian Jonston

Director of British Association of Social

Workers

Judi Egerton

Clinical Nurse Specialist in Psychotherapy

Dr Judy Harrison

Manchester MH and Social Care Trust Dept of Psychiatry, Consultant Psychiatrist Dr Robin Arnold

BMA and Central Consultants & Special

Committee

Chair of the Psychiatry Sub-committee

Ron Shields

Sainsbury Centre for Mental Health Formerly Head of Service Development

Rowena Daw

National Association for Mental Health

Head of Policy Development

Dr Suresh Joseph

Newcastle, North Tyneside and

Northumberland Mental Health Trust

Consultant Psychiatrist/ Director of Medical

Education

Prof. David Kingdon

University of Southampton

Professor of Mental Healthcare Delivery

Stephen Dalton

CCIIT Lead - North/ Chief Executive

NCMHLD-Trust

Dr Malcolm Hawthorne

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Roslyn Hope

Director NIMHE national Workforce

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Andrew Butters Chief Executive

Manchester Mental Health and Social Care

Dr. Stephen Merson

Assertive Outreach Team, NNNs Trust

Oxford Centre, Newcastle

Erville Millar Chief Executive

Camden and Islington Mental Health

and Social Care

Elizabeth Collins

CCIIT

New Ways Working Team Modernisation Agency

Ian Pullen

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Professor Shula Ramon

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Roger Browning Chief Executive

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Jane Shears

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BPS/

The University of Hull

Appendix 3 A Summary of the Hypothetical Options Consulted on by the Royal College of Psychiatrists

Option 1: No change in consultant psychiatrists' responsibilities

The main features of this option are that:

- Consultants continue to be responsible for very large numbers of patients in secondary care;
- Consultants accept continuing workload problems and the likelihood of further increases in demand;
- Consultants hope that more colleagues will be recruited from the increased output of medical schools this is likely to require us to wait a decade or more for any significant impact on consultant numbers; as
- There is a much lesser requirement for professionals from other disciplines to develop greater clinical autonomy.

Option 2: Smaller and selected consultant caseloads with responsibility for other patients *delegated* to other professional disciplines in the teams that provide services

The main features of this option are that:

- Consultants have reduced personal caseloads but continue to be responsible for very large numbers of patients;
- There is a named consultant for all patients in secondary care whether they are inpatients or outpatients;
- Consultants develop *supervisory* relationships with other professionals

- The other professional disciplines need to develop competencies so that they can accept greater clinical autonomy;
- There is no need to negotiate with the GMC with the aim of developing its current guidance; as
- There would be the need to develop guidelines to define the meaning, nature and range of 'complexity' and the training required to address it.

Option 3: Smaller and selected consultant case loads with responsibility for other patients *distributed* among other professionals in teams

The main features of this option are that:

- Consultants have reduced caseloads and direct responsibility for fewer patients in secondary care;
- Consultants have clinical responsibility for selected high risk or complex cases;
- Consultants need to develop *consultancy* relationships with other professionals;
- Professionals from other professions need to develop competencies for more clinical autonomy;
- There might be a need for the RCPsych to request the GMC to develop guidance on the responsibilities of consultant psychiatrists; and
- There would be the need to develop guidelines to define the meaning, nature and range of 'complexity' and the training required to address it.

Appendix 4 Pilot Sites supported by the Changing Workforce Programme

Newcastle, Northumberland and Tyneside NHS MH Trust

The Pilot work on consultant roles and teams in Newcastle, Northumberland and Tyneside NHS Trust is being undertaken alongside a major service review and change programme.

Their plan is to move away from a traditional sector approach with consultants working across in-patient wards, Community Mental Health Teams and primary care. The increasing complexity of service provision meant that consultants found it difficult to provide adequate levels of input consistent with a specialist service. For the last 30 months, they have reviewed their roles and workload and agreed role changes as part of an overall service redesign process.

Over the next 6 months, 12 consultants in Newcastle will begin to move from generic roles to specialist roles. Consultants will then work exclusively with either in-patient teams or community multi-disciplinary teams. Specialist Consultants will be able to focus on their particular area of service. It is hoped that this will enable:

- Strong clinical leadership and direction;
- Easy access for the patient to an expert assessment and review;
- Easy availability, to members of the multi-disciplinary team, other specialists and primary care, of support, discussion and supervision;
- Better joint working between senior professionals and managers; and
- Greater availability of supervision and training of junior medical staff and other staff.

Changes will have to be made to junior doctors' roles and job plans will have to be rewritten.

Avon and Wiltshire Mental Health Partnership

The Avon and Wiltshire Mental Health Partnership NHS Trust is redesigning the roles and responsibility of consultants and new and changing roles in mental health teams, particularly to support primary care.

That Trust has been working on various ways of developing the role of the consultant psychiatrist, in order to both make the job more attractive to potential recruits and use the skills of the psychiatrist in the most effective way to improve the quality of patient care.

They intend to further develop the guidance on the role of the consultant, which gives management support and 'permission' for roles to change within the multidisciplinary team, and to roll-out and evaluate a different way of working for the consultant in a community setting, which reduces waiting times and administration, and increases the quality of assessment. A copy of the above Guidance can be found at Appendix 9. Organisations may find this guidance helpful as a starting point for their discussions on NWW.

Appendix 5 New Roles and Staff Skills Map: A Matrix Model

Although the primary focus of the NSG has been on consultant psychiatrists, mental health services are delivered by teams of multi-disciplinary staff, which jointly, offer comprehensive care. No individual staff group can be expected to possess all of the capabilities, knowledge, skills and values required.

The challenge is to map capabilities that meet the needs and aspirations of the users of the services. A matrix is being developed to illustrate the model for use by services to review the workforce requirements and skill mix options. This means that services will require staff with a range of capabilities that are determined by:

- The needs and number of users and carers;
- The functions of each team in balanced and purposefully designed system of care;
- The supply of staff; and
- Other needs and resources in the area

The users, their families, carers and members of each of the community have needs that cross many domains including those for mental health care, housing, spirituality and employment. Some, but not all, of these needs should be met by staff who intervene and the tasks, they take on cover a range of activities. The capabilities to undertake these tasks need to be specified. Some capabilities are unique to staff groups (for example RMO responsibilities under the Mental Health Act for psychiatrists are directed by law to that profession), some are shared across several groups (prescribing or Cognitive Behavioural Therapy) and some are common for the whole workforce (good communication). The combined capabilities of a staff group across the domains determine the role of the staff group.

Work is progressing to develop a matrix to help determine tasks of staff groups within the mental health workforce. Key questions addressed by the cross-boundary subgroup are:

- what are unique, shared and common tasks and responsibilities of individual staff groups,
- what tasks can be delegated to other groups under what conditions, if any;
- what tasks are not met by the existing workforce.

Appendix 6 The Workforce Consequences of Developing Mental Health Services

1.1 List 1 shows the kinds of workforce provision that all modern developing services require and the (support to staff) if they are to be effective. This list is derived from work done by the external working group for the mental health and psychological well-being module of the NSF for children in England and is informed by the Carlisle Review and the Bristol Inquiry.

List 1

- A workforce of adequate size and skill mix, that reflects the needs of service users and their families, that is not isolated but an acknowledged part of a network
- Services to support the skills of the workforce
- All staff are trained to do they jobs that they are asked to do
- All staff, including managers, have dedicated time and resources for continuing professional development
- Clinical mangers have protected time away from clinical responsibilities to carry out their responsibilities
- Managers and clinical managers receive advanced leadership and management training
- All staff are subject to regular appraisal and mentoring and supervision is readily available
- Service users have ready access to advocacy services in which they are offered choice
- Staff have ready access to advice, including properly qualified and informed legal advice, about consent and information sharing
- Services are well led and well managed
- The design of services is based on evidence-based and values-based approaches and espouse a similar ethic in practice
- All senior staff are able to exercise the option of having regular research sessions within their contracts

1.2 List 2 depicts the infrastructure support that staff require. This has emerged from work done on workforce developments in Wales.

List 2

- High quality service leadership and management
 - Getting commissioning right
 - Good leadership and management of provider agencies
 - Use of effective care and case management mechanisms
- Underpinning service delivery with opportunities for audit and clinical research
- Providing the right initial training and opportunities for realistic CPD
- Providing appropriate levels of clerical and administrative support
- Getting right the physical environment of work
 - The premises for service users and staff are adequate in size, design and decor
 - All staff have adequate access to private office accommodation, telephones, networked IT and other communications
- 1.3 List 3 shows some of the headline themes that act as barriers in inter-professional and cross-agency and cross-sector partnership. It summarises a substantial volume of research from the Dartington Social Research Unit in the University of Bristol.

