

Care Services Improvement Partnership **CSIP**

National Institute for
Mental Health in England



The
British
Psychological
Society

New Ways of Working for Applied Psychologists in Health and Social Care

*Organising, Managing, and Leading
Psychological Services*

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Organising, Managing, and Leading Psychological Services

The National New Ways of Working Programme has been led by the National Institute of Mental Health in England (NIMHE). As part of this programme of work New Ways of Working for Applied Psychologists (NWWAP) was established which met between July, 2005, to July, 2007. This particular report is from one of the seven NWWAP project groups established to look at aspects of the work of applied psychologists. The roots of this programme are clearly linked to the English NHS and related social care contexts. This has meant that those applied psychologists whose work is mostly involved with the Health and Social Care sectors (namely Clinical, Counselling, Health and Forensic) have been at the forefront of the work.

This background means that the NHS context dominates much of the thinking and considerably more work is required to think through in depth, the implications for the applied psychologists working predominantly in other contexts (e.g. education, prison services, private sector). It is also worth noting that the origins of the project arose from concerns about mental health services and this has influenced the scope of the work. However, there have been active attempts to adopt an inclusive approach and involve all the applied psychologies including representatives from Scotland, Wales and Northern Ireland so that lessons could be shared and the wider implications considered.

The document also contains views from outside of applied psychology including representatives from NHS senior and middle management, team co-ordinators, and psychiatrists, who were interviewed as part of an action research project (Coak, 2006)¹. A brief overview of the project is located in Appendix A. For further information regarding the project, contact the authors of this document directly.

¹ Unpublished Leadership Project, conducted as part of organisational placement using an action research approach to organisational development.

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Executive Summary

The content of this document incorporates the views of the British Psychological Society (BPS), National Institute for Mental Health in England (NIMHE) New Ways of Working Project Group for Organising, Leading, and Managing Psychological Services, and applied psychologists, from pre-doctorate trainee to executive level.

All professional groups are clarifying their roles and contribution to delivering person centred care. Applied psychologists represent an extensively trained, scarce resource that is diverse in roles and function across the whole health care system, providing services beyond traditional mental health and learning disability services into primary care and the acute sector.

The recommendations made in this document were developed for applied psychologists but the themes will be applicable to other professional groups, as strong leadership is needed across all professional groups. New Ways of Working will mean a stronger focus on multi-disciplinary, situational and task leadership in the context of a strong Capable Teams approach to service delivery. Professional Leadership for Applied Psychology requires strategic and operational leadership at the highest levels across the health and social care. Moreover, delivering on the Well-being and Happiness agenda will require strategic access to Applied Psychological expertise.

This document is for the guidance of leaders and commissioners who will be addressing the governance requirements of services which will be developing in a variety of new settings, provided by people in new roles. People who use services may be interested particularly in the context of becoming members of foundation trusts and using the opportunities afforded by becoming governors to press trusts to deliver the improving access to psychological therapies agenda. Last but not least, applied psychologists and other health professionals with specialist training in psychological approaches need to consider the professional regulation and clinical leadership arrangements which will best support changing practice and the development of the next generation of effective psychological therapies.

Introduction

This document is primarily for leaders, commissioners, and people who use services but will also be of interest to applied psychologists and other health professionals with specialist training in psychological approaches. It focuses on the need for leadership and leadership development in relation to delivering psychological services.

It is important to highlight that the term ‘services’ will apply to providers of health and social care from across the public, voluntary, and independent sectors. It is intended to be applicable to all settings and across the lifespan. It endeavours to take into account, as far as possible, recent, imminent, and future government initiatives that will be driving developments and reform in service delivery.

In the current political climate, all professional groups are clarifying their roles and contribution to service delivery. Applied psychologists represent an extensively trained, scarce resource that is diverse in roles and function. There is now increasing pressure for their contribution to be clarified. The recommendations made in this document were developed for applied psychologists but the theme will be applicable to other professional groups, as strong leadership is needed across all professional groups.

How to use this document

The target audience for this document is diverse and the relevance of each section will depend on the needs of the reader. As there is likely to be a range of prior knowledge amongst readers of this document, supplementary information that expands upon areas of the main document, is located in the appendices.

The BPS/NIMHE, NWWAP joint working party, was made up of seven project groups. These were; Organising, Managing, and Leading Psychological Services; Career Pathways and Roles; Improving Access to Psychological Therapies; Team-working; New Roles; Mental Health Legislation; and Training Models for Applied Psychology. The issue of leadership was a common theme that arose across the project groups. As such, there were overlapping areas and this paper, therefore, functions as a matrix document connecting the work of the NWWAP project groups. Those who require further information are directed to the final NWWAP document or the contributing papers produced by the other project groups.

People Organising, Managing and Leading Psychological Services

The 1996 Department of Health report on *NHS Psychotherapy Services in England: Review of Strategic Policy* (DoH, 1996) was the first document of its kind to be published in England. This was followed by the 2001 evidence-based guideline *Treatment Choice in Psychological Therapies and Counselling*. The Department of Health (DoH, 2001a) *Treatment Choice in Psychological Therapies* summarises those disorders found to benefit from talking therapies, and specifies which therapeutic approach is beneficial for which condition. Depression, anxiety, panic disorder, social anxiety, and phobias, post-traumatic disorders, eating disorders, obsessive compulsive disorder, personality disorders, including repetitive self-harm were all found to benefit. Together, these two documents collated evidence for the effectiveness of psychological therapies and offered practical guidance about how to drive forward the evidence-based practice agenda.

In addition to this, *The NHS Plan* (2000) and *Priorities and Planning Framework* (PPF) for 2003–2006 set out a number of proposals for new teams and services to fast-forward the mental health National Service Framework (NSF) and modernise services. Effective psychological therapies for common disorders were addressed specifically in the PPF (2002) target to develop new workers in primary care.

Building on the information contained in the above documents, *Organising and Delivering Psychological Therapies* was published on behalf of NIMHE (DoH, 2004b). It was commissioned by the Mental Health Care Group Workforce Team (MHCGWT) to assist thinking about the most effective way to organise and develop effective psychological therapy services and to inform training commissioning. The document provides a model of good practice in the management, training, access, choice, and supervision of psychological therapists.

The main actions points that came out of this document were to:

- Improve access to therapies to avoid long waiting times
- Define clear ‘care pathways’ to psychotherapeutic help for different psychological conditions
- Attend to the psychotherapeutic needs of different groups: for example, older people, ethnic minorities
- Involve users in choosing the most appropriate therapy for their condition and situation. This requires psychological therapy services to provide more effective information about their services and how they can be accessed, to both users and potential referrers
- Have systematic training in psychological therapies for mental health professionals supported by specialist supervision once they return to the workplace
- Have clear leadership, both professionally and managerially. This would best be achieved through the development of an organisation-wide body, i.e. a Psychological Therapies Management Committee (PTMC) (DoH, 1996).

In addition, the Healthcare Commission core standard C5b requires that all clinical care be carried out under appropriate supervision and leadership, and core standard C5c requires that clinicians from all disciplines participate in activities that update their skills. Therefore, well-organised and timetabled clinical supervision, leadership development, and appropriate continuing professional development are essential components of psychologists’ work. In many of its Clinical Guidelines and some of its Technology Appraisals, the National Institute for Health and Clinical Excellence (NICE) has recommended that a range of psychological therapies be made available on the NHS. There is persuasive evidence of their effectiveness and cost-effectiveness in improving outcomes for people experiencing a range of common and severe mental health problems. NIMHE has highlighted care pathways as an important system for targeting appropriate interventions. Although care pathways are increasingly available, they do not specify levels of skills needed to provide specific psychological interventions.

Implementing NICE Technology Appraisals is obligatory in accordance with Healthcare Commission core standard C5a, and although implementation of the Clinical Guidelines is within the Healthcare

Commission's developmental standards, monitoring of this will be much more stringent from 2007/2008. Trusts will, therefore, have to make optimal use of their psychological resources to have any chance of achieving the demanding targets set by NICE. This is likely to involve much wider use of applied psychologists in training and supervising other clinical staff in the appropriate delivery of psychological therapies.

Models of Service Delivery

One of the Project Group aims was to determine whether there was a preferred way of organising psychological services that led to improved retention and morale of its staff members. The findings of the group revealed that this appears to depend on the synergy between staff members, the service, the organisation, and the overarching strategic direction. Organisational effectiveness is therefore partly contingent on the degree of congruence between the organisation's external environment and the internal structure. This approach is largely descriptive, and may have limited, if any, causal features. Defining preferred models of service organisation and delivery was, therefore, not found to be appropriate. Instead of prescribing a 'best' model for service delivery, guiding principles for services are considered more helpful.

Key Guiding Principles for Organising Psychological Services

- Board level representation specifically for the delivery of Psychological Services.
- Services must be aligned with the vision of future service delivery and the key external drivers for organising Psychological Services.
- Need to consider how psychological therapies and approaches are organised and delivered in multi-professional, multi-disciplinary context.
- Leaders or those with a leadership role in service delivery need to be business-minded, politically aware, demonstrate alignment to the organisations strategic objectives and adopt a competency-based approach to informing commissioners.
- Chartered psychologists could facilitate external understanding of the profession and improve their attainment of collective aims by aggregating and working together under the title of 'Applied Psychologists'.
- The overarching approach of applied psychologists is the application of psychology across the whole health and care system.
- Applied psychologists should be deployed and organised in accordance with Healthcare Commission standards (especially core standard C5a, C5b and C5c) so that Trust Boards can be assured that psychological services are safe and clinically and cost effective.

Contribution of Applied Psychologists to service delivery

It is evident from current trends that the demand for psychological therapies and services will continue to rise. The patient-led health and care services of the future will be characterised predominantly by clinical teams and multidisciplinary working.

Applied psychologists are an invaluable resource due to their broad knowledge base and extensive training in psychological theory and practice. They are found across the whole of the health care system; in mental health (across lifespan and all tiers, although less well represented at Board level), Department of Health, learning disabilities, primary care prevention, acute health care, independent and voluntary sector, drug and alcohol services, and public health including health prevention and promotion. Psychologists also work outside of the health care systems such as in businesses and prisons, either directly or indirectly working to improve physical and mental health of the workforce and forensic population. However, the overall number of applied psychologists is low given the demand for psychological services (Sainsbury Centre, 2006; Lavender & Paxton, 2006). There is a need, therefore, to demonstrate their contribution, show it is cost-effective and that it provides value for money when compared to other professions that deliver psychological therapies. Clarity about how applied psychologists fit into future services and contribute to meeting the needs of services users is vital.

Applied psychologists contribute psychological knowledge from a broad theoretical base and extensive range of approaches. This broad knowledge base means that they can offer flexibility and use of integrative approaches to working with individuals and groups. This knowledge relates to the role of psychological factors in the health care process, from ill health to well-being. Psychologists use psychological theory to understand and then identify ways to alleviate psychological and emotional distress. Within this, they assess risk, promote maintenance of health, prevent and manage illness and identify psychological factors contributing to physical illness. They also apply their skills and knowledge to improve the health care system and influence the formulation of health policy, optimising the performance of people at work or in training, including stress reduction and increasing self-efficacy and work satisfaction. Applied psychologists use core skills of psychological assessment, formulation, intervention, and evaluation. These processes can be carried out directly using therapeutic skills and/or through enlisting support of professionals from other perspectives who will deliver the intervention. Their work incorporates a wide range of 'clients'. The focus here can be on direct or indirect work with service users, families' and carers. Within systems, the focus of their work may be with individual teams or staff groups or with the wider system where their psychological knowledge and skills can be applied to understand and influence organisational behaviour and the psychological impact of change on organisations and communities.

As part of the Leadership Project, participants (Directors, General Managers, Service managers, Psychiatrists, Applied Psychologists, and other Professionals) were asked for their views on applied psychologists in terms of both contributions to service delivery and specifically in relation to adoption of leadership roles. