

New Roles Early Implementer Site Project

*A report for the NIMHE National Workforce and
National Legislation Programmes*

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Preface to the MHACT New Roles document

This report was commissioned to test out with willing Trusts the flexibilities in the Mental Health Act to develop new staff for the clinical roles of the Approved Mental Health Professional and the Approved Clinician.

These field testing sites were first engaged by Chris Merchant in his workforce lead role. The sites have been followed up and the results have been drawn together and analysed by Teresa Hewitt-Moran, Workforce Specialist for NHS West Midlands and Catherine Jackson, NIMHE Legislation Team.

The work has been overseen by a group of key stakeholders:

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We hope this early work will offer ideas and shortcuts in exploiting the new roles for other Trusts nationally.

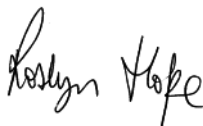
We are grateful for the hard work of all the early implementer sites, and particularly our thanks go to Bruce Gilmer and John Taylor for their pioneering work in the North East.

Jim Symington



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New Roles Early Implementer Site Project

Introduction

The 2007 Mental Health Act introduces two new roles with statutory powers to detain and discharge patients: the approved mental health practitioner (AMHP) and the approved clinician (AC).

The AMHP role extends to non-social worker mental health professionals (nurses, occupational therapists, psychologists) the statutory powers and responsibilities of the approved social worker (ASW). The AC role extends similarly to non-medical mental health professionals (nurses, occupational therapists, psychologists, social workers) the powers and responsibilities of the responsible medical officer (RMO).

The roles came into effect from November 2008.

In July 2008 the NIMHE National Workforce and National Legislation Programmes jointly commissioned a piece of work to track the progress of early implementer NHS trusts and local social services authorities that were actively seeking to extend the AMHP role to non-social work professionals and/or the AC role to non-medical professionals.

The aims of the project were to:

- Carry out an initial survey of sites and progress to date
- Gather examples of policies, processes, procedures, tender/training specs to be shared as templates
- Draft a report giving the overall picture
- Conduct site visits to carry out interviews to generate detailed case studies
- Generate final report and other related articles for relevant publications
- Organise a conference to share learning and good practice

All NIMHE regional workforce leads were asked to forward to the project team details of any trusts within their region where this activity was taking place.

The project team then followed up these contacts and conducted interviews with the identified sites. These were followed up by visits to selected sites to explore in more detail the barriers, challenges, processes and procedures put in place.

This report summarises the findings from the field sites and highlights key messages drawn from their experience to date.

The survey was not intended to be exhaustive. We hope we have successfully identified all sites where these new roles are being extended to non-social worker and non-medical professionals. However we accept that, despite several information requests put out via the NIMHE regional offices and the professional bodies representing all mental health professionals, we may have missed some sites where activity is taking place.

1. Quantitative findings

Table 1 summarises the activity we identified.

Table 1: MHA New Roles Early Implementer Field Sites

Region and organisation	Progress
<p>NORTH WEST</p> <p>Cumbria Partnership NHS Foundation Trust</p>	<p>ACs</p> <p>Phase 1: Two nurses undertaking preparation for AC role: one nurse consultant, manager of older adults nurse-led unit; one advanced nurse practitioner/prescriber based in crisis resolution/home treatment team.</p> <p>Phase 2: May include other professionals, particularly psychologists and social workers. Shortage of Occupational Therapists (OTs) so not expecting any OT ACs in first phases.</p> <p>Aim to have both ACs approved and undertaking the role in autumn 09.</p> <p>AMHP</p> <p>10 nurses commencing stage 1 training January 09.</p>
<p>NORTH EAST</p> <p>North East Lincolnshire Care Trust</p> <p>Northumberland Tyne and Wear NHS Trust</p>	<p>AMHP</p> <p>One mental health nurse and one social worker starting AMHP training at Lincoln University October 08. Have at least four other non SW practitioners interested in training but trust can't sustain more than two trainees per year.</p> <p>AC</p> <p>Five non-medical professionals - two nurses, three psychologists - engaged in action learning set in preparation for seeking approval to undertake AC role May 2009, based in the learning disabilities and forensic directorates</p>
<p>WEST MIDLANDS</p> <p>North Staffordshire Combined Healthcare Trust</p> <p>South Staffordshire & Shropshire Mental Health Foundation Trust</p>	<p>AC</p> <p>North Staffs</p> <p>Two nurses and one occupational therapist to commence the AC learning set and development programme in October 08. One of the nurses is from learning disability services.</p> <p>South Staffs</p> <p>Three senior nurse/nurse consultants in Staffordshire:</p> <ul style="list-style-type: none"> • one senior nurse in eating disorders unit • one nurse consultant in assertive outreach • one learning disabilities nurse consultant.

WEST MIDLANDS

North Staffordshire
Combined Healthcare Trust

South Staffordshire &
Shropshire Mental Health
Foundation Trust

Dudley & Walsall Mental
Health Partnership Trust

Worcester Mental Health
Partnership Trust

Hereford PCT

AMHP

Two cohorts running 08/09. Five trusts piloting non-social work AMHPs.

11 students, all mental health nurses, commenced stage 1 training in April 2008 and due to commence stage 2 training in April 2009.

Second cohort of seven students commenced stage 1 training in Sep 08.

A further 20 places have been commissioned by the SHA to commence in March 09.

EASTERN

Bedfordshire and Luton
Partnership NHS Trust

AMHP

Five nurses and six social workers enrolled on new AMHP course – four commencing September 08; seven January 09. First cohort aiming to be approved Feb 09.

LONDON

South London and Maudsley
NHS Foundation Trust

AMHP

Eight non-social work AMHPs to start training January 09 – all nurses, based in Croydon service. Bournemouth University providing training.

AC

AC to be considered for new community PD service in Croydon, subject to confirmation of funding for service.

SOUTH EAST

Kent & Medway Health and
Social Care Partnership Trust

Oxfordshire and
Buckinghamshire Mental
Health NHS Foundation Trust

AMHP

Five nurses and four social workers recruited for this year's ASW intake and started training September 08.

AC

Two non-social work participants, both nurses, enrolled for training from January 09.

1.1 Approved clinician

We identified a total of 13 non medical professionals preparing for the approved clinician role: nine nurses, one occupational therapist and three psychologists. [Another occupational therapist on one site was reported to be planning to take the training towards the end of 2009.] In one further trust, the final decision rested on funding from the local commissioners for a new, community-based personality disorder service. We identified no social workers preparing for the role.

The AC applicants were based in a range of services: acute in-patient and community mental health teams for working age adults; assertive outreach and crisis resolution/home treatment teams; an older adults service; an eating disorders unit; a learning disabilities service and a forensic learning disabilities service. It was notable that in some cases those preparing for the role were working in units with minimal involvement from a psychiatrist, or difficulties in recruiting psychiatrists and a heavy reliance on locum psychiatrists. Many of the nurses preparing for this role were already highly experienced nurse consultants heading up a nurse-led specialist unit.

1.2 Approved mental health practitioner

We identified 49 non-social worker professionals, all nurses, either currently enrolled on or due to start AMHP training early in 2009. The reports from trusts were that either they did not have many, if any, OTs working within the trust, or that OTs did not put themselves forward or were at too junior a level to qualify to undertake the training.

The trainee AMHPs were based in a range of services: mostly in working age adult mental health community teams, but small numbers in CAMHS teams, older adult community mental health services and learning disabilities teams.

2. Qualitative findings

We developed an interview checklist (see annex a) to guide our questions in the site visits. We profiled in detail eight trusts (see table 2); seven were recruiting non-social work applicants for the AMHP role, and four were recruiting non-medical applicants for the AC role.

Table 2: Field sites profiled in depth

- Worcester Mental Health Partnership NHS Trust (AMHP)
- South London & Maudsley Foundation NHS Trust (AMHP)
- Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (AMHP)
- Bedfordshire & Luton Mental Health and Social Care Partnership NHS Trust (AMHP)
- North Staffordshire Combined Healthcare NHS Trust (AMHP and AC)
- South Staffordshire & Shropshire Mental Health Foundation Trust (AMHP and AC)
- Cumbria Partnership NHS Foundation Trust (AMHP and AC)
- Northumberland, Tyne & Wear NHS Trust (AC)

2.1 AMHP role

2.1.1 New ways of working

Only one of the seven trusts profiled who were extending the AMHP role to non-social work applicants had introduced either New Ways of Working or the Creating Capable Teams approach in those areas where the new AMHPs would be working. NWW, where it had been introduced, was generally regarded as being more relevant to paving the way for the approved clinician role (see below).

2.1.2 Workforce challenges

Most, but not all, of the field sites profiled had been experiencing acute difficulties in recruiting

social workers to train as approved social workers. Sites where there were no immediate plans to extend the role to non-social workers did not report recruitment difficulties, suggesting that shortages of social work applicants may be a strong motivating factor in these trusts pushing ahead with extending the new role.

'The other boroughs didn't have a recruitment problem, so they weren't interested in the new roles. X borough had major recruitment issues and were very welcoming. That was the major lever.'

'We have acute ASW shortages; there are currently only 15 ASWs across the whole county. We have 50 registered, but only 15 whole time equivalents working on the rota.'

2.1.3 Senior management support

The field sites reported strong and active support at trust board level in extending the AMHP role to non-social worker professionals. Very often the senior managers involved in taking the initiative forward had a background in social care, which of itself ensured a favourable climate in that the mental health and social care services were likely already to be fully integrated. In partnership trusts, the director of social care ensured direct representation at senior trust management level, and a good understanding of social care issues.

So, for example, in one partnership trust, the director of social care was supported by a consultant practitioner with a social work background, and an AMHP co-ordinator, also with a social work background, who was responsible for managing the AMHP team leaders in each locality, who in turn managed the AMHPs.

'We have a director of social care at board level, and the rest of the architecture.'

All the trusts had some form of Mental Health Act implementation working group concerned with the introduction of the new Act, which reported to the trust board, and many reported having a working group specifically concerned with the workforce issues of the Mental Health Act.

2.1.4 Staff attitudes

Field sites reported a diversity of opinions and attitudes among staff to the new AMHP role.

Mental health nurses were generally reported to be enthusiastic about the new role. Their social work colleagues were said to have mixed views. Some welcomed the additional pool of professionals from which AMHPs could be recruited, as it would boost the strength of the existing, overloaded teams in areas where there were recruitment difficulties.

'The ASWs here are overloaded and looking towards retirement. Mental health nurses have absolutely embraced the opportunity. Some have just been waiting for it. But psychologists and CAMHS social workers are very much against it... For psychologists the biggest single concern was that their clinical time is already limited and they would find it difficult to find time out for the rota and training. Some had concerns about the impact on their therapeutic relationship with clients.'

'Five years down the line, [nurses] aren't going to think twice about doing AMHP training. They'll see it as an alternative to doing CPN training. It will be seen as normal career progression.'

Others expressed concern that mental health nurses lacked the values-base and independent decision-making they considered fundamental to the AMHP role.

'Staff in some quarters still remain to be convinced of the ability of nurses to operate autonomously from medical colleagues.'

In some trusts there were concerns about pay differentials in that a social worker AMHP might

be earning much less (up to £9000 in one trust) than a nurse AMHP.

'The main anxiety is about differentials in salary between non-social work AMHPs and social work AMHPs. Social work AMHPs aren't happy to be practice assessors to staff who may be earning more than they are for undertaking the same role.'

2.1.5 Recruitment criteria

Recruitment methods varied, although the criteria were broadly similar. Criteria included:

- At least two years community experience
- Knowledge of mental health issues
- Experience of working with people with a mental disorder.
- Experience of carrying own caseload
- Endorsement of senior staff.

One trust wanted evidence of continuing professional development that had a social care base – child protection training, for example, or a qualification in social care and management.

'We were looking for evidence of a social perspective, and those we selected were best able to demonstrate that broader approach. We were also focusing on their ability to demonstrate independent decision-making and ability to take decisions and defend those decisions. Some really struggled with that concept.'

Another sought evidence of competence to study for a higher specialist level/masters level course. The local university had developed a foundation module to prepare applicants for this.

One trust held a formal 'information day' where interested candidates were invited to take part in activities and workshops designed to demonstrate the demands of the role and their suitability. Participants then went on to submit a formal application if they were still interested.

'The information day was a "living job specification". We tried to make real

connections by including mental health service users and carers giving their perspectives and through case studies and activities. It was a full training day.'

'Meeting academic requirements was a priority. Evidence of experience and competence to study for a higher specialist level/masters degree level course was required.'

'What set applicants apart was their ability to demonstrate an understanding of empowerment, and independent decision-making.'

AMHP selection panels often included representatives from the trust and the local authority.

A number of trusts reported high levels of initial interest but far fewer applicants (up to 90 participants attended one trust's information day, but the trust received only six expressions of interest and two applicants for the training).

2.1.6 Main challenges/barriers

The main challenges and barriers reported were:

- resolving disparities in pay scales between social worker and non-social worker AMHPs
- concerns about AMHP rota duties and the impact on community mental health team caseloads when a senior practitioner was covering the rota
- backfill funding (for trust staff undertaking AMHP training and for trust staff covering AMHP rota).

One trust highlighted a shortage of AMHP practice assessors locally.

However most of the sites said they were surprised by how easy it had been. This is perhaps unsurprising as in all sites the community mental health teams were already well-integrated, and the social workers were either directly employed by the trust or employed under section 75 arrangements.

'If there are secondment issues, there might be a problem, but we are TUPEd and have strong

social work leadership within the trust. We are a partnership organisation so we do everything except issue the warrant.'

'It's been really easy, partly due to the level of control the director of social care has. We have just applied the same terms and conditions. We've had total organisational backing and the local authority isn't bothered. They allocate the training places and how we fill them is up to us.'

One trust said it had chosen only to invite non social work applicants in a borough where the community mental health teams were well integrated and where the model of working supported the extension into the AMHP role.

'The models of working in other parts of the trust might not support this role. We use a generic model. We've been working this way for six to seven years. The care co-ordinators can be nurses, OTs or ASWs. They come from a range of backgrounds and we expect them to do a lot of the work around assessment anyway, to set up the process. The AMHP only has to do the final assessment. The care co-ordinators see taking on the AMHP role as being able to do more for their own caseload.'

2.1.7 Funding

None of the sites reported any new or additional funding to support implementation of the new role, other than that provided by some local social service authorities for additional AMHP training places if needed (see below). In one region (West Midlands) the SHA is directly funding AMHP training for NHS staff – 22 places in 2008, and 20 places in 2009.

'You can spend years looking for funding and not moving anything forward. We made a decision not to look for additional funding. We just wanted a decent quality of staff.'

'We have had extra funding from the local authority for additional training places, but that is based on the need to have more AMHPs.'

However several sites expressed concerns about covering the backfill costs for trust staff

undertaking AMHP training. Most of the trusts were covering the backfill costs for their own staff undertaking the training (see also below).

'There is no backfill available for nurses. The local authority covers backfill for social workers on the training.'

One trust had made ingenious use of unspent monies from two unfilled ASW vacancies.

'The two ASW vacancies we've carried for some time could allow us to employ two newly qualified nurses to provide backfill for the nurses going on the AMHP training and the shortfall for the re-grade to band 7 for those completing it.'

2.1.8 Relationships/systems/processes

established with approving local authority
In all cases, the ASWs were already either employed by or seconded to the trust under section 75 arrangements, and had been for some years, so systems were already well integrated and managed by the trust.

'Local authority staff are seconded across to the trust. The arrangement has been in place for four years and the services have a well-integrated management structure.'

'We are co-terminous with the local authority. We have strong working relationships. In general the trust works closely with local authority colleagues.'

'Locality managers in the trust control the budgets for the local authority and NHS, which means there'll be opportunities to be creative with [funding].'

'Senior relationships are key. Our assistant service director [in the locality] has a background in social care and is keen to move things forward with the local authority director of social services. It has made the path so much smoother.'

One trust raised the issue of the local authority having to approve staff that they didn't directly

employ. Two highlighted issues of legal indemnity and insurance and disciplinary/grievance procedures for trust staff when doing AMHP (ie. local authority) work. Both issues were being dealt with the trust and LSSA legal departments.

Another had put some work into ensuring that mental health nurse and social worker AMHPs would be subject to the same performance appraisal and personal development processes – using the trust's processes – rather than different ones depending on their employer.

2.1.9 Rota arrangements

Rota arrangements were either already established and working well, or were in the process of being sorted out.

'The plan is to pull the existing ASW rota service out of the CMHTs and attach it to the CR/HT teams as an assessment only service. This will also assist with the anticipated high numbers of Deprivation of Liberty Safeguards (DoLS) assessments.'

'The rota is managed within the service. There used to be one borough rota for all ASWs but two years ago we split it so the local authority deals with child protection issues and the trust deals with mental health, and there's also an out-of-hours rota. Every team within the borough is on the rota every six weeks. Each team has two AMHPs and they deal with anyone new to the service who needs a Mental Health Act assessment. They absorb the time within their own caseloads. We also have a separate out-of-hours rota.'

'AMHPs will be required to undertake duties on one of the two generic rotas that cover the north and south of the county.'

'There are three distinct rotas across the two local authorities. Each operates differently, but all daytime AMHP activity is operated within a single management structure.'

2.1.10 Additional support mechanisms

In most cases, no additional or special support

mechanisms were in place for non-social work AMHP trainees. The expectation was that senior ASW practitioners (as was) would mentor new AMHPs.

One trust had offered nurse applicants support with academic work but the offer had not been taken up.

'However it now seems apparent that the challenge of writing to competencies at a post-graduate diploma level is tougher than expected. We may consider building this support into a more formal support mechanism.'

2.1.11 Training

In most cases, the training was being funded by the local authority, as previously when the role was only open to social workers. However trusts were paying (reluctantly or without question) to cover staff absence while undertaking the training, in the same way that local authorities were covering backfill costs of social workers.

In one area, as noted above, the Strategic Health Authority was funding the training for NHS staff – a total of 42 places over 2008/09. In another, the training was self-funding as the trust ran the course and also took applicants from neighbouring trusts. These fees covered the costs of training its own AMHPs.

One trust was experiencing particular difficulties accessing training for AMHPs. The university from which its local authority commissioned the training had limited spaces, as it covered the entire region, and was also some distance from the trust. The trust approached a more local university, who designed an AMHP course to meet their needs. However the local authority would not agree to pay for AMHPs to attend this university, and the strategic health authority maintained it was the responsibility of the local authority to pay. The trust is having to cover the costs itself, and is providing some of the staff to do the teaching element of the course, while having to cover the costs itself.

In several areas where there was an acute shortage of AMHPs locally, the local authority had agreed without question to increase the number of training places it was prepared to fund.

2.1.12 Pay bands

Pay bands for nurse AMHPs were Agenda for Change bands 6 or 7. In one trust AMHPs received an on-call supplement; in another nurses completing the training received an uplift from band 6 to 7; in another AMHPs were paid a £2000 honorarium on top of their salary, whether nurse or social worker; in another they received two increments, regardless of grade or banding, and the trust was considering introducing an honorarium to ensure pay equity.

Table 3: Pay banding for AMHPs

- Band 6 plus on-call supplement when staffing on-call rota (same as social workers) (South London & Maudsley NHS Foundation Trust)
- Band 7 – subject to being put through the Agenda for Change process (Worcester Mental Health Partnership Trust)
- £2000 honorarium on top of existing band, whether nurse or social worker (Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust)
- Band 6 or 7 (tbc) (Kent & Medway NHS Health and Social Care Partnership)
- Band 7 (Cumbria Partnership NHS Foundation Trust)
- Two increments, whatever grade/band the practitioner is on – exploring possibility of honorarium to ensure pay equity across social workers and mental health nurses (Bedfordshire & Luton Partnership Trust)
- Band 7 (South Staffordshire & Shropshire Mental Health Foundation Trust)

2.2 Approved clinician

2.2.1 New Ways of Working

One trust had taken part in a national New Ways of Working pilot to introduce a two-tier psychology system, with lesser qualified associate psychologists employed in order to free up the more highly qualified psychologists to take on the AC role.

'It provided useful bedding because it demonstrated our interest in developmental and cultural change. We were growing people at the bottom of the pyramid to free up people at the top to take on the AC roles.'

A specialist service for people with severe learning disabilities within the same trust was introducing the Creating Capable Teams Approach:

'We are redesigning our inpatient services to be much more focused on treatment and assessment rather than being silted up de facto long stay wards. In the process we are trying to use the Creating Capable Teams framework – new roles and non-medical prescribing. Having nurses who can act as AC/RC brings decision making closer to the patient and put it in the context of the nursing relationship, because what nurses are good at is developing ongoing relationships with people who struggle to communicate.'

'CCT is integral to the way these new roles will be used. We will be working with the teams, trying to create safer processes of discharge. It's about team leadership – nurses and OTs working together to develop assessments together, and thinking much more strategically and systematically.'

Another had piloted the 'Chambers' model, introducing service-based rather than patch-based psychiatrists:

'Psychiatrists are only allocated to very complex cases. Team managers have control of psychiatrists' diaries, enabling them to book assessments. This also means that New Ways of Working is already in place and successful in this trust.'

One trust had trained a large number of nursing staff as non-medical prescribers, and had a programme of work in process around New Ways of Working.

One trust was involved in a pilot with the Strategic Health Authority to examine staff activity to output directly in relation to preparation for the introduction of the AC role.

2.2.2 Workforce challenges

Three of the four trusts introducing non-medical approved clinicians reported difficulties in recruiting consultant psychiatrists either specifically to their directorate or to the trust in general. One did not. In one trust, it was pointed out that, even with a full psychiatrist establishment, the trust had been under-supplied with RMOs, according to the Royal College of Psychiatry's recommended ratio.

'Recruitment of consultant psychiatrists is an issue. We have long-standing vacancies. Developing the AC role will free up existing consultant time.'

'We have continued and repeated use of locum psychiatrists, particularly within the forensic directorate. Also these areas are highly specialist. It's really difficult to recruit people at our level of specialty. But even if we were up to full establishment, the RMOs would be working well over the Royal College of Psychiatry's limits. The driver is there to get other properly qualified people in that role to share the load.'

2.2.3 Staff attitudes

There were reports of hostility from psychiatrists in one trust, and in two trusts social workers expressed concerns that, as there are no consultant level social worker posts, it is unlikely that social workers would be considered sufficiently qualified to take on the role.

'The medics are split. Some are quite enthusiastic and others say it's never going to happen. Some medics are looking forward to having some of that responsibility placed with people who are better placed to do it. On the other side, people

don't see the value in it and some of that is about losing that control and power. Frontline staff raise their eyebrows at first, and then they think, this could be quite useful for us. The next question is, how do I get to be one. There's quite a lot of interest, particularly among nurses in working age adult services.'

'I got a response from medical colleagues – why on earth do you want to do it? It's a load of aggro, running around CPAs, tribunals. Why vote for it if you don't have to?'

In one trust staff involved in extending the role were very keen to stress that they considered it a way to improve the service to clients by introducing a more collegiate, collaborative way of working and one that brought the service closer to the client. Those with AC responsibility would be working with the client already, as a member of their care team. It would also ensure that the most appropriately qualified professional was working with the client, according to the client's particular care and treatment needs.

'It's a big imaginative leap. People will be expecting us to work like RMOs, but we have a different conceptual framework. RMOs paddle their own canoes and don't necessarily confer about cases. We see it as providing effective leadership with and through teams, and that sits quite easily with the culture of our service.'

One trust stressed the benefits for continuity of care and discharge planning if the AC was based locally, within the service, and an RMO did not have to be called in from outside the service to fulfil the role.

2.2.4 Challenges/barriers

The challenges and barriers identified by these trusts were due in many cases to the absence of clear guidance from the centre at that time (guidance on the role and competencies expected of ACs was published in November 2008, subsequent to site visits and interviews).

One trust identified as a major barrier the absence of any local systems and protocols for

the extended AC role, at either SHA, trust or service level.

'We are flying by the seat of our pants.'

Other challenges and barriers included:

- Backfill arrangements – who will do the work the AC can't do when they are on call?

'The knock on effect is that, if senior qualified psychologists take on these functions, what are the things they are not going to be doing and how do you provide for that? That is partly why we are keen on piloting the psychology associate role.'

- Confidence and credibility issues – will non-medics be confident to take on patients; will medics feel confident to hand over patients to non-medics?

'Will doctors feel confident to hand over to non-medics and will non-medical ACs be confident to take on other patients?'

'It's a question of whether we have the credibility to take decisions. Nurses are very used to doing what the doctor says and working within structured boundaries. You may make the decision, but the doctor is accountable. So this does feel like a major step to being the person who puts their signature on the bottom of the page. That is not an argument for not doing it, but it does need to be recognised. It's a cultural issue.'

'Our decision to have an integrated learning set [ie. multi-disciplinary participants] was to do with containing some of those anxieties and some of the issues around management and support to people taking on these new roles. People think they have to be able to do what the psychiatrist does. They don't get it that it's an extension of their particular skills and competencies. We see it as enhancing the way we work currently.'

- Allocation of patients – who decides who is 'the most appropriate' AC for that patient?

'We have no local arrangement for deciding if this is an appropriate patient for me and how that patient is allocated. We are having to develop these protocols through the learning set.'

- What if a patient's needs change – who decides and what mechanisms should there be in place for a patient to change AC?

'If someone is recalled to hospital, who will take over the reins? Their needs may have changed and they may need to be in the care of a doctor. How is that decided and actioned?'

- Integration with other statutory requirements – ie. Department of Justice, Home Office will only accept medical reports (ie. written by doctor).

2.2.5 Formal training

Arrangements for accessing the formal, taught AC training varied.

One trust reported that the SHA was in the process of commissioning AC and Section 12 training, and that there was some possibility than it would commission the training from another region if numbers wanting to train within its own region were low.

Another said the SHA had commissioned AC training but that another local university was also developing a new AC programme incorporating the components of the formal AC training, and that the trust's AC applicants would be using this, when it come on stream early in 2009.

A third trust said they had been unable to find out from their SHA what the arrangements were for either the formal AC training or the approval process.

The fourth trust did not supply this information.

Annex b reproduces the AC implementation timeline produced by Northumberland, Tyne and Wear NHS Trust, and adapted for use by North Staffordshire Combined Healthcare NHS Trust

and South Staffordshire & Shropshire Mental Health Foundation Trust.

2.2.6 Additional support mechanisms

The trusts had instituted a range of different methods of identifying and meeting non-medical professionals' training needs beyond the formal AC training provided by SHAs.

In one trust the professionals seeking to become ACs were carrying out a diary exercise, logging their involvement in Mental Health Act work over the next six to 12 months, which they would then review to identify learning and development needs and further training.

In another, participants were involved in a multi-disciplinary learning set, and were following a formal course of identifying and making arrangements to meet both their individual learning needs and the group's learning needs. (The action learning set's terms of reference are attached at annex c.) So, for example, one nurse was undertaking nurse prescribing training not because it was absolutely required for the role but because he felt it would enhance his competence when taking AC decisions. The group as a whole were undertaking training in mental health law, commissioned from the local law school. All participants in the learning set were constructing portfolios of competencies and experience. Shadowing arrangements with experienced RMOs and ASWs had been set up to continue through to when they were approved to practise. The portfolios would initially be submitted either to the individual's professional body or to a local senior clinician pre-scrutiny panel, prior to submission to the SHA approval panel. The whole process was expected to take some 12 months, with the newly approved clinicians coming on stream in May 2009, and being in a position to mentor the next set of applicants from October 2009.

'We are making up the portfolio as we go along, based on the published guidelines. But you have to interpret that and what you think is a sufficient level of competency. We are moving along, if not in the dark, certainly in a fog. For me, the key

arbiters are the SHA and our employers, who will amend our job descriptions and indemnify us. These are the two routes that I can see at present for someone reviewing and putting a stamp on our ability to practise in that role.'

Another planned to access an accredited AC programme developed by their local university. This will comprise six months preceptorship with a clinical and academic mentor, two hours a week. The course was expected to be validated in February 09.

The trust planned to follow up newly approved clinicians for 18 months to evaluate their practice and compare outcomes with those of other early implementer sites.

All had made some use of the national guidance on preparation for AC approval.

'Yes, applicants are currently developing personal preparation plans based on the national preparation for approval document.'

2.2.7 Approval processes and procedures

One trust reported that its SHA was compiling a register of ACs, and that the existing section 12 approval panel was expected to take on the AC approval function, with the addition of colleagues from other professionals, as recommended in national guidelines. This trust wanted its SHA to set minimum standards that non-medical ACs would have to demonstrate prior to accessing the course, and levels of evidence needed for approval (ie. numbers of Mental Health Act shadowed).

Another reported that a non-medical approval panel model had been agreed between the SHA and the regional AC/Section 12 panel.

Another had been unable to get any information from its SHA as to approval processes and procedures.

2.2.8 Pay and remuneration

All trusts were clear that the AC function is a role, not a job per se, and that remuneration should reflect this.

AC applicants in one trust were very clear that they not interested in pay issues. In this trust the non-medical ACs did not expect to be paid any more than their current banding.

In another trust the plan was to pay a higher grade only for the proportion of the clinician's time that he or she would spend doing AC work (ie. band 8d for AC days, and 8b for non-AC days). Where the AC role was likely to occupy a large proportion of the clinician's time, because there were greater numbers of people needing Mental Health Act input, the clinician would be paid at band 8d.

Another had decided that non-medical ACs would be paid at band 8d.

In the remaining trust, where the role was part of a planned new personality disorder service, the clinical lead post would be paid at 8d, but this would rise to band 9 if the individual undertook AC and other specialist training (see annex c for job description).

2.2.9 Funding

One trust had secured £20,000 carried over from involvement in a previous national pilot programme, which it was spending on additional group training for AC applicants.

Another trust had secured £3500 from a pilot programme funded by the SHA, which would be used towards backfill for ACs while undertaking the training.

The remaining two trusts reported no additional funding.

2.2.10 Job descriptions

As reported above, the view was that the AC function would be part of the clinician's role, not a distinct job, as illustrated in the extract from a sample job description in table 4 below. This makes clear that the clinician would be expected to undertake AC responsibilities for clients of the service in addition to their lead clinician role.

Table 4: Head of Personality Disorder Service

Job Purpose

This pioneering post represents an exciting and challenging opportunity to work in a new service with the prospect of contributing to service development and embracing the principles of NWW (New Ways of Working) for psychiatry by practising as an Approved Clinician (AC) within the guidance of the revised MHAct. The new MHAct Code of Practice makes it clear that non-medical ACs need to be prepared to assume the functions and not the competencies of another profession (in this case psychiatry) and may enact the functions of a Responsible Clinician once Approved.

The post holder will be required to provide clinical, managerial and professional leadership across the team and to support multidisciplinary team working.

The post-holder will have overall clinical responsibility for clients under the care of the Personality Disorder service and provide supervision and consultation as appropriate.

The main components to the post are as follows.

Lead clinician role

- To ensure the systematic provision, and management of a highly specialist and high quality personality disorder service to clients with a wide range of mental health needs and their carers, within [the] Integrated Adult Mental Health services.
- To provide expertise in a highly specialist clinical area and offer advice and consultation on clients' care to other members of the team
- To propose and implement service development within this new specialist service.
- To undertake when necessary the role of an Approved Clinician (AC) and demonstrate to the team a comprehensive understanding of the role of the AC, including legal responsibilities and key functions.
- To work autonomously within professional practice and Trust guidelines.
- To provide an expert specialist clinical and supervisory service to the team
- To work within a Mentalisation Behavioral Therapy (MBT) model, this model underpins clinical practice within this service.
- To utilise research skills for audit, policy and service development.

Conclusions

While this survey found only limited numbers of trusts who were pioneering the extension of the AMHP and AC roles, these trusts were able to provide valuable information about the processes involved and some challenges and barriers. Other trusts reported preparatory activity towards extending the AMHP role to non-social workers, but because they were not experiencing recruitment problems, there was clearly less of a sense of urgency.

For the AMHP role, it seems clear that fully integrated community teams are essential to the smooth implementation of nurse and OT AMHPs. Issues such as rotas, backfill arrangements and legal indemnity need to be addressed, as potentially do pay bands and equity of pay and conditions between social worker and non-social worker AMHPs.

The presence of a strong social work presence within the trust's management structure would also appear to be important, in order not to lose sight of the unique values base that social workers bring to the AMHP role.

For the AC role, the trusts introducing this extension were clearly pioneers, finding their own way to a large extent in the absence, at the time of the survey, of national steer and guidance.

Publication of the guidelines for approval will undoubtedly make more straightforward the training and approval processes, but engagement of SHAs does seem to be absent in some areas.

Annex A

Interview checklist

Interview checklist	
Pilot Leads	Name Organisation Job Title E-mail Tel numbers Name Organisation Job Title E-mail Tel numbers
Participating organisations & main contact	
<p>Which new roles are you implementing?</p>	
<p>Have there been any initiatives regarding New Ways of Working or new role implementation that this organisation has been involved with recently – and if yes, how has this impacted on/facilitated the implementation of the new AC/AMHP roles?</p>	
<p>Have any of the teams that these new roles will be utilised within been part of the Creating Capable Teams Approach?</p>	

Are there any workforce challenges/ retirement profiles or recruitment difficulties that have impinged on RMO or ASW numbers within the organisation?

What are staff attitudes within your organisation to the opportunities offered by these new roles?

What are the main challenges/barriers to introducing the new roles?

What senior management support/backing is available to you for the introduction of the new roles?

Has any new funding been made available to you to support the introduction of the new roles?

Have you made any arrangements for training/informing colleagues within the wider organisation/service users on the introduction of the new roles?

How will these new roles enable you to improve the care and treatment offered to patients?

AC

What is the clinical setting/service?

Numbers & details of participants including professional background & employing organisation

Please detail any additional support mechanisms that have been put in place to enable development and demonstration of competencies: eg. learning sets, shadowing arrangements, mentoring, portfolio development work.

Remuneration - will this role be undertaken at existing pay bands or have separate arrangements been made for remuneration? (eg. honorariums, increments)

Training

Please give details of how you plan to deliver/access the AC taught training element

Have you accessed/ utilised the national preparation for AC approval guidance document?

Are there any changes to organisational governance/ policies as a result of the introduction of this new role?

What are the regional arrangements for approval panel processes and procedures including timeline? Who is the contact leading on this?

Anything you would like to share with other sites, requests for further information, advice or support from other sites or any forms of support you require?

Examples: tender docs, job descriptions, local agreements with LA etc, training specs etc

AMHP

Are the AMHPs going to be working in adults/older adults/ LD/ CAMHS?

Numbers and details of participants, including professional background and employing organisation

What relationships/ systems/ processes have been established in partnership with the approving Local Authority to ensure processes run smoothly?

What were the recruitment criteria?

Have any agreements been made with the LA AMHP lead regarding rota arrangements?

Please detail any additional support mechanisms that have been put in place to enable development and demonstration of competencies: eg. learning sets, shadowing arrangements, mentoring, portfolio development work.

Training

Please give details of training provider including cohort details (eg; numbers, professional mix) and time line.

Who is funding the training?

Practice supervision

Please detail practice supervision arrangements

Has a band been established/ agreed at which AMHPs will be remunerated?

Are there any changes to organisational governance/ policies as a result of the introduction of this new role?

Anything you would like to share with other sites, requests for further information, advice or support from other sites or any forms of support you require?

Examples: tender docs, job descriptions, local agreements with LA etc, training specs etc

Annex B

Approved clinician project timeline

January 08	February 08	March 08	April 08
Trusts agree to field testing AC as part of national pilot with Stafford university National advisory group for AC training first meeting	Attendance 'field testing' initial workshop	Field test project group reports directly to regional AC group which meets bi monthly Project sets up evaluation mode	Select 1st cohort Employer guidance and Code of Practice publication expected Draft trust policy protocols to support new professional groups
May 08	June 08	July 08	August 08
Learning set commences	Shadowing of RMOs and ASWs commences Learning set Ongoing mentoring/ supervision agreed	Shadowing Learning set Consider suitable patients for non medical ACs Trust policies & protocols in place	Shadowing Learning set
September 08	October 08	November 08	December 08
Shadowing Learning set Approved clinician training (2 days)	Shadowing Learning set Approved clinician training (2 days) Act implemented	Cohort submit competency portfolios	Cohort go through approval process as defined by SHA Begin case work on identified patients in patients and community
January 09	February 09		
Complete evaluation of cohort 1	Present report of pilot to Regional AC Group & conference		

This timeline was originally produced by Northumberland, Tyne and Wear NHS Trust and adapted for use by North Staffordshire Combined Healthcare NHS Trust and South Staffordshire & Shropshire Mental Health Foundation Trust.

Annex C

Northumberland Tyne & Wear NHS Trust Forensic & LD Directorates

Agreed Terms of Reference

Approved Clinician/ Responsible Clinician Action Learning Set

1. Purpose

This group is charged with actioning the Trust's undertaking to develop and implement the extension of approved clinician/responsible clinician (AC/RC) professional roles (in accordance with the Mental Health Act 2007).

Its prime tasks are to:

- prepare members of the action learning set (ALS) for Approval under the Act.
- consider and develop the evidence of competency.
- provide peer support.
- communicate appropriately about its activities within the Trust, externally with professional and government bodies and to establish networks with other early implementation groups.
- evaluate the process of implementation.

2. Membership

The ALS was identified by the Field Test Working Group (FTWG) of the Trust, from those recognised within their service areas/ directorates as being eligible professionals with sufficient skills, knowledge and experience to undertake this process.

3. Frequency

The ALS will meet on a monthly basis for a duration of 12 months.

4. Convenor

A Chair is not required for the purposes of an action learning set. X [director of service] will report to and act as link with the FTWG.

5. Record of Meeting

A record of agreed actions, appropriate to an action learning set, will be kept by the designated minute taker (to be agreed) and circulated to members within 5 working days. A copy will be provided to the Chair of the FTWG. Detailed notes will not be circulated and confidentiality will be maintained for support and sharing of issues within the boundaries of professional practice.

6. Structure

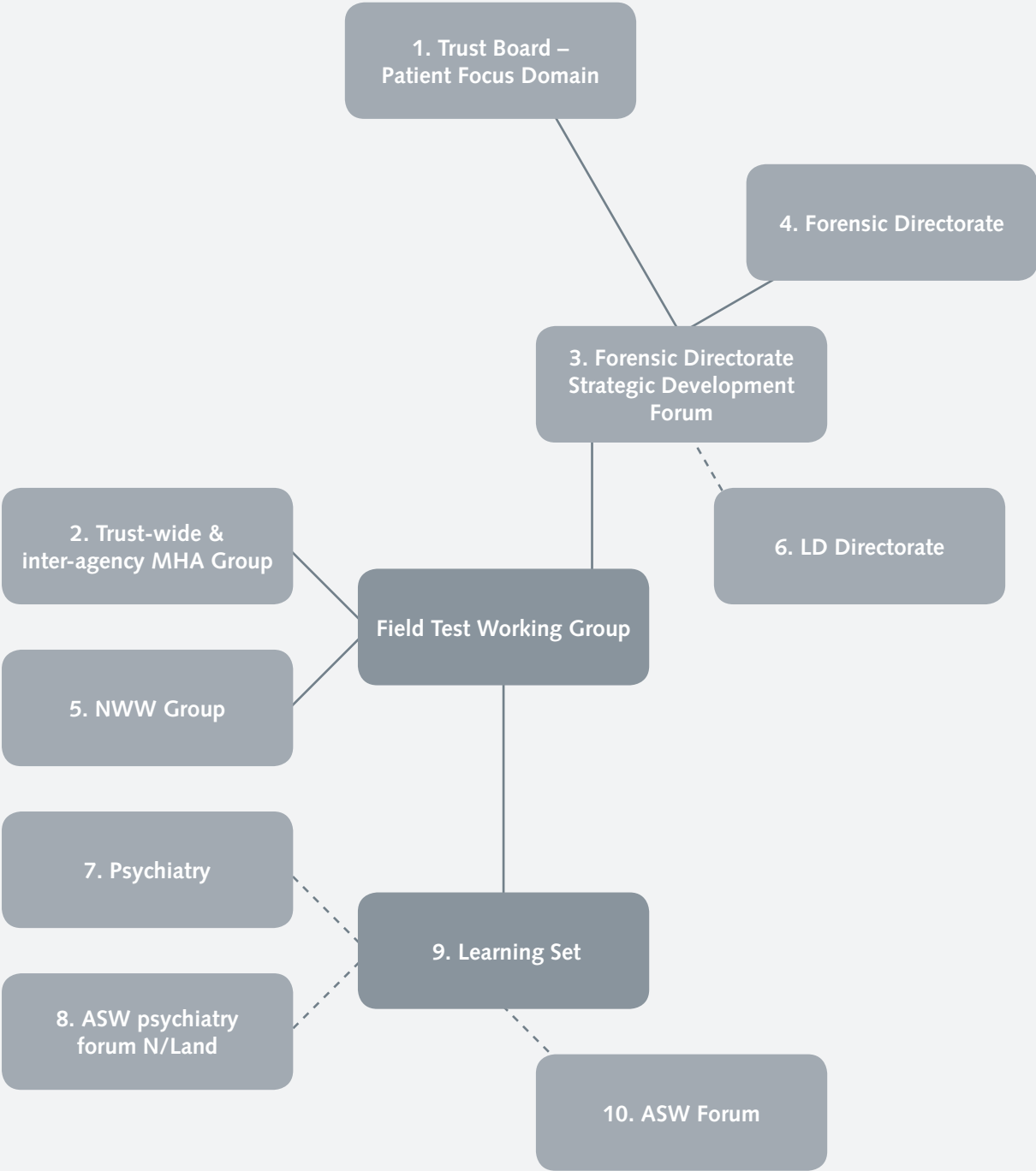
An action-reflection model will be used, following this suggested format:

Apologies
Actions from the last meeting
Reflections on actions
Further agreed actions
Broader business considerations
Prioritisation
Date & Time of next meeting

7. Accountability

The ALS is accountable to the Trust's FTWG. The Chair of that group will provide mediation, as appropriate, should any conflict arise or issue not be resolvable within the ALS.

Accountability to the Trust Board via the Strategic Development Forum (Forensic Directorate)



New Ways of Working in Mental Health

National Institute for
Mental Health in England
National Workforce Programme