List 3 – Barriers to Collaboration

Differences in:

- Theoretical and doctrinal bases of, and approach to working with service users
- Organisational functions and structures

- Professional perceptions of: Service intent, purpose and direction;
 - Need
 - Risk
 - Processes, outcomes and effectiveness
- Who is within vulnerable groups of clients.
- 1.4 List 4 provides a summary of evidence-based solutions to the challenges summarised to collaborative working. This list summarises research conducted in Wales.

List 4 – Some Remedies to Barriers in Collaboration

- Developing a common language
- Organisational development to remove glass ceilings
- Leadership
- Training together
- Long-term relationships
- Freedom from re-structuring as solutions to wider problems
- Identifying and using the lessons from success;
- Clear agreements between the agencies, departments within agencies and members
 of teams about who does what and how services and care plans are agreed, coordinated and reviewed
- Persistence and sheer hard work

1.5 List 5 is based on current adult education theory and practices. It shows how much views of appropriate professionalism should be continuously actively reviewed and revitalised.

List 5 – Critical Reconstruction of Professionalism

- Conversations with service users and their families so that professionals remain alive to the core purpose of their work
- Conversations between professionals
- Learning from talk but also learning to talk critically and creatively
- Absorbing and being absorbed into a critical community of practice
- Gaining access to the relating writing of others that form the recoded history of professional practice
- Becoming immersed in the traditions of practice that survive the rigours of review
- Each professional critically reconstructing anew those traditions and practices that they adopt rather than mere replication

Appendix 7 Helpful Methodologies

There is a range of toolkits, videos, guidance packs that can provide support for organisations undertaking a review of roles and changing or developing new roles. Helpful information about the new Consultant Contracts process and Agenda for Change is available for the NWW Team.

Below is a brief outline of one such tool.

The use of role redesign can be helpful when looking at new ways of working and fits well with a matrix model. Role redesign allows four main types of change:

- 1) Moving levels up or down a traditional uni-disciplinary career ladder
- 2) Expanding the breadth of a role
- 3) Increase the depth of a role
- 4) Creating new roles which look at tasks differently from before, such as Support, Time and Recovery worker.

Benefits of Role Redesign for the workforce can be:

- Quality care when the patient needs it
- Reduction in waiting times
- Management of an ever-increasing workload
- Job satisfaction
- Reduced vacancies and staff turnover
- More suitable education and training
- Career development through the skills escalator
- A flexible, responsive workforce

Service Improvement is a NIMHE National Programme, led by Jackie Ardley. Details can be accessed through www.nimhe.org.uk

Appendix 8 Further Reading

Useful papers and reports have been produced by the RCPsych, NIMHE, DoH, BMA and other organisations. The NSG will incorporate these in its final guidance. A selection is:

- New Roles for Psychiatrists: shaping the national debate;
- Workload of Consultant Psychiatrists and working patterns;
- Joint Action Plan to enhance recruitment and retention of Consultant Psychiatrists;
- National Mental Health Workforce Strategy [published August 2004]
- Ten Essential Shared Capabilities [published August 2004]
- Values Based Practice [published August 2004]

Appendix 9 Trust Guidance on the Role of the Consultant Psychiatrist: Avon and Wiltshire Mental Health Partnership NHS Trust

Guidance from a variety of national bodies on this topic is not well aligned. The Trust has taken legal advice, which is that the organisation can offer an interpretation of current guidance if endorsed by the Trust Board. The Avon and Wiltshire Mental Health Trust Board endorsed these guidelines on 26th September 2003.

Introduction

Confusion exists as to the limits of the role of the consultant psychiatrist. This is evident from listening to the views of doctors and other professionals within and outside the Trust, and from the ambiguous nature of the national guidance that is available.

This confusion has made many think that the responsibilities of the consultant are now so allencompassing that the goal of producing 'do-able' jobs is receding further and further, at a time when the shortage of consultants means that we need to be striving for the opposite. In order to effect new ways of working for both consultants and their colleagues within the multidisciplinary team, the limits of medical responsibility need to be clarified.

During the national conferences on 'New Roles for Psychiatrists' held in Swindon and Newcastle in March/April 2003, it was acknowledged by their representatives that the Royal College and GMC guidance on this topic was out of step with service developments and needed revising. However, until this is done, and until national guidance from medical and other professional organisations is all in harmony with each other and with the definitions in the New Mental Health Act, the confusion will remain, and the development of new ways of working will be hampered. AWP staff at the Swindon conference asked the Trust to produce its own guidance to provide clarity in the meantime, and this document has therefore been prepared by the Executive Management Team working with the Trust's solicitors.

The Trust will support its staff in abiding by the guidance in this document.

National statute and guidance

Guidance note: The Mental Health Act 1983 is law, documents from the GMC, Royal College of Psychiatrists etc are GUIDANCE only, to be read alongside this Trust Guidance and considered in the same way.

The Responsible Medical Officer

- This term refers to the Mental Health Act 1983 ONLY.
- The Responsible Medical Officer (RMO) is defined in Section 34 as the doctor in charge of treatment for the patient.
- This will normally be the consultant psychiatrist but does not legally have to be a consultant.
- In the absence of the consultant, it must be clear who has been delegated this responsibility in the interim.
- A patient detained under the Act can only have one doctor acting as RMO at any one time
- In the case of someone subject to Guardianship, the RMO is authorised as such by the social services authority.
- The RMO does not have to be a Section 12 approved doctor, except in the case of the RMO of a patient subject to supervised discharge.

The Draft Mental Health Bill (2002) states that the managers of the hospital will appoint an 'approved clinician to be in charge of the assessment of the patient and his medical treatment in accordance with the Act.' This person is to be known as the clinical supervisor. The term Responsible Medical Officer does not appear in the Draft Bill.

Guidance note: Only use the term Responsible Medical Officer or RMO when referring to the responsibilities of a consultant in relation to the Mental Health Act 1983.

Guidance from the Royal College of Psychiatrists

- Medical care of outpatients remains the responsibility of the GP, with consultants acting in an advisory capacity or providing specialist treatment (1996).
- All aspects of the medical care of an inpatient are the ultimate responsibility of the consultant (1996).
- Medical role has 'primacy in the process of assessment and/or diagnosis' (1996).
- Consultant can only accept responsibility for 'a patient of whom they have specific knowledge' (1996).
- Consultants 'have the ultimate responsibility to diagnose illness and prescribe treatment. This authority may be delegated to other professionals but the responsibility cannot be abrogated.' (2001a).

Guidance from the General Medical Council

The General Medical Council guidance in Good Medical Practice and Maintaining Good Medical Practice (1998) states that

- If you lead the team you must take responsibility for ensuring that the team provides care which is safe, effective and efficient.
- Delegation involves asking a nurse, doctor, medical student or other health care worker
 to provide treatment or care on your behalf. When you delegate care or treatment you
 must be sure that the person to whom you delegate is competent to carry out the
 procedure or provide the therapy involved. You will still be responsible for the overall
 management of the patient.
- Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that such health care workers are accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.

Summary of the law and guidance

The Royal College guidance is taken to mean that one of the important roles of the medic in the team is to diagnose. The terms 'primacy' and 'ultimate responsibility' are taken to refer to the fact that an important part of medical training is to train doctors as diagnosticians – this aspect does not have such emphasis in the training of other professionals, and therefore the medic may be considered to be the 'expert' in this area, as other professionals will be for other areas of care and treatment. Diagnosis is taken to include the diagnosis or exclusion of organic causes of mental illness. To say that the medical role has 'primacy' in 'assessment' is both more contentious and more ambiguous.

The term 'prescribe treatment' is taken to mean the prescribing of medication (or a physical treatment, eg ECT). At the moment this is the sole preserve of the doctor, but Department of Health driven changes in prescribing practice will mean that this statement will become out of date. The national guidance therefore uses a very narrow definition of treatment – the Trust interprets 'treatment' in its widest sense as encompassing all therapeutic interventions, and only a minority would in this case be carried out by doctors.

'Medical care' is taken to mean general medical, rather than psychiatric, care – hence that becomes the responsibility of the consultant if a patient is admitted.

If the statements about delegation from both the College and the GMC are taken to refer to the same thing, then we can conclude that they are saying that the responsibility for diagnosis and/or drug treatment can be delegated to another, but remains ultimately a medical responsibility. This is **not** the same as saying that the doctor is responsible for all aspects of the patient's care. Professionals other than doctors will clearly also delegate aspects of care for which they are responsible.

The GMC statement about referral has been written to refer primarily to a general practitioner, but a doctor (or any other professional) can legitimately assume the standards that another individual belonging to a different profession will operate to.

Trust guidance

Responsibilities of individual professionals

Definitions (Onyett, 1995)

Professional responsibilities are defined by a duty of care to users, professional codes of conduct, and in some cases registration requirements.

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 else to whom you refer is also appropriately qualified and competent. Certain members of the team will also have additional legal responsibilities, for example the Approved Social Worker.

Individuals, of whatever profession, are responsible for the quality of the care that they provide to individual patients, and accountable if it falls below acceptable standards. Team members will have a line manager, and a professional head who may or may not be the line manager.

Doctors are not therefore responsible for the quality of care provided by another team member.

There is therefore no requirement to have the consultant's name on the notes of an outpatient who is not actually been seen by the consultant.

Guidance note: Consultants do not have to consider that their total caseload is the combined caseloads of all the other team members plus their personal caseload.

Individual consultants are encouraged to discuss with their teams the best way of using their expertise and their time. If a consultant does not see a patient, but provides advice, he/she is responsible for the quality of that advice, but not responsible for the ongoing care of the patient provided by others, or for whether the advice is taken or not. The conclusion is frequently drawn, from team right up to national level, and by users as well as professionals, that care co-ordination is not generally a good use of a consultant's time.

Guidance note: A consultant does not have any responsibility for patients referred to, assessed by, and treated by, other team members where he/she has no input.

Some teams operate multidisciplinary assessments. Where this occurs, it should be agreed between the team members concerned as to which person takes responsibility for ensuring that that details of patients assessed as requiring ongoing care are fed back into the appropriate team processes for allocation. Whether or not assessments are done by one or more professionals, it should be discussed with the patient as to how to access help in a crisis whilst ongoing care is being arranged, particularly if this involves being put on a waiting list.

Following the publication of the NICE guidelines for schizophrenia, there has been some confusion as to responsibility for the checks on the physical health of outpatients. Some GPs have assumed that this will be done by the CMHT. Both current guidance, and possession of the requisite expertise and facilities, indicate that the checks themselves should be the responsibility of the GP, but communication about the findings, and the upkeep of case registers, should be seen as an opportunity to promote better shared care.

Responsibilities of the care co-ordinator

The care co-ordinator is responsible for co-ordinating the activities of a number of others in order to provide the best package of care for the individual patient. The care co-ordinator is entitled to assume that a fellow professional will provide care to a certain standard, provided that the fellow professional has not been asked to provide something for which he/she is not trained/qualified.

The care co-ordinator will in addition have the responsibilities of an individual practitioner.

Responsibilities of the Clinical Team Leader

Teams need to decide who their Clinical Team Leader is. This person takes responsibility for the organisation of processes within the team to ensure its smooth operation – for example, the systems around single point of access and allocation. This person needs to be a senior clinician within the team, but could come from any profession. Teams must be very clear as to who the Clinical Team Leader is, and referrers should be made aware that this is the person to contact with any queries relating to the referral process itself.

The GMC guidance sets out the responsibilities for the consultant **if** he/she is the clinical team leader.

New ways of working

The guidance above seeks to clarify roles, and thereby free up thinking about possible new ways of working in teams. Examples might include:

- Triaging of referrals by a senior clinician, especially in areas of medical staff shortages;
- Multidisciplinary assessments;
- The reduction or elimination of 'routine follow-ups' from consultant outpatient clinics, and the redesign of such clinic time to optimise the use of consultant skills;
- Improved caseload management within teams, a 'stepped care' approach to the provision of secondary care, etc; and
- Paving the way for crisis team gatekeeping of inpatient beds as well as facilitation of early discharge.

Practicalities

- This guidance needs to be shared with PCTs and local GPs;
- Teams need to be clear about who the clinical team leader is;
- Teams need to have robust processes for the allocation of work and the management of
 clinical risk and integrated care planning. If resources are insufficient to meet demand,
 this needs to be recorded, and the reasons for not providing care given. In the case of
 legal challenge, it is often the processes which get challenged, rather than the actual
 clinical decisions, so there need to be clear audit trails;
- Routes for the expression of concerns about team functioning by individuals need to be thought through and agreed proactively. The responsibility of maintaining a functional, as opposed to dysfunctional, team, lies with the members of that team;
- Teams should review together the best use of consultant time, in the light of this guidance;
- Teams will need to ensure that they do not use the consultant's name as a designation for the team itself;

- Single Health Records should record the team and the care co-ordinator's name for an
 episode of outpatient care, and the team and consultant name for an episode of
 inpatient care;
- Teams need to ensure that they are reviewing the need for patients to remain on Section 117 aftercare. There is a Section 117 policy developed for use in Bristol which could be used trustwide to support this.

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