



Suffolk **NHS**
Mental Health Partnership NHS Trust

Care Services Improvement Partnership **CSIP**

National Institute for
Mental Health in England

**“THE CHANGING PROFESSIONAL ROLE OF
PSYCHIATRISTS IN THE CONTEXT OF
MULTI-DISCIPLINARY WORKING”**

**SUFFOLK MENTAL HEALTH PARTNERSHIP
NHS TRUST – EAST SUFFOLK**

FINAL REPORT

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EXECUTIVE SUMMARY

- 1) The Changing Professional Role of the Psychiatrist has been recognised as one of the most important ingredients in New Ways of Working (NWW). NWW for Psychiatrists is about supporting and enabling Consultant Psychiatrists to deliver an effective, person centred service for people with mental health problems. Inevitably changing the role of the psychiatrist has a profound effect on the multi-disciplinary team and the whole system.
- 2) As a Care Service Improvement Partnership (CSIP) Eastern Pilot Project site, Adult Mental Health services in East Suffolk changed profoundly in June 2005. The previous geographical sectorised model was replaced by a functional specialist one where Consultants worked with one specialist team, either in the community or hospital based.
- 3) The national drivers for change included abundant literature and evidence supporting NWW for Psychiatrists, the local ones included numerous problems in delivering timely focused care for patients, lack of clarity on the role of Consultants and large numbers of out of area treatments (OATs). The first part of this report describes the historical background and drivers for change.
- 4) Before launching the project, all stakeholders were involved, we learned from other sites and ensured Consultant and organisational commitment. The Generic Community Mental Health Teams were reconfigured into Triage/Brief Intervention with a single point of referral and Recovery functions. The preparation phase and launch are described in this report.

- 5) The progress of the project has been closely monitored. Outcome measures include data relating to various levels of activity within the system as well as regular audits of patient and staff satisfaction questionnaires and a peer review. The report outlines the progress and outcome measures.
- 6) The impact of the changes on the inpatient service was very noticeable from the outset and there are clear indications of improvement on the community side. The functional specialist model of working has its merits which far outweigh its disadvantages. It is certainly a more efficient and more focused way of delivering care than the previous sectorised models and offers better opportunity for training and supervision of junior medical staff.
- 7) There is evidence of improved patients' experience of the service, clarity of the role of the Consultant, focused medical time and expertise, improved multi-disciplinary team working, improved skill mix in teams and dissemination of clinical skills. The model also provides a high degree of transparency in addressing working practices. It brought a major culture shift by moving away from a service that fostered dependency to a recovery focused one with improved access to care. The report describes benefits, sharing our experience and the impact of the changes.
- 8) Teething problems were encountered as the project evolved such as anxiety and resistance to change, interface issues, mixing agendas, lack of suitable premises, lack of Trust guidance for the Role of the Consultant and anxieties to dissemination within the Trust. Difficulties and obstacles are described in the report.
- 9) The report describes the journey with a series of natural evolutionary steps. The journey began with the changing roles of individuals, namely Consultants, which

then led on to the formation of capable teams and the implications on the roles of various team members. We are now going through a further evolutionary stage regarding the capability of the whole system and how teams interrelate with a sense of belonging to a whole unit.

- 10) Although this is a final report on the pilot, which will now cease, we hope that with the agreement of the Trust Board, the project will continue and its future progress will be reported.

HISTORICAL BACKGROUND

The Department of Psychiatry in East Suffolk serves a catchment area of around 350,000 total population. This represents the area of Suffolk which stretches from Stowmarket in the West to the North Sea in the East and from the Norfolk border to the Shotley peninsula bordering Essex. Ipswich is the county town of Suffolk with a total population of around 150,000. The majority of East Suffolk is rural with scattered market towns. The other major conurbation is Felixstowe which is a large port.

Mental Health Services in Suffolk were provided by three Trusts, Mid Anglia Community Services, Allington Trust and East Suffolk Local Health Services. They merged in 1999 to form Local Health Partnerships NHS Trust and in 2004 merged with social services to become Suffolk Mental Health Partnership Trust.

In the past St Audry's Hospital in Woodbridge was the county asylum for the whole of Suffolk. This was a typical Victorian asylum with a large number of inpatients and was closed with a progressive move to community care with hospital services relocating to the St Clements Hospital site in Ipswich.

Adult Mental Health Services in the East of the county were delivered in the traditional way with eight Consultants, each managing their own sector with associated general practices and working both in the community and St Clements Hospital (appendix 1). The Rehabilitation Consultant worked closely with his Adult Mental Health colleagues. There were two open wards of 20 and 24 beds respectively, and a locked ward of 8 beds. In 2003 a 72 hour Assessment Unit was also developed on the St Clements Hospital site consisting of 6 beds. In addition there was a 12 bedded Rehabilitation Ward and the 15 bedded Chilton House for longer term rehabilitation. An Assessment Team was developed in 2003 with a view to evolving into a Crisis Resolution and Home Treatment

Team. The community services were provided in Ipswich by two Community Mental Health Teams, one for East and one for West Ipswich, each with two full time Consultants. The rural areas were divided into four sectors namely Hadleigh, Stowmarket, Wickham Market and Felixstowe, each with one Consultant. In addition, there was a fully established Assertive Outreach Team in the Ipswich locality but there was no Assertive Outreach provision in the rural areas. A community Eating Disorder Team was operational, with some Consultant input since October 2003.

DRIVERS FOR CHANGE

National Drivers

In England work around New Ways of Working began in 2003 with the realisation that the jobs of many psychiatrists had become untenable and the need for the profession and other mental health practitioners to work collaboratively and differently with service users and their families in order to face the new challenges. New Ways of Working for Psychiatrists is about supporting and enabling Consultant Psychiatrists to deliver an effective, person centred service for people with mental health problems.

The Planning and Priorities Framework (PPF), the National Service Framework (NSF) and the plans for a new Mental Health Bill set a new context for the profession with new challenges for the workforce, a relatively limited supply of all professional groups and an urgent need for review. Accordingly two national conferences were held in the Spring of 2003 and the British Medical Association (BMA) published findings identifying areas of concern for psychiatrists. These were issues relating to responsibility, power and accountability, training in leadership and management skills and concerns relating to continuity of care. Traditionally guidance for psychiatrists has been ambiguous and created an expectation that the Consultant carried “medical responsibility for all people referred to secondary care.” In many areas there were unmanageable workloads and increased stress and there were also unrealistic expectations of psychiatrists by Trusts and the public. There was also, naturally, role confusion particularly to do with leadership. This added stress and team conflict was created when there was an automatic assumption that psychiatrists should be both team managers and leaders. There were also clear issues emerging for the need to balance and rationalise the work of community based multi-disciplinary teams and the work of psychiatrists in traditional outpatient services.

The Royal College of Psychiatrists via the College Research Unit in 2003 examined the effects of different Consultant roles on stress levels and the findings included “that an alarming proportion” of Consultants exceeded clinically significant stress levels.

Consultants adopting “New Ways of Working” were significantly less stressed than those in traditional practice.

There was a clear realisation that New Ways of Working were needed to improve the ability of the Mental Health Workforce to work in teams to deliver flexible person centred care. Service users and carers wanted a different approach and the traditional roles were not sustainable.

The Royal College of Psychiatrists in 2003 developed three major hypothetical role options for psychiatrists:

Option 1: No change in Consultant Psychiatrist responsibilities.

Option 2: Smaller and selected Consultant caseloads with responsibility for other patients delegated to other professional disciplines within teams.

Option 3: Smaller and selected Consultant caseloads with responsibility for other patients distributed among other professionals within teams.

The current President of the Royal College of Psychiatrists, Professor Sheila Hollins, the Vice President, Dr Peter Kennedy, Professor Hugh Griffiths of the Department of Health are very keen on moving the agenda forward on New Ways of Working and have made it one of their key priorities. Already some important centres in the country such as Leeds, which has one of the largest training schemes in the UK, has adopted a Functional Model

of working and they are training the next generation of doctors accordingly. A similar programme is being rolled out in Newcastle as well as Norwich in conjunction with the University of East Anglia.

The National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists, in partnership with the World Psychiatric Association, have supported national and international work in this area.

Local Drivers:

- 1) Enthusiasm and willingness for change on the part of both users, carers, clinicians and Managers
- 2) Problems with many psychiatrists on the inpatient wards
- 3) Lack of clarity of the role of the psychiatrist
- 4) Increasing demands on psychiatrists with limited time spent with their Community Mental Health Teams
- 5) Many outpatient clinics carried out on the hospital site in isolation from the teams and consequently large Consultant caseloads
- 6) Stress, lack of job satisfaction amongst psychiatrists
- 7) Large numbers of patients placed out of county for psychiatric care due to lack of available beds locally causing huge financial pressures on the Trust
- 8) Lack of equity in workload of psychiatrists
- 9) A culture that fostered dependency rather than promoting recovery
- 10) Problems with recruitment and retention

THE BEGINNING

On the 30 September 2004 the Department of Adult Mental Health in East Suffolk held an away day. Present at that meeting were all Adult Mental Health Consultants, Team Managers, Locality Director, Service Director and later attended by the Chief Executive and the Medical Director of the Trust. Because of the multiple problems that we were encountering in providing timely psychiatric care for our patients, it became obvious that there was an urgent need for change. This was shortly followed by invitations from the National Institute of Mental Health in England (NIMHE) – Eastern Region for Trusts to apply to become pilot sites for New Ways of Working for Psychiatrists. This was discussed at length with all our Consultant colleagues in Adult Mental Health in our locality and there was unanimous agreement that we should apply to become a pilot site.

In October 2004 we submitted our proposal to NIMHE Eastern entitled “The Changing Professional Role of Psychiatrists in the Context of Multi-disciplinary Working.” We proposed a Functional Model of service in Adult Mental Health for our locality with Consultants operating Option 3 of the Royal College of Psychiatrists’ Role Options (smaller and selected Consultant caseloads with responsibility for other patients distributed among other professionals within teams). Six Consultants were to be based in the community and two on the inpatient site. The structure is based on the Stepped Care Model (Katon et al). The model is well researched worldwide in the management of chronic conditions such as diabetes, hypertension and asthma. In stepped care the vast majority of patients are seen in primary care and only those with complex problems receive specialist input. Within secondary care various disciplines can have input in chronic illnesses and it doesn’t always have to be the doctor. By deploying the most suited individual at a particular time to provide for the needs of the patient, staff are used more effectively and efficiently. The patient can then move throughout the different tiers

within the system of varying intensity depending on their needs, however, this does not mean that continuity of care is disrupted. On the contrary, once the initial assessment is made the various disciplines and teams that interface with the client will build on a body of information gained at the outset to inform of ongoing developments thereby making the assessment richer and more focused. The first tier of engagement by secondary services for a large number of conditions is time-limited and carried out by the Triage and Brief Intervention Team, only in cases of more enduring mental illness the patient will graduate to the Recovery Teams.

The proposal was accepted in November 2004. This was followed in January 2005 by a presentation of the proposal at the NIMHE Eastern regional conference in Cambridge which was attended by all other pilot sites in the region. We reviewed our proposal in April 2005 and it was successfully accepted (appendix 2).

In support of this project NIMHE Eastern provided us with £4000 as enabling money and this was to be matched by the same amount by our Trust.

PREPARATION PHASE

The preparation phase required an enormous amount of ground work in terms of reading both national and international literature on New Ways of Working, liaising with colleagues, learning from other sites around the country, keeping all stakeholders involved and addressing the likely impact of the changes on day to day working. We also worked extremely closely with NIMHE Eastern, our Managers and developed a Core Project Group to manage the pilot project.

Workshop on Crisis and Home Treatment organised in collaboration with NIMHE Eastern on the 20 January 2005

This was a Trustwide event which focused on managing organisational change addressing future challenges and focusing on the evidence available both nationally and internationally, presented by Dr John Hoult, Consultant Psychiatrist (Regional Advisor for NIMHE), around Crisis Resolution and Home Treatment. There was also input from an Expert by Experience service user from Birmingham where Crisis Resolution and Home Treatment Teams have been operating for a number of years. Mr Barry Foley (National Lead for Mental Health, Changing the Workforce Programme) focused on the National experience in terms of New Ways of Working. Albert Caracciolo spoke about the future Role of the Psychiatrist and the importance of working within whole systems. There was a focus in the afternoon on developing an integrated whole systems service map which optimises the impact of Crisis and Home Treatment Services. Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division) facilitated the day.

Learning from Other Sites

Newcastle Visit – 19 and 20 April 2005:

We decided in conjunction with the Service Director (Sandra Cowie) and Service Manager (Margaret Little) to plan a trip to Newcastle where a Functional Model of multi-disciplinary teamworking had been in operation for approximately 8 months. We utilised some of the NIMHE enabling money for the visit. We were very keen to see at first hand the benefits of such a system and the potential difficulties that might be encountered so that we would not repeat possible mistakes in setting up our new systems. The meeting lasted for two days and we had an opportunity to meet with all the key people that were involved in that scheme. The meeting was very educational and they were very transparent and honest in telling us about their experiences. We had the opportunity to visit their inpatient teams, community teams including Crisis Resolution and Home Treatment, Assertive Outreach and Early Intervention. One of the concepts we particularly liked was their Capacity Management Group meeting as a way of understanding capacity issues within the system and facilitating the movement of individuals through the various teams. This was held weekly and included all Team Managers, a number of Consultants and the Associate Medical Director.

Stakeholder Involvement

In order to keep all stakeholders fully informed and aware of the impending changes we carried out a number of presentations about the nature of the pilot. There were presentations to users and carers, Trust Executive Board, Medical Management Team, East Suffolk Local Implementation Team, General Practitioners and junior medical staff.

Preparation for the Transition

In order to ensure a smooth transition to a new system, we produced a detailed document shortly before the launch of the project addressing operational issues such as the

designated posts for Consultants, cross-cover arrangements, on-call rota and day to day clinical activities etc. That document was widely distributed to all parties concerned.

This was also an important time when Consultants were transferring their caseloads to other Consultants in the service and it was particularly important that this took place in a well coordinated and planned manner in order to avoid any disturbance to patients care. Patients were fully informed in writing of the process that was ongoing and the impending changes.

Allocation of Medical Manpower

There were detailed discussions regarding the deployment of medical manpower in the new system, particularly whether Consultants would be based with Inpatients or exclusively with Community teams. In the Community whether they would be assigned to Recovery, Assessment and Brief Intervention, or Crisis Resolution and Home Treatment Teams. All Consultants were given the opportunity to choose to work where they would be most productive and efficient. The final allocation of the medical manpower was done by mutual agreement. We were aware that the previous system engendered a degree of dependency in a number of patients and that there were numerous outpatients being held by all doctors, mostly at the hospital site. Once Consultants were clear in which particular part of the Functional Model they would work, they took it upon themselves to do a detailed analysis of their caseloads with their Team Managers to assess the exact level of need within the patient population and the best way to plan future management.

The Inpatient doctors planned at length how they would integrate most effectively with the Inpatient Nursing team and the outline of a clear structure to their working day was formulated.

Liaising with NIMHE Eastern

From October 2004 to the launch of the project there were monthly meetings between us (Project Leads), Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division) and other members of the NIMHE team. This involved several visits to their Head Office in Colchester to further discuss and refine the shape of the model.

Organisational Commitment

Before the launch of the project, we liaised closely with the Chief Executive of our Trust and the Trust Board to ensure their full commitment and agreement for the launch to take place on 7 June 2005.

THE LAUNCH

On the 7 June 2005 Adult Mental Health Services in East Suffolk underwent a dramatic change by adopting a Functional Model of specialist teams with designated Consultants and Junior Doctors. Consultants started to work solely with functional teams either in the community or in the hospital. There was one designated Consultant for Adult Mental Health patients on each of the two acute wards, namely Mistley (20 beds) and Playford (24 beds). The two Inpatient Consultants shared clinical responsibility for Adult Mental Health patients on the locked ward, Parham, and the continuous care wards. The acute wards were aligned in such a way so as to admit patients from specified catchment areas and deal with specified community teams.

The 72 hour Assessment Unit was linked to the Crisis Resolution and Home Treatment Team with identified medical input. The Consultant and supporting medical staff for the Assertive Outreach Team/Rehabilitation continued to provide medical care for their inpatients. This was due to capacity issues related to the large volume of inpatients.

In the community there was an initial functional split of teams in Ipswich into two Recovery and one Assessment and Brief Intervention teams. Each team had designated Consultant input. In the rural areas (Coastal and Central), there were two Recovery Teams (Wickham Market and Felixstowe, Stowmarket and Hadleigh) each with a designated Consultant. Assessment and Brief Intervention for the rural areas continued to be provided by the generic teams with a designated part-time Consultant. The future plans at this stage were to combine the rural and Ipswich Assessment and Brief Intervention teams into one Eastwide Triage and Brief Intervention Team with a single point of entry. Mainstream Rehabilitation services in the Community were carried out predominantly by the Recovery

Teams and the Consultant input to the Assertive Outreach Team was provided by a designated Consultant (appendix 3).

We were fully aware that strong care coordination was crucial for the successful outcome of this model since that would provide the glue coordinating the patient's pathway in a smooth way throughout the system.

The Capacity Management Group Meeting was also launched at the same time in order to closely monitor the flow of patients, and to allow timely intervention if capacity issues arose. The meeting took place on a weekly basis for one hour.

There were plans to close the long stay wards, rehabilitation ward, the 72 hour Acute Assessment Unit and to establish a fully operational Eastwide Crisis Resolution and Home Treatment Team.

PROGRESS

Project Reviews

Since the launch of the pilot progress has been closely monitored by three monthly audits of patient and staff satisfaction questionnaires, regular in-house reviews with all the senior clinicians and management, Consultants' Away Days in close collaboration with NIMHE to focus on emerging issues and set up clear action plans, other outcome measures and monthly meetings of the Core Project Group.

We established a Core Project Group in early January 2005. The members were:

Albert Caracciolo (Associate Medical Director – Project Lead)

Kamal Mohamed (Associate Medical Director – Project Lead)

Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division)

Sandra Cowie (Service Director)

Rob Hall (PCT Mental Health Lead)

Margaret Little (Service Manager)

Kevin Byford (Suffolk User Forum)

Andrew Bass (Manager of Suffolk Carers)

Bob Bolas (Deputy Chief Executive/Director of Nursing)
Joined in July 2006

The Core Project Group met on a monthly basis and emerging themes from those meetings were:

- 1) Consultants to refocus on roles and responsibilities in the new scheme, through case analysis, focusing on more complex cases, reduction in the number of outpatient clinics and increased time with teams.
- 2) The importance of developing a Trust Guidance as used by Avon and Wiltshire, to provide a framework for Consultants' roles and responsibilities.
- 3) An emphasis on the importance of having reliable outcome measures.
- 4) Developing capable teams and strengthening leadership.

As time passed on the Core Project Group focused on other relevant aspects namely publication and dissemination of Primary Care guidelines, linkworkers, Trust Guidance for Consultants and refining the Outcome Measures.

The Consultants' away days took place on 8 September 2005 and 16 December 2005. The meetings were attended by all Adult Mental Health Consultants, Sandra Cowie (Service Director), Margaret Little (Service Manager) and was facilitated by Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division). The purpose of these days was to re-define the Role of the Consultant within the Multi-disciplinary Team, look at areas of difficulty, reflect upon ongoing practices and to address these. An early emerging finding was that the Changing Role of the Consultant had a big impact on other members of the multi-disciplinary team and the need for other disciplines to look at their own roles became more evident. Areas discussed at length were interface issues and the role of the Consultant Psychiatrist in promoting the Recovery Model. Action plans were developed and agreed upon during these days. They consisted of addressing team interface issues through clarification of the patient pathways across the system, emphasising on the importance of the role of the Care Coordinator and for teams to work collaboratively, with a sense of ownership and with a whole systems approach, ensuring good continuity of care and avoiding tension between teams. The vital importance of communication within teams and between teams was again stressed.

- Action points for psychiatrists were: to spend more time with their teams, agree on the role of the Consultant within the team and implications on other disciplines, relocate to team bases, actively support team morale in the process of change, review personal and team caseloads with a view to more focused management.

The Role of the Psychiatrist in a Multi-disciplinary Team Context was discussed at length and collectively we agreed on the following role:

- Represent the team to other Consultants and management
- Clinical areas:
 - Diagnosis
 - Biopsychosocial approach to treatment
 - Difficult cases
 - Legal issues
 - Boundary setting
- Clinical Leadership:
 - Enabling/Encouraging other team members
 - Strategic planning and development
 - Available to the team both to individuals and the team as a whole
 - Active team member
 - Attend regular reviews
 - Ensure high team morale
- Education:
 - Junior Doctors
 - Other disciplines
- Participate in:
 - Evaluation
 - Audit
 - Research
 - Purpose and functioning of the team
- A source of wisdom to the team

We also decided that each Consultant would explicitly discuss the Changing Role of the Consultant with their respective teams and Team Managers so that every member of the team would have a clear idea of the new and changing role.

By the December away day Consultant role issues were reviewed and it was noted that the progress so far indicated a significant reduction of team caseloads and outpatient clinics. Although the process of caseload reduction had started Eastwide, it was proceeding at a different rate in various areas.

Meetings with GPs indicated that they welcomed an easy to use single point of entry system to secondary care, but some were reluctant to accept discharges. There were discussions relating to the urgent need for primary care guidelines.

Further actions were discussed including, the need to evidence progress, improve the audit cycle/process of evaluation, engage Junior Doctors more effectively in the audit process, review methodology of the evaluation to ensure robustness, identify “hotspots” in the system redesign i.e. where it is working well/where it is not.

Other important actions points were:

- NIMHE to help teams address the various management styles of Team Leaders and manage interface issues.
- Enabling timely access to the service for patients who have been discharged when the need arises
- Develop relapse drill/pre-planned pathways for all patients.

It was decided that there would be a NIMHE/CSIP regional event hosted by Suffolk Mental Health NHS Partnership Trust where all the development sites in the region would participate.

We discussed the need for Consultant job plans to reflect the changing work practices.

Closure of the 72 Hour Assessment Unit and Establishment of the Crisis Resolution and Home Treatment Team

In September 2005 the 72 Hour Acute Assessment Unit was closed and the Crisis Resolution Home Treatment Team launched. Initially it operated for the Ipswich area and focused primarily on early discharges. Subsequently the rural sectors also became under its remit over a phased two month period. Once they were covering the whole of East Suffolk, they focused almost exclusively on reducing the need for hospital admission. The Crisis Resolution Home Treatment Team has designated Consultant input. Two 72 hour crisis beds in each acute ward were allocated for use by the Team.

Closure of the Short Term Rehabilitation Ward (Ashfield) and the Continuous Care Wards

The aim was to channel resources into providing more focused community care and to reduce dependency on the hospital. This took place in a phased manner over several months and Sandra Cowie (Service Director) played a central role.

Development of the Rural Assertive Outreach Team

This was developed with designated Consultant input.

The Inpatient Experience

The impact of the changes on the Inpatient service was very noticeable from the outset and it helped to build on and enhance the refocusing of psychiatry work led by Tim Smith, Modern Matron. This is understandable since prior to the change there were multiple Consultants, up to 9 admitting to a ward in conjunction with their Junior Doctors. This led to a logistically impossible situation for the Nursing staff trying to accommodate numerous ward rounds at all times of the week, resulting in an environment that was generally chaotic, poorly conducive to good patient care and with little time for Nurses to become involved in purposeful activities with patients. The medical input was very diluted, often consisting of a weekly ward round which was disliked by the vast majority of patients who found the experience very distressing and often had difficulty in talking frankly about their problems in that context. Decisions about patient care were frequently postponed until the weekly ward round delaying timely decisions. The input to the hospital from the Community Mental Health Teams including Care Coordinators tended to cluster around the times of the ward round. Given this environment, the medical leadership on the wards was lacking and there was also limited implementation of the Re-Focusing Project due to different styles of medical input.

The week before we started the changes the two Inpatient Consultants met with the Modern Matron and the Ward Managers to outline a clear pathway of how patients would be handled. It was agreed that there would be a weekly Ward Manager and Consultant Meeting, monthly Multi-disciplinary Operational Group Meetings and away days for all acute wards on a regular three monthly basis.

One of the first tasks the Inpatient Consultants took upon themselves was to completely abolish the traditional weekly ward round, to the relief of patients and Nursing staff.

The Inpatient review pathway includes the following:

- The Morning Report chaired by the shift coordinator and minuted by the Medical Secretary. The minutes of this meeting are distributed on the same day to all Community Mental Health Teams and Adult Mental Health Consultants (appendix 4). The meeting occurs on a daily basis, starting at 9 am and lasting one hour. During this session all cases are discussed and it provides a valuable opportunity for all disciplines to obtain an updated report on the progress of all patients. Importantly, it also determines the work schedule for the ward team for that day and week. All disciplines contribute to the morning report in order to enhance full assessment, and appropriate management.
- From 10 am until 1 pm there are regular medical reviews/assessments, multi-disciplinary team review meetings including CPAs. Care planning and issues relating to leave planning, discharge planning, risk assessments are also discussed during these times. The frequency of medical reviews is tailored to the needs of the individual patient. Patients have timely medical input on a daily basis if required. The inpatient medical team is available to the wards during working hours. The acute ward inpatient teams have had away days on a three monthly basis. These days have been utilised to refocus further on operational issues and improve multi-disciplinary team working. Now that the medical staff are a truly integral part of the team, the benefits have been undeniable (appendix 5).

Since the writing of the Interim Report it has become clear that there is increased and more timely input from the Community Teams to the inpatient service. Although this is a process that needs ongoing development to ensure a seamless service.

The Inpatient team produced a ward booklet which gives a detailed account of the journey of the patient through the system, this is now available on Suffolk Mental Health Partnership Intranet site under Fairways Lodge Inpatient Pathways and a copy can be printed.

The Community Experience

The Community Teams were divided into Recovery and Triage - Brief Intervention functions.

The Consultants focused on reducing their caseloads, outpatient clinics and spending more time with their teams in a recovery oriented approach. The Recovery approach was not just confined to the Recovery teams but to be implemented across all areas of the service.

“Recovery is a journey as much as a destination. It is different for everyone. For some people with mental illness, recovery is a road they travel on only once or twice to a destination that is relatively easy to find. For others, recovery is a maze with an elusive destination, a maze that takes a lifetime to navigate. Recovery is happening when people can live well in the presence or absence of the mental illness and the many losses that come in their wake.” (Mental Health Commission, 2000)

“Recovery is not just about what services do to people, rather recovery is what people experience themselves as they become empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a contributing, positive sense of belonging in their community.” (NIMHE, January 2005)

The community teams underwent major changes in implementing the Functional Model. The Recovery Teams had a very successful away day in April 2006 when they shared their experiences and reflected on their practices. They developed an operational template to be used in all Recovery Teams. It was agreed that caseloads will be team-held, a traffic light system of organising and prioritising cases and a daily morning meeting including their Consultants is to be implemented.

The traffic light system was subsequently adopted across all community teams. Essentially this is a system whereby the team caseload is prioritised according to their needs i.e. red, amber and green. This will enable all teams to visualise clearly the level of acuity and degree of care that needs to be allocated to various cases encourages greater team ownership of cases and facilitates cover of clients when care co-ordinators are away.

Establishment of an Eastwide Triage - Brief Intervention Team

In April 2006 the two Community Assessment and Brief Intervention Teams from Ipswich and the Rural Areas merged to form an Eastwide Triage and Brief Intervention Team with a single point of referral. The team has a strong triage function and referrals channelled to the relevant teams. The rationale behind having a single point of referral is to provide a consistent and uniform approach to all referrals. The Brief Intervention Function entails providing short term intensive care for up to approximately three months (appendix 6).

Capacity Management Group Meeting

The Capacity Management Group Meeting was an idea we borrowed from Newcastle where it worked very effectively. The purpose is to have senior medical staff and senior Managers from all services to discuss weekly in detail the workload and any areas of hold up in the system or capacity issues. It is also an opportunity to discuss in more depth

problematic cases that will be moving through the various teams so that this can take place in a smooth and timely manner (appendix 7).

More recently an additional function was introduced to the meeting focusing on complex clinical cases causing interface difficulties which are discussed.

Training

During the last Royal College of Psychiatrists visit to our training scheme it was mentioned that there was relatively little focus on training of Junior Doctors in the community. The changes allow Junior Doctors to be exposed on a full time basis to community work as an integral member of the multi-disciplinary team in a way that was unthinkable before. Their supervision is more frequent and intense because they work very closely with the Consultant and other disciplines in the team. This is evident in the extremely high pass rate of approximately 70% in the most recent MRCPsych Part II examination.

The model lends itself well to adapting to the modernising medical careers agenda and its training requirements.

OUTCOME MEASURES

Prior to the launch of the project we were very mindful of the need to closely monitor its progress and worked closely with the Audit Department of the Trust to ensure this. The initial outcome measures included a patient and staff satisfaction questionnaire on a three monthly basis (appendix 8). It was evident from the early results of these two measures that the changes had a very positive impact on the inpatient side (appendix 9).

There were other outcome measures which we discussed with Sandra Cowie (Service Director) and Bob Bolas (Deputy Chief Executive). Bob Bolas fully supported the data collection and took active measures to facilitate this. These include:

- 1) Diagnostic coding on discharge
- 2) Community Mental Health Team Consultant caseloads and contacts in the East of the county
- 3) Admission data
- 4) Length of stay
- 5) Readmission data
- 6) Mental health activity in terms of compulsory admissions
- 7) Bed occupancy
- 8) Number of patients on enhanced or standard CPA
- 9) Activity around Assertive Outreach and the Crisis Resolution and Home Treatment Teams
- 10) Analysis of Serious Untoward Incidents (SUIs)
- 11) Levels of stress amongst Consultants

The Maslach Burnout Inventory was used to assess levels of stress at the beginning of the project. It will be repeated in the near future.

In order to ensure an assessment of the project by an outside agency, a peer review panel was organised for the 26 September 2006. The members included Dr Christine Vize, (Consultant Psychiatrist and National Co-Lead for NWWP), Paul O'Halloran, (Director: Development, Education and Training, CSIP Eastern Division), a Consultant Psychiatrist from another Trust and a service user from the CSIP Regional Expert by Experience programme.

Initially we tried to involve out junior medical staff in the various audit projects relevant to the outcome measures. It became evident, however, that there was no adequate capacity within the medical staff to do this task as well as difficulties accessing the relevant data. As a result of this we called a meeting with Bob Bolas (Deputy Chief Executive) and Paul Spencer (Trust Statistician) to discuss ways of obtaining the data in a timely fashion and further refining the outcome measures. It was agreed at that time that we would focus on the following parameters:

- 1) Patient and Staff Satisfaction Questionnaires
- 2) Diagnostic Coding on Discharge from inpatient care
- 3) Community Mental Health Team Consultant caseload and contacts
- 4) Length of stay in hospital
- 5) Mental Health Act activity across the service
- 6) Serious Untoward Incidents
- 7) Level of stress amongst senior medical staff
- 8) Number of out of area treatments (OATs)

The project has demonstrated positive change on many fronts. At present routine data gathering to measure change is only occurring consistently on the inpatient wards.

Patient Satisfaction Questionnaires (Appendix 8 and 9)

Patients were asked to complete a satisfaction questionnaire in August 2005, December 2005, April 2006 and September 2006. There were a small number of responders (between 5 and 13) to a large number of questions, so the results have to be treated with caution. Clearly improved satisfaction was reported on involvement in reviews and discharge planning, care planning and service from doctors.

Staff Satisfaction Questionnaires (Appendix 8 and 9)

Staff in both the community and inpatient settings were asked to complete a satisfaction questionnaire in August 2005, December 2005, April 2006 and September 2006. Approximately 60 responses were received. The level of staff satisfaction on the inpatient side was consistently high from the outset and improved as time went on and systems became more fully embedded.

In the community a higher level of staff satisfaction was reported from the second questionnaire onwards. Improved satisfaction was reported on:

- Access to medical staff
- Joint working
- Team work
- Decision making
- Communication between inpatient and community teams
- Clarity in individual's roles and responsibilities
- Involvement of doctors in teamwork

Following discussions with senior clinical staff and managers there is qualitative improvement in access to the service and timely medical interventions.

Diagnostic Coding on Discharge from Hospital

The proportion of discharges from the acute wards where no diagnosis was recorded on the information system (ePEX) decreased from 23% in May 2005 to 8% in 2006. This suggests considerable progress towards better standards of record keeping. The level of diagnosis recording has been a key indicator in the Health Care Commission assessment of Mental Health Trusts data quality.

Community Mental Health Teams Consultant caseloads and contacts

The Adult Consultant caseload in East Suffolk fell from nearly 1400 at the end of May 2005 to 800 at the end of May 2006, a reduction of more than 40%. At the same time the average number of contacts per Consultant team increased slightly from 470 a year to 495. This would suggest that patients remaining on the caseload are receiving a more intensive medical service and there is qualitative evidence that this is continuing to improve steadily. It is evident that across the community the volume of outpatient clinics decreased markedly. These indicate a progressive move to a much more integrated team approach.

Inpatient Length of Stay

Average lengths of stay in the open acute wards are between 25 days and 30 days and 16 days in the locked ward. For comparison we obtained information from the Sainsbury Centre on the national average length of stay in acute wards. They found that the median length of stay for 2002/3 varied across the country from 38 days in London to 44 days in the East Midlands and the South West. The statistics came from the HES data at <http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937>.

It needs to be said that these figures are contaminated by a very small number of patients who remain on the wards for a considerable amount of time because of placement problems in the community rather than the acuity of their presentation.

Mental Health Act Activity

The number of patients on the acute wards on a Section of the Mental Health Act has increased from 136 between 2004 to 2005 to 159 between 2005 and 2006. This could be interpreted as an indicator that the wards are now treating a higher proportion of sicker patients.

Serious Untoward Incidents (Appendix 10)

Serious untoward incidents are not specifically categorised, however absconsions and suicide are the two main categories of serious untoward incidents. Bearing in mind that the level of recording of these incidents has improved dramatically in the last year, we can at least say that there has not been an increase in serious untoward incidents (appendix 10).

Stress amongst senior medical staff

There is strong qualitative evidence following multiple discussions with our Consultant colleagues that the level of stress amongst senior medical staff has been substantially reduced as a result of the more focused approach and role clarity in New Ways of Working.

Out of Area Treatments (OATs)

There has been a marked reduction in the number of OATs which remain at zero.

Health Care Commission Assessment of Suffolk Mental Health Partnership Trust

The Health Care Commission assessed this year Mental Health Services across England and Wales. They reviewed East and West Suffolk services separately. East Suffolk was given a score of “good” and West Suffolk as “fair” on community services. The Trust as a whole, which has been zero rated for two consecutive years was awarded a rating of “fair”.

When interpreting the outcome measures one should be aware that the changes coincided with many other major factors such as closure of services, financial restraints and a historical culture of dependency and resistance to change.

Peer Group Review

This took place on 26 September 2006. The purpose of the review was to provide an opportunity for an external and objective stock-take of developments in the East Suffolk NWW pilot project. This enabled participants to feedback their perspectives on progress made, challenges, experiences and lessons learnt. It also provided an opportunity for those involved locally to access expertise from a national and regional level in new ways of provision of psychiatric care, service user perspective, service development methods and evaluation. The framework or parameters for the review were provided by the original application made to CSIP to become a development site (appendix 2), as well as the published report on New Ways of Working for Psychiatrists.

The members of the Peer Group were Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division), Dr Christine Vize (Consultant Psychiatrist and National Co-Lead for NWWP), Debbie Roberts (Programme Manager, Experts by Experience, CSIP Eastern Division) and Dr Liam Callinan (Consultant Psychiatrist, Norfolk and Waveney MHPT).

A Programme was carefully devised for the day to ensure that the peer group would meet with all key stakeholders. These included the Trust's Chief Executive, key Trust Board members, Service Managers, Consultants, and representatives of service users and carers.

The key findings were:

- The project represents a very positive piece of work within the area of New Ways of Working and whole system re-design.
- Data gathering occurred consistently on the inpatient wards.
- Evaluation of the project would benefit by extension to community based services and include development in the West.
- The importance of implementing a recovery approach to service delivery and practice across all elements of the organisation.
- Development of better care coordination and continuity of care throughout the system.
- Improving link working with primary care.

They emphasised that everybody was very motivated and that this was not an end to the journey but just part of it, that development would need to continue and that an inclusive whole team approach is crucial.

The Trust is very keen to develop an action plan which is informed by the findings of the peer group review and this will hopefully take place in the very near future.

The findings of the peer review visit are detailed in the attached report (appendix 11).

BENEFITS

“Not every change is an improvement, but every improvement is a change.” Although we are not claiming that the model is perfect, we have more than enough evidence to say that its benefits far outweigh any disadvantages. It is certainly a more efficient and more focused way of delivering care than our previous Sectorised Model.

The benefits are many but we will summarise the most important ones:

- **Improved patients’ and carers’ experience of the services**

This has been especially evident on the inpatient side from the start and is steadily improving in the community based services. In the community there is improved contact with patients experiencing difficulties even if the care coordinator is away.

There is also much easier availability of medical staff including Consultants.

We believe that this model provides ready access to more than one senior medical opinion, particularly in very complex cases as they move through the system, giving patients and carers the benefit of all the available experience and expertise.

Carers have a better opportunity of meeting up with the inpatient medical staff.

- **Clarity of the Role of the Consultant**

Historically there has been role confusion and unrealistic expectations of Consultants.

This was particularly the case in responsibility, leadership and accountability. All these factors, as well as increasing unrealistic expectations led to increasing levels of stress. The pilot project provided an excellent opportunity to clarify the role of the Consultant.

Traditional Role

- Member of several teams
- Multiple areas of expertise
- Weekly supervision of a number of teams
- Delegation of work
- Increased burden of responsibility
- Professionals who meet infrequently
- Job unattractive to trainees
- Risk of “burnout”
- Style – Controlling

New Role

- Member of one team only
- One focus of expertise
- Daily supervision of the team
- Distribution of work
- True multi-disciplinary working
- Collective responsibility
- Style – enabling

- **Focused medical time and expertise**

This is reflected in the reduction in Consultants’ caseloads in the community, the number of outpatient clinics and the increased time spent by Consultants with the relevant community teams.

Now that the community Consultants and Secretaries move to their respective team bases, team members have easy access and improved communication with senior medical staff. They are now an integral part of the team and this has led to improved efficiency and better utilisation of medical time compared to the previous sectorised model.

- **Improved Multi-Disciplinary Team Working**

The change also provided an opportunity for true multidisciplinary teamworking in which disciplines can learn from each other and therefore enhancing dissemination of clinical skills and improving skill mix in teams. There is now abundant opportunity for all team members to learn from each other’s knowledge and experience and this obviously impacts positively in the standards of patient care. The daily contact

amongst team members, including medical staff, greatly improves communication between team members and allows for more timely and proactive interventions. Bearing in mind that in the previous sectorised model the Consultant had only half a day to spend a week with their community teams, this change has certainly been a huge step forward in the right direction. The Consultant is no longer distracted by multiple tasks on a daily basis and competing demands on their time.

The change provided a very valuable opportunity for all members of the multidisciplinary team including Consultants to reflect on their individual practices and to improve their standard of care. Examples of this are the various morning reports taking place now in all team both inpatients and the community which reduces duplication of effort and waste of valuable resources. This allows teams to ensure that the right intervention is carried out by the right person in the right place at the right time. In the community the traffic light system has enabled teams to have a much more proactive approach to care and more open risk taking shared amongst the team. Team members are greatly empowered in this system as they feel much more supported.

- **Creating a whole system approach**

Within this system the patient's needs are addressed by the most suitable team and the most suitable professionals. This, of course, needs close liaison between individuals and teams to ensure that the patient receives the most appropriate level of care, depending on the acuity and severity of their problems. To ensure this whole system approach, individual teams need to communicate efficiently and effectively with each other and have a collective sense of ownership of the patient's problems.

- **Culture shift**

There has been a shift from a culture that fostered dependency and was dominated by scepticism, cynicism, counter-productive criticism and resistance to New Ways of

Working, we have become a much more recovery oriented, dynamic and forward thinking department.

- **Transparency**

One of the major benefits of this system we noticed from the outset is the high degree of transparency it provides to people's working practices. The close multi-disciplinary team working allows various members of the team to look at each others performance and roles in a constructive and enabling manner, "who is doing what, when, why, how and for how long." The traffic light system adopted by community teams encourage a more open and transparent service.

- **Decreased need for inpatient care**

Since the launch of the project, a number of inpatient facilities have been closed including the 72 hour Assessment Unit, Ashfield House (Rehabilitation Ward) and Sutton and Brightwell (Continuous Care Wards). This reflects improved efficiency in all parts of the system.

- **Out of Area Treatments (OATs)**

Despite the closures stated above, the numbers of OATs have been consistently reduced to 0 at present.

- **Exposure**

The project, through exposure to other sites, has been an opportunity to move away from a rather insular and parochial way of practicing to a more outward looking approach keen to learn from other people's experiences.

- **Improved Recruitment and Retention of Consultants**

Before the launch of the project there were three locum Consultant posts. Subsequently two new Consultants have joined the department, one in September 2005 and the other in November 2005. At present we have one locum Consultant.

Although we cannot claim that change is the main reason for improved recruitment we certainly feel that for the future we will be a far more attractive place to work in.

- **Reduced level of stress in Consultants**

Although we have not repeated the Maslach Burnout Inventory, the feedback from our Consultant colleagues is that they feel more relaxed and focused in their new role.

SHARING OUR EXPERIENCE

On 9 June 2005 we attended a National Meeting on New Ways of Working in London organised by the National Workforce Programme and NIMHE and had the opportunity to hear presentations from other evolving pilot sites around the country and shared our experience.

On 4 July 2005 we presented to a regional NIMHE meeting in Ipswich which included other pilot sites. This was particularly helpful as we had just launched the project and were grappling with teething problems.

On 2 March 2006 we hosted a NIMHE regional meeting in East Suffolk focusing on the progress of the Changing Role of Psychiatrists in the Region. This was attended by our Chief Executive. The progress around the Region was reviewed by Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division). Dr Christine Vize, (Consultant Psychiatrist and National Co-Lead for NWWP) reviewed the national perspective. There were also workshops involving pilot sites in the region including our project.

In April 2006 Dr Kamal Mohamed presented our project at the British Arab Psychiatric Association meeting in Bahrain. The feedback from the presentation was extremely positive and several UK psychiatrists expressed a desire to visit our site and learn from our experience. There was also interest in our work from psychiatrists in the Arab world.

On 9 May 2006 we attended the Royal College of Psychiatrists' Eastern Division Meeting in Cambridge. The President of the Royal College and the College Chair for the Eastern Region were present. They both highlighted that New Ways of Working was high on their

agenda. They emphasised the importance of proper training in New Ways of Working for the new generation of psychiatrists. The whole afternoon was devoted to presentations by various pilot sites around the region and we presented our project. Paul O'Halloran outlined national and regional developments in New Ways of Working.

We are also members of NIMHE Eastern – CSIP Acute Care Forum which is an advisory regional board for developing New Ways of Working in acute mental health care. On 14 June 2006 we had the opportunity to meet with groups working in acute care from other Trusts for a sharing and learning event. We distributed the booklet (Fairways Lodge, St Clements Hospital Inpatient Assessment Pathway) produced by our inpatient teams.

We have learned a great deal from these events, supported each other and hope to continue doing so in the future.

In June 2006 we produced a detailed interim report on the pilot project. This was widely distributed to all relevant parties including all Consultants in the Trust, Trust Board and other pilot sites in the region and CSIP. The feedback we received was very positive. We also plan to circulate this final report widely and would welcome any feedback.

PRODUCTS FROM THE PROJECT

The following have been developed as part of the pilot project:

- Patient and staff satisfaction questionnaires (appendix 8)
- Capacity Management Group meeting template (appendix 7)
- Morning report template (appendix 4)
- Inpatient Assessment Pathway (appendix 5)
- Fairways Lodge Inpatient Assessment Booklet.

This can be obtained on request from the Project Leads.

DIFFICULTIES AND OBSTACLES

This was a huge whole system change. It is obvious that it no longer relates to the New Ways of Working for Consultant Psychiatrists but in fact significantly impacts on all other disciplines. It also implies a massive culture shift in Adult Mental Health Services in East Suffolk. These changes require full commitment at all levels of the Trust and strong leadership. The teething difficulties we encountered as the project evolved were numerous and particularly striking was the transparency of the system which brought to the surface a multitude of inherent longstanding problems.

Some of the difficulties can be summarised as follows:

- Anxiety and resistance to change
- Interface issues and continuity of care
- Mixing agendas
- Financial problems
- Care pathways
- Lack of suitable premises
- Trust guidance for the Role of the Consultant
- Burden of project management
- Anxieties to dissemination within the Trust

Anxiety and Resistance to Change

Many felt threatened by the changes and others were very cynical about New Ways of Working. Initially in some areas of the community there was lack of team engagement with the development process, lack of clarity regarding team leadership and management,

and problems with entrenched values, low team morale, fear of change and the traditional culture of many teams.

Interface Issues and Continuity of Care

One of the major criticisms of the Functional Model has been disruption to continuity of care and friction between teams. We were very aware of these issues prior to the launch of the project. Through emphasising the vital importance of the role of the Care Coordinator, Team Managers and Consultants interfacing at the weekly Capacity Management Group Meeting we minimise the likelihood of fragmentation of patient care and tension between teams. Once an initial assessment is made in secondary care, the various teams add relevant information as the case evolves but do not repeat the core assessment. An important ethos of this model is that, although teams have become more specialised, they need to have a keen sense of ownership of problems and to work flexibly with each other, always putting the needs of patients first.

Work had already been done on the Role of the Care Coordinator but there is still lack of consistency between teams. A CPA workshop headed by the Director of Modernisation and Nursing took place on 7 June 2006 to address this issue.

Mixing Agendas

Particularly during times of major change, some individuals may try to push through agendas that are not relevant in an opportunistic fashion. Some might see the change as an opportunity for shifting responsibility and capacity issues to others and developing services without adequate resources. These issues can be a recipe for tension between individuals and teams. Fortunately we were relatively spared from these difficulties although at times they surfaced and had to be dealt with head on with clarity and resolve.

One of the criticisms levelled at this model particularly by certain senior psychiatrists outside East Suffolk is that it is a way of “Managers managing Doctors”. They have anxieties about loss of power and status in becoming an integral member of the team. Although we strongly disagree with this view, this model might be misconstrued by some as a way of “disempowering or controlling doctors”. Doctors play a crucial role in this model and are valued by all team members because of their input and worth. Empowering other members of the team does not mean that doctors are devaluing themselves.

Financial Problems

The launch of the project, unfortunately, coincided with enormous financial difficulties in our Trust. We had to carry out all changes within the financial envelope and absorb the closure of some services. The financial pressures understandably but regrettably at times can predominate and cause difficulties. Although this Functional Model is an efficient and a cost-effective way of running a service, the financial drivers should not be the predominant reason behind the changes.

Care Pathways

At the start of the project the Primary Care Guidelines that had been produced after great effort in our Trust were not published because of the difficulties concerning the Venlafaxine judgement. There were no designated linkworkers between primary and secondary care to rationalise the number of referrals. With a fully operative Crisis Resolution Home Treatment Team and the establishment of an Eastwide Triage - Brief Intervention Team, care pathways between teams had become more clear but they need ongoing refinement.

Lack of Suitable Premises

The emphases of this model is on community care. However the provision of premises fit for purpose was and remains extremely poor. This has resulted in teams who would optimally be best placed in the community and some outpatient clinics remaining on the hospital site. There are plans for such developments in the community and for a New Build Scheme at the St Clements Hospital site.

Lack of Trust Guidance for the Role of the Consultant

Our proposal to NIMHE Eastern made it clear that we needed a Trust Guidance on the Role of the Consultant. Other Trusts such as Avon and Wiltshire have produced such a document. Although there have been concerns in some quarters that this isn't a legally enforceable document, it nevertheless shows Trust commitment and provides a clear framework to support the New Ways of Working for Consultants. Such a guidance has also been adopted by Norfolk and Hertfordshire Mental Health Trusts where it has been felt to be both viable and useful. We have raised this issue on numerous occasions but as yet no such document is forthcoming, our efforts will continue.

Project Management

Similar schemes around the country have often had a dedicated Project Manager to oversee the numerous ongoing aspects of the changes. In our case the burden of the project management rested mainly on Project Leads with the support of NIMHE Eastern, our Locality Director and the Director of Modernisation in the Trust.

Anxieties to dissemination within the Trust

Although it has never been our intention to impose this model in other areas of the Trust, we were aware of anxieties in other localities in response to the change. This did not

distract us from our basic and fundamental remit to focus on this project and monitor its progress.

FUTURE PLANS

- **Beyond the Pilot Phase**

The pilot has now come to an end and it is time for the Trust to make a firm decision about adopting the model on a permanent basis in East Suffolk. We strongly recommend that this should be the case.

- **Continued monitoring and evaluation of the project**

We hope that the project will continue and in order to inform future decisions will be crucial to collect relevant data so that timely decisions can be made. This will need the full cooperation of senior managers, senior clinicians and all teams involved. We plan to obtain the services of a professional and recognised statistician to help further analyse the data collected.

- **Developing premises fit for purpose**

The lack of premises which are fit for purpose severely hampers progress. An outline business case will be submitted at the end of 2006 and this will provide the basis for future development of premises.

- **Primary Care Mental Health Guidelines**

These have been developed and their launch is imminent.

- **Primary Care Linkworkers**

Work is ongoing to adopt a Trustwide model for linkworkers. This is clearly a major and important piece of work as it will control and rationalise the flow of referrals from primary care.

- **Age Inclusive Services**

There has been a strong move across the NHS to eradicate ageism. Discussions are ongoing between Adult Mental Health Consultants, Old Age Consultants and Senior Managers to develop an Age Inclusive Service. A protocol has been agreed between these two services in East Suffolk.

- **Addressing Interface Issues**

The service still has arguments about interfaces and where people fit. However, the feeling is that although more work needs to be done in this area, overall the ability to provide care for patients has improved.

The Capacity Management Group meeting was a good development but will be used more explicitly as a means of informing policy developments as well as dealing with immediate difficulties.

There is still room for improvement in communication between various teams and within teams. The individual teams need to develop a greater sense of ownership of the whole system and commitment to ensure that patients receive the highest standards of care at all times.

- **Keeping all stakeholders involved**

In order to keep the momentum of the changes, it is vital to keep all stakeholders involved and informed of the progress.

- **Learning from other sites**

We will continue to liaise with CSIP and other progressive sites both in the UK and abroad.

- **Future services**

Development of a Trustwide Psychiatric Intensive Care Unit (PICU) and Early Intervention Service.

- **Trust guidance for Consultants**

So far our attempts have been unsuccessful in obtaining a clear Trust guidance for Consultants. This has been adopted in other Trusts and we will continue to pursue this issue with the Trust Board.

- **Developing capable teams and leadership**

A five day programme took place in July 2006 through CSIP to help develop effective team working and leadership in mental health. The focus of the training was to help managers develop effective leadership to transform services and enable them to move forward in a socially inclusive way. It is expected that the participants will disseminate their expertise throughout the Trust and cascade this valuable information to improve leadership qualities in all members of the various teams.

- **Communication with the Coroner**

Unfortunately we have so far been unable to communicate the changes with the Coroner, however, this is part of our future plan.

- **Foundation Trust Status**

The Trust is keen in becoming a Foundation Trust. A lot of work is ongoing to achieve this end. We are very hopeful of a successful outcome.

SUMMARY

Adult Mental Health Services in East Suffolk changed profoundly in June 2005. The change followed a successful proposal to NIMHE Eastern to become a pilot site for “The Changing Professional Role of Psychiatrists in the Context of Multi-Disciplinary Working”. The previous geographical Sectorised Model was replaced by a functional specialist one where Consultants worked either on the Inpatient or Community side with one specialist team.

The drivers for change were both national and local. At the national level there is abundant literature and evidence supporting New Ways of Working for Psychiatrists. At a local level we were experiencing numerous problems in delivering timely care for our patients. These difficulties were evident by multiple input from psychiatrists in the inpatient wards resulting in an inefficient and non-therapeutic environment, large number of routine outpatient clinics, limited Consultant time devoted to Community Mental Health Teams, lack of clarity of the role of the Consultant Psychiatrist, increasing demands on psychiatrists and many patients receiving their care out of county due to over-crowded local services. There was also a willingness of users, carers, clinicians and Managers for change.

The main aims and objectives of the project were to improve service delivery within the NSF guidelines, improve patients’ and carers’ experience of the service, reduce competing demands on Consultants’ time with opportunity for professional development and developing special interests, refocus clinical expertise so that Consultants provide input to one specified area of service and dissemination of expertise and skills to other multi-disciplinary team members.

The preparation phase required an enormous amount of ground work in terms of reading both the national and international literature on New Ways of Working for Consultant Psychiatrists, liaising with colleagues, learning from other sites around the country, keeping all stakeholders involved, addressing the likely impact of the changes on day-to-day working, ensuring Consultants and organisational commitment and liaising closely with NIMHE Eastern.

On 7 June 2005 Adult Mental Health Services in East Suffolk were reconfigured in such a way that two Consultants worked solely on the inpatient side and six Consultants worked solely with community specialist teams. The Community Mental Health Teams were organised into Triage - Brief Intervention and Recovery Functions. These generic teams were supported by Crisis Resolution Home Treatment, Assertive Outreach and Eating Disorder Teams. All referrals to secondary care in East Suffolk are channelled through a single point of access through the Triage - Brief Intervention Team. The Brief Intervention function addresses short term psychiatric problems whilst the Recovery focuses on enduring mental illness. The structuring of services is based on the Stepped Care Model. Historically services in East Suffolk fostered dependency. We moved to a Recovery focused approach with emphasis on service users becoming empowered to manage their lives.

Since the launch of the pilot, progress has been closely monitored by the Core Project Group, three monthly audits of patient and staff satisfaction questionnaires, regular in-house reviews and Consultants' away days. The development of a weekly Capacity Management Group meeting provided the opportunity for senior medical staff and managers from all services to discuss workload and capacity issues throughout the whole system.

Outcome measures include data relating to various levels of activity within the system. Also a peer review took place, the feedback from which was generally positive. It provided an opportunity for an external and objective stock-take of developments. An action plan will be formulated by the Trust following the report from the peer group. When interpreting outcome measures one needs to be mindful that the changes coincided with closure of some services, a culture resistant to change, a previous model that fostered dependency and financial restraints.

The impact of the changes on the inpatient service was very noticeable from the outset. With a designated Consultant per ward and the inpatient medical team, medical care is delivered in an organised, timely and focused manner. An inpatient review pathway was developed which abolished the traditional weekly ward round and was substituted by timely and purposeful reviews. On the community side Consultants focused on reducing their caseload, outpatient clinics and spending more time with their teams, dealing with more complex cases.

The daily presence of the Consultant within the team enhances multi-disciplinary teamworking and provides a much better opportunity for training and supervision of junior medical staff and other disciplines.

Although the project focused on New Ways of Working for Psychiatrists, it became apparent they impacted on all other disciplines. We encountered many teething problems as the project evolved such as anxiety and resistance to change, interface issues, mixing agendas, lack of suitable premises, lack of Trust guidance for the Role of the Consultant and anxieties to dissemination within the Trust.

Far from being perfect, the Functional Specialist Model of Working has its merits which far outweigh its disadvantages. It is certainly a more efficient and more focused way of delivering care than our previous Sectorised Model. There is evidence of improved patients' and carers' experience of the service, clarity of the Role of the Consultant, focused medical time and expertise, improved multi-disciplinary teamworking, improved skill mix in teams and dissemination of clinical skills. One of its greatest strengths is the degree of transparency in addressing the working practices of all disciplines and elucidating who "is doing what, when, why, how and for how long." It has brought a major culture shift from a service that fostered dependency to a recovery oriented approach. The project has been an opportunity to have exposure to other sites and move away from an insular and parochial way of practicing to an outward looking service. A tangible benefit has been that despite closures of some services, the number of out of area treatments have dropped to zero. Had it not been for the project, the Crisis Resolution Home Treatment Team would have had multiple medical input instead of a designated Consultant which has greatly impacted on its efficiency.

The future plans include the Trust to make a firm decision adopting the model on a permanent basis in East Suffolk, continued monitoring and evaluation of the project, developing premises fit for purpose, primary care mental health guidelines, primary care linkworkers, Age Inclusive Services, addressing interface issues, keeping all stakeholders involved, learning from other sites, development of a Trustwide Psychiatric Intensive Care Unit (PICU), an Early Intervention Service, Trust Guidance for Consultants, developing capable teams and leadership, communication with the Coroner and for the Trust to become a Foundation Trust.

A Carer's View from the Final Report on New Ways of Working for Psychiatrists by the Royal College of Psychiatrists, National Institute of Mental Health in England and Department of Health:

“Carers trust that examples of New Ways of Working will inspire others to look at their services and to break down the barriers, which inhibit flexibility and effective care for the whole of the person and their families, who must not be overlooked.”

ACKNOWLEDGEMENTS

These major changes in East Suffolk would have not been possible without a very open and honest collaborative relationship between us, the two project leads, the commitment of our Consultant colleagues in Adult Mental Health in East Suffolk (Dr Gaddal, Dr Weatherley, Dr Sirag, Dr Razzaque, Dr Mansvelt, Dr Sembhi, Dr Peeler), our Chief Executive, Mark Halladay, Sandra Cowie (Service Director), Margaret Little (Service Manager), Bob Bolas (Director of Nursing and Modernisation Programme), Tim Smith (Inpatient Modern Matron at St Clements Hospital), Community Teams and Ward Managers. The continuous support, encouragement and guidance of Paul O'Halloran (Director: Development, Education and Training, CSIP Eastern Division) throughout this project has been invaluable. We are thankful for the help we received from his colleagues Martin Flowers (Community Teams Programme Manager), Ray Baird (Primary Care Programme Manager) and Dr John Houlton (CSIP Regional Advisor).

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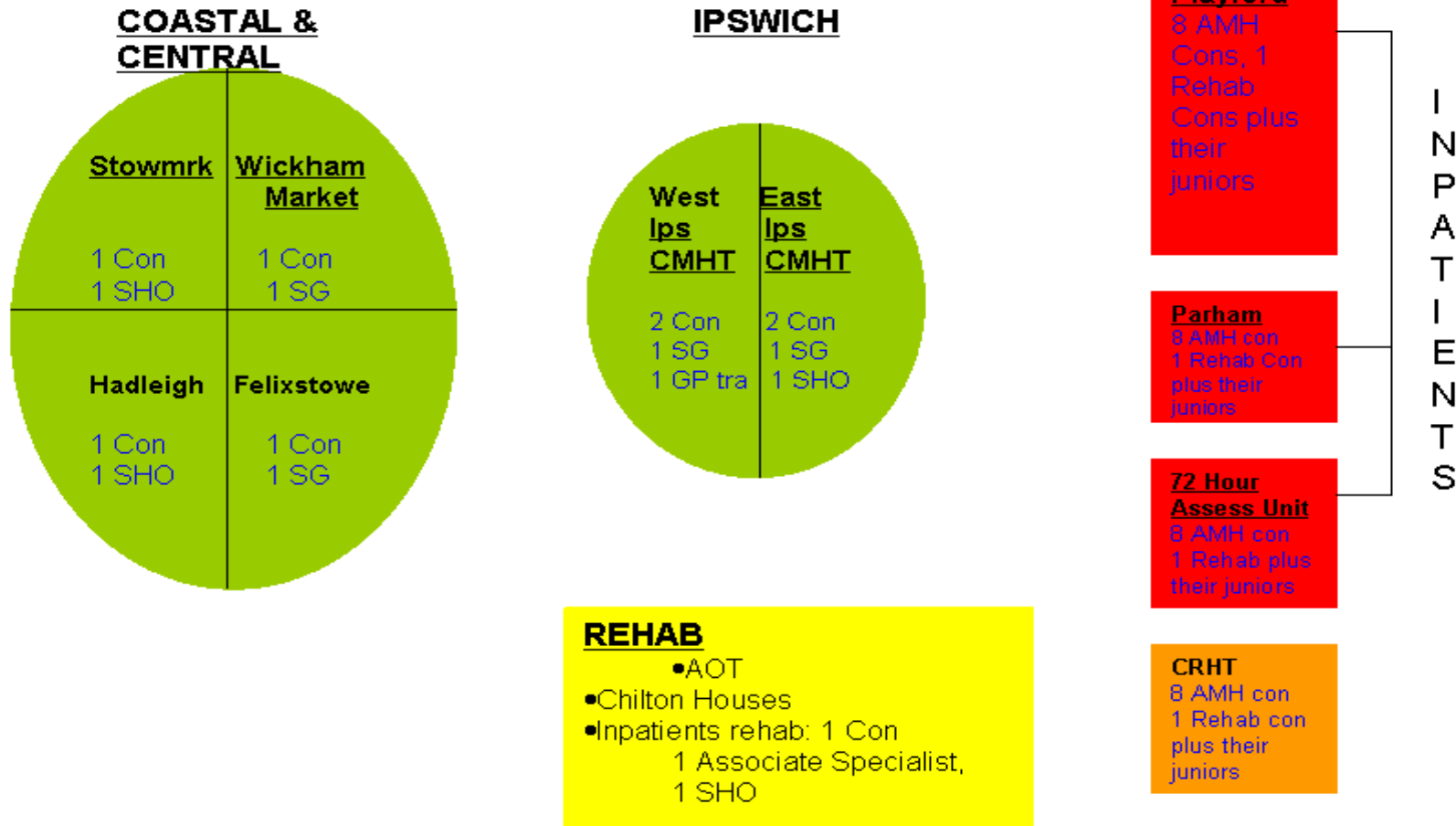
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THE PAST SECTORISED MODEL

COMMUNITY



NIMHE EASTERN
The changing professional role of psychiatrists
in the context of multi-disciplinary working

Application form

NIMHE Eastern Programme for the changing professional role of psychiatrists in the context of multi-disciplinary working	
Name of Lead Psychiatrists	Dr Kamal Mohamed Dr Albert Caracciolo
Full postal address	St Clements Hospital Foxhall Road Ipswich IP3 8LS
Name of host or employing organisation	Suffolk Mental Health Partnership NHS Trust
E mail	Kamal.mohammed@smhp.nhs.uk Albert.caracciolo@smhp.nhs.uk
Telephone and fax numbers	01473 329658, 07855 762536, 07855 773427 fax 01473 715894
Named lead in the NIMHE Development Centre	Paul O'Halloran, Director: Development Education, Training & Development, CSIP Eastern Division
Please answer the following questions as fully as possible	
<p>1. What would be some of the key development issues locally that this pilot programme would seek to address?</p> <ul style="list-style-type: none"> • Clarity of the role of the consultant psychiatrist within a multidisciplinary team which includes psychologists, occupational therapists, nurses, social workers and support workers • Creating a whole system approach across adult mental health including community, specialist teams, rehabilitation and inpatient mental health services • Recruitment and retention of consultant psychiatrists • Levels of stress amongst senior medical staff 	
<p>2. Give a brief outline of the aim and objectives of this proposal.</p> <ul style="list-style-type: none"> • Improve service delivery within NSF guidelines • Improve patients and carers' experience of the service • Reduce competing demands on consultants time with opportunity for professional development and developing special interests • Refocus clinical expertise so that consultants provide input to one specified area of service • Dissemination of expertise and skills to other multidisciplinary team members 	

<p>3. What degree of support and commitment is available from fellow psychiatrists to participate in this pilot?</p> <ul style="list-style-type: none"> • Comprehensive discussions with fellow consultants in adult mental health services in the east localities with sign up to modernisation of the service, moving towards more functional roles
<p>4. What is the commitment and capacity of your employing organisation to support this project to achieve the aim and objectives of the pilot?</p> <p>The organisation is fully committed to supporting the proposed changes in adult mental health services across the east localities, which in turn will support this particular initiative. Trust Board sign up to developing and implementing Trust Guidance on the role of the Consultant Psychiatrist.</p> <p>This pilot project will be a key component in the development of the whole system approach, alongside</p> <ul style="list-style-type: none"> • Developing crisis resolution and home treatment • Assertive outreach in the rural areas • Modernisation of inpatient wards through the 'Refocusing Project' • Implementation of more functional components within the CMHT's <p>The coming together of these developments and service changes will enable the project be successful.</p>
<p>5. How would you see this project operating locally? e.g. within a specific team or unit or on a wider locality basis.</p> <ul style="list-style-type: none"> • Adult mental health, East Suffolk localities – population covered = 319,00 people in mixed rural/urban context; 6 CMHTs; 9 Consultant Psychiatrists
<p>6. Please provide detail of the anticipated outcomes of the pilot for your locality.</p> <ul style="list-style-type: none"> • More effective service delivery with care and treatment provided when needed, utilising crisis and home treatment services • Purposeful admission to inpatient facilities with increased access to medical expertise • Increased users' and carers' satisfaction • More focused role for consultants with increased job satisfaction • More equity in workloads • More effective interdisciplinary working across the system • Improved recruitment and retention of consultants and other disciplines • Improved skill mix in teams • Development of skills and more educational opportunities
<p>7. Give details of how the enabling monies would be used to support achievement of objectives.</p> <ul style="list-style-type: none"> • To provide opportunities to look at similar services and learn from their experience • Training, team building and group facilitation • Educating junior doctors, other members of the multidisciplinary teams, service users and carers about the pilot

8. What additional resources would the host organisation provide to support this initiative ?

These would include – but not be restricted to

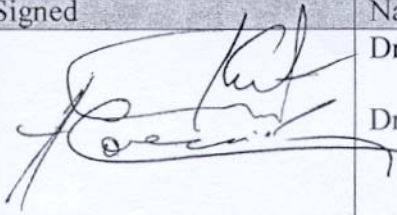
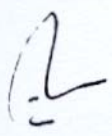

- To match funding provided by NIMHE to support this initiative.
- If successful, similar funding to other groups of psychiatrists within the Trust, which identify equivalent objectives for redesigning their working styles
- Access to the Trust's Centre for Service Excellence to support data collection, clinical audit and analysis as needed for any service improvement elements of the programme
- Access to the Trust's service user and carers networks to help inform the programme
- Participating psychiatrists' time (after the project) to support spread of the benefits regionally and nationally with NIMHE
- Chief Executive's time and Board support to the programme
- Adequate junior medical staff and secretarial support

9. How will you disseminate learning from this pilot initiative locally?

- Audit outcomes and report to be available to all Trust staff and other agencies, users and carers.
- Via in-house teaching programme for junior doctors
- Through operational management teams and Trust Board
- Reports to PECs to ensure dissemination to primary care

10. What process do you plan to use locally to ensure continued development and improvement in the new ways of working for psychiatrists in a multi-disciplinary and multi-agency context?

- Ensure feedback loops and forums are in place to discuss and consider the outcomes and to further develop new initiatives
- Utilise existing training events
- Contribution to the Modernisation Forum to ensure results and good practice are disseminated across the Trust and to all agencies

	Signed	Name in block capitals
Lead Psychiatrist/project lead		Dr K H Mohamed Dr Albert Caracciolo
Medical Director		Dr Tim Webb
Chief Officer of host/lead agency		Mr Mark Halladay
NIMHE Eastern		Paul O'Halloran, NIMHE, Eastern

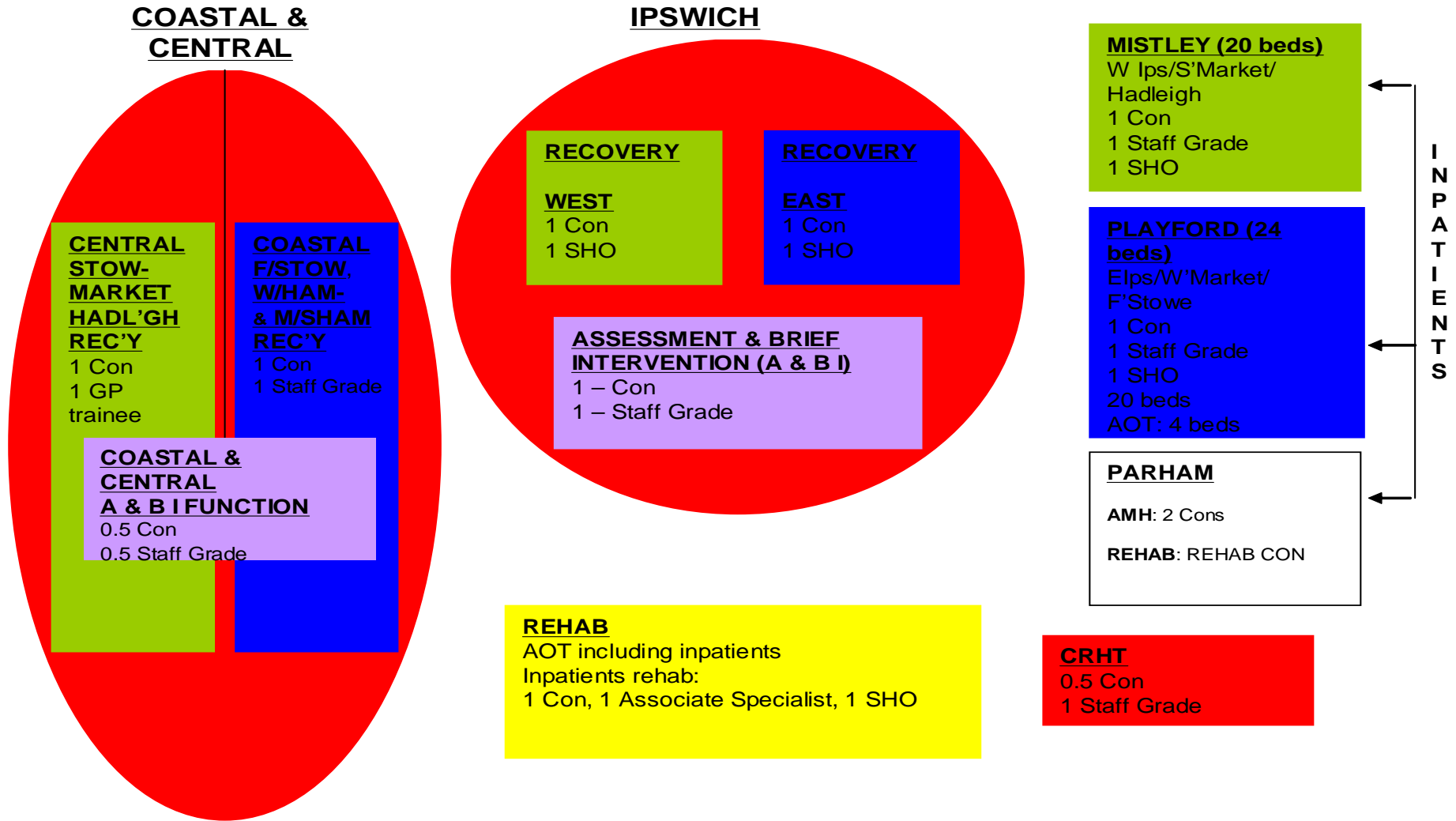
to: PAUL O'HALLORAN
DIRECTOR
TRAINING, EDUCATION & DEVELOPMENT
NIMHE EASTERN, 654 The Crescent
Colchester Business Park
COLCHESTER
ESSEX CO4 9YQ

EMAIL: paul.ohalloran@tiscali.co.uk

FAX: 01206 287 597

TEL: 01206 287 577

THE INITIAL FUNCTIONAL MODEL



Appendix 4

DAILY REPORT – INPATIENT ACUTE WARDS, ST CLEMENTS HOSPITAL, IPSWICH

STRICTLY CONFIDENTIAL

	NAME	CMHT & COMMUNITY CON	AD DATE & VIA	DIAGNOSIS	ACTION BY	REPORT	APPT DATE	DIS. DATE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
ADMITTED								
DISCHARGED								

PLEASE ENSURE THAT A RISK REVIEW IS CARRIED OUT ON ALL PATIENTS BEFORE
AND ON RETURN FROM LEAVES AND ON DISCHARGE.
CONTACT **MUST** BE MADE WITH PATIENTS WHILST THEY ARE ON LEAVE

Signed: _____

IN-PATIENT ASSESSMENT PATHWAY

January 06

The planned new configuration of wards with dedicated Consultant Psychiatrist and specialised inpatient teams.

Multi Disciplinary Clinical Operational Meeting Schedule to Support Inpatient Pathway

- Weekly Ward Manager and Consultant Meetings
- Weekly AMH Capacity Meeting
- Monthly Multi Disciplinary Operational Group Meetings

In attendance:- Consultant Psychiatrists, Modern Matron (Chair), Med Sec (minutes), Staff Grade, SHO, Ward Managers, Home Treatment Team Modern Matron and Consultant, Locality Consultants, CMHT Team Leaders, Assessment Unit Ward Manager.

IN-PATIENT REVIEW PATHWAY

1. Morning Report (Chaired by Shift Coordinators & Minuted by Ward Secretaries)

These individual ward reviews will take place daily between the hours of 9am and 10am on each of the two adult acute inpatient wards. It is envisaged that these meetings will be attended by the Consultant Psychiatrist, Junior Doctors, Shift Coordinators from Mistley, Playford and Parham Wards, Ward Managers, Occupational Therapists, the Medical and Ward Secretaries. This will allow inpatient medical staff to be familiar with all of the current inpatients, which in turn should provide continuity of care for service users, enhanced multidisciplinary care planning, and more effective communication and enable a speedier response to service users' needs. ***The meeting will primarily be used to enable the team to prioritise and plan their workload diaries for the day and forthcoming week.***

Purpose of the daily review:

- Daily update and handover from nursing staff over each 24-hour period
- Any significant changes in patient's presentation e.g. mental state, interactions, behaviour etc.
- Daily update of progress regarding treatment plan e.g. medication, side effects, attitude to treatment, leave etc.
- Daily update of security plan e.g. assessment and management of risk, level of supportive observation and Absconsions etc.
- Results of assessments, tests including physical examinations e.g. EEG, blood tests, dietary intake, sleep profile etc.

- Possible referral for Early Discharge
- Possible admissions from CMHTs
- Possible transfers from Parham Ward
- Possible referrals to Parham Ward
- Determine work schedule for the Team for that day.
- ***Determine “face to face” review schedule for the junior Drs during the day.***
- Booking schedule for: - MHA activity, CPAs, Weekly Coordination Meetings and Family/Carer consultations.

2. Admission Reviews

In attendance: - Primary Nurse and Medical representative.

The admission review will take place within 24 hours of admission or transfer to the ward. These meetings will be attended by representatives from the core MDT not necessarily with the Consultant Psychiatrist in attendance. Following this Review the next weekly review will be booked and brought forward in the diary.

Purpose of the Admission Review:

- Conduct a comprehensive review of the community care plan for those service users who already have an identified care coordinator.
- Re clarify the purpose of admission, the goals for the admission and a provisional assessment or treatment plan.
- Identify a provisional discharge date
- Identify and plan needs at the earliest opportunity e.g. housing, access to therapy, review of medication etc.
- Identify level of community support required at the earliest opportunity e.g. referral to the Home Treatment Team, CMHT, AOT etc
- Promote continuity and facilitate a smooth transition from community to inpatient based care.
- Complete relevant care coordination documentation including comprehensive MDT risk assessment, risk management and inpatient care plan.
- Address leave & discharge planning at the earliest stage.

3. Weekly Co-ordination & Review Meeting

All formal CPA meetings will be booked and scheduled during this allocated time.

These reviews will be booked in advance via the Daily Review meetings by the ward secretaries in liaison with the Medical Secretaries and will occur between the hours of 11-12.30 on a daily basis. These reviews can be attended by the CMHTs, AOT, Care Coordinators and in particular any family members and Carers. Relevant others identified in advance who may contribute to the decision-making or clinical management will also be invited and booked to attend.

Purpose of the weekly coordination meeting:

- Establish progress via a weekly summary of care needs.
- Identify what service users want and need from their stay in hospital

- Review and develop a MDT package of care based on the principles of care coordination.
- Retain the focus of admission
- Develop action plans to address leave and discharge needs.
- Review Risk and Risk management plans
- Review Patient Ward Round Preparation homework documentation.

4. Ward Secretaries Roles and Responsibilities

- Record CPAs and appointments from diary on daily sheet, prioritised by the Consultant
- Amend Inpatients Record Sheet as necessary, and E-mail to relevant CMHTs and Medical Secretary. File in ward file.
Record CPAs and appointments involving Carers, relatives or Care-coordinators in the diary, if possible between 11.am – 12.30pm, to see the Consultant. If it is appropriate to see the Staff Grade or SHO then appointments can be made at any other time. . Relevant others identified in advance who may contribute to the decision-making or clinical management will also be invited and booked to attend.
- Inform Medical Secretaries on a regular basis of any new appointments.

5. Medical Secretaries Role and Responsibilities

- Attend morning report
- Liaise with Ward Secretaries regarding appointment changes.

6. All Staff Roles and Responsibilities

- To liaise with the Shift Co-ordinator following Daily Report regarding daily schedule.
- Handover to Shift Co-ordinator at the beginning of the early shift any relevant issues regarding their patients, to be highlighted and discussed within the daily report meeting.
- Check diary for scheduled appointments for weekly reviews and ensure pre-conference reviews are completed prior to the meeting.
- Ensure Risk Assessments and Care Plans are completed, reviewed and recorded on the office board.
- Chair reviews as allocated by the Shift Co-ordinator
- Complete leave & Discharge planning documentation
- When recording in the patients notes identify the following in the margins using the appropriate Audit Codes:

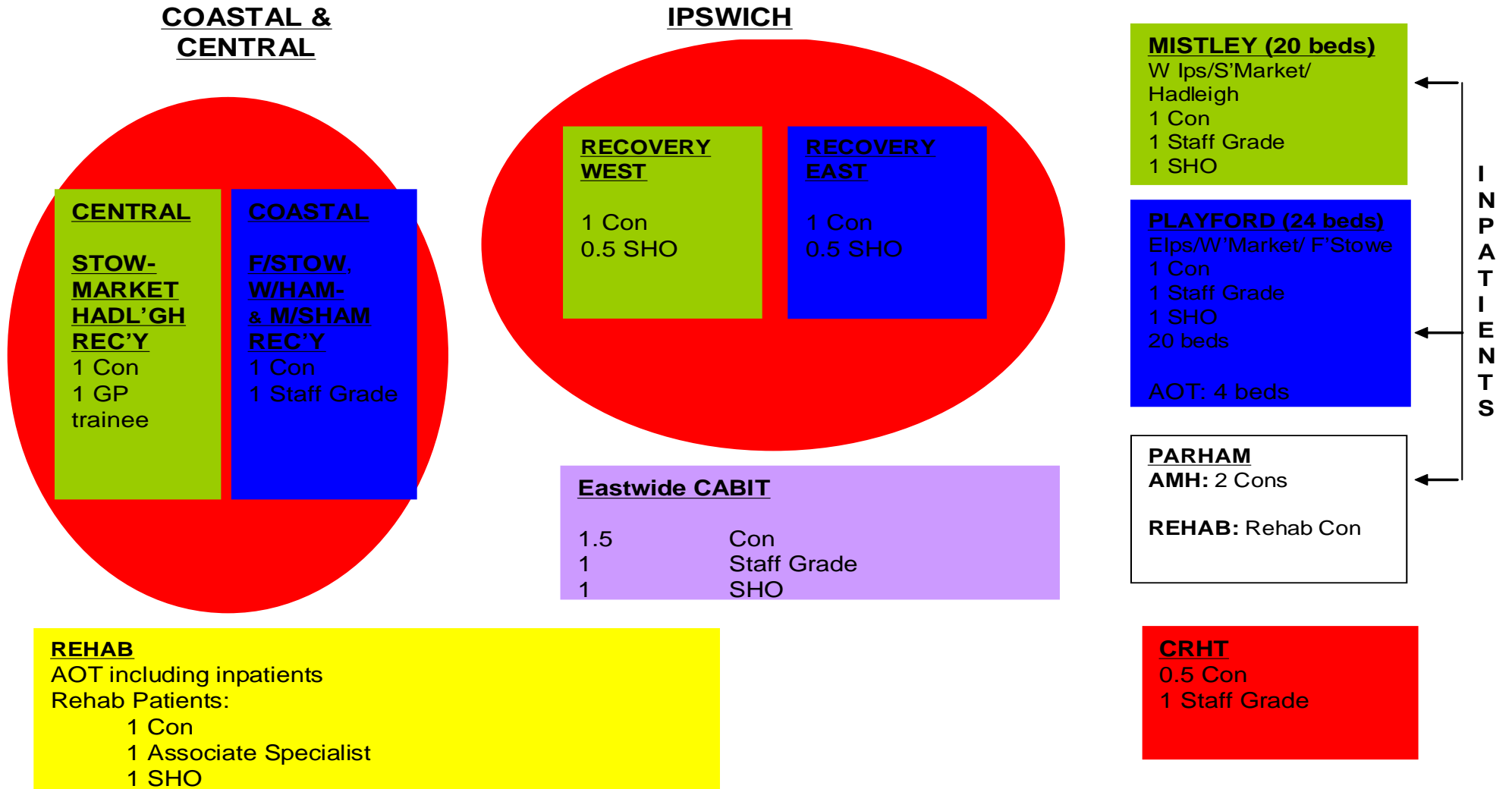
Daily Review	-	DR
Weekly Review	-	WR
Admission Review	-	AW

CPA	-	CPA
Leave Planning	-	LP
Discharge Planning	-	DP
Risk Assessment	-	RA
Solution Focused Conversation	-	SFC
Care Plan Review	-	CP
Mental State Monitoring	-	MM
Non Specific Intervention	-	NS

7. Shift coordinator Role and responsibilities

- Chair daily report meeting and ensure that attendees are updated with all relevant information including referrals, transfers, assessments and physical investigations, and to facilitate planning of work schedule for that day.
- Identify possible referrals to Parham, to be presented at the beginning of daily report.
- Forward weekly reviews dates in appointments diary.
- Ensure bed and information board is updated at the end of each shift.
- Ensure tasks identified in morning report are completed or delegated to the appropriate persons.
- Delegate reviews arranged to take place that day to other trained staff on duty in order that they can continue with shift co-ordinator role in nursing office.
- Ensure that close and continuous observations are allocated and carried out, and that necessary forms are completed by the end of the shift.
- Delegate daily tasks to staff including physical observations, helping patients with hygiene needs, escort duties, assisting in the kitchen etc.
- Check that the next shifts are fully staffed and bring deficits to the attention of the team leader, or in their absence, to the senior staff on duty.

THE CURRENT FUNCTIONAL MODEL



Appendix 7

SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST

CAPACITY MANAGEMENT MEETING

DATE: Wednesday

CRISIS RESOLUTION HOME TREATMENT

ASSESSMENTS		ADMISSIONS	HOME TREATMENT	DISCHARGES
Joint	Sole			

<u>ASSESSMENTS BETWEEN 9AM – 5PM</u>	
A&E	
Central Recovery (Stow, Hadleigh)	
Coastal Recovery (Felixstowe, W Market)	
Consultant	
Criminal Justice Liaison	
East Ipswich Recovery	
Forensic	
Ipswich Outreach	
Rural Outreach	
Triage	
West Ipswich Recovery	
TOTAL	

<u>ASSESSMENTS OUT OF HOURS</u>	
A&E	
Coastal Recovery	
East Ipswich Recovery	
G.P	
Ipswich Hospital	
Police	
Suffolk Doctor's On Call	
TOTAL	

<u>CURRENT HOME TREATMENT</u>	
Central Recovery (Stow, Hadleigh)	
Coastal Recovery (Felixstowe, W Market)	
Criminal Justice Liaison	
East Ipswich Recovery	
Forensic	
Ipswich Outreach	
Rural Outreach	
Triage/CABIT	
West Ipswich Recovery	
Discharge to Primary Care	
TOTAL	

INPATIENT UNITS

INPATIENT UNITS (Bed Nos)	Number OF Patients	Admissions	Discharges	DTOC's	DTOC's	Accommodation issues
Mistley (20)						
Playford (24)						
Parham (8)						
Easton (10)						
Bromeswell (23)						
Chillesford (12)						
Brightwell (12)						
Chilton Houses (15)						

COMMUNITY MENTAL HEALTH TEAMS – EAST SUFFOLK

CMHTS	Case load		Referrals			Assessment completed	Waiting List (assessed & awaiting allocation)	Waiting List (awaiting assess)	Disch.		Issues
	Enhanced	Standard	Crisis	7 day follow up	Non urgent				Caseload	Assessment	
Triage & Brief Intervention											
Recovery East Ipswich											
Recovery West Ipswich											
Central Recovery											
Coastal Recovery Team											
OPMH Coastal											
MHICOP											

ASSERTIVE OUTREACH	Caseload	Waiting List (assessed & awaiting allocation)	Waiting List (awaiting assessment)	Discharged	Issues
Assertive Outreach Ipswich					
Assertive Outreach Rural					
FORENSIC & CRIMINAL JUSTICE	Numbers	Waiting to be Assessed or Allocated	Comments		
Forensic Caseload					
Criminal Justice Liaison Duty Work					

OPMH	Case load		Referrals		Waiting List (awaiting assess)	Disch.		Issues
	Enhanced	Standard	Crisis	Non urgent		Caseload	Assessment	
Ipswich CPN's								
Redwald Unit								
Nurse led Memory Clinic								
Central CMHT's								
Ipswich Hospital Liaison								



‘The changing professional role of Psychiatrists in the context of multi-disciplinary working’

Patient Satisfaction Questionnaire

Consultant psychiatrists in the East submitted a proposal to the National Institute for Mental Health in England (NIMHE) ‘Changing Roles of Psychiatrists’ programme and have been accepted as a pilot site – their involvement will be evaluated on an ongoing basis by the Trust and at the end of the year will contribute to the overall project evaluation facilitated by NIMHE.

What this means

There are nine Adult Mental Health Consultant Psychiatrists currently working in the East of Suffolk across community, inpatient, rehabilitation and Assertive Outreach services with some input to Crisis Resolution and Home Treatment. Until recently all Consultants provided both community and inpatient services - it has now been agreed that particular consultants will take responsibility for the inpatient facilities. This will ensure standardised processes are implemented and further develop close working relationships between disciplines on the wards, including contributing to the refocusing psychiatry project. The remaining Consultants are working within the community in specific roles; either involved in the assessment and brief intervention or recovery functions in the Community Mental Health Team’s (CMHT’s). The aim of all these changes is to provide more focussed expertise in particular areas, to further develop specialisms within teams, to provide more effective multi-disciplinary team approaches to care and more importantly to ensure that service users as far as possible are receiving equitable standards of care and treatment

WE WANT TO KNOW WHAT YOU THOUGHT OF YOUR STAY AND THE CHANGES WHICH HAVE BEEN MADE TO THE WAY IN WHICH WE PROVIDE SERVICES

Running an in-patient mental health unit is often difficult, and we need your feedback on which bits we get right and where we can improve. We would be grateful if you could spend a few minutes telling us what you thought of your stay here.

Please try to answer every question by ticking the most appropriate box. Try to answer the questions from your overall experience of the service, rather than one particular incident.

Although we read all the questionnaires, your answers and comments are kept anonymous. Your identity will not be revealed to anyone or mentioned in any report.

Ref	Section 1: Information and support before being admitted to hospital	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I was given information about what to expect before I came into hospital.					
2	I was given a letter prior to admission about the changes to services including those provided by Doctors					
3	I found the leaflet regarding the changed responsibilities of Doctors useful.					

4	I found the ward staff welcoming.					
5	I found the ward area comfortable.					
6	It was explained to me that information about me would be shared with community Doctors and the community team.					
7	The ward staff were able to offer information/answer queries regarding Doctors' responsibilities					

Ref.	Section 2: Therapies and activities.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I found the group activities helpful.					
2	I found the one-to-one sessions with a member of staff helpful.					
3	I felt involved in my treatment.					
4	I had a choice of activities and pastimes.					
5	I had enough to do during the day.					
6	There was enough for me to do at weekends.					
7	The treatment I received was properly explained to me.					
8	The effects and side effects of my drug treatment were properly explained to me.					
9	I had enough time to discuss my treatment with the Doctor					
10	I found the Reviews including the ward Doctor and my care co-ordinator to be useful					

Ref.	Section 3: The ward team. Did you find the following staff and services to be satisfactory	Very satisfactory	Satisfactory	No opinion	Poor	Very poor
1	Admin and reception staff.					
2	Physiotherapy staff.					
3	Nurses.					
4	Junior Doctors.					
5	Doctor Psychiatrist.					
6	Occupational Therapy staff.					
7	Health Care Assistants.					
8	Group work.					
9	Psychology input.					

10	Physiotherapy input.					
11	Art Therapy input.					
12	Chaplaincy input.					
13	Community key worker input whilst in hospital.					
14	Advocacy and Suffolk Carers input.					
Ref.	Section 4: Staff attitudes.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	The overall attitude of staff was good.					
2	They involved me in choosing my care.					
3	They answered my questions.					
4	They understood and tried to meet my ethnic and cultural needs.					
5	They kept their appointments with me.					
6	My complaints were taken seriously.					
7	I knew the name of my Doctor					
8	I was able to see my Doctor in private.					

Ref.	Section 5: During my admission my involvement in my reviews was as follows:	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I was informed of the dates of my reviews.					
2	I was given adequate notice of my reviews.					
3	I was given a choice of who attended my reviews.					
4	I found the room that the review was held in was comfortable.					
5	I felt involved in the decisions made.					
6	I was happy with the outcome of my reviews.					

Ref.	Section 6: Care Plan.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I was consulted before my care plan was written.					
2	I was consulted when my care plan was reviewed.					

3	My care plan was explained to me.					
4	I understood my care plan.					
5	I felt that my care plan reflected my individual needs.					

Ref.	Section 7: The involvement of my family/carers was as follows:	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	My family/carer was involved in my care programme.					
2	If not, that was my decision.					
3	I was offered the choice of whether to involve my family/carer.					
4	I was offered the choice in the on-going involvement of my family/carer.					
Ref.	Section 8: Discharge	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I was involved in planning my discharge.					
2	I felt I was offered appropriate aftercare.					
3	I felt my family, friends and carers were involved.					
4	My community care co-ordinator was involved with my discharge planning.					

If you have used Mental Health services previously, what are your views about seeing one Doctor in the community and a different Doctor whilst an in-patient.?

Please use this section to comment and to make any suggestions you may have on how we may possibly improve the service we provide:

THANK YOU FOR TAKING TIME TO COMPLETE THIS QUESTIONNAIRE

Please place the completed form in an envelope and hand to a member of staff by

24th April 2006

DATA PROTECTION

The information you provide on this form will be recorded on a computer system which has been registered under the DATA PROTECTION ACT, 1998. The information will only be used for the purposes disclosed in the DATA PROTECTION REGISTRATION APPLICATION by the Trust.



‘The changing professional role of Psychiatrists in the context of multi-disciplinary working’

Staff Satisfaction Questionnaire

Consultant psychiatrists in the East submitted a proposal to the National Institute for Mental Health in England (NIMHE) ‘Changing Roles of Psychiatrists’ programme and have been accepted as a pilot site – their involvement will be evaluated on an ongoing basis by the Trust and at the end of the year will contribute to the overall project evaluation facilitated by NIMHE.

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WE WANT TO KNOW WHAT YOU THINK ABOUT THE CHANGES

Please try to answer every question by ticking the most appropriate box.

Although we read all the questionnaires, your answers and comments are kept anonymous. Your identity will not be revealed to anyone or mentioned in any report.

Ref.		Yes	No
1	a) Do you work in the community or		
	b) Do you work on an in-patient ward		

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
2	Do you now have improved access to medical staff?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
3	Do you now have improved communication with medical staff?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
4	Do you have improved joint working since a specified member of the Medical team has been allocated?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
5	Have the changes which have been implemented improved team work?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
6	Have the changes led to an improved decision making process within the team?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
7	Has communication between the in-patient and community teams improved?					

	If you have ticked a) or e) please state reasons					
Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
8	In your opinion have the changes improved care for service users?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
9	In your opinion is there greater clarity in the individuals' roles and responsibilities within the team?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Greatly improved	b)Slightly improved	c)Remained the same	d)Slightly worse	e)A lot worse
10	Do you feel that doctors are more involved in team work?					
	If you have ticked a) or e) please state reasons					

Ref.		a)Great impact	b)Slight impact	c)Remained the same	d)Slightly worse	e)A lot worse
11	In your opinion has the allocation of a specified member of the medical team to your area impacted on the team?					
	If you have ticked a) or e) please state reasons					

Please use this section to make any suggestions for improvement and to make any comments on the different way in which Psychiatrists are now working:

**THANK YOU FOR TAKING THE
TIME TO COMPLETE THIS QUESTIONNAIRE**

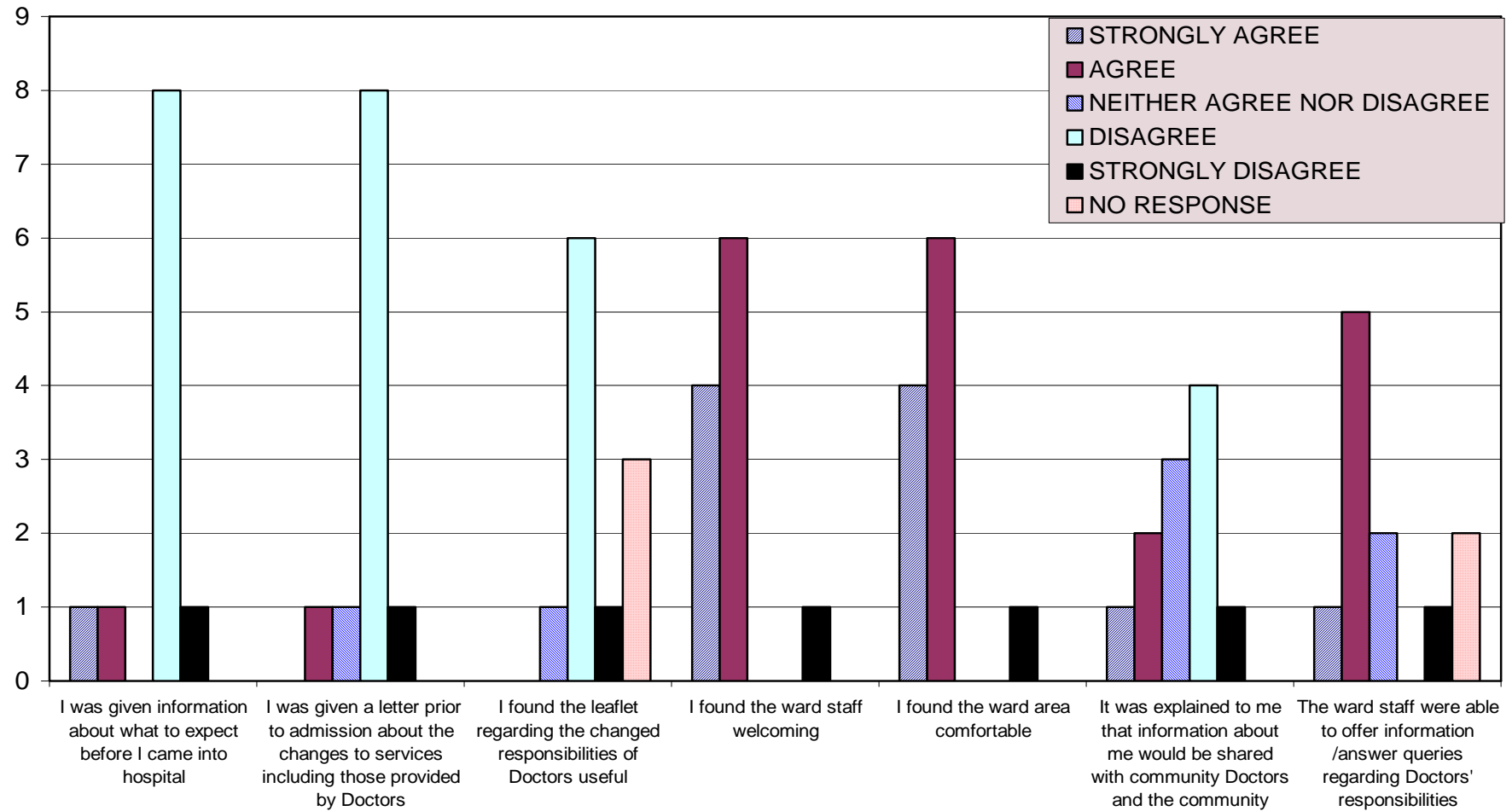
Please return by internal mail to :-

**Janet Roper, Clinical Effectiveness & Audit Advisor, Centre for Service Excellence,
Suffolk House, St Clements Hospital Site, Foxhall Rd, Ipswich by 24th April 2006.**

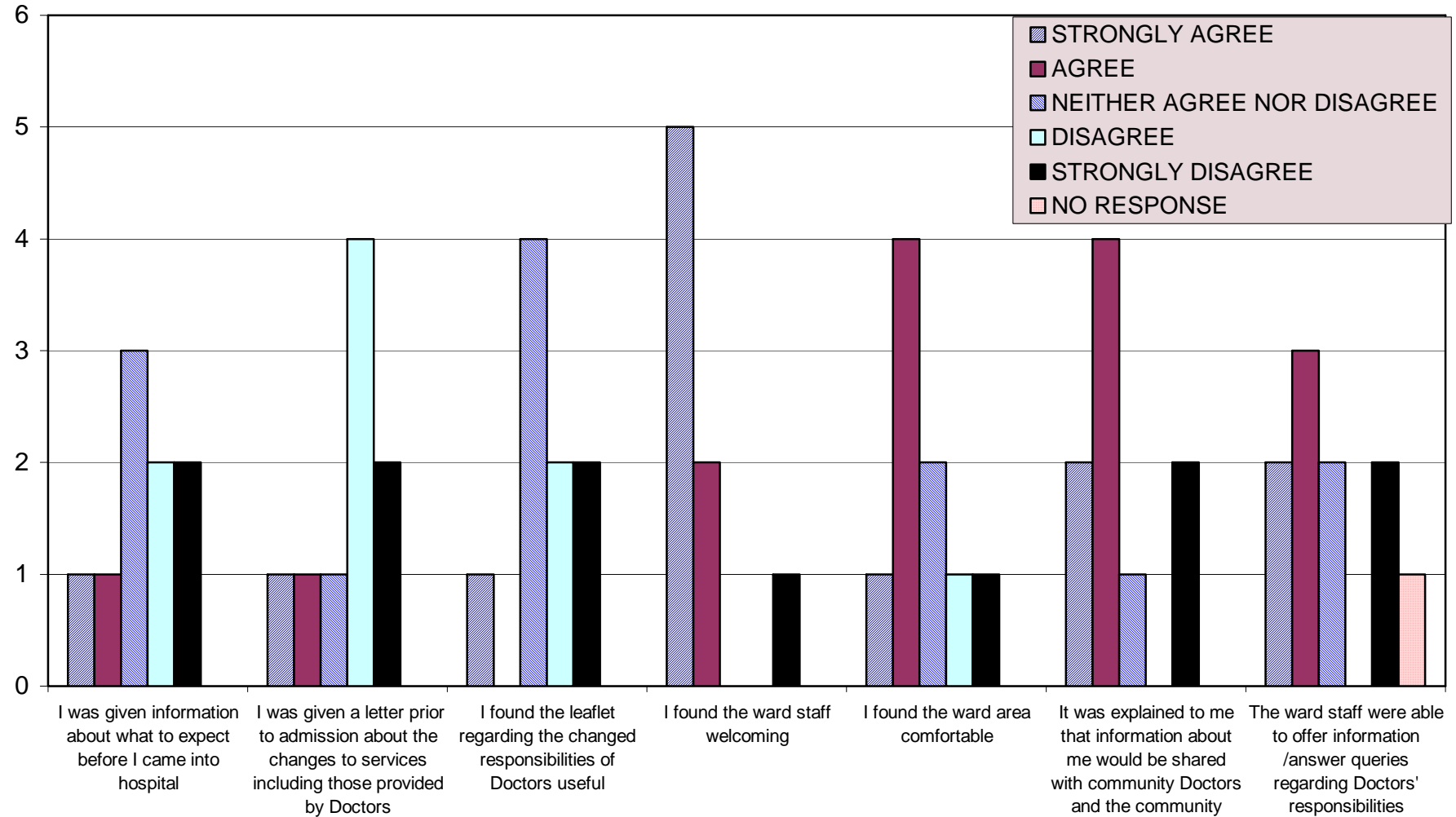
DATA PROTECTION

The information you provide on this form will be recorded on a computer system which has been registered under the DATA PROTECTION ACT, 1998. The information will only be used for the purposes disclosed in the DATA PROTECTION REGISTRATION APPLICATION by the Trust.

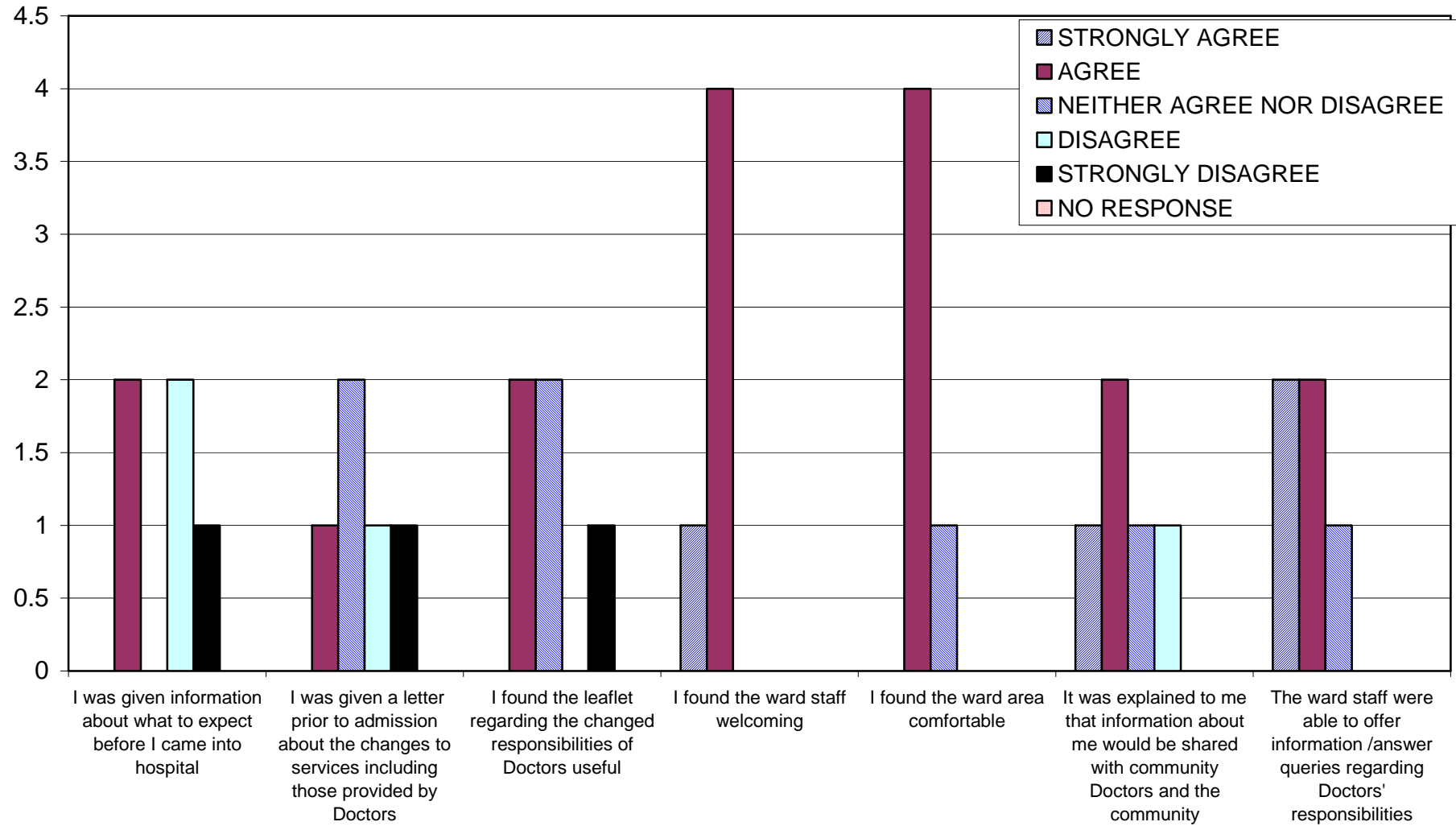
Appendix 9 Section 1 - Information and support before being admitted to hospital - August 2005 Questionnaire



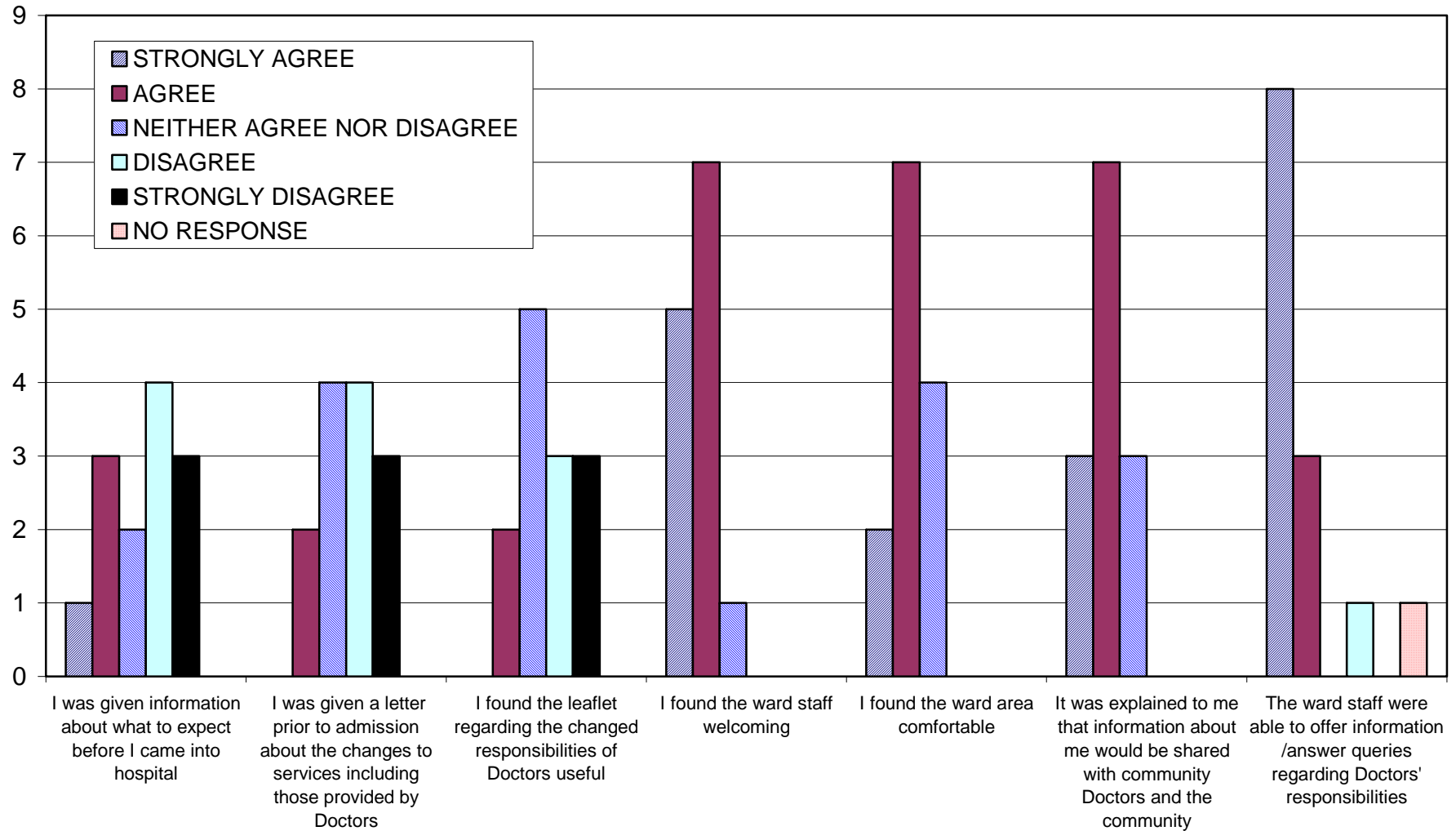
**Section 1 - Information and support before being admitted to hospital
December 2005 Questionnaire**



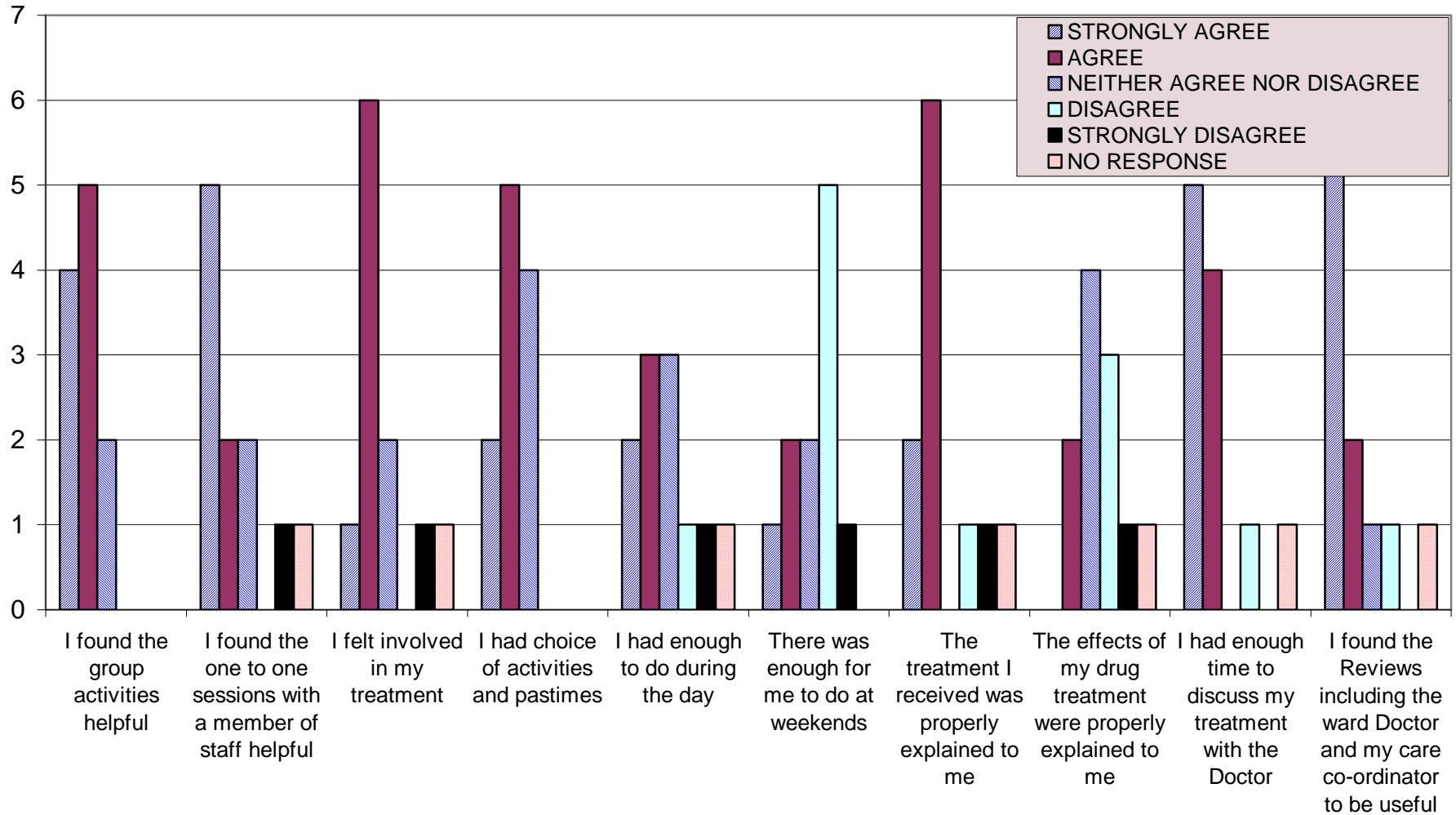
Section 1 - Information and support before being admitted to hospital - April 2006 Questionnaire (5n)



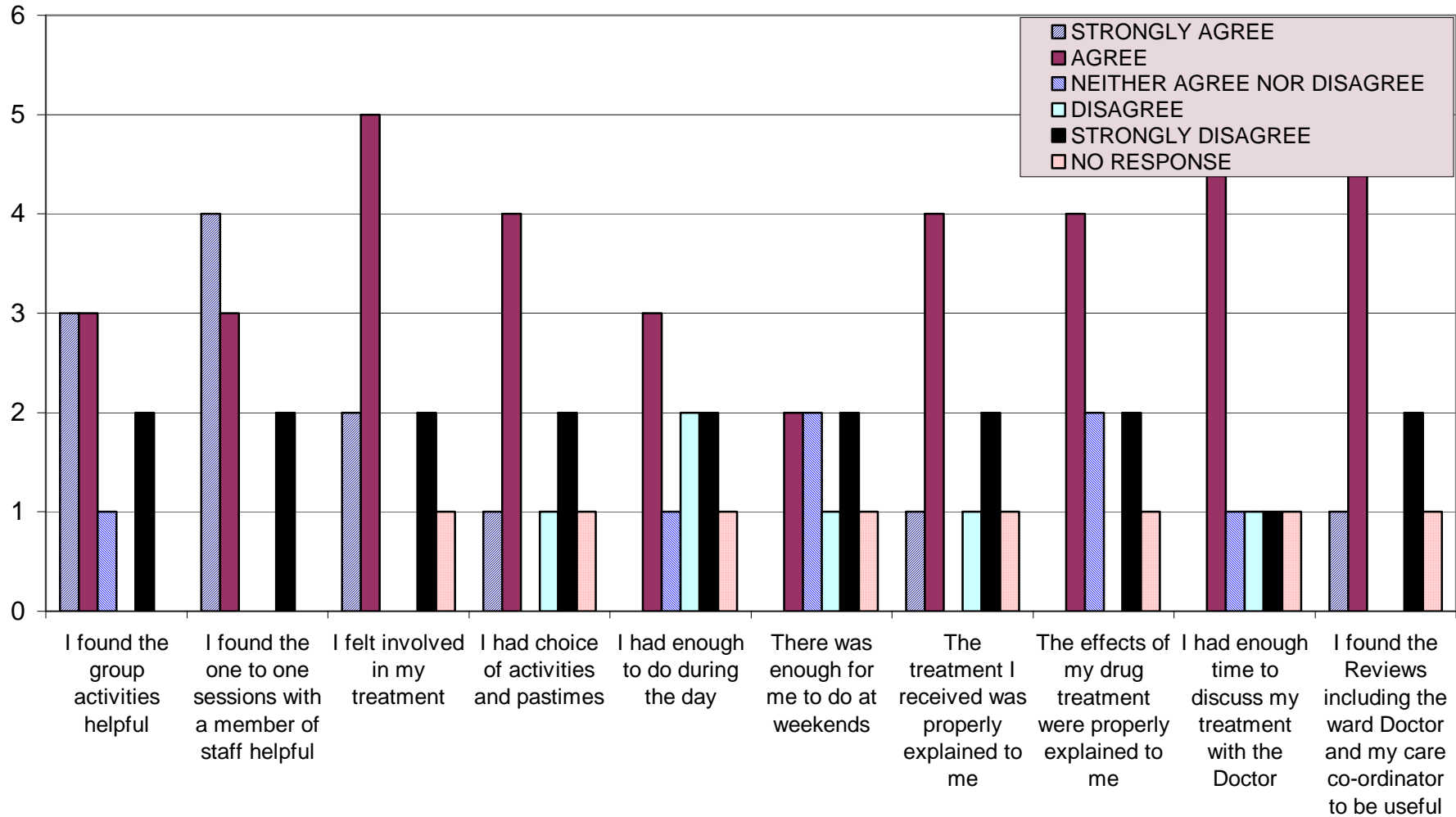
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Questionnaire (13n)**



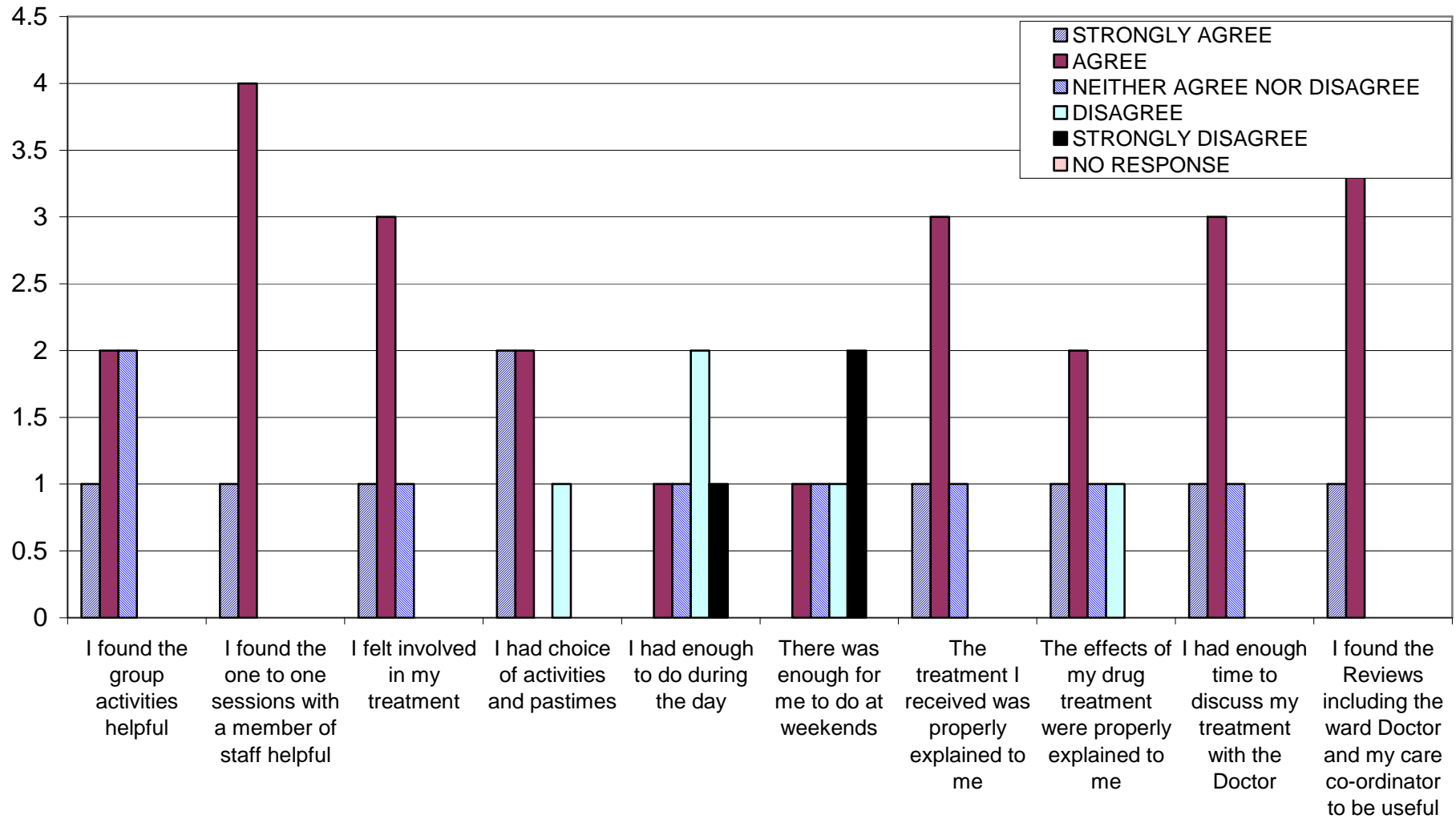
Section 2 The ward team - Therapies and Activities August 2005 Questionnaire



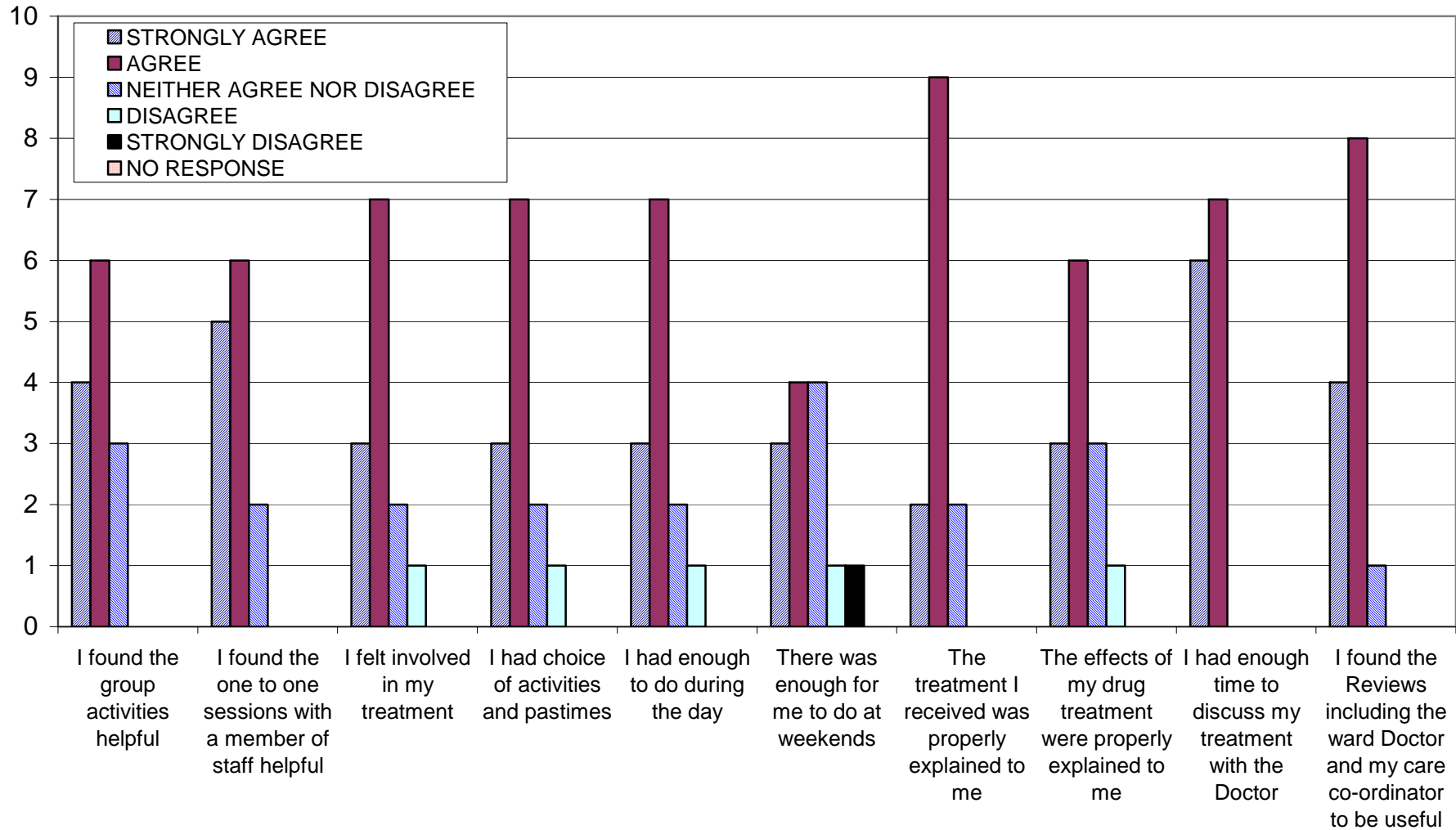
Section 2 The ward team - Therapies and Activities December 2005 Questionnaire



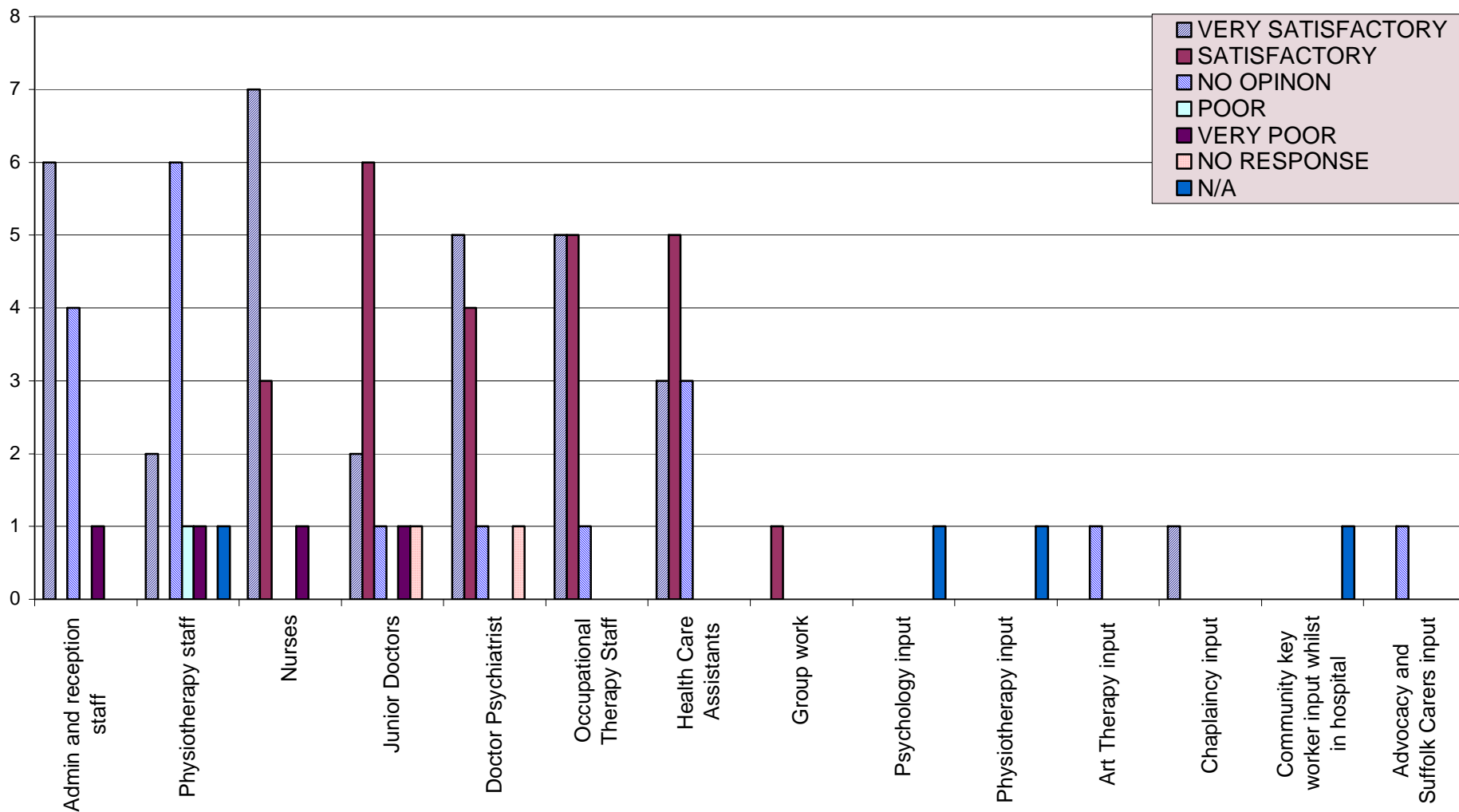
Section 2 The ward team - Therapies and Activities - April 2006 Questionnaire (5n)



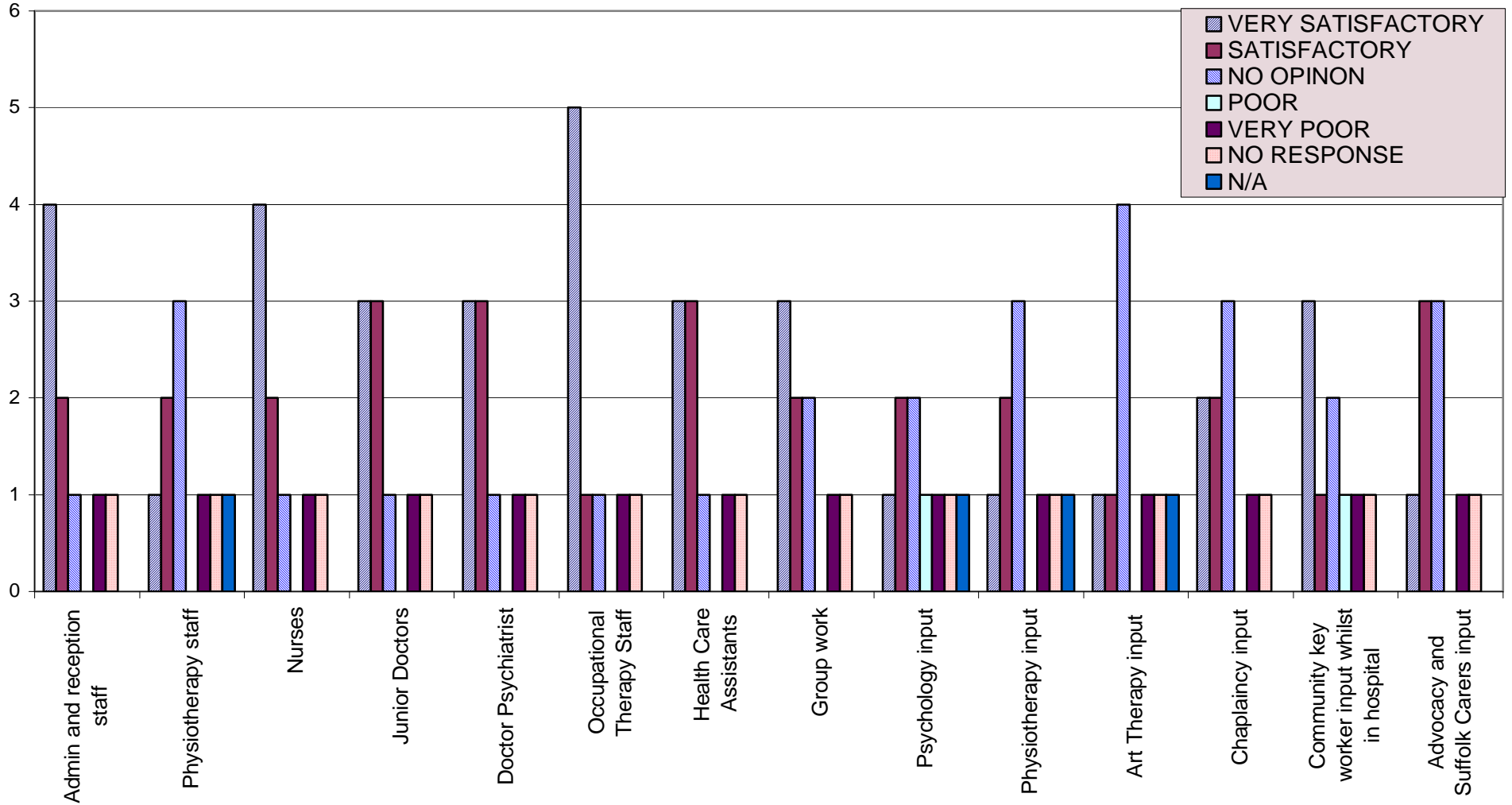
Section 2 The ward team - Therapies and Activities - September 2006 Questionnaire (13n)



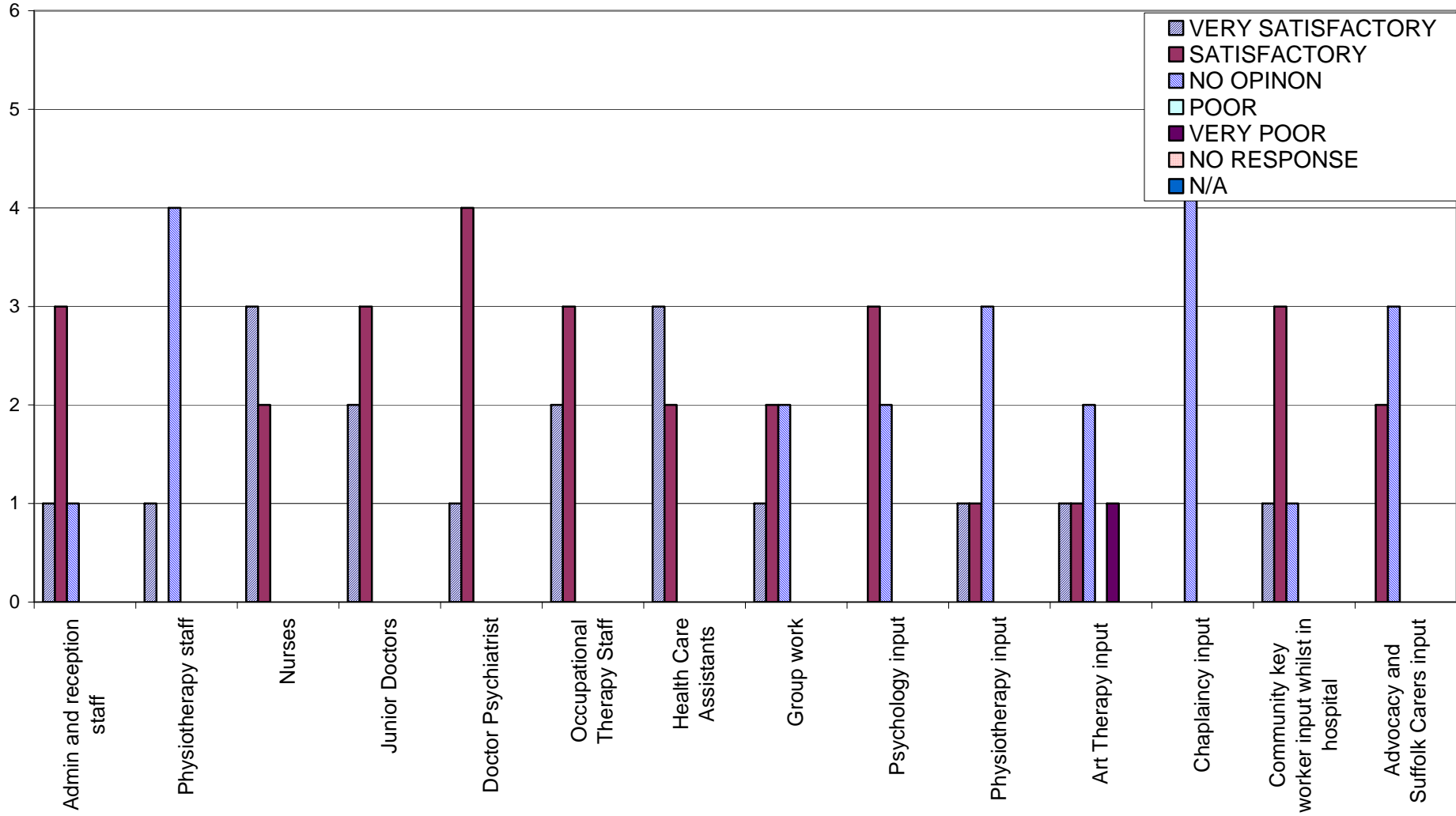
**Section 3 The Ward Team - Did you find the following staff and services to be satisfactory
August 2005 Questionnaire**



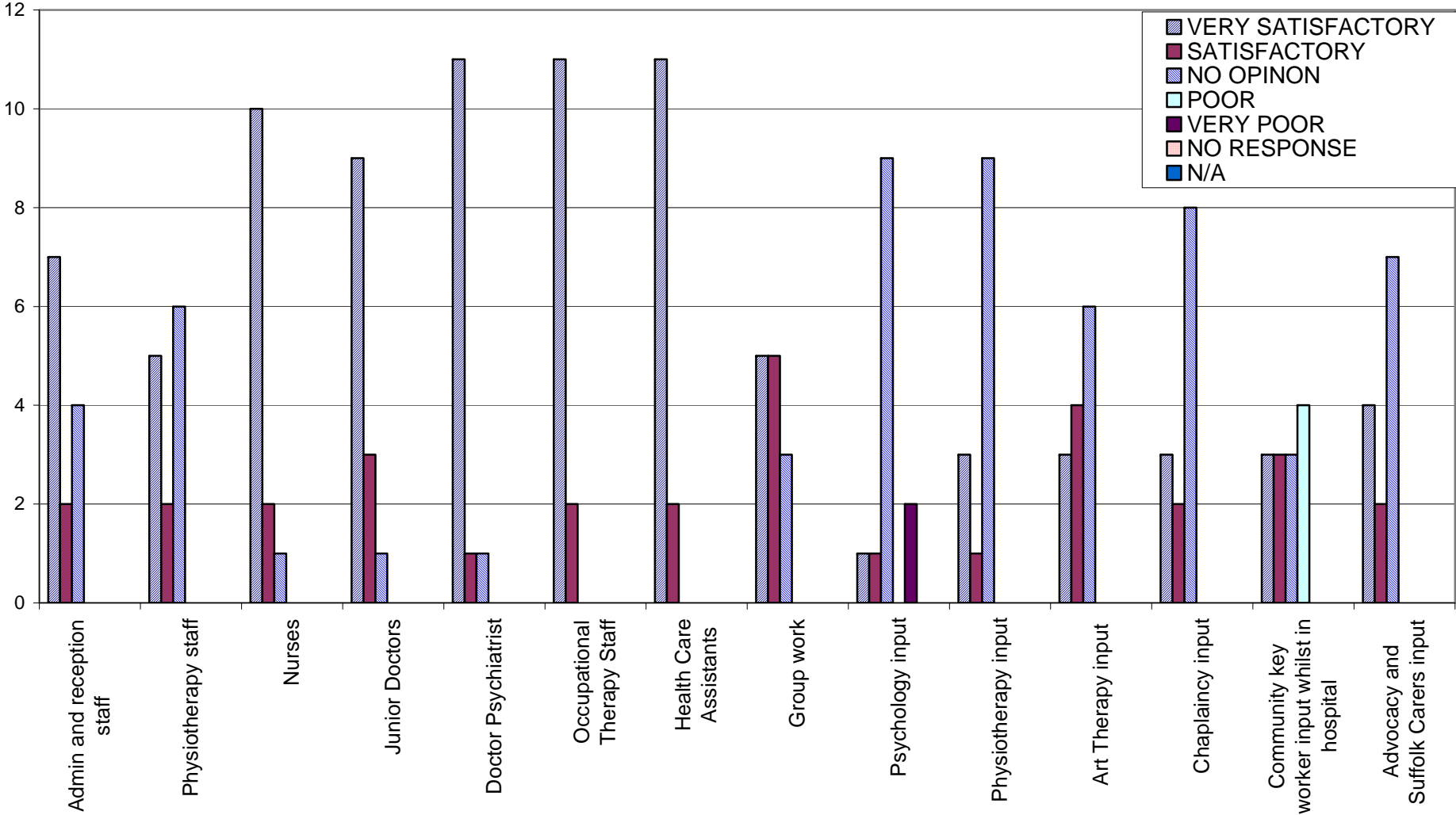
**Section 3 The Ward Team - Did you find the following staff and services to be satisfactory
December 2005 Questionnaire**



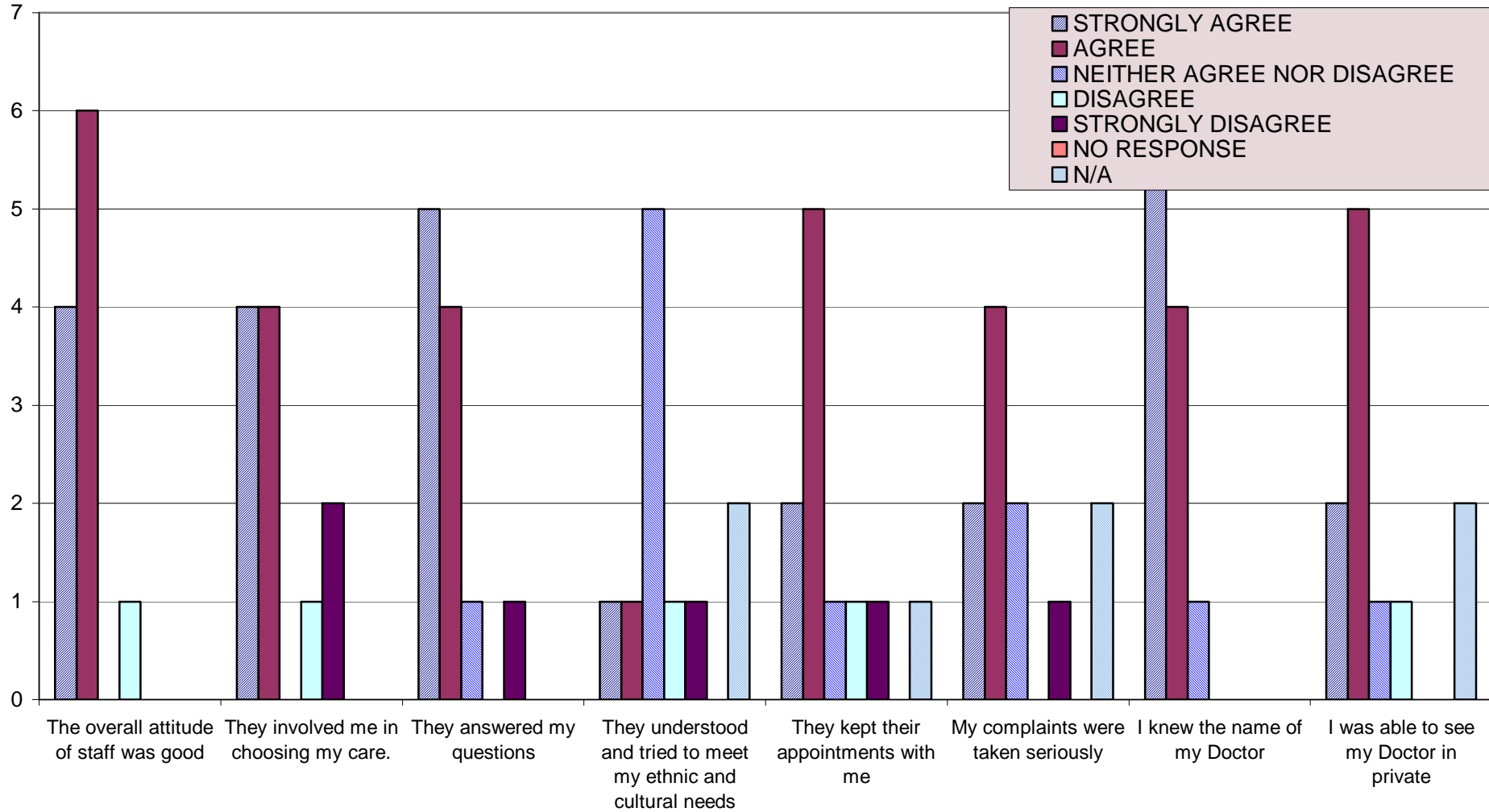
Section 3 The Ward Team - Did you find the following staff and services to be satisfactory - April 2006 Questionnaire (5n)



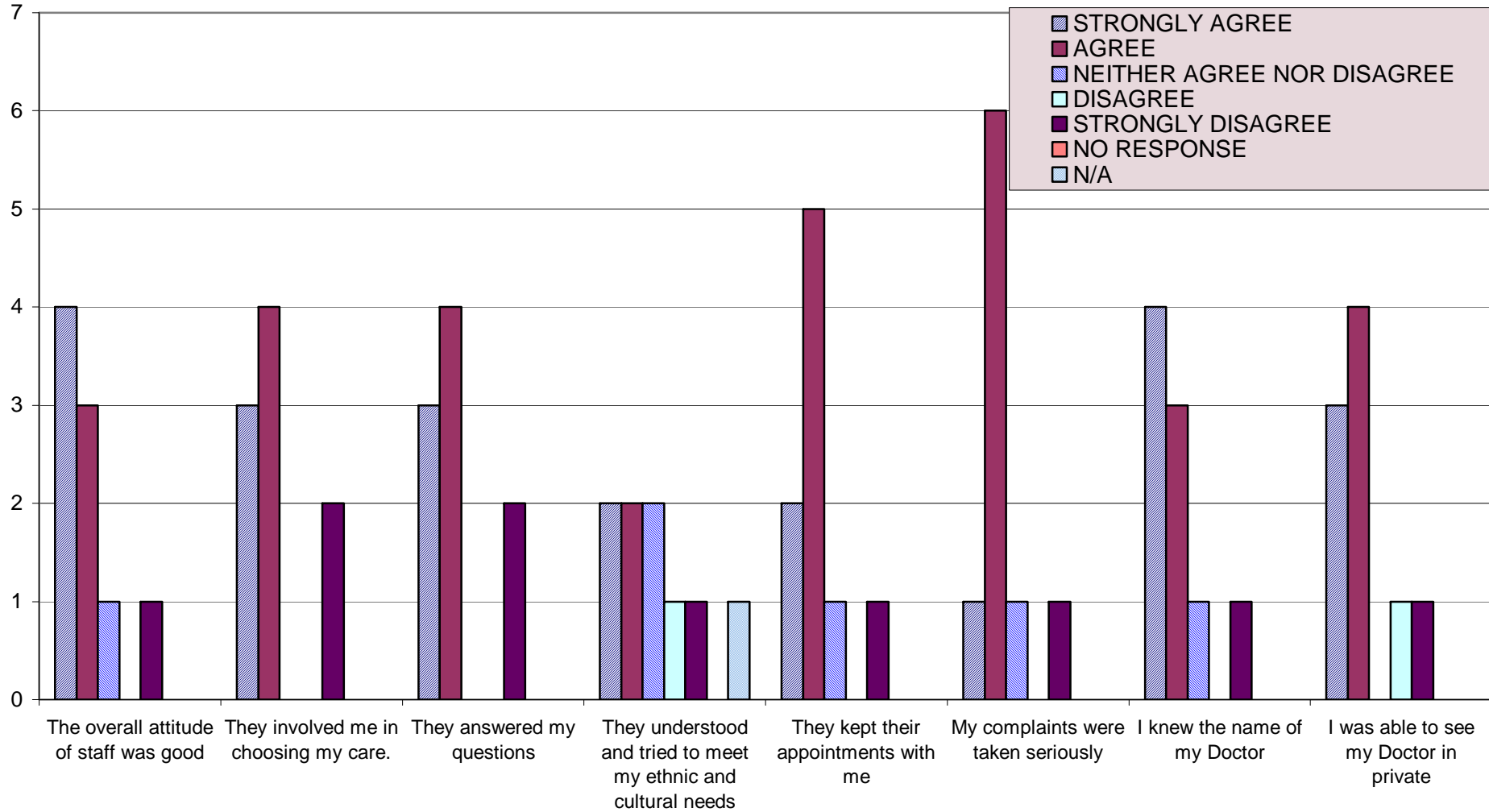
**Section 3 The Ward Team - Did you find the following staff and services to be satisfactory -
September 2006 Questionnaire (13n)**



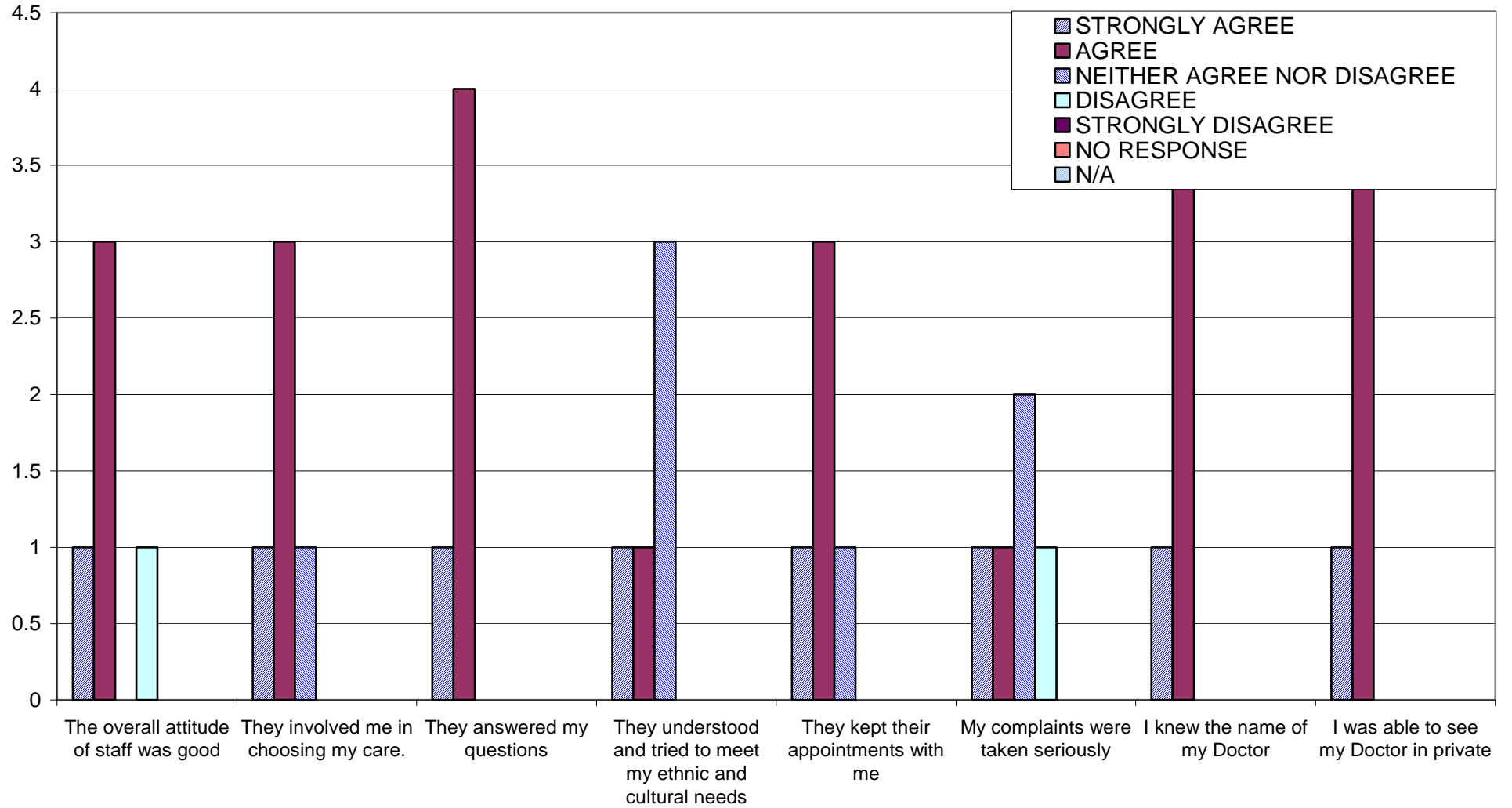
Section 4 - Staff Attitudes - August 2005 Questionnaire



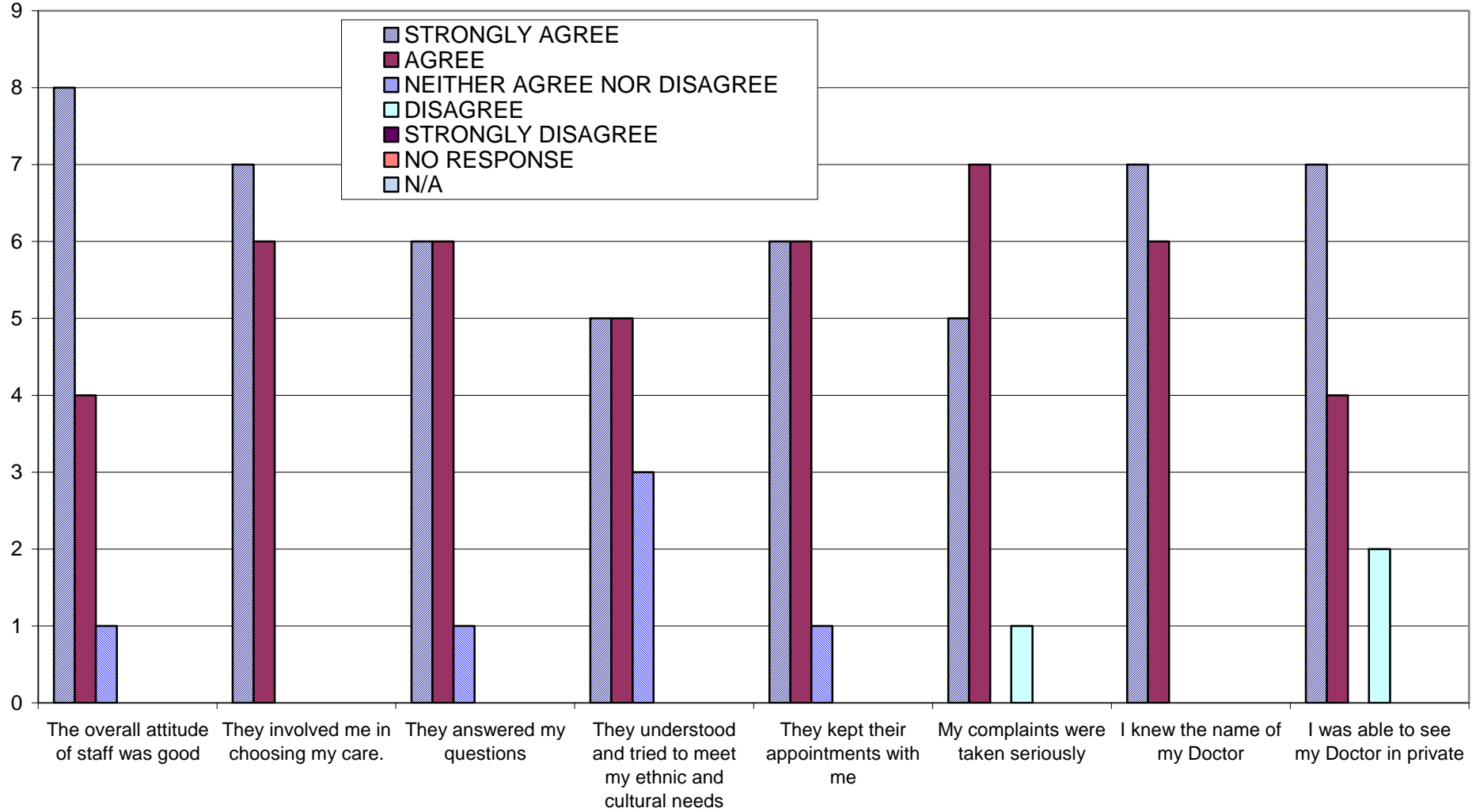
Section 4 - Staff Attitudes - December 2005 Questionnaire



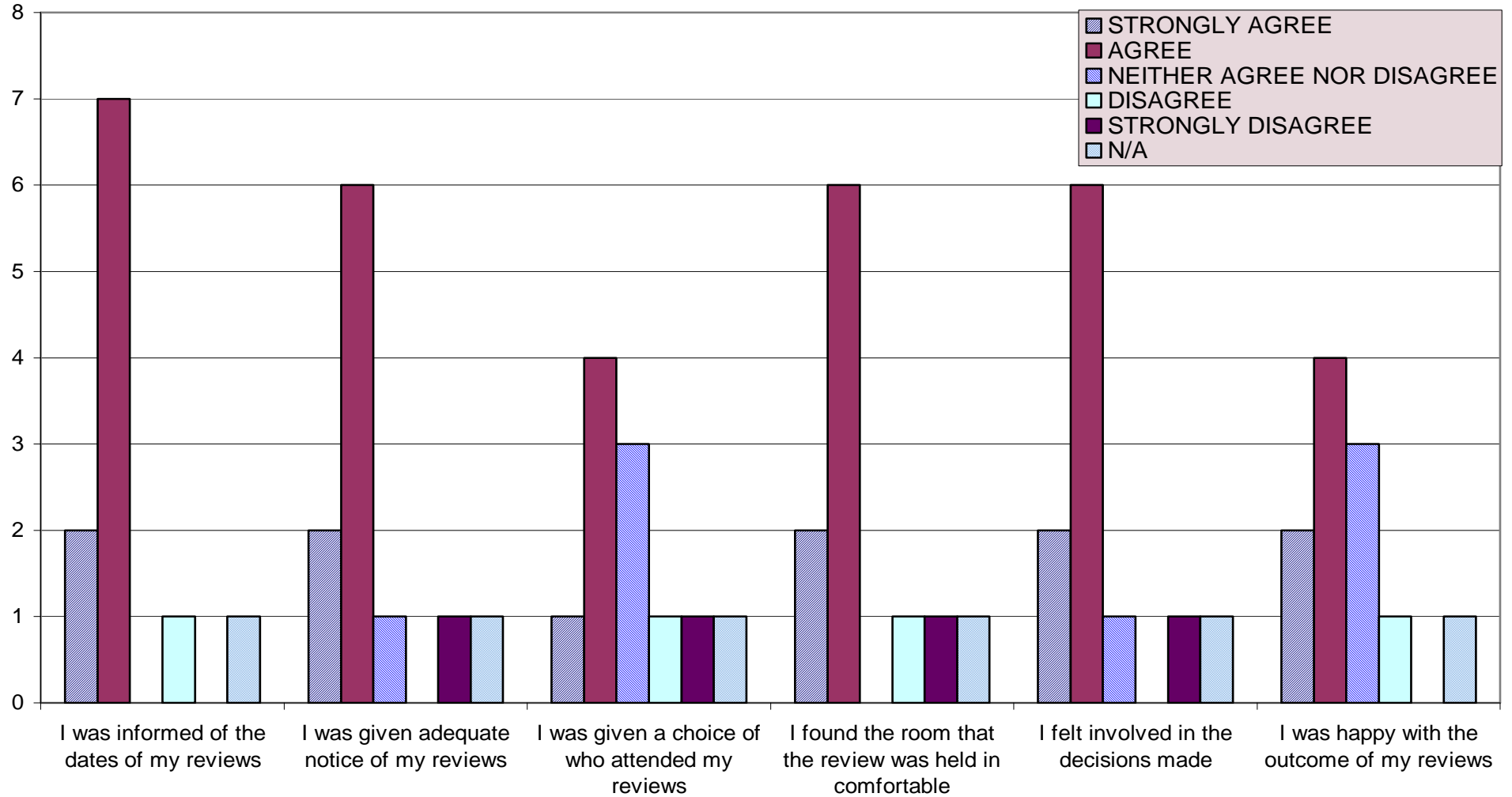
Section 4 - Staff Attitudes - April 2006 Questionnaire (5n)



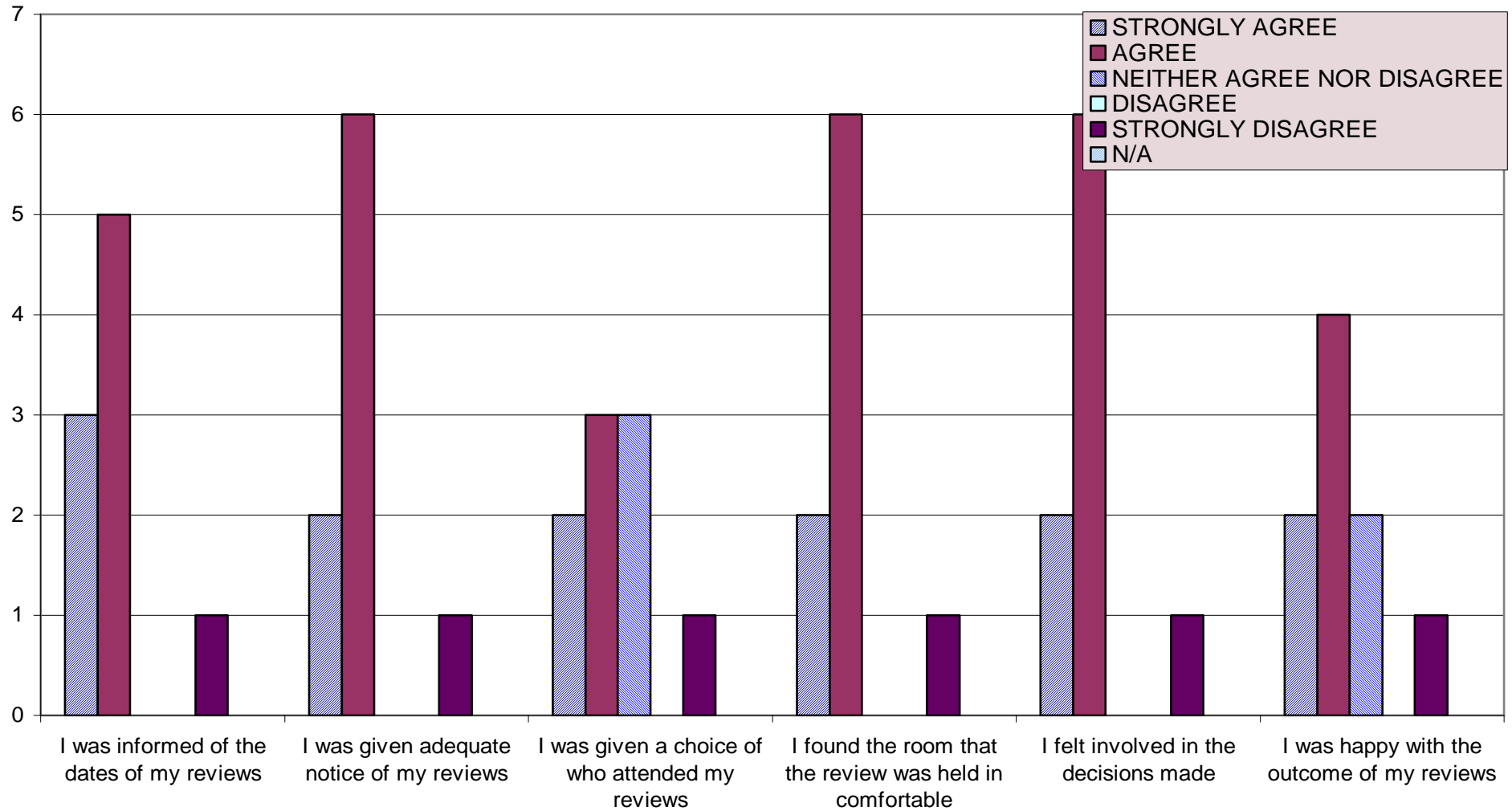
Section 4 - Staff Attitudes - September 2006 Questionnaire (13n)



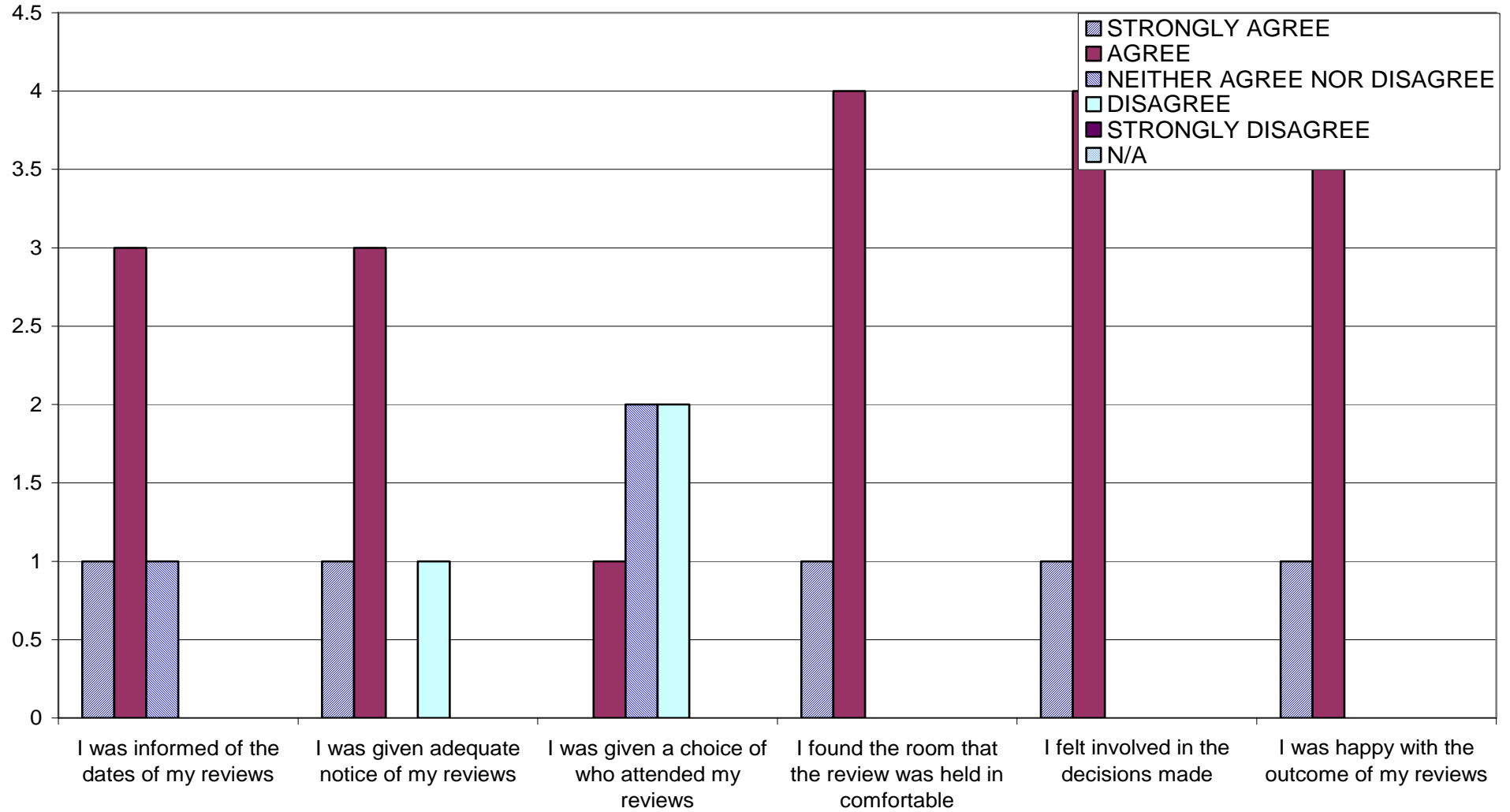
**Section 5 - During my admission my involvement in my reviews was as follows
August 2005 Questionnaire**



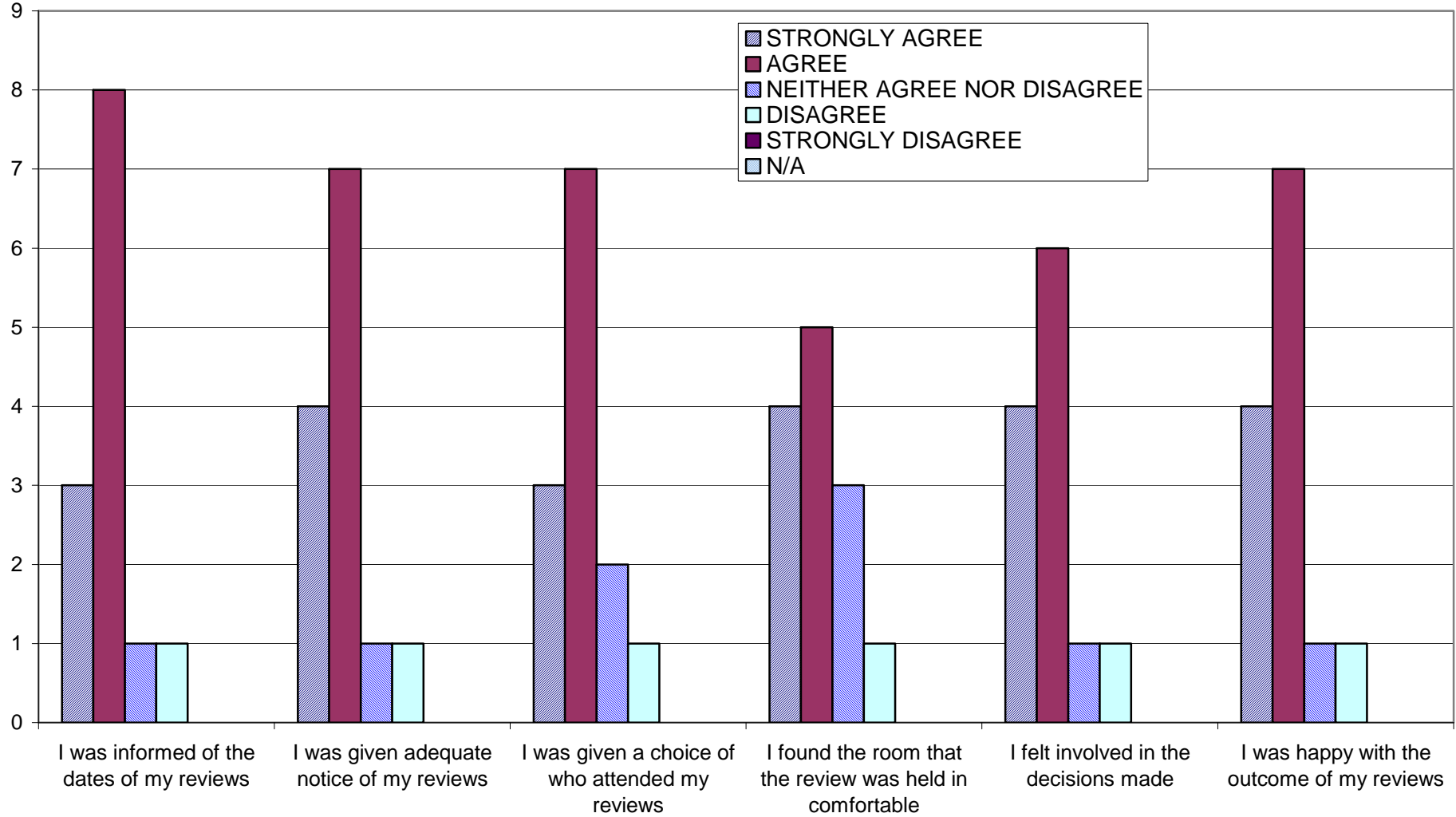
**Section 5 - During my admission my involvement in my reviews was as follows
December 2005 Questionnaire**



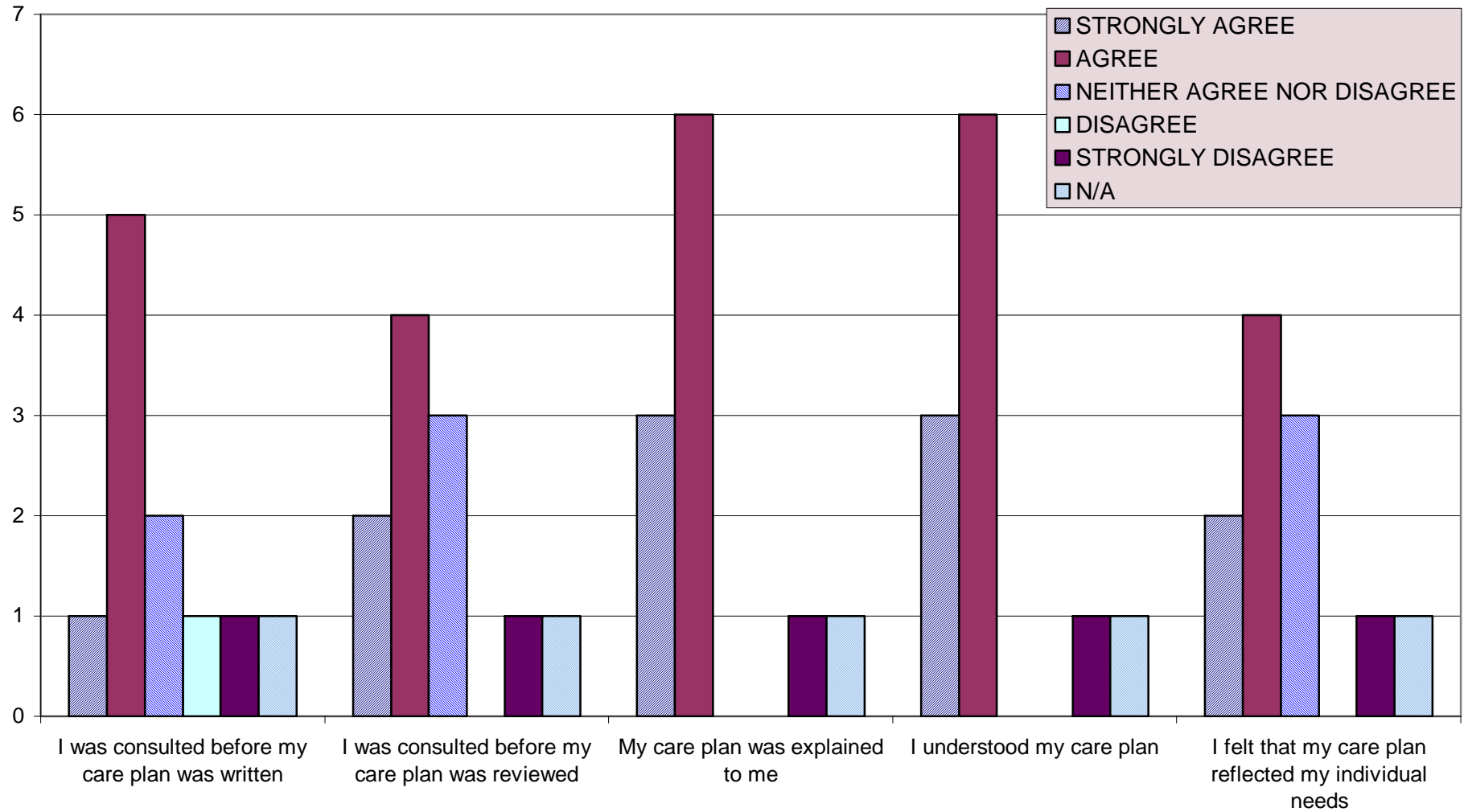
**Section 5 - During my admission my involvement in my reviews was as follows - April 2006
Questionnaire (5n)**



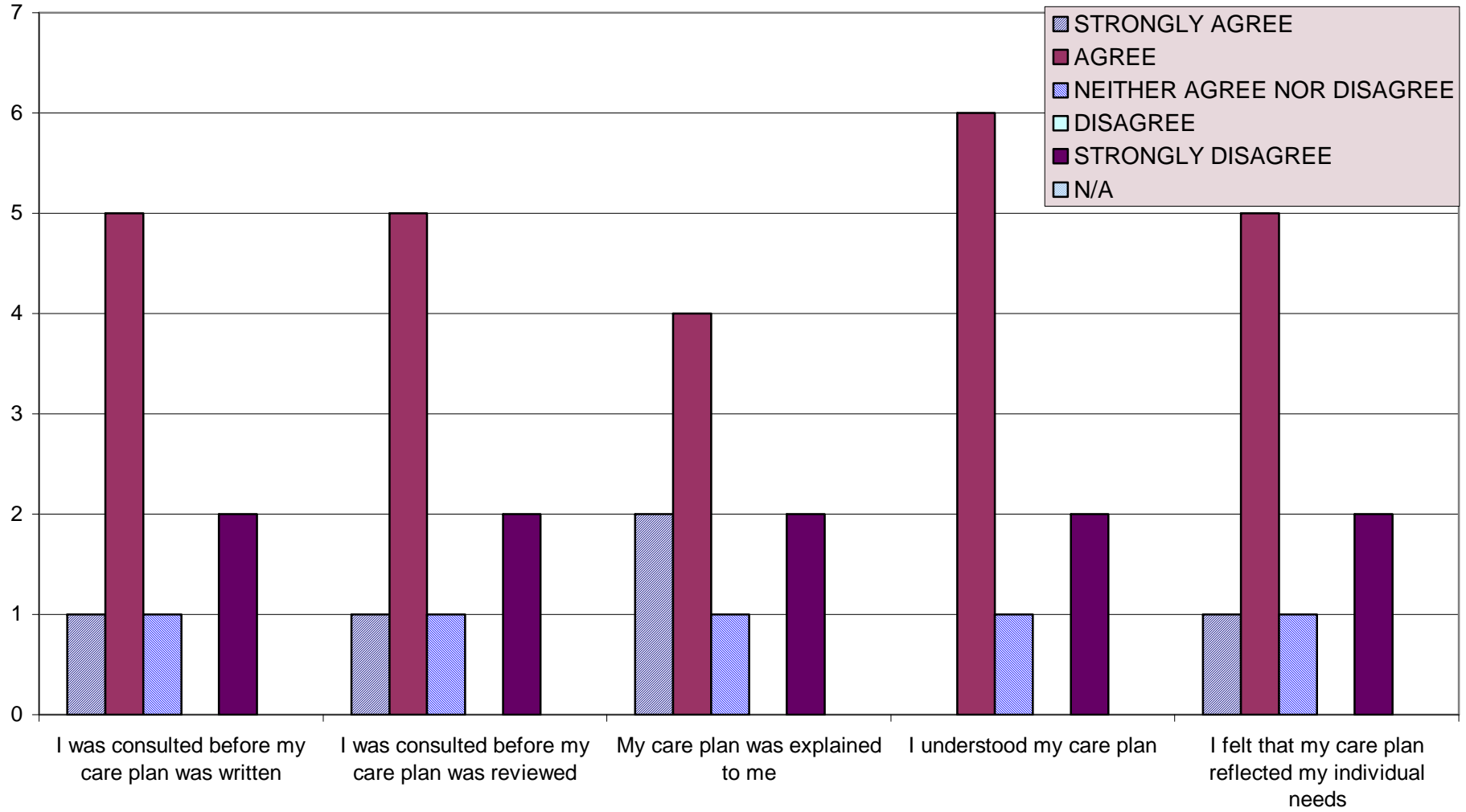
**Section 5 - During my admission my involvement in my reviews was as follows - September 2006
Questionnaire (13n)**



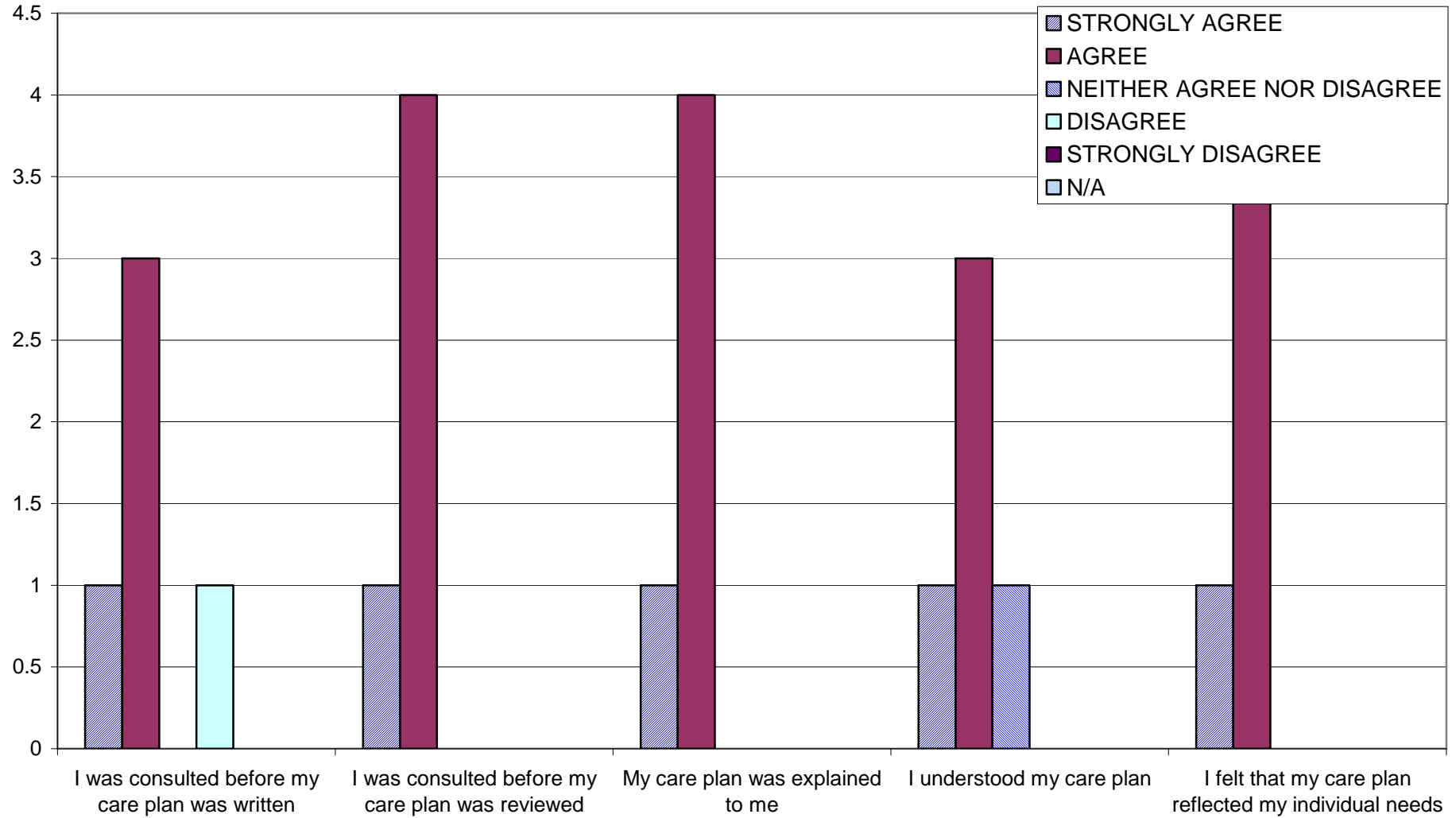
Section 6 - Care Plan - August 2005 Questionnaire



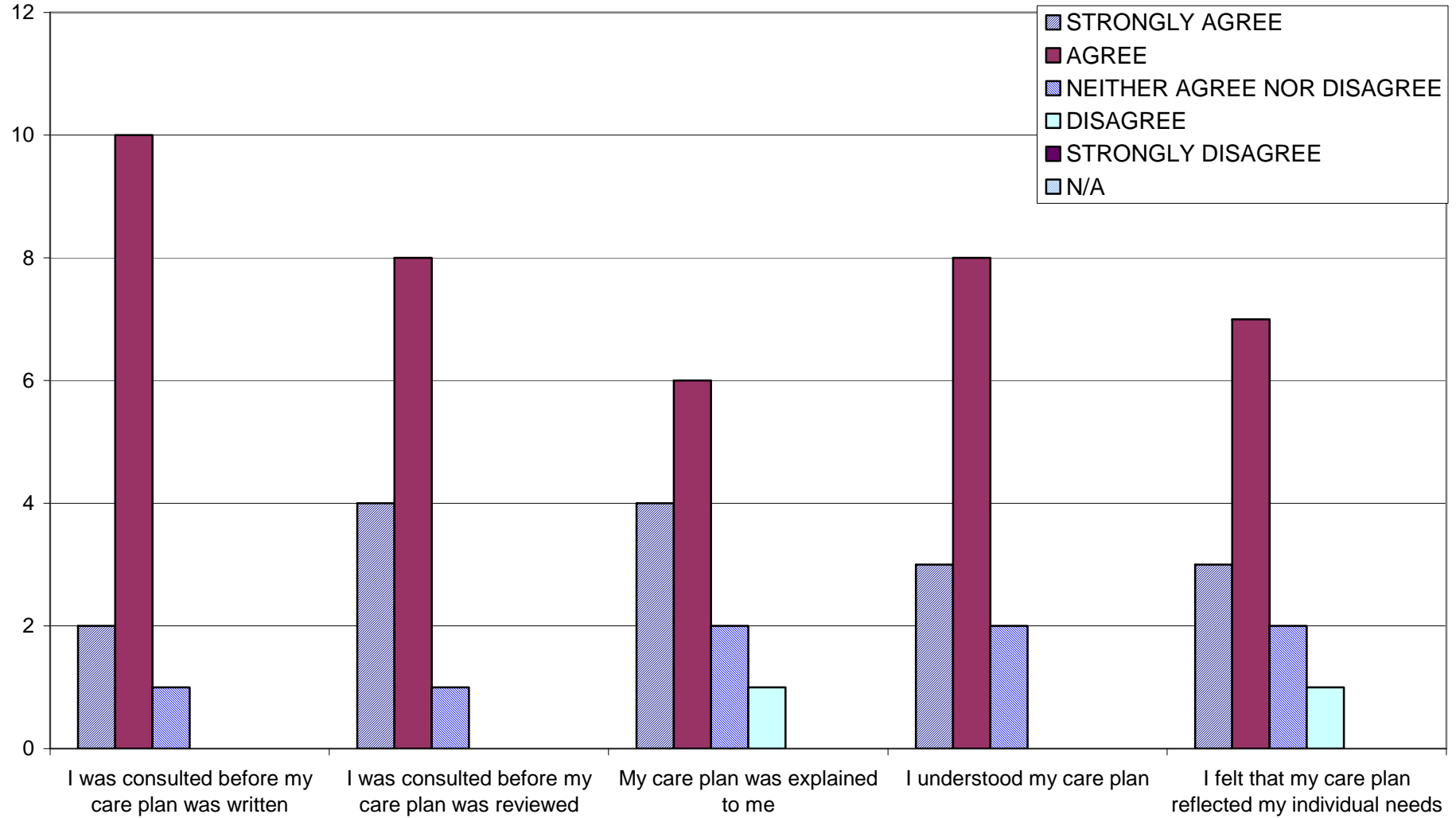
Section 6 - Care Plan - December 2005 Questionnaire



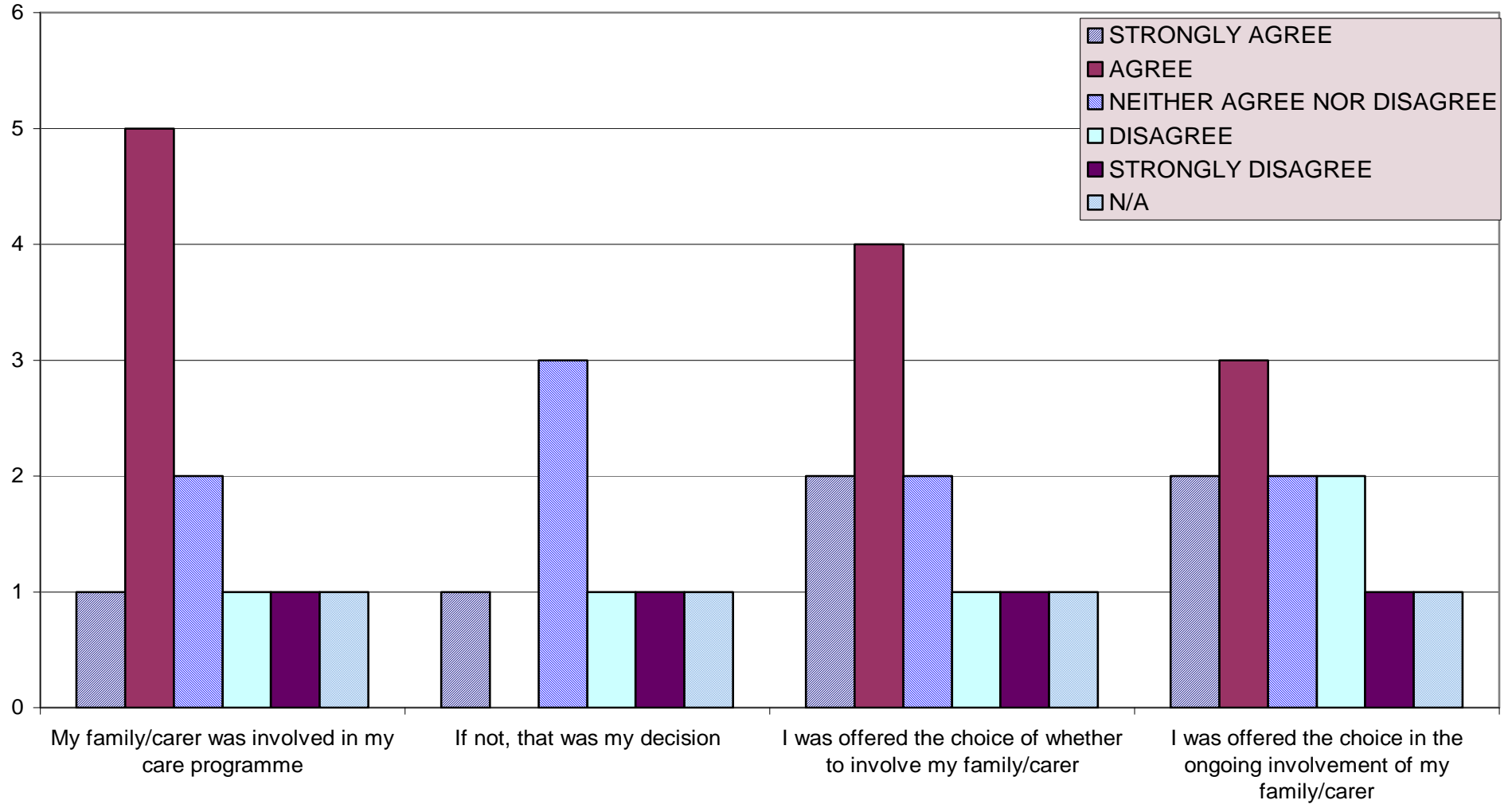
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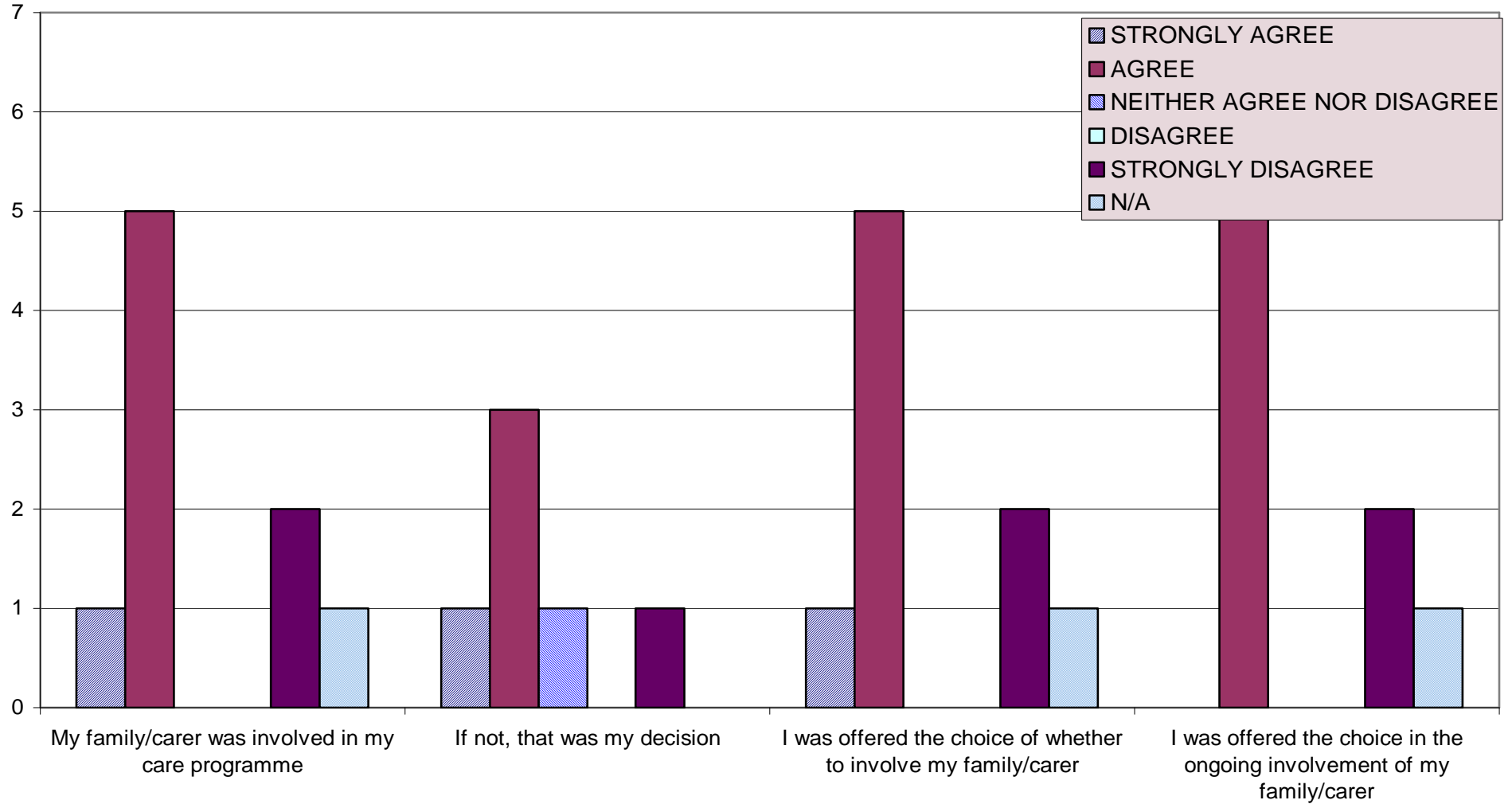
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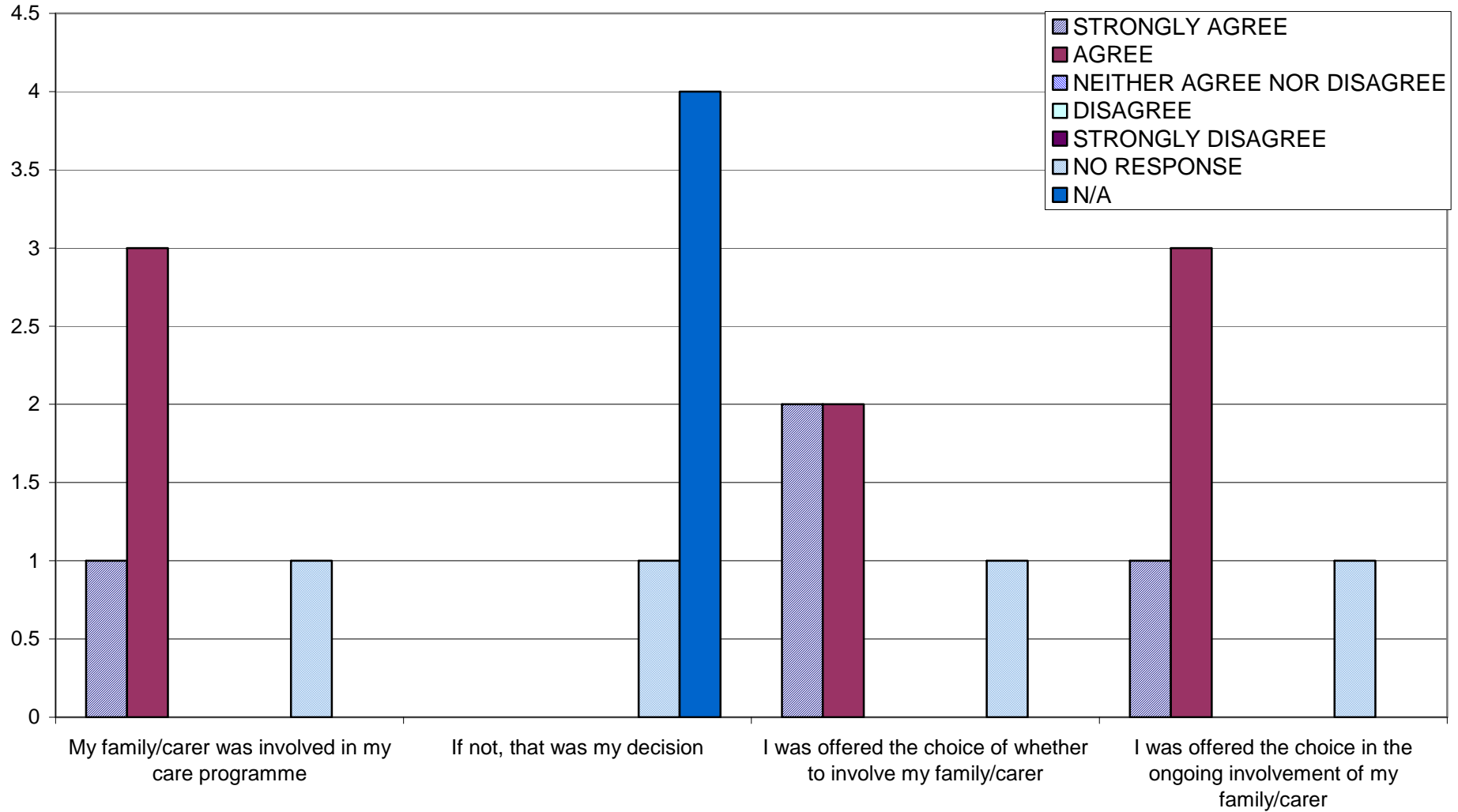
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August 2005 Questionnaire**



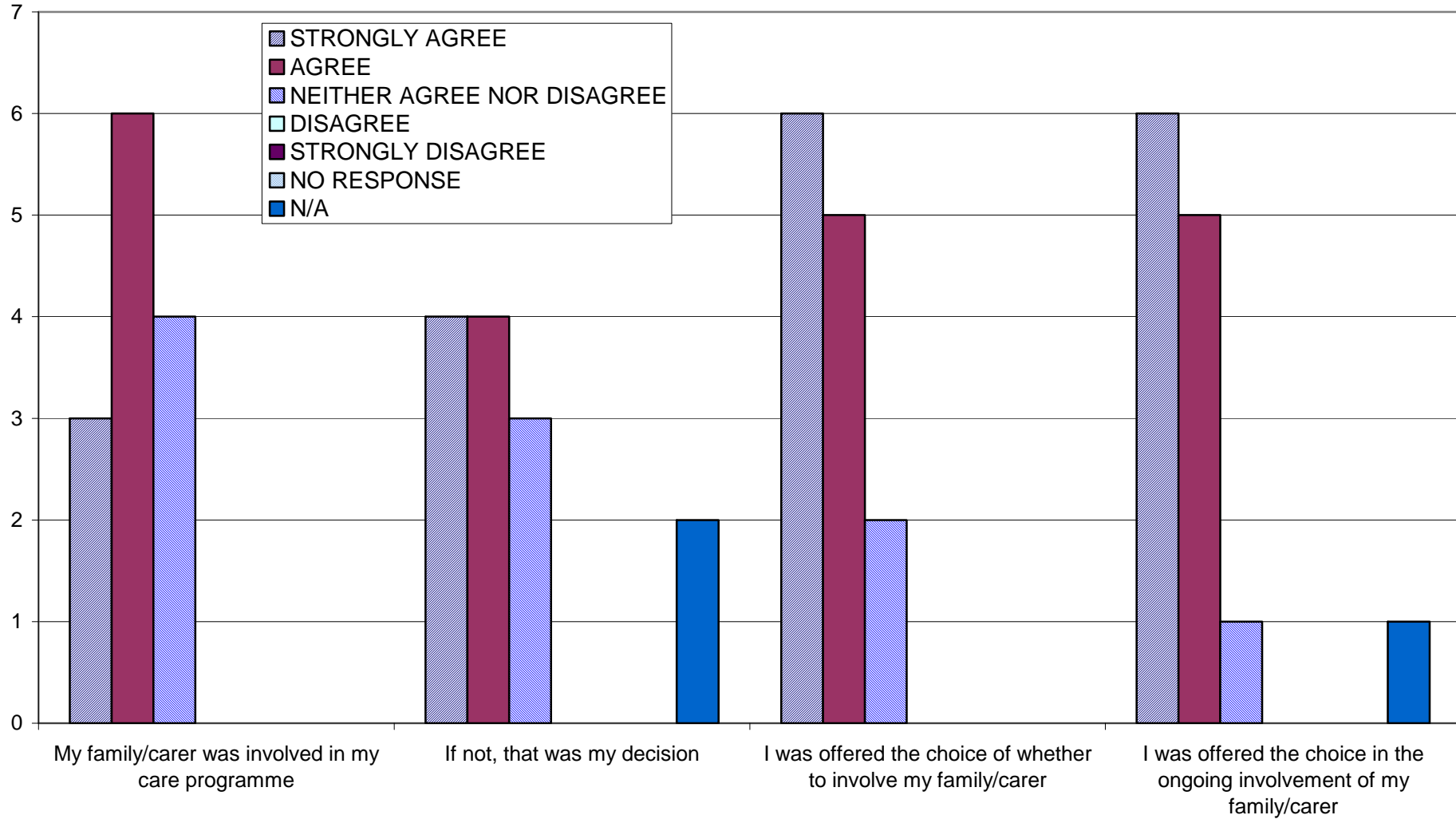
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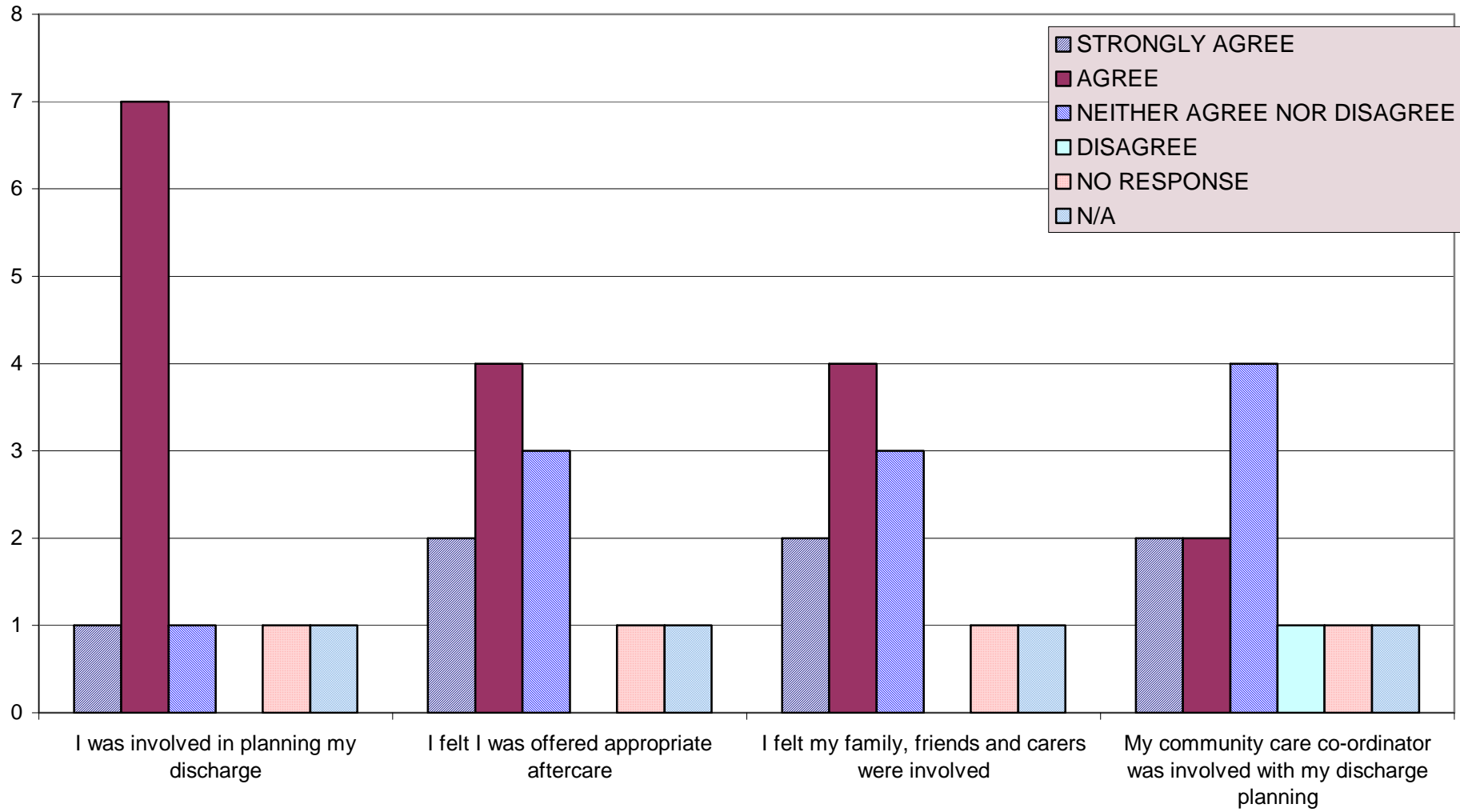
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April 2006 Questionnaire**



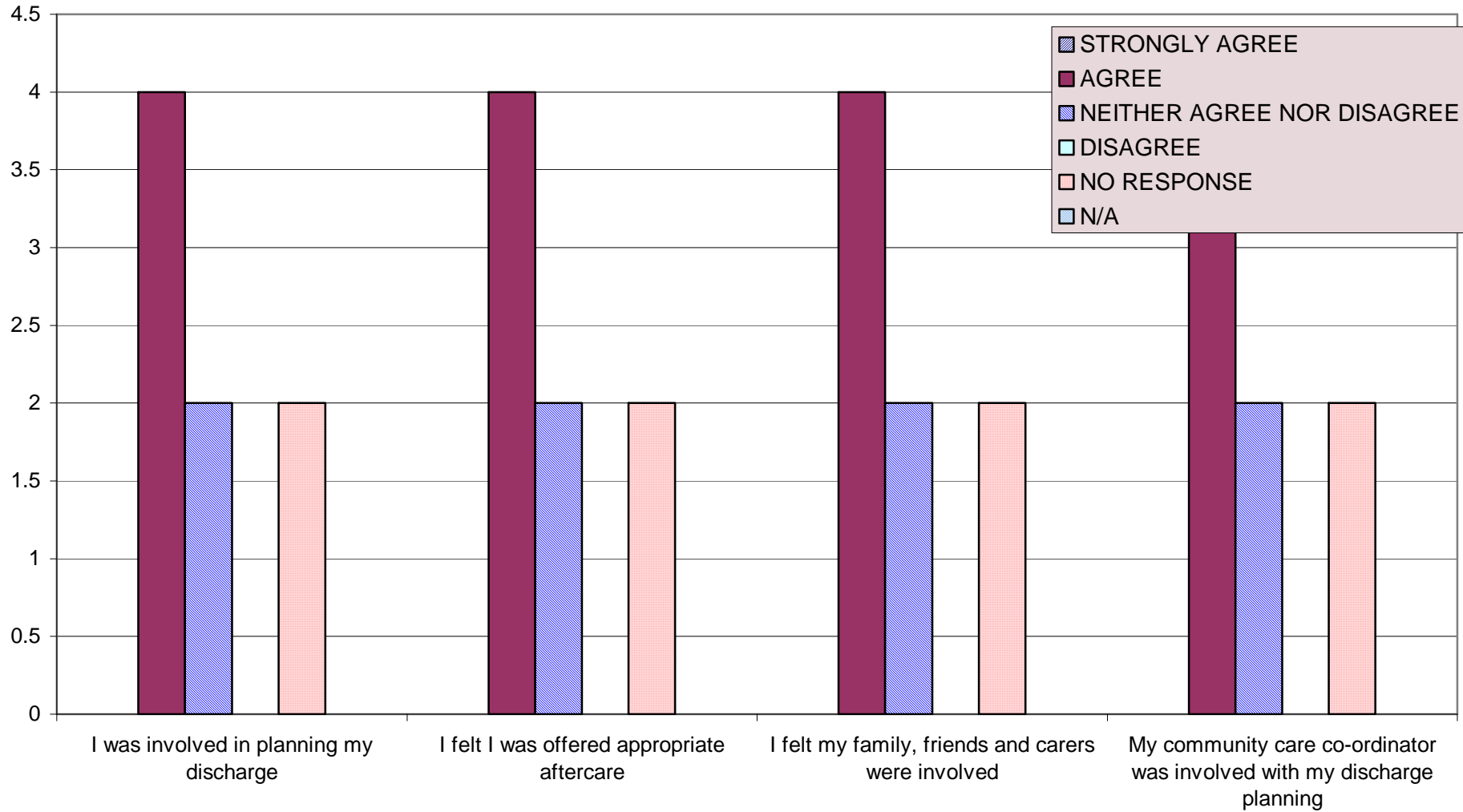
September 2006 Questionnaire
Section 7 - The involvement of my family/carers was as follows (13n):



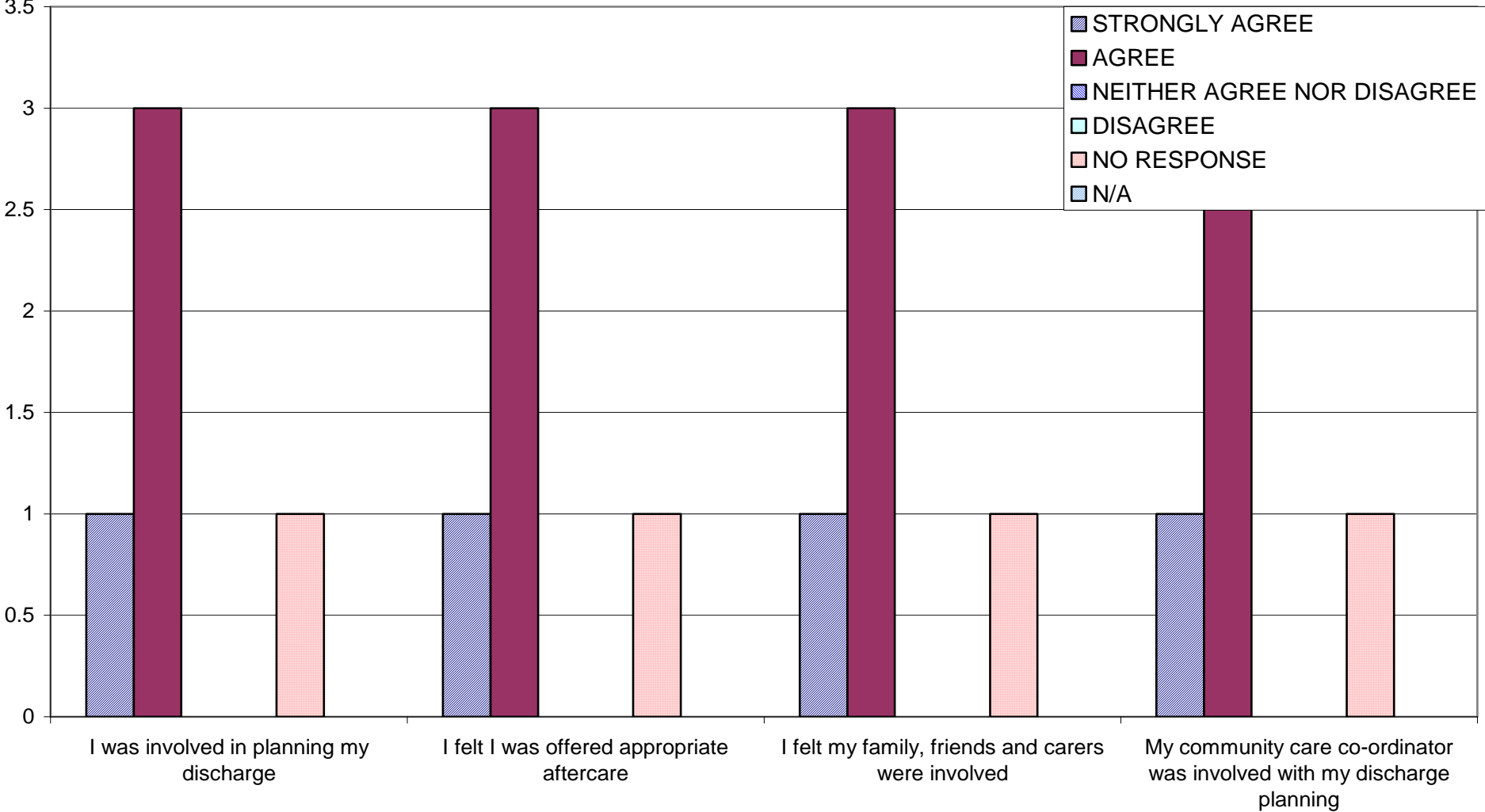
Section 8 - Discharge - August 2005 Questionnaire



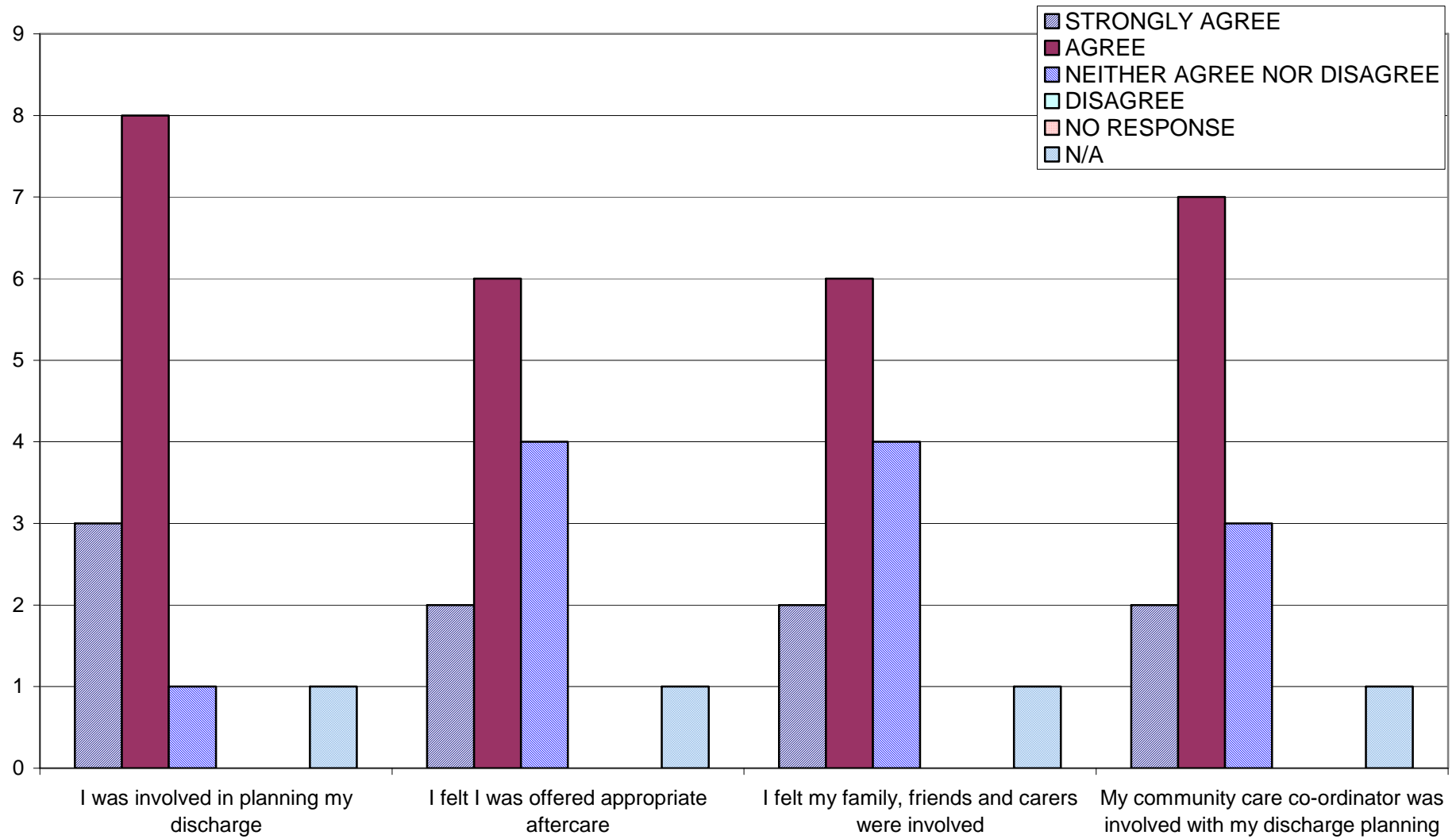
Section 8 - Discharge - December 2005 Questionnaire



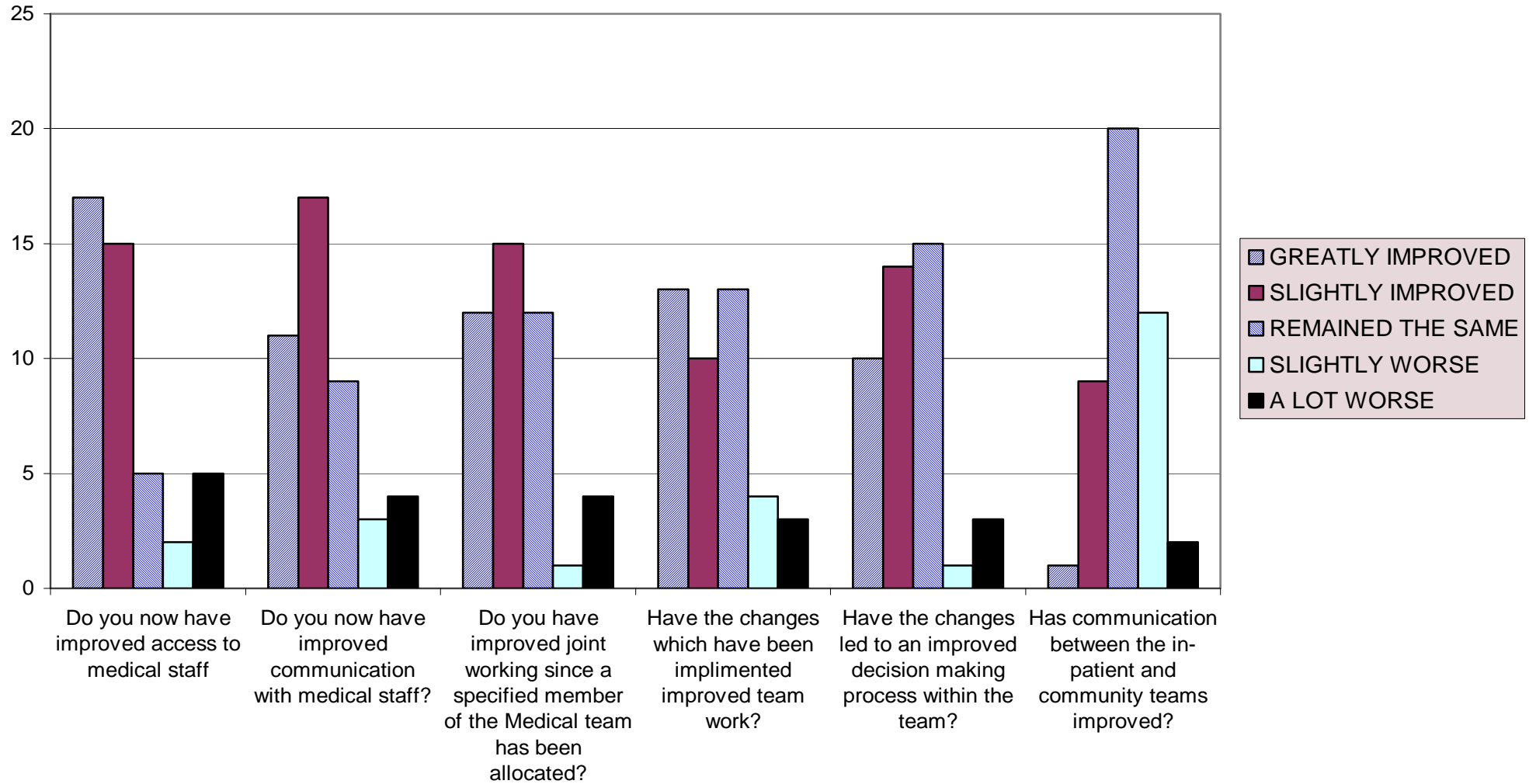
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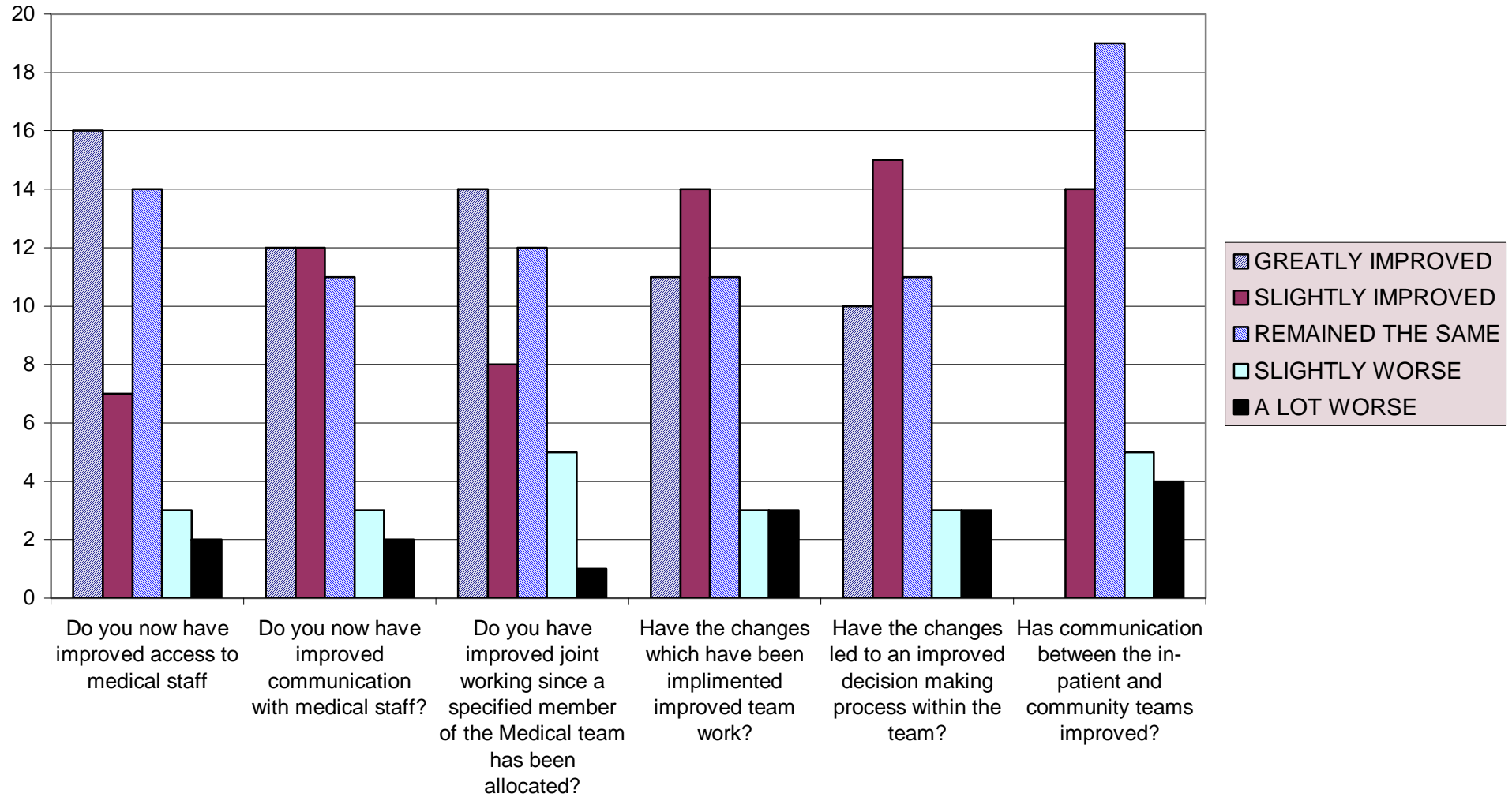
Section 8 - Discharge - September 2006 Patient Questionnaire (13n)



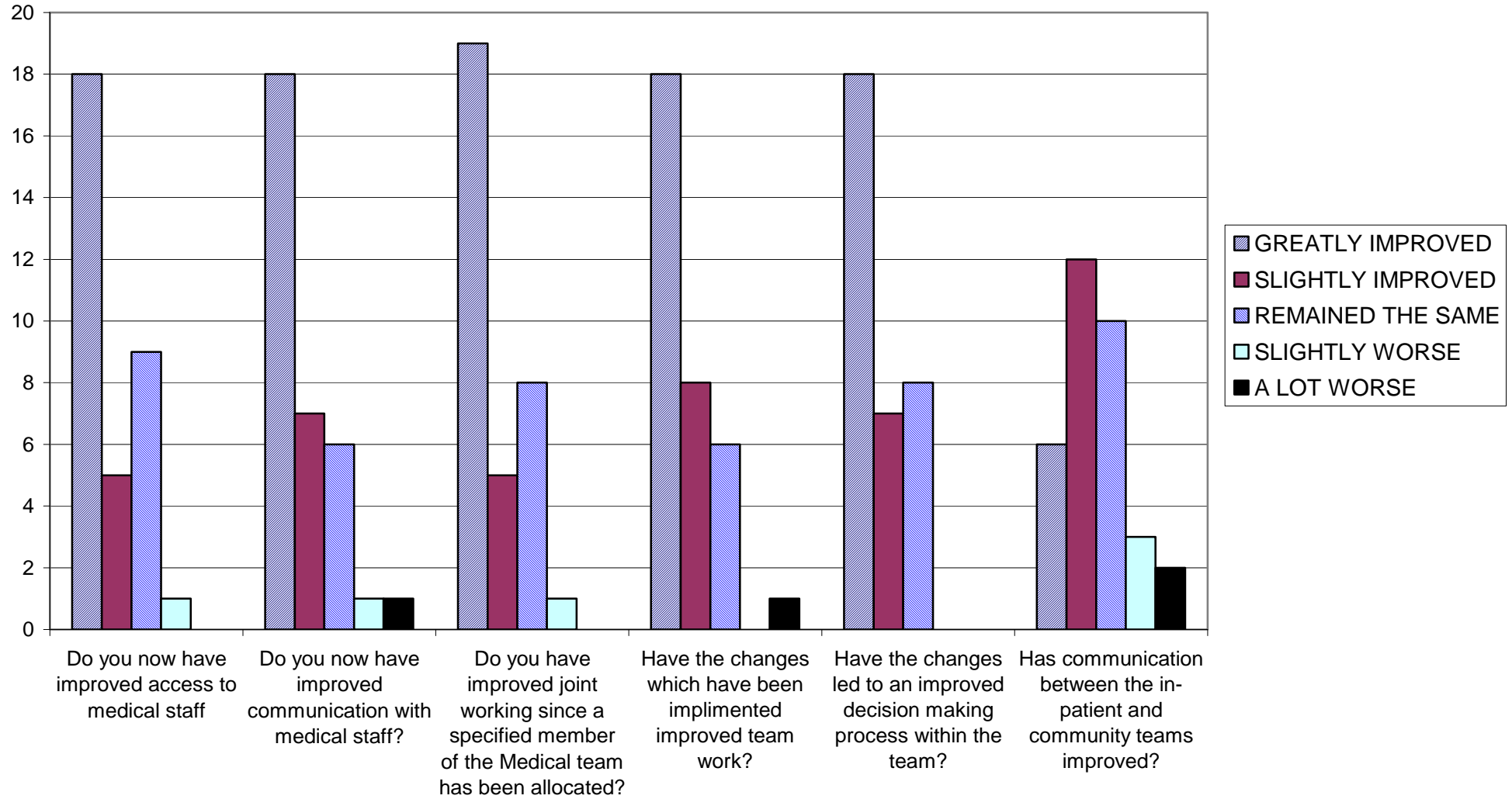
Q2-Q7 All Staff - August 2005 Questionnaire



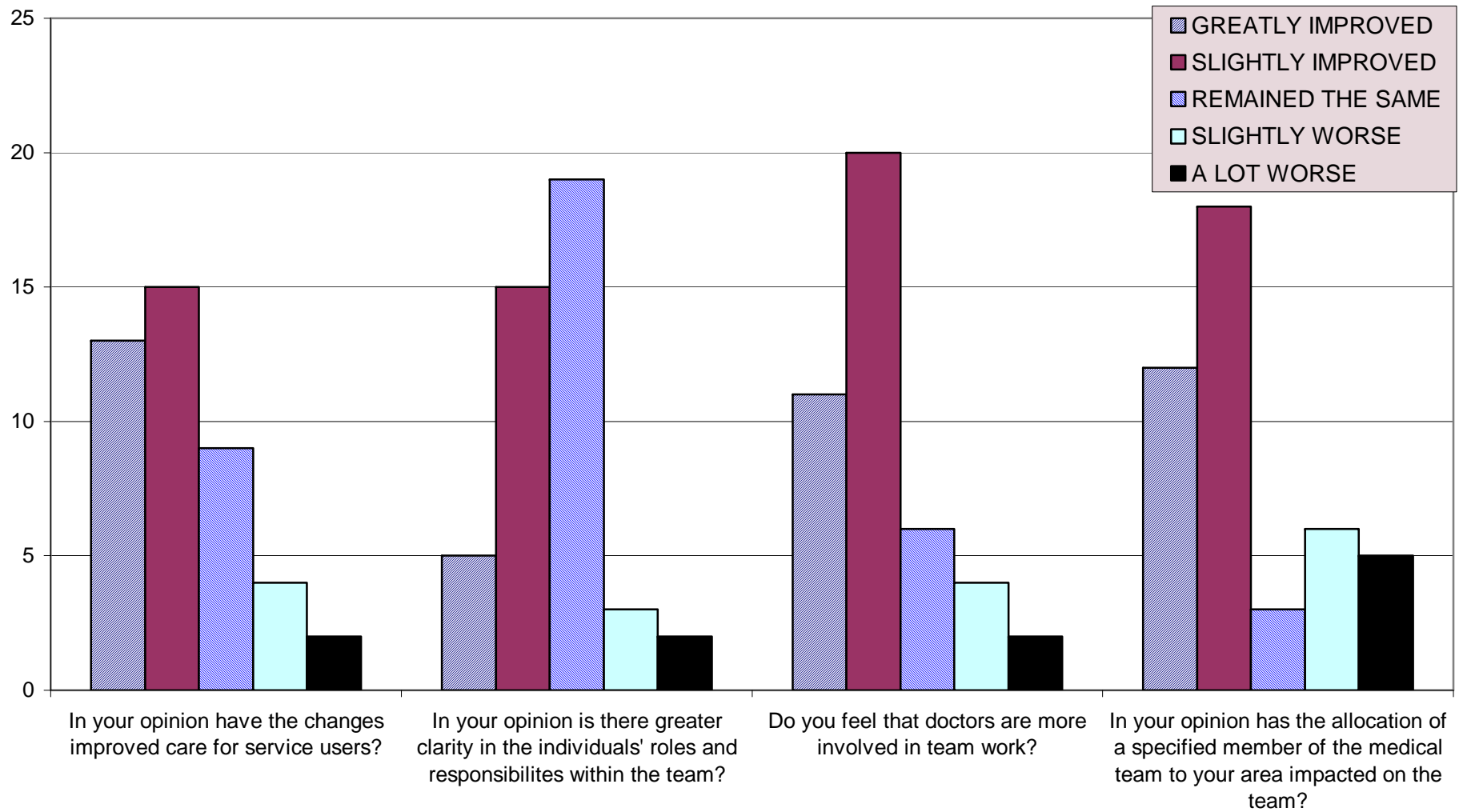
Q2-Q7 All Staff - December 2005 Questionnaire



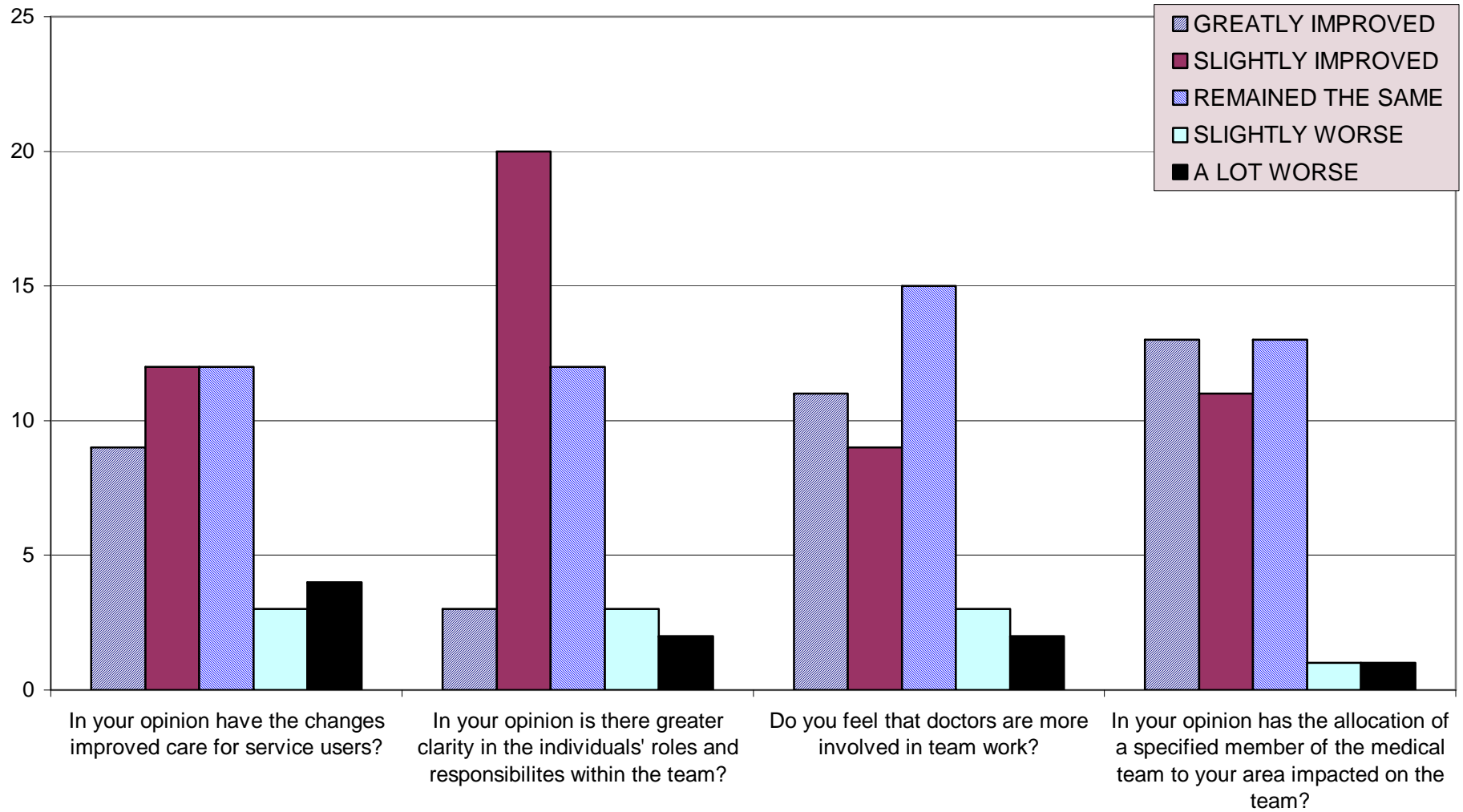
Q2-Q7 All Staff responses in April 2006 (33n)



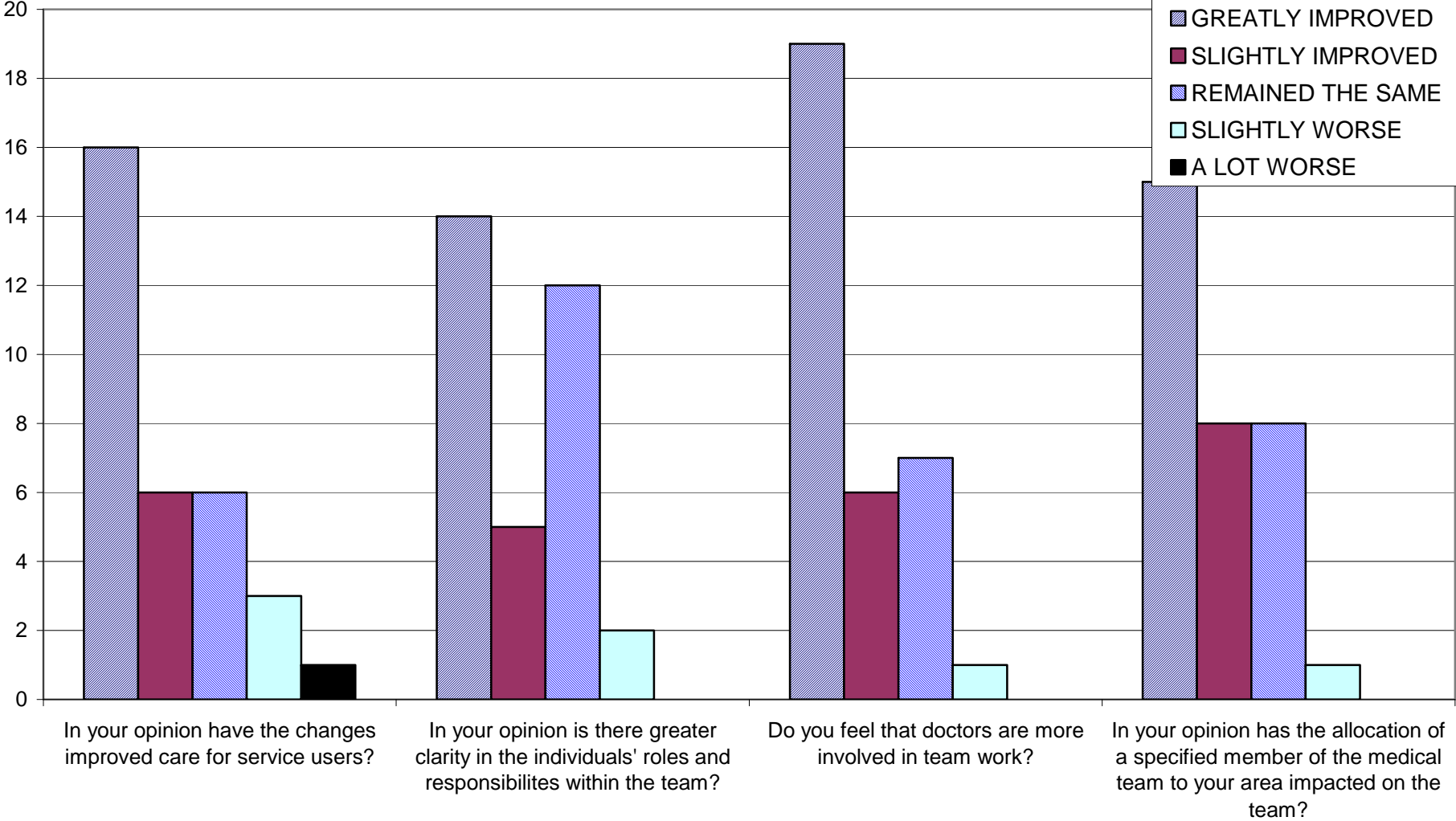
Q8-Q11: All Staff - August 2005 Questionnaire



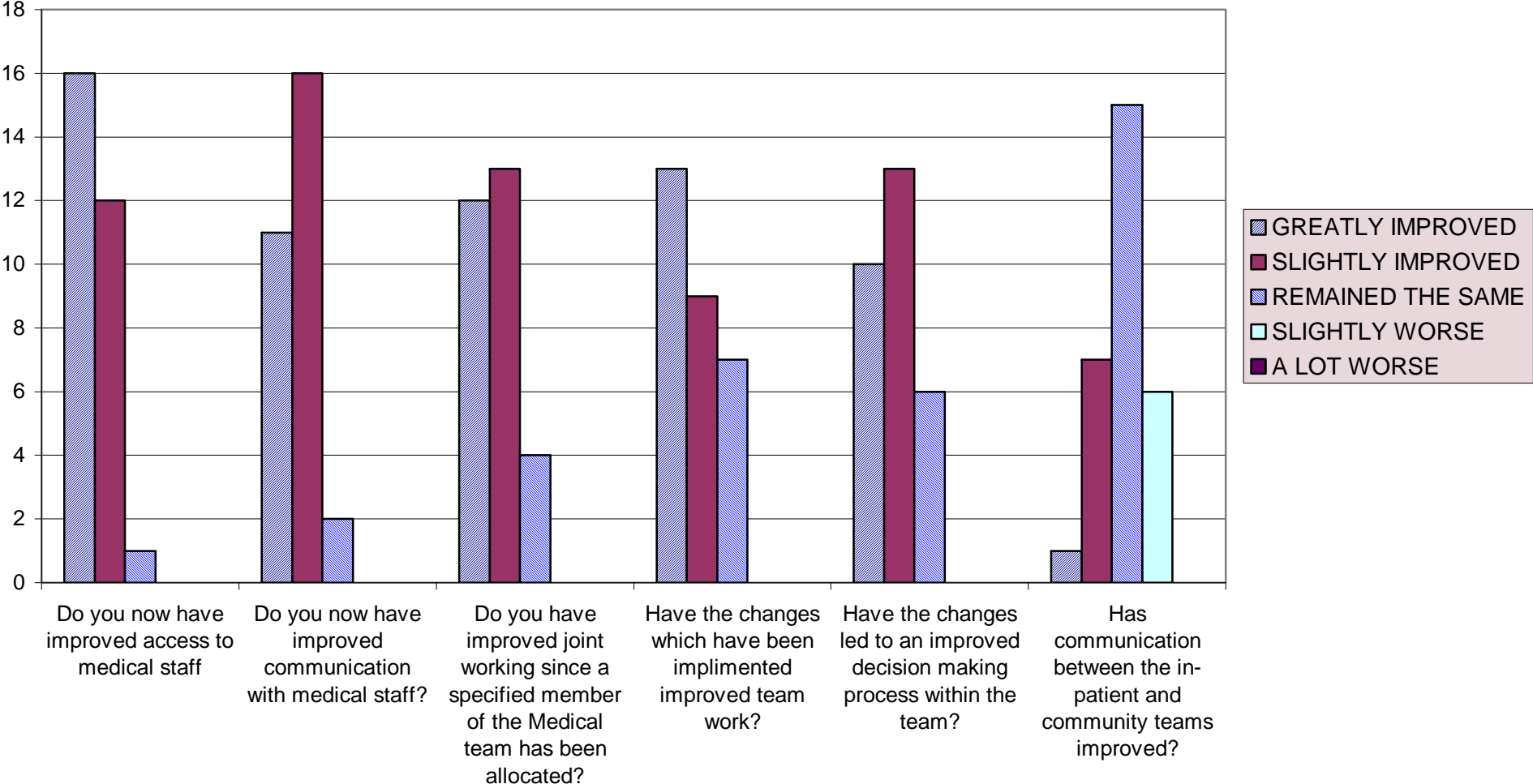
Q8-Q11: All Staff - December 2005 Questionnaire



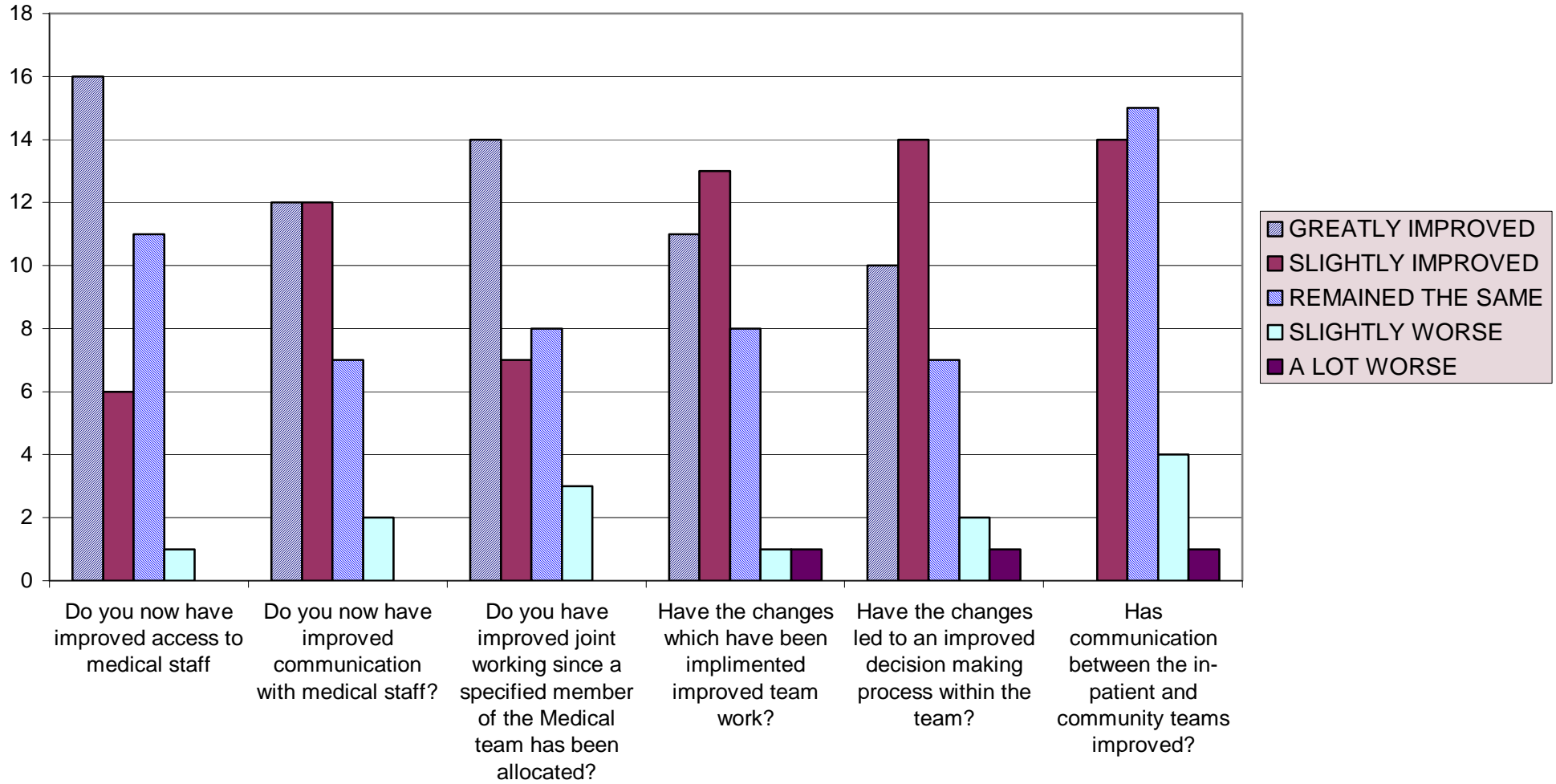
Q8-Q11: All Staff responses in April 2006 (33n)



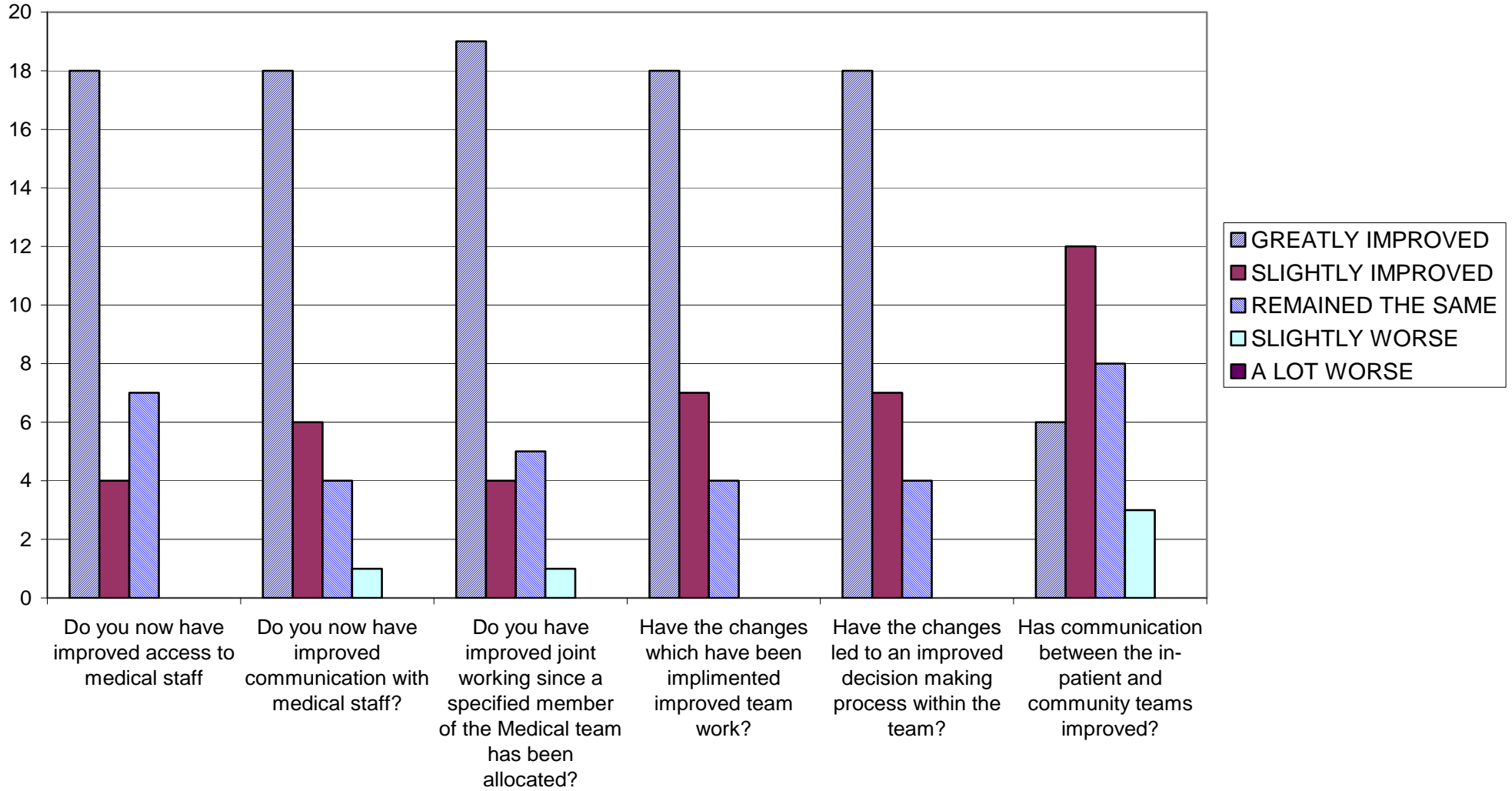
**Staff Questionnaire - Inpatient Staff Responses Q2 - Q7
August 2005 Questionnaire**



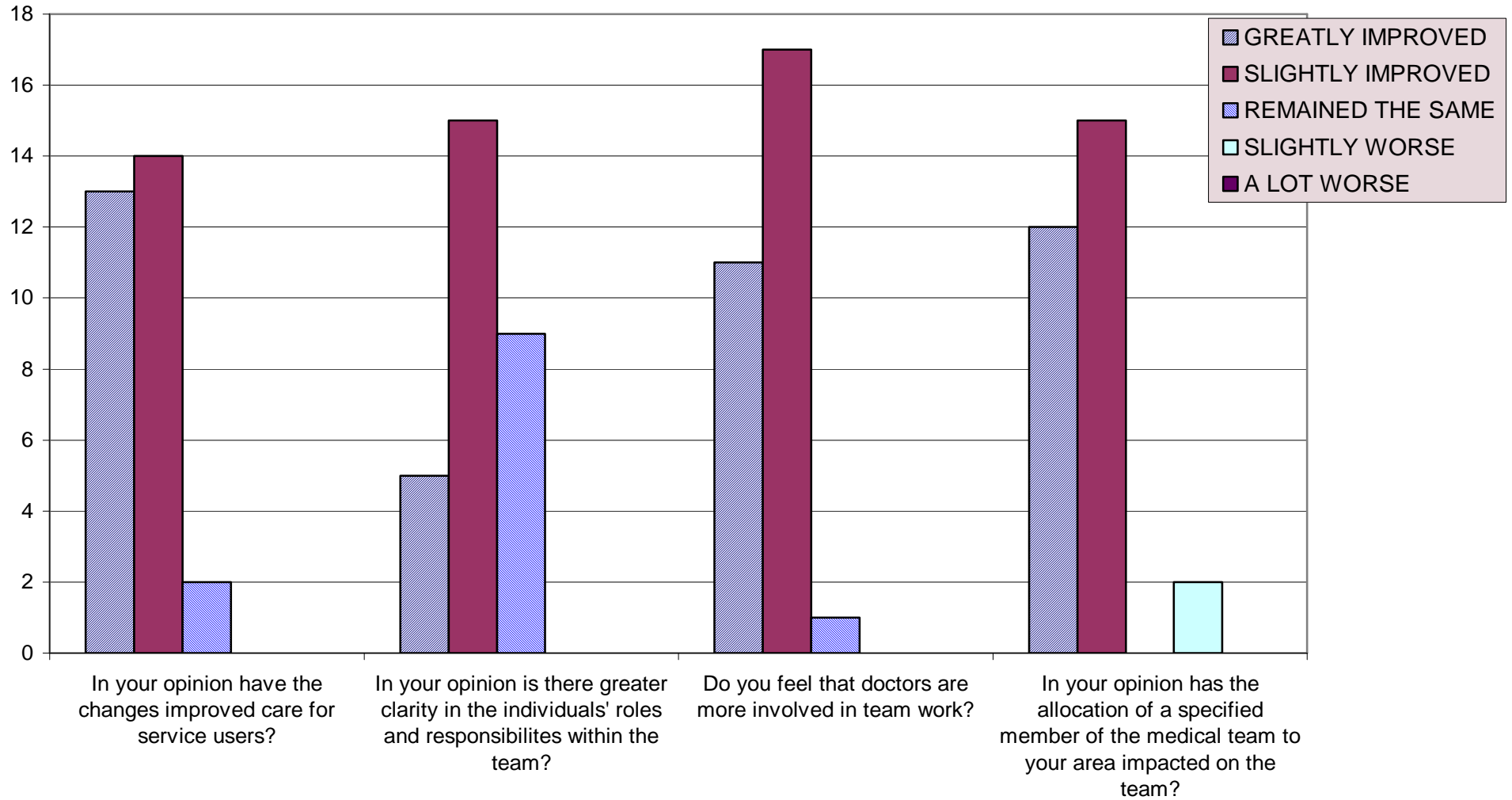
**Staff Questionnaire - Inpatient Staff Responses Q2 - Q7
December 2005 Questionnaire**



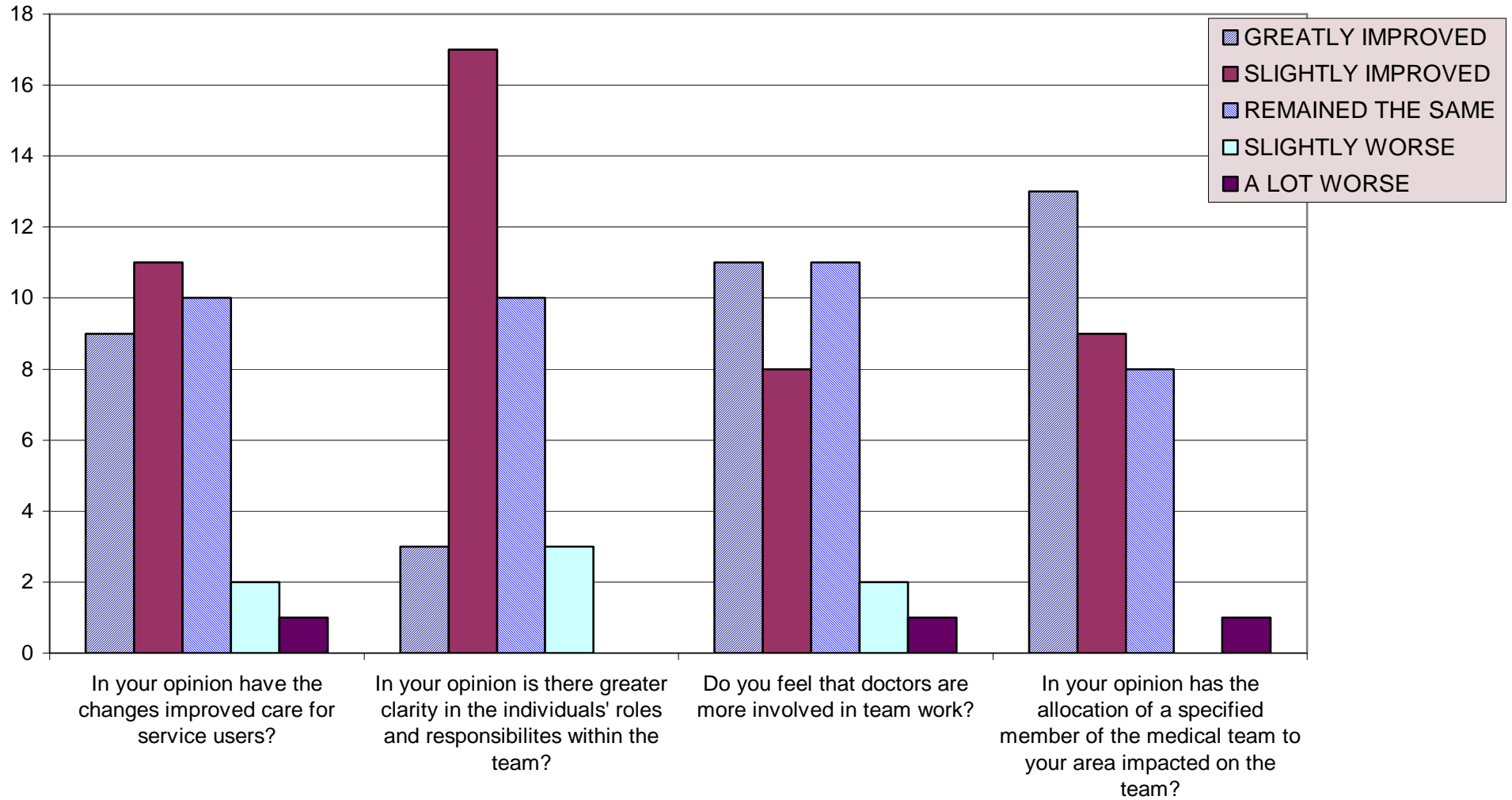
Staff Questionnaire - Inpatient Staff Responses Q2 - Q7 in April 2006 (29n)



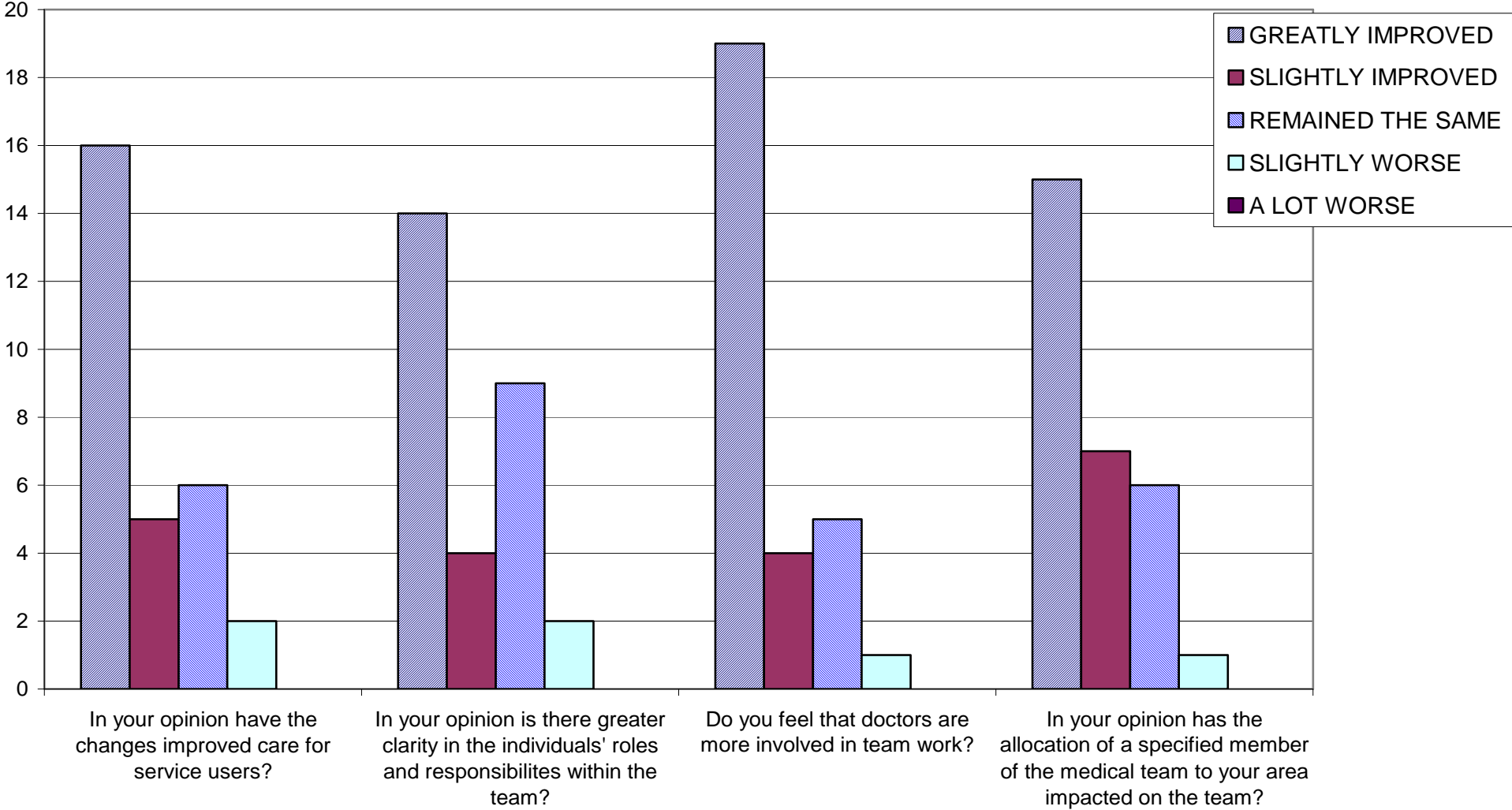
**Staff Questionnaire Q8-Q11- Inpatient Staff Responses
August 2005 Questionnaire**



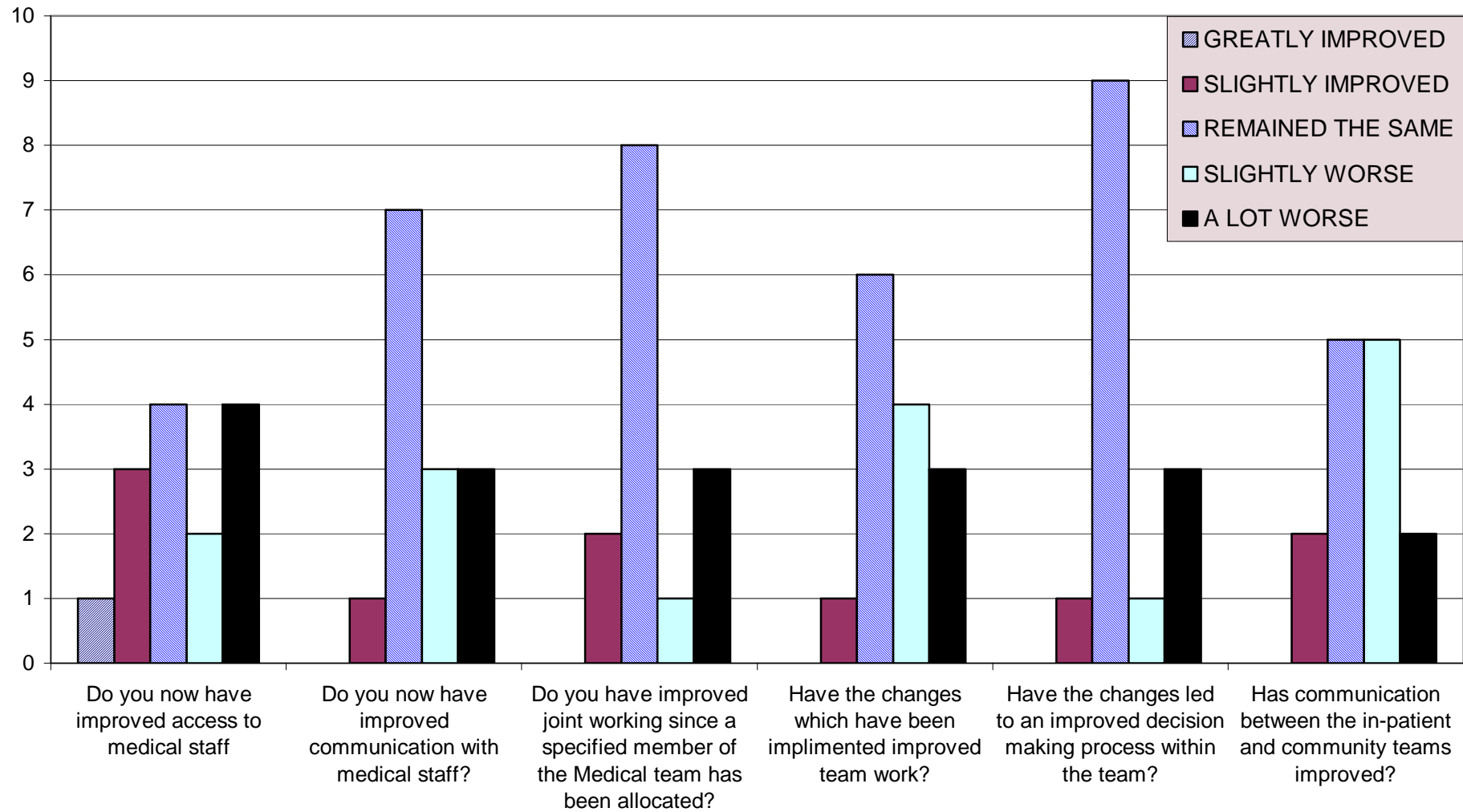
**Staff Questionnaire Q8-Q11- Inpatient Staff Responses
December 2005 Questionnaire**



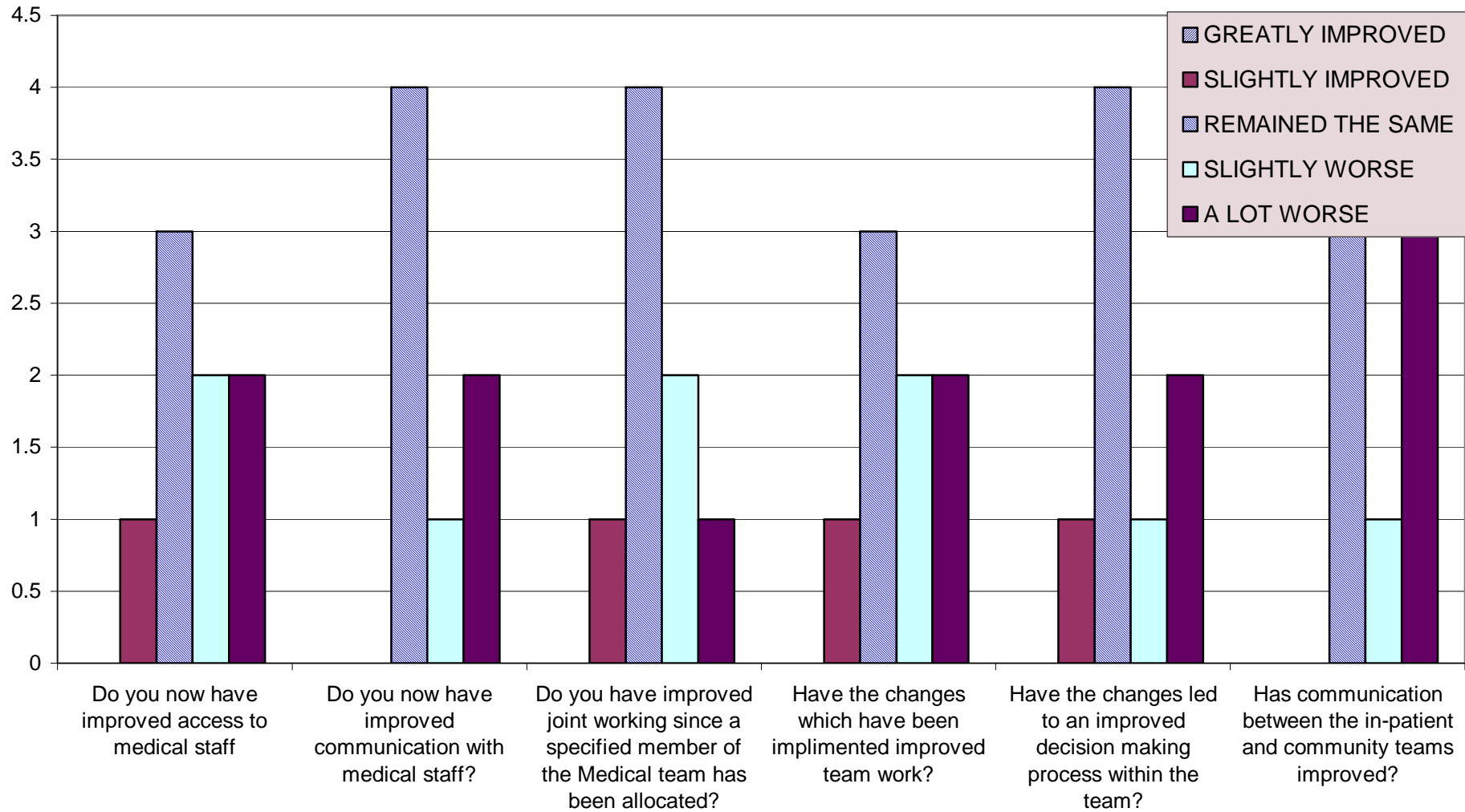
**Staff Questionnaire Q8-Q11- Inpatient Staff Responses (29n)
April 2006 Questionnaire**



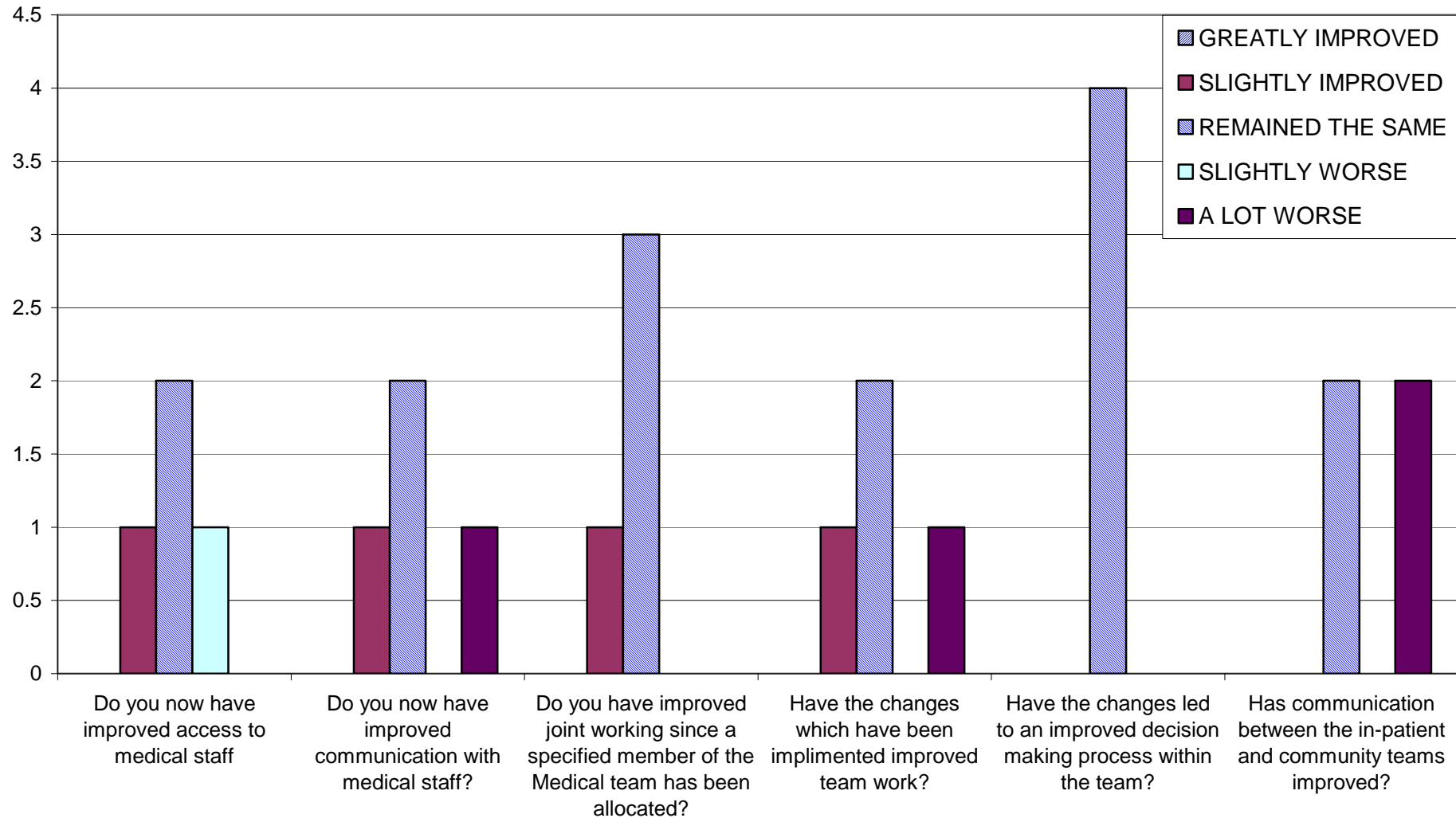
Question 2-7: Community Staff Responses - August 2005 Questionnaire



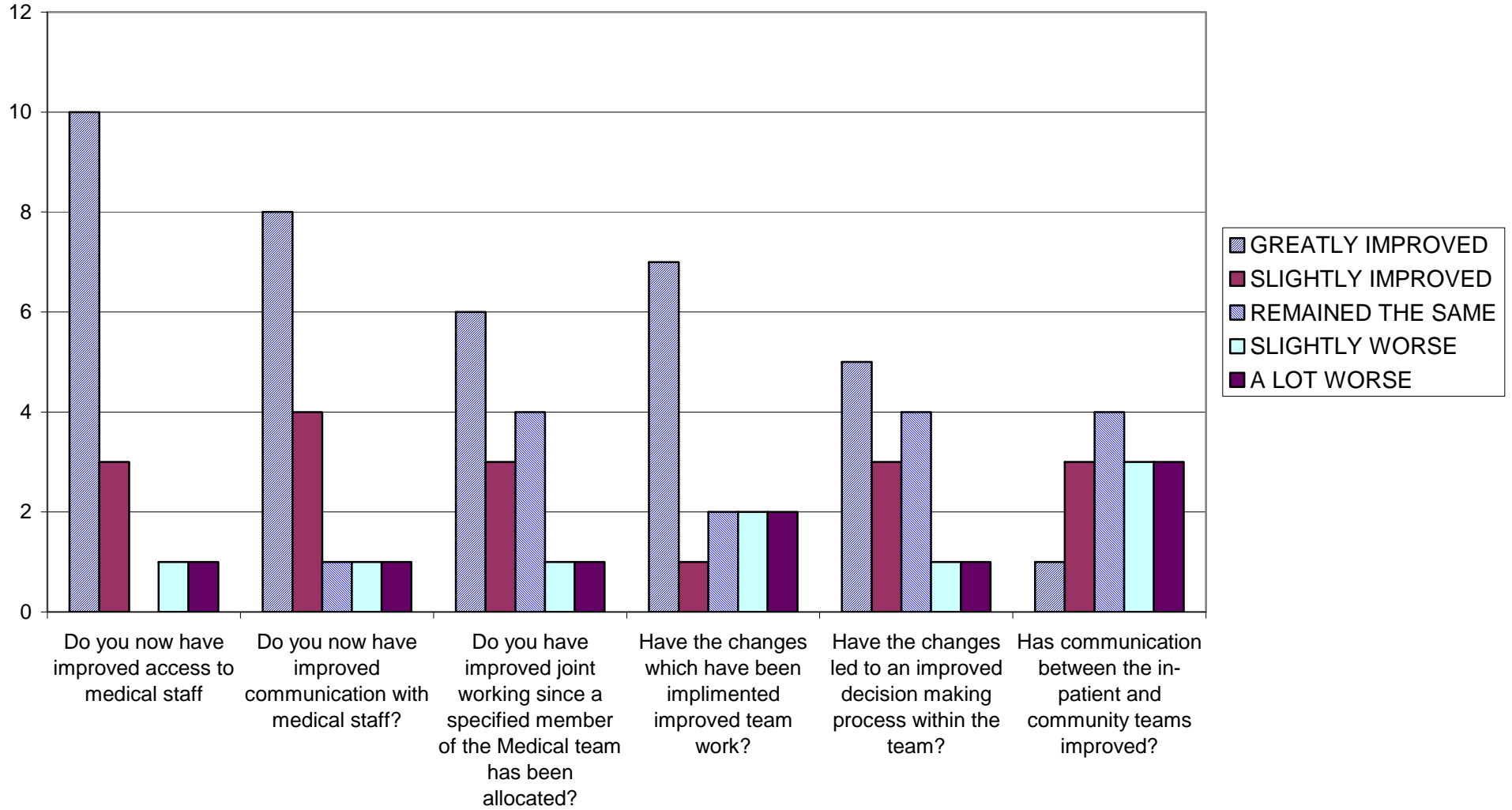
Question 2-7: Community Staff Responses - December 2005 Questionnaire



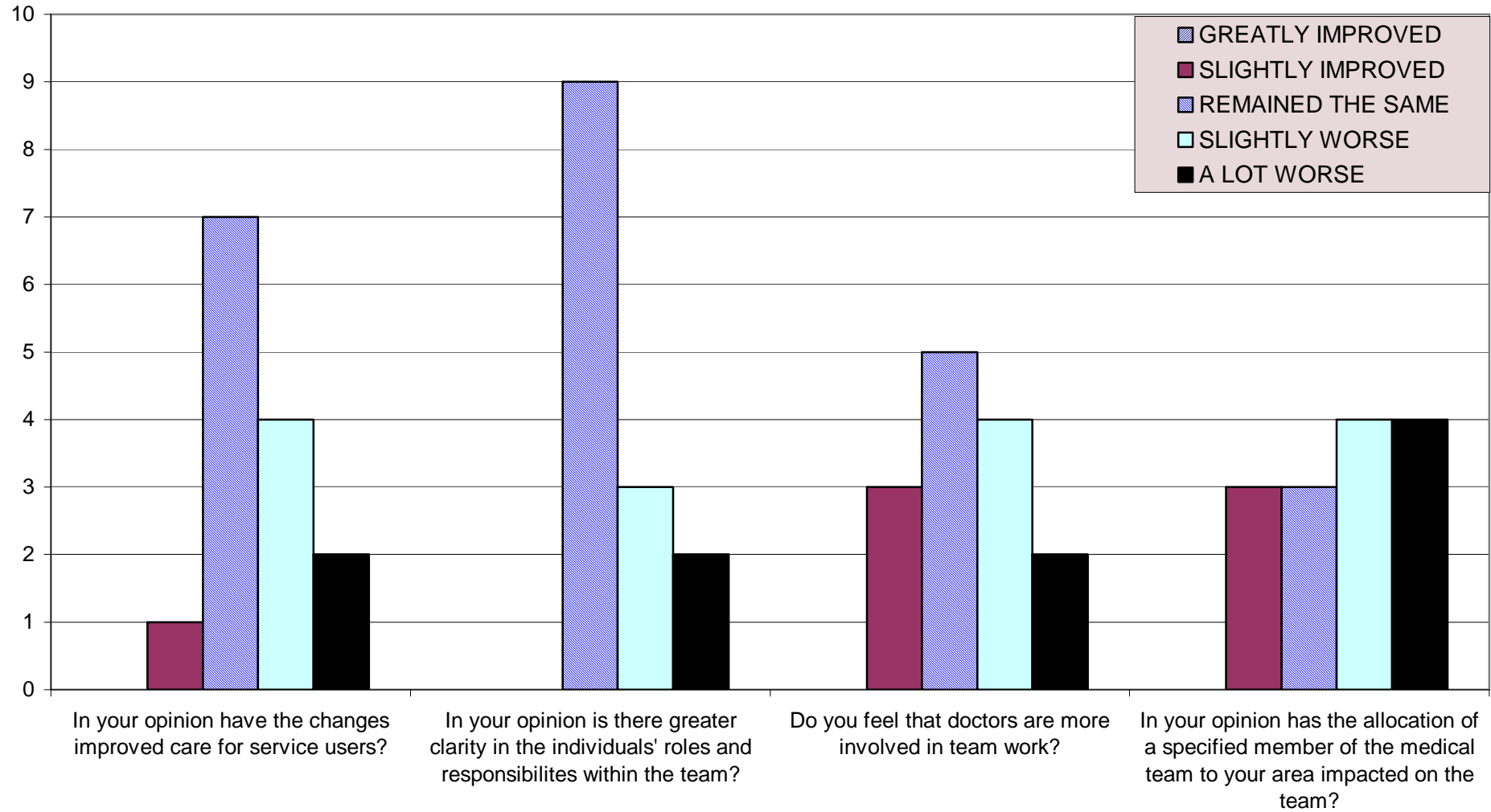
Question 2-7: Community Staff Responses in April 2006 (4n)



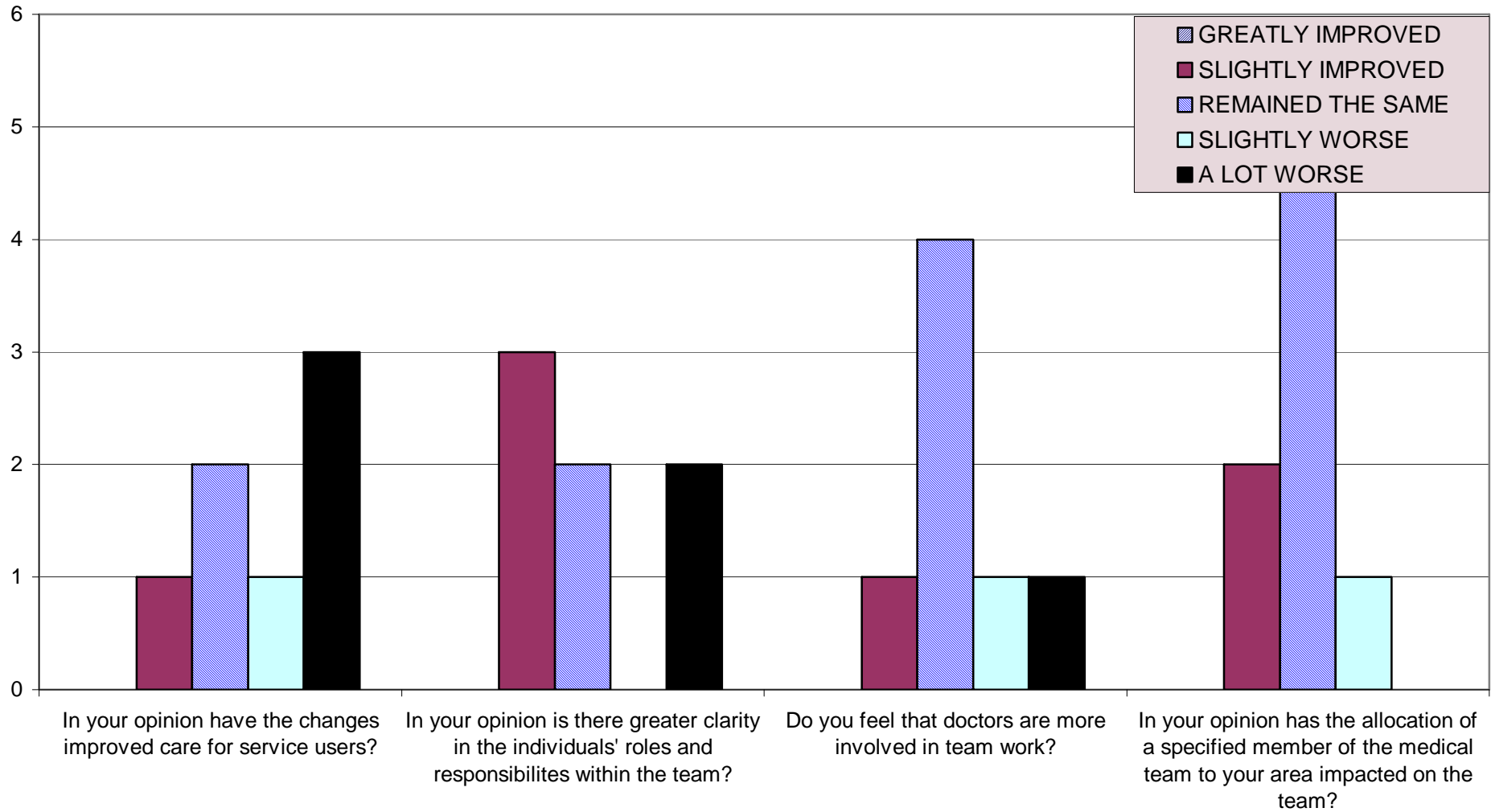
Staff Questionnaire - Community Staff Responses Q2 - Q7 in September 2006 (15n)



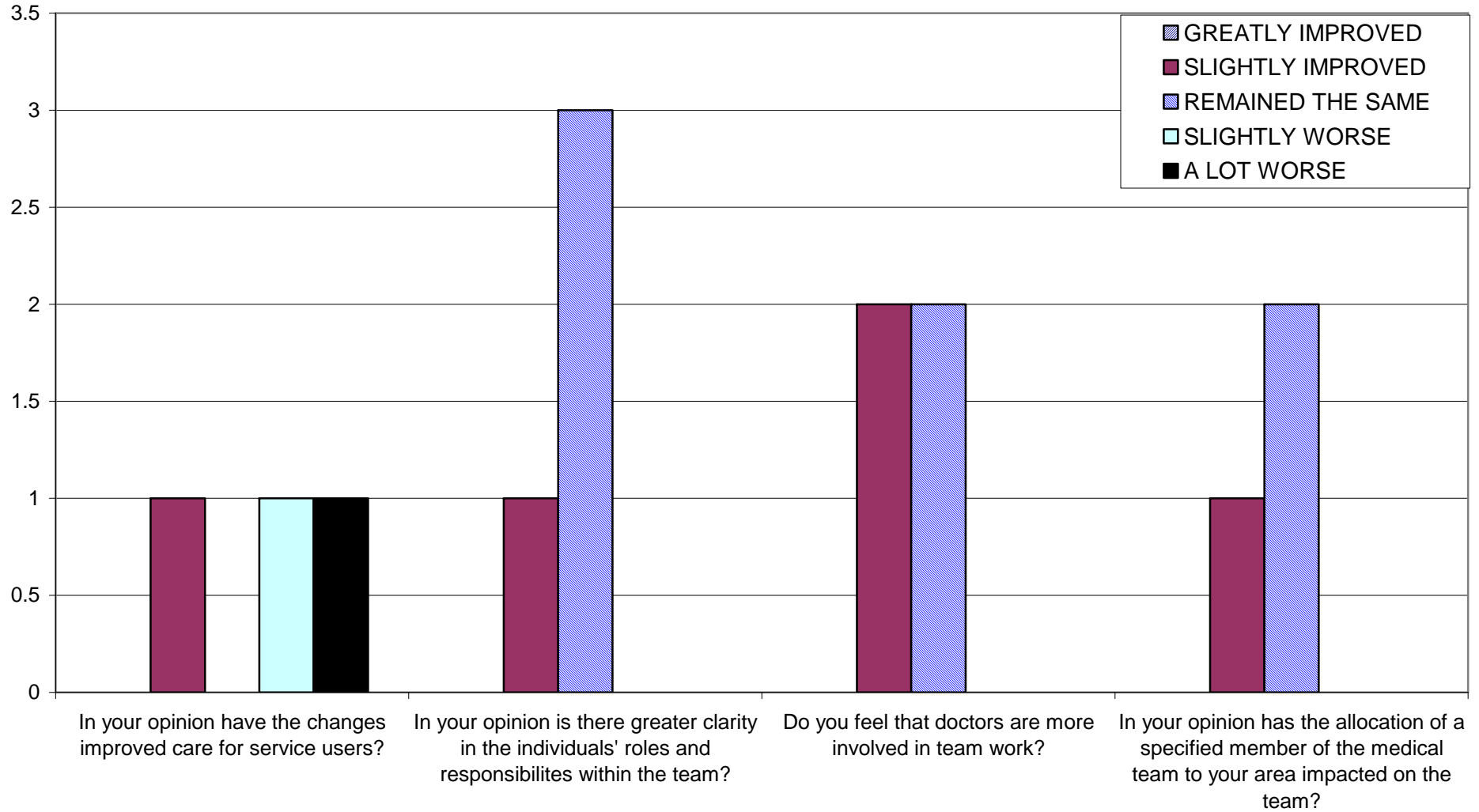
Q8-Q11 Community Staff Responses - August 2005 Questionnaire



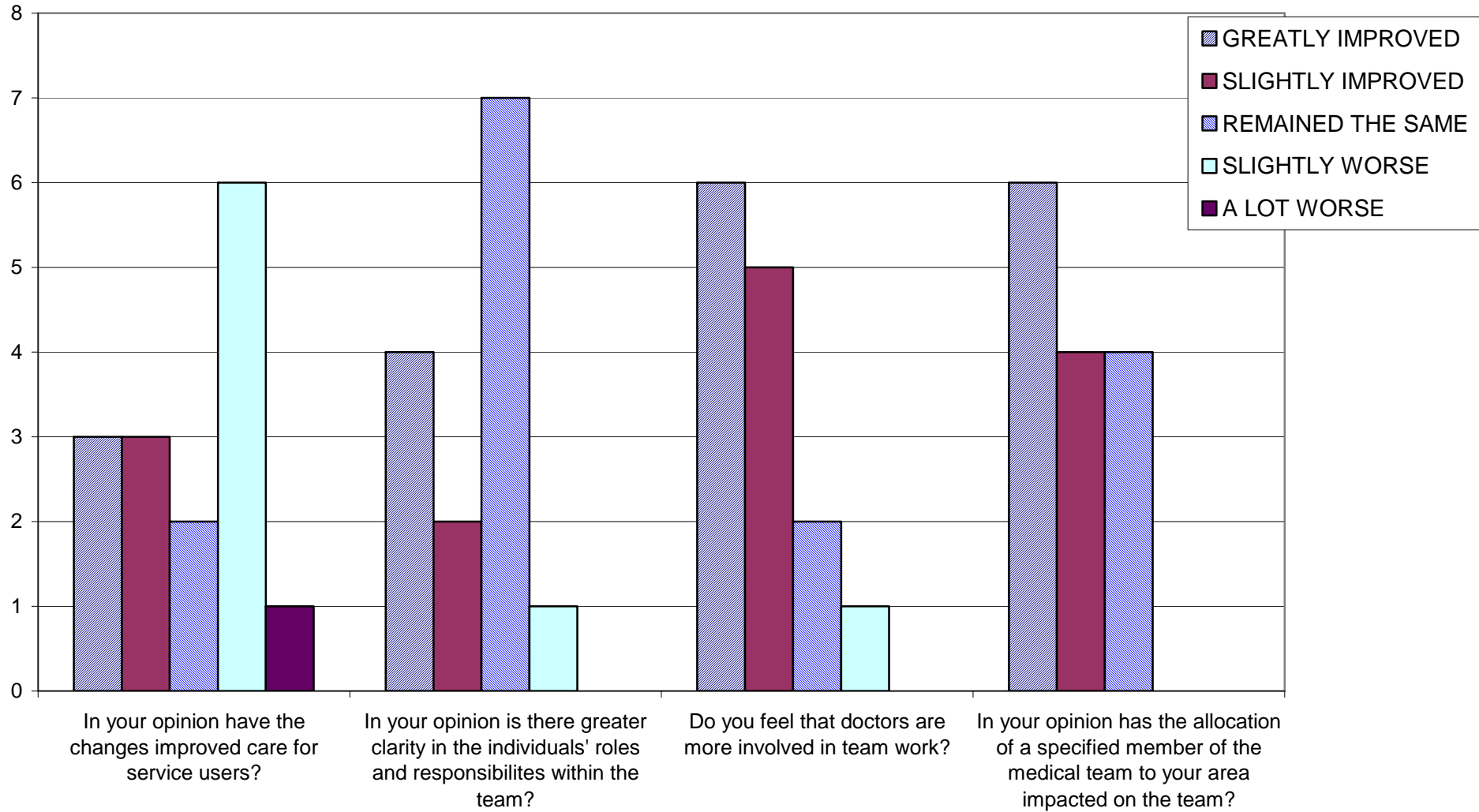
Q8-Q11 Community Staff Responses - December 2005 Questionnaire



Q8-Q11 Community Staff Responses in April 2006 (4n)

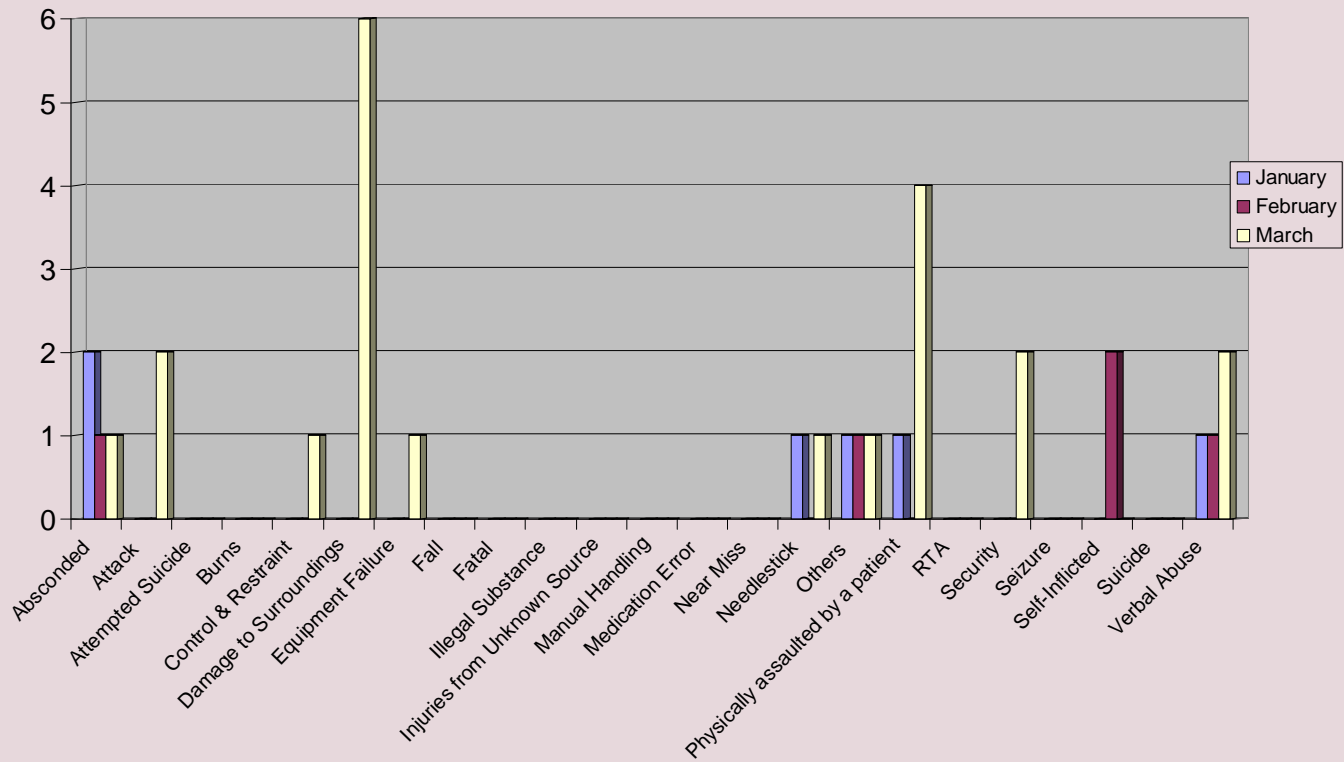


Staff Questionnaire Q8-Q11- Community Staff Responses in September 2006 (15n)

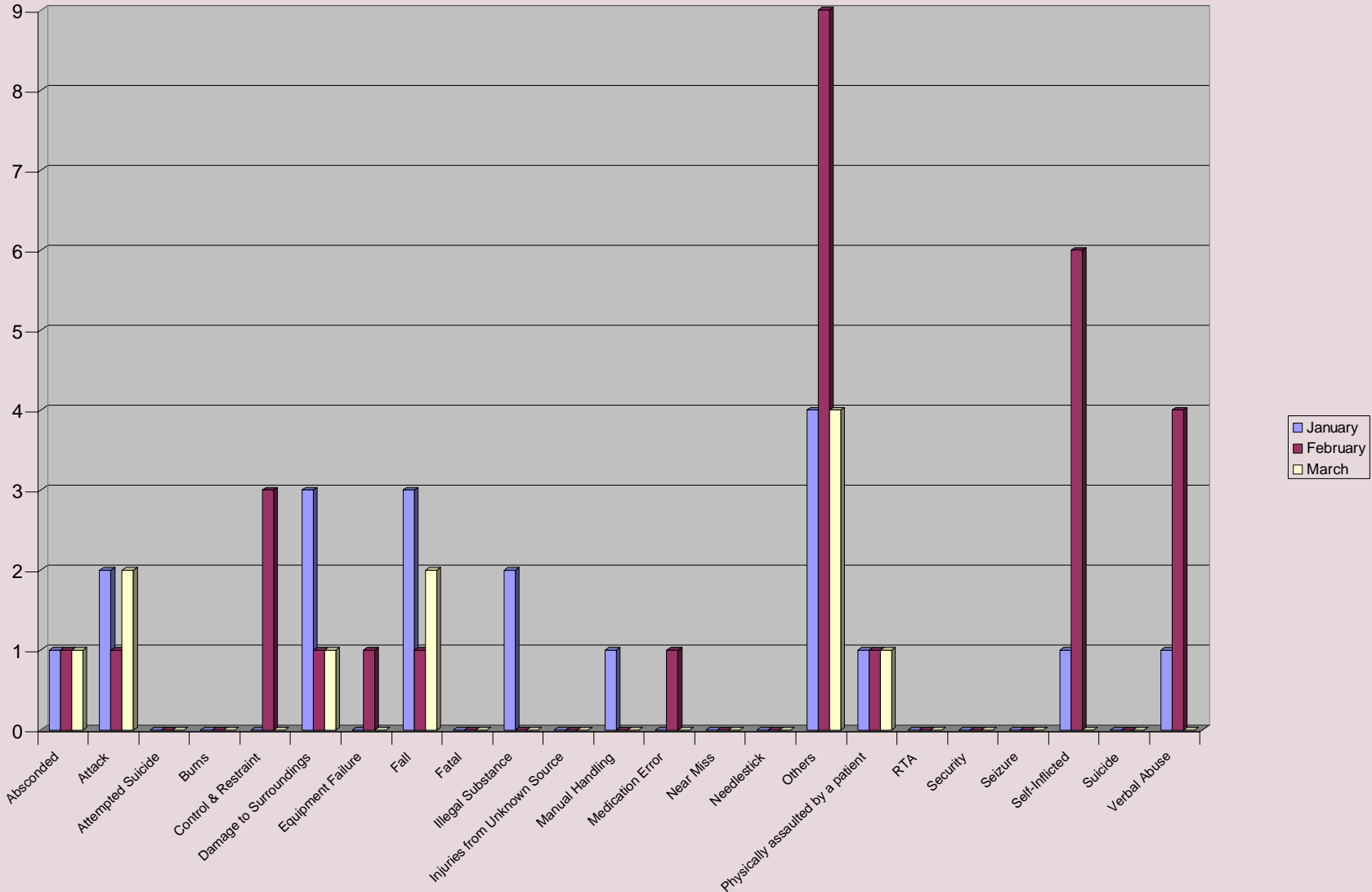


Appendix 10

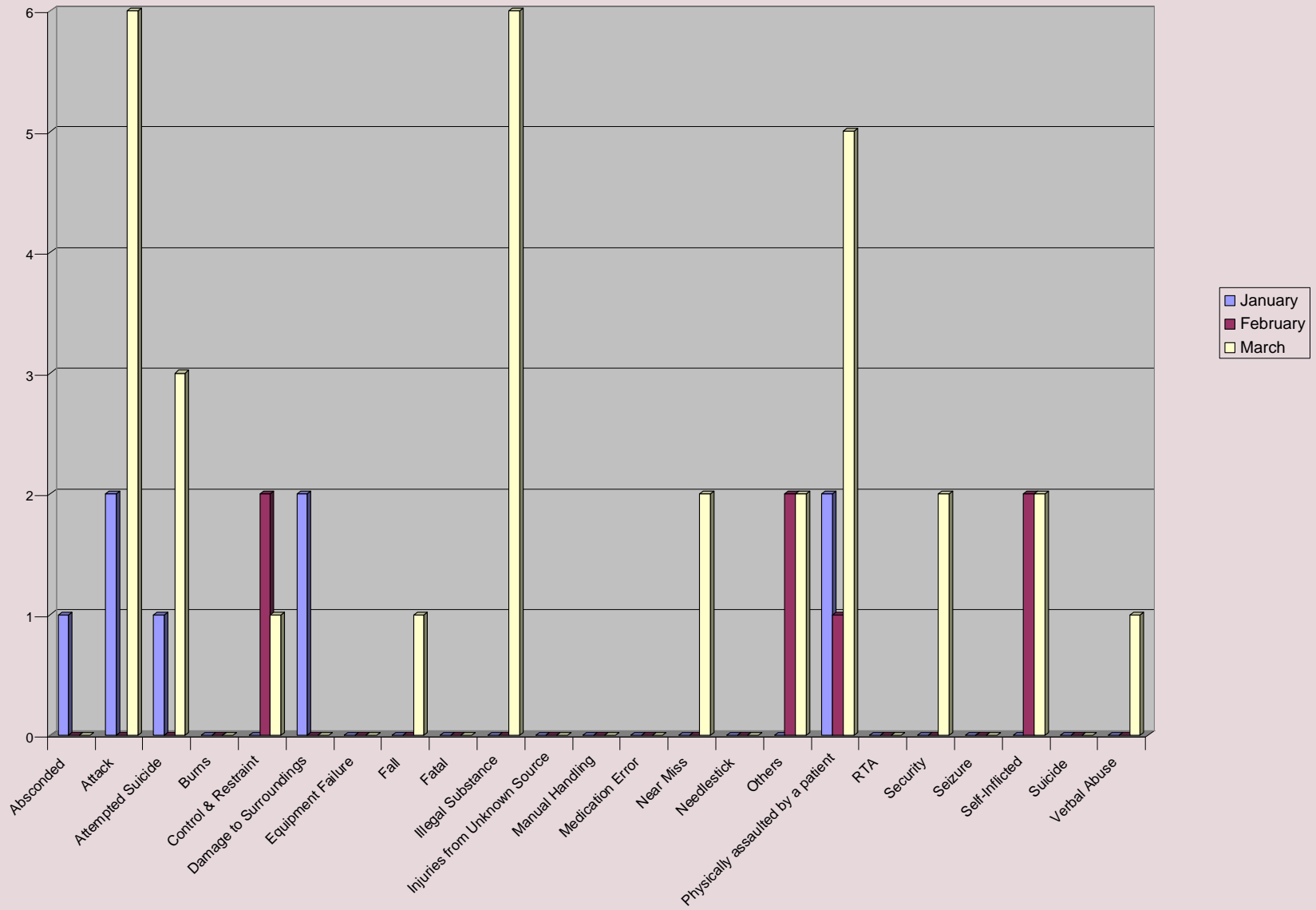
Serious Untoward Incidents Playford Ward (January to March 2005)



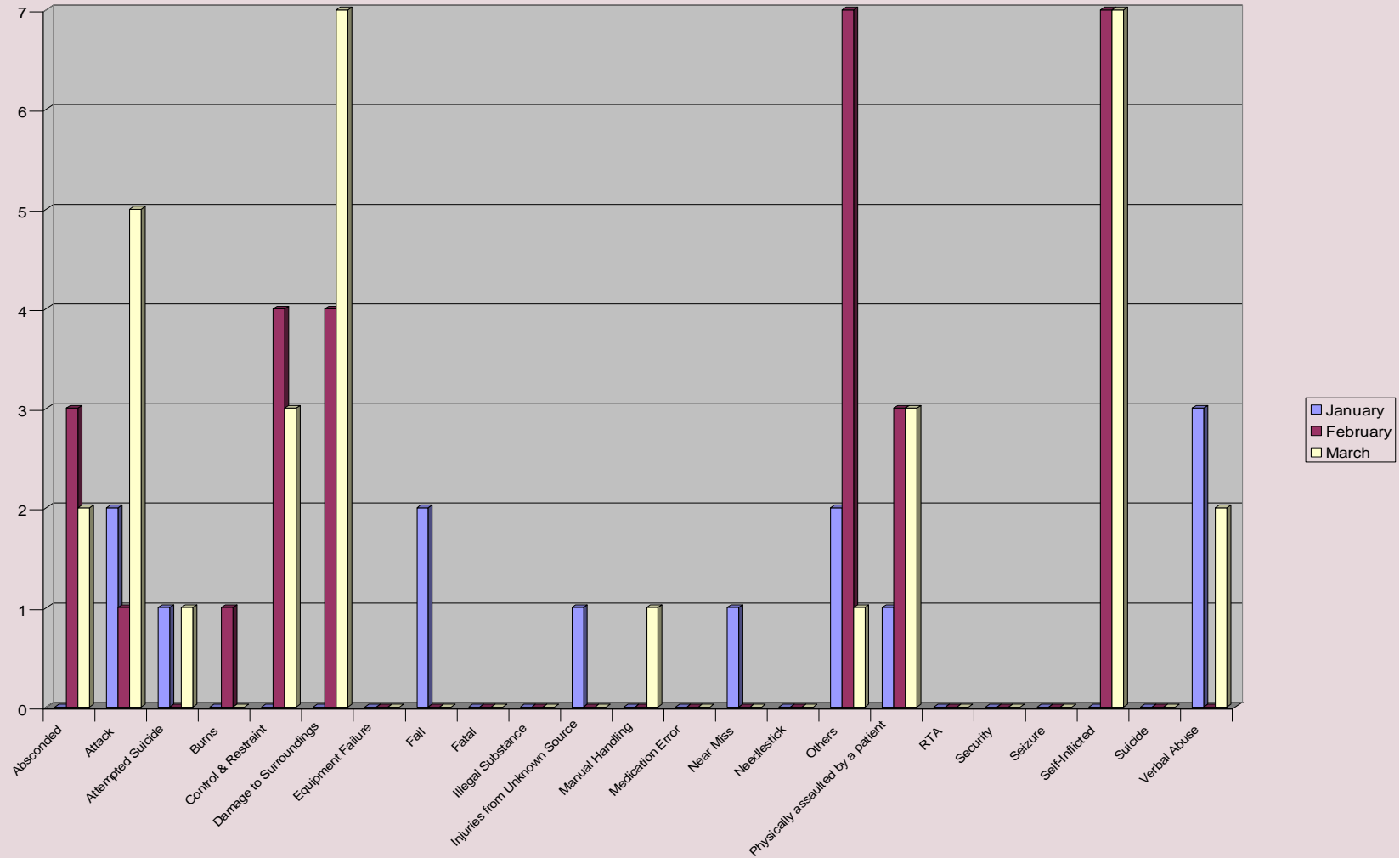
**Serious Untoward Incidents
Playford Ward (January to March 2006)**



Serious Untoward Incidents Mistley Ward (January to March 2005)



Serious Untoward Incidents Mistley Ward (January to March 2006)



Appendix 11

**“THE CHANGING PROFESSIONAL ROLE OF PSYCHIATRISTS IN THE CONTEXT
OF MULTI-DISCIPLINARY WORKING”**

REPORT OF THE CSIP PEER REVIEW VISIT

26 SEPTEMBER 2006

**SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST - EAST SUFFOLK
NWWP PILOT PROJECT**

Paul O'Halloran	Director: Development, Education & Training, CSIP EDC
Christine Vize	Consultant Psychiatrist & National co-lead for NWWP
Debbie Roberts	Programme Manager, Experts by Experience, CSIP EDC
Liam Callinan	Consultant Psychiatrist, Norfolk & Waveney MHPT

1.0 INTRODUCTION & CONTEXT:

The agreed purpose of the review was to provide an opportunity for:

- an external and objective stock-take of developments in the Suffolk east NWW pilot project
- participants to feedback their perspective on progress made, challenges experienced and lessons learned over the course of the pilot project
- those involved locally in the pilot project, to access expertise from a national and regional level in new ways of provision of treatment and care, service user and carer perspectives, service development methods and evaluation.

The framework or parameters for the review are provided by the original application made to NIMHE/CSIP to become a development site as well as the published report on New Ways of Working for Psychiatrists.

2.0 BACKGROUND

In January 2005, following an application by Dr Albert Caracciolo and Dr Kamal Mohamed, the East Locality of the Trust was successful in being selected to be part of a regional New Ways of Working for Psychiatrists initiative led by the National Institute for Mental Health in England, now part of the Care Service Improvement Partnership, Eastern Development Centre.

2.1 Project Aims:

The original aims of the project in the east locality were to:

- Achieve greater role clarity of the AMH consultant psychiatrist
- Create a whole system approach across AMH
- Improve Recruitment and retention
- Reduce levels of stress amongst senior medical staff
- Improve service delivery within NSF
- Improve patients' and carers' experience of the service
- Reduce competing demands on psychiatrist's time
- Refocus clinical expertise
- Disseminate of expertise and skills

2.2 Local Drivers for Change:

1. Enthusiasm and willingness for change on the part of both users, carers, clinicians and managers
2. Increasing demands on psychiatrist's time due to problems of numerous psychiatrists on the inpatient wards with consequently limited time spent with their Community Mental Health Teams
3. Lack of clarity of the role of the psychiatrist, especially in relation to the multidisciplinary team
4. Many outpatient clinics carried out on the hospital site in isolation from the teams and consequently large Consultant caseloads
5. Stress, lack of job satisfaction amongst psychiatrists
6. Large numbers of patients placed out of county for psychiatric care (OATs) due to lack of available beds locally causing huge financial pressures on the Trust
7. Lack of equity in workload of psychiatrists
8. A culture that fostered dependency rather than promoting recovery
9. Problems with recruitment and retention of medical staff to the Trust

2.3 Baseline situation

The situation in the East at the commencement of the project was described as:

- Patch or sector based consultant model
- Poorly integrated teams and lack of effective multidisciplinary working
- Disproportionately high numbers of consultants on acute wards with consequently lack of medical time in community settings
- Excessively High Outpatient case loads
- High 'overspill' ECR or OAT usage
- Dependency model resulting in very low rates of progression or discharge from secondary care
- High workloads with constant fire fighting

3. MODERNISATION METHODOLOGY:

3.1 Role redesign-

The original group of eight psychiatrists opted to redesign their new role around Option 3 of the NWWP Guidance. This involved working with diagnostically more complex presentations, and specialising in care involving those with higher need and with potentially greater risk. This further entailed concentrating on smaller and selected Consultant caseloads with responsibility for other service users distributed among other professionals within the multidisciplinary teams.

Further to this, the 8 project psychiatrists undertook to adopt the functional specialisation model, moving away from sector based approaches to become a consultant attached to and integrated within a specialist team. This involved both acute inpatient settings as well as various community based teams and necessarily involved whole system redesign across the locality.

3.2 System redesign

In addition, working closely with management and with input from service users, carers & NIMHE/CSIP, the Pilot NWWP project extended to include whole system redesign within Suffolk East Locality. This included:

- Redesigned traditional Community Mental Health Teams, CMHT's, to become either Assessment and Brief Intervention teams (for people from primary care with Mild and Moderate Mental Health Problems in line with the NICE Guidelines Stepped Care Model) and Recovery teams (for people with enduring and severe mental health problems).
- Set up new Crisis Resolution and Home Treatment Teams with reduction in acute inpatient beds
- Refocus acute inpatient services to become more therapeutically effective
- Assertive outreach services
- Community Rehabilitation

3.3 Creating capable teams

The need for capable and integrated team working has been a key feature of all pilot NWWP programmes. CSIP has worked with the Trust to begin to build a process of developing capable teams in the context of NWW for psychiatrists and to develop an approach to disseminate a recovery based approach to service delivery.

3.4 Leadership

Effective Team Leadership has also emerged as a critical ingredient of success. CSIP is working with the Trust to provide the Team Effectiveness & Leadership Programme.

4. OUTCOMES

This project has demonstrated positive change on many fronts. At present, routine data gathering to measure change is only occurring consistently on the inpatient wards. Although evaluation continues, preliminary data and other information and feedback appear to demonstrate:

- Improved patient's and carer's experience of inpatient services. Although limited response rates and other methodological constraints makes for cautious use of the information at present.
- Improved service efficiency through reduced acute admissions and Out of Area Treatments. The Crisis Resolution & Home Treatment Team, report a 46% reduction in admissions since September 2005. OATs have been reduced to and remain at zero. The average length of stay on the acute ward is relatively low.
- Clarity of the role of the consultant and the emergence of medical leadership
- Focused medical time and expertise on the most in need
- Improved multidisciplinary team working
- Creating a whole system approach
- Dissemination of clinical skills
- Improved recruitment and retention of consultants and other disciplines

5. INPATIENT SERVICES

- There has been a very positive impact on inpatient nursing staff from the changes, particularly what was described as the ‘emergence’ of medical leadership on the wards.
- **The project has also had a positive impact on Workloads and skill mix.** The inpatient staff appeared to value greatly the increased availability of the psychiatrists, for the psychiatrists to have greater direct contact with patients and other members of the team as a valuable knowledge base that they have access to. Equally the distribution of responsibilities across the team did appear to help the whole team share responsibility of individuals for whom it was caring. This also potentially creates the path for further individual professional development and a wider skill mix in any given team. It was not so clear whether this was also at present with the case with the community teams.
- The inpatient wards have also benefited from the ‘refocusing’ work, so it is not always possible to distinguish the origin of improvements, but there was agreement that it had been significant in the following areas:
 - Communication
 - Relationships between different staff groups
 - Innovation on the wards
 - Team identity and ethos
- The inpatient staff need more information about community care pathways and the alternatives available in the community if they are to assist the community teams and prepare patients for discharge effectively.
- Carers have appreciated the greater visibility of medics on the wards as well as patients and nursing staff, there was a feeling that this meant that any incipient problems could be nipped in the bud – perhaps an audit of complaints could provide evidence for this.
- Crisis beds on the wards are not working particularly well – they are not guaranteed to be available, and the needs of the short term crisis patient are different.

6. INTERFACES, ELIGIBILITY AND CONTINUITY

- The service still has arguments about interfaces and where people fit in the service. However, the feeling was that although more work needed to be done in this area, overall the ability to provide effective care for patients had improved.
- Interfaces which are based on timescales seem to be the most problematic for people to understand and work with, and several people raised questions about the purpose of brief intervention versus recovery. The teams have all defined their own eligibility criteria which causes difficulty
- The development of eligibility criteria for the various functional teams appears to be an important element in trying to gain control of effort particularly within teams rather than the service as a whole. Individually developed team based criteria without reference to the overall system of care pathways, create a potential of serial rejection of referrals from primary care or other sources, putting the service user at risk of receiving nothing.
- Data on patient flows between teams (particularly CABIT and recovery teams) should be used to help find ways to overcome interface problems and allocate capacity appropriately. The 10 High Impact Changes for Mental Health could be a useful 'hook' for this work. The Capacity Management meeting was a good development but could be used more explicitly as the means of informing policy developments as well as dealing with immediate difficulties.
- Interfaces which could be prioritised for attention:
 - Between crisis and CABIT
 - Between CABIT and recovery
 - Between ward and community

7. CPA AND CARE CO-ORDINATION - WHOLE SYSTEM CONTINUITY OF CARE

- **Whole system approach and effective interdisciplinary working across the system** (Transition of care between teams, team interfaces). This was the area that seemed to raise the most practical difficulties. Where a person previously had one psychiatrist when either inpatient or in the community they would now have a psychiatrist based on their functional location. The challenges appear to boil down

to teams being able to hold a global responsibility for people across the whole system as well as the specific individuals on their current caseload.

- Thus, while medical access has been enhanced, the continuity of care issue remains to be further developed. The consultants have not yet fully cracked the continuity of care issue, and at present, this tends to put too much responsibility on an undeveloped care co-ordinator role. Hence the wards describe a variable response to their efforts to engage with care co-ordinators, which will have a number of causes but these presumably include pressure of work and travelling requirements
- Given the impact NWWP and the wider NSF service modernisation has had on the rest of the team including Care Coordinators, there emerges an urgent requirement to ensure that CPA, as the main vehicle for ensuring continuity, is working effectively. The trust will need to assure itself of practitioner and team capability in working within these changed contexts. Put another way are practitioners sufficiently well trained to undertake these tasks and does the Trust have a means to assess these capabilities and offer training where needed?
- Again, the role of the care co-ordinator is a key issue (as it is for all trusts). Some staff are not clear what it is, others do not recognise the CC as having some authority in the arrangements with respect to the patient. If the Trust is going to work on this issue it would be useful to have links with the national work which is doing the same thing for the CPA review
- However, whilst this might be helpful, it would probably be worth not doing much on other aspects of CPA pending the results of the national review which may help to simplify matters. One person said that it felt as if they had been constantly reviewing CPA and this is unsurprising as all trusts have difficulties operationally with it.

8. COMMUNITY TEAMS

- Triage and brief intervention has provided a means of ensuring a single point of access which has been a positive development.
- There may need to be a reappraisal of the skill mix in the community teams – when the project was started there was not really enough data to decide where to put the capacity, and pinch points are appearing.

- The recovery teams have had difficulty introducing the recovery model at the same time as being part of all the other changes; nevertheless there is evidence that patient access to help when they need it has improved, as has staff job satisfaction.
- The problems the recovery teams are working on relate to not being able to start from scratch, a lack of variety, multiple team interfaces to deal with, and less close working relationships with GP surgeries – however the proposed link worker model should help with the last.
- The philosophy of recovery needs to be made clearer to carers, perhaps service users could help the service to do this. There was some evidence that the function of different teams was also not clear enough to carers, and this could lead to dissatisfaction.
- Whilst the acute wards have enjoyed a sense of rediscovered purpose (through NWW & refocusing) some of the community teams report a loss of direction and impaired relationship with primary care: for example a large excess of referrals and with very limited ability to provide psychological treatments.
- This impacts on the crucial understanding between the commissioners, primary care and the service teams. More is asked of the community teams than can be provided, probably because primary care lacks other resources.
- The community teams appear to be struggling to provide an effective, evidence based service with much the same effect on staff morale as acute wards experienced until recently. A good deal of effort needs to go into “refocusing the community teams”.

9. NEW WAYS OF WORKING AND IMPACT ON MEDICAL ROLES

- **Role of the psychiatrist and access to medical expertise**

The first thing that became obvious was the new apparent access that people needing an inpatient stay and other inpatient staff would now have to a psychiatrist. The inpatient psychiatrists may be on the ward for approximately three to four days per week which was a major contrast to the previous arrangements where over half a dozen different psychiatrists may make one or more ward rounds to visit their respective patients in the week but no consistent access to a psychiatrist during the rest of the time would be available. The psychiatrists are now available to patients and to the staff of the wards enabling more focused and timely solutions rather than having to rely on a set date or

ward round, in turn enabling earlier discharges and quicker responses to difficulties arising for individuals etc.

The practical issues of a workforce will naturally arise such as holiday cover and sickness cover for psychiatrists covering a given area. A further potential issue is psychiatrists working purely in one area may lose touch and contact with the issues and practice of another area. This could in time potentially become a larger problem as the lack of contact deepens a gap between inpatient and community team working which is already emerging as an area of tension. One consideration maybe some form of rotation of community and inpatient practice or utilising a shadowing approach, whereby for limited periods of time, each psychiatrist could shadow a fellow psychiatrist in a different team, during which time practice and model development could be discussed and further enhanced (similar practice for other staff could also be considered). There may be many other solutions, meetings and development days etc, but this area will likely benefit from attention over time.

- For SHOs the specialisation of roles was not a problem if they were psychiatric trainees, but is a potential problem for GP trainees, as in six months they may not get a rounded experience. The college tutor could lead a piece of work to examine the effects on SHOs and how to preserve the gains (eg more opportunities for meaningful community work, better supervision) whilst improving some other aspects. There won't be an ideal solution, and if SHOs are to see the range of things, continuity may end up having to be sacrificed more.
- The SHOs get good supervision on the ward, and are more embedded in some of the teams than previously, particularly the ward teams and the crisis team.
- However there is evidence of some dissatisfaction amongst some trainees. The SHOs in community placements being reported as less content with the quality of training, than those in the acute wards.
- Given the new structures: separated community teams and acute/inpatient areas, are all senior house officers able to benefit from a training experience in each individual six month placement which offers a sufficient depth, variety and intensity of work?

- Quality of care has been improved by having inbuilt second opinions in the new system, and by the increased scrutiny of practice that it affords. It also provides better arrangements for risk sharing which can ease stress on staff.
- Whilst consultant jobs are more manageable, there are some difficulties in getting the balance right between having ready access, and immediate access being interpreted as meaning that the consultant is hanging around with nothing to do. Teams and the Trust need to ensure that all the new types of work that a consultant is doing are being captured as legitimate activity – provision of support, advice, supervision to other professionals, etc, and if the consultant has a leadership role within a team this should be explicit and time allowed for it.

10. RELATIONSHIPS WITH PRIMARY CARE

- Relationships with primary care have probably suffered with the new model and need re-invigorating, and some sort of primary mental health tier (e.g. graduate primary care workers and Link Workers) could ease the pressure on referrals and criticism about ‘bouncing’ patients back without assessing them – commissioners must therefore be involved in determining the type of service that is to be provided.
- We heard a good deal about “ eligibility criteria”, “ sent back referrals”. This is an area for concern. When a GP refers a person to secondary care the professional judgement of the GP is that they need further input to support their patient. Considering the high rate of assessments of primary care referrals that turn out to be ineligible, it appears that either the GP is ignoring the criteria, there is a dearth of services in primary care for mental health, the criteria are not agreed mutually between primary and secondary care or the criteria are ambiguous or variable between teams. It is crucial to address these issues to help prevent mismatched expectations involving the GP, the service user and the Trust and to reduce the many inefficiencies involved in the current process. The eligibility criteria alongside alternative community and self help resources may be very useful information to GP's in the community. While this is not purely the remit of the changing role of psychiatrists the disempowerment that both a GP and a person

requiring a service can face on having a referral returned should not be underestimated.

- Naturally practitioners want to be able to manage demand on their teams: unmanaged access has been a major difficulty for mental health teams for many years. Nevertheless in the present climate if general practitioners cannot find a service for their patients they will soon find themselves able to stop paying an NHS mental health trust and pay someone else to do it. It is important for the Trust and the service teams to think very carefully about the future of services and a managed, productive relationship with primary care. At the least this means surveying primary care satisfaction with the new service structures.
- The GPs have not always heard what they have been told about the new model, and may try to circumvent the system. However the teams had all been trying to showcase themselves separately to GPs, and the new model needs to be presented to them as a cohesive system.
- More could probably be done with primary care in the provision of advice and support, to reduce the number of referrals and to facilitate discharge back.
- The traffic light system used for the local formulary needs to be re-examined in discussion with commissioners, as restrictions on prescribing can hinder discharge for some patients.

11. THE CULTURE OF RECOVERY VERSUS DEPENDENCY

The culture of recovery versus dependency is adopted by this model of working. In a world focused currently on recovery it is important to remember the ethos behind the recovery culture. Recovery is for each individual to describe in their own terms and what it means to them. Interpretation of your own recovery may be very different to how any given system may describe it. The aim of an inpatient stay with the emphasis on recovery as opposed to dependency would be one that supports an individual to address a mental health crisis and to tackle issues that are preventing the person from leading their life. The

work appears to have adopted this form of a recovery culture but recognizes there are still many developments that would further this. It also appears to be a continuing area of work, developing the concepts of recovery and care planning etc, which we would fully support.

12. USER & CARER INVOLVEMENT & SATISFACTION

While feedback on service user and carer experience was largely positive, there are areas around the quantitative evaluation of this area that could be improved. The data from the user satisfaction questionnaire does not allow for any strong conclusions to be drawn at this stage because of a quite weak response rate (between 5 and 11 responders). This is an important piece of work and as a result there are several needing further consideration including:

- Only patients were asked to respond to the questionnaire, no carers were asked
- The questionnaire was long and was given by the staff that provided the care
- The questionnaire was only given to inpatients; no community patients were given the questionnaire.

Suggested recommendations for improvement;

- 1) Involve patients and carers in the design of the questions for the questionnaire.
- 2) Consider commissioning an external service user or carer organisation to conduct the questionnaires.
- 3) Have satisfaction questionnaires as part of the ongoing practice for all patients, inpatient and community, and where possible for all carers.

Whilst the above has resource implications we would offer the analogy that it is very difficult to see out of the windscreen to see where you are going if you only have a fraction of the visibility.

13. TRUST OBJECTIVES

- The trust has two models of service delivery, but should be able to sustain this providing there are common objectives and standards, and the criteria the CEO has

set are met (i.e. the two models are equal in terms of costs and resources, service quality and outcomes, satisfaction with services by primary care and there is no added value to be obtained by insisting on one across the trust). However, at present there are some fundamental differences in thinking within the Trust about who the services are for, and these threaten to undermine the success of future development if they cannot be reconciled. On the one hand is the view that the work should concentrate on the most seriously ill within the recovery framework, on the other is the view that some of this work is likely to be lost to other providers in the future, and that unless the service pays more heed to what GPs want provided at the other end of the spectrum, and seeks to expand services for those it has not traditionally seen, it will lose out at both ends under PBC.

14. OVERALL-FEEDBACK FROM THE PEER REVIEW TEAM

- A great deal of energy and commitment was evident from the leaders of the project Dr Caracciolo and Dr Mohamad, along with their medical and managerial colleagues involved in the pilot. They should be commended for the developments they have made in such a short time, especially considering the ambitious whole system nature of the project. Inevitably the NWW project has become joined with other issues common to many mental health trusts: introduction of functional teams; cost savings; foundation trust status. This reflects how NWW as a concept has moved on considerably since its inception several years ago; it now is an important part of the thinking in developing a service which is user centred, responsive, business focused and cost effective.
- The ward teams were proud of what they had achieved and the service they were offering and this was very heartening, and their morale will no doubt increase further when they can move into modern premises.
- Within teams, of whatever sort, it was clear that effective clinical and managerial partnership was key to success.
- There was energy and buy-in for the new model in the community services as well, but it was patchier, and the overall conclusion was that community service

refocusing, including the use of Creating Capable Teams Approach and Team Leadership Development, now needs to be the next phase of service development.

- Continued uncertainty about the status of the changes in East Suffolk, and the concern of the West that the same model would be imposed on them, has led to evident tension. The Trust needs to decide swiftly if the criteria the CEO has set for supporting different models in parts of the Trust, which have a different heritage and demographics, are met. If this happens, the two models could learn from each other rather than being in competition.
- The evaluation element of the project as it exists provides a backbone of the modernisation process and should continue and be extended to include community services. In addition, there are important considerations to be taken on board on how to improve the quality of user & carer satisfaction data. There was also interest from the West in participating in the evaluation and this would be important to pursue, especially if objective data is required to inform future decisions. The matched funding agreed by the Trust could be used to further this important area.

15. CONCLUSIONS

This project represents a very positive piece of work within the area of New Ways of Working and whole system redesign. As outlined throughout, there are several key areas that should remain the focus for further development including:

- The Evaluation would benefit by extension to community based services and include developments in the west
- The resolution of issue of two different models of consultant practice and ways of working needs to be resolved
- The development of better care coordination and continuity of care throughout the system
- Improving link working with Primary Care
- Implementing a recovery approach to service delivery and practice across all elements of the organisation

This has been a brave step in difficult times (system reform, financial balance etc), it was very clear how during this system change many other changes and other parts of the health and social care systems have impacted on this development. It also demonstrates how when you change one area of a large system the ripples are felt throughout. Despite all of this there seems to be a genuinely collaborative approach to this system change. The inpatient and community teams were involved at the review on the 26th September and they appeared very enthusiastic and motivated to make things better for people who use services. Everybody also seemed very motivated that this was not an end to the journey but just a part of it, that development will need to continue and that an inclusive whole team approach to supporting people in a whole life and recovery focused way was now part of their own ongoing journey.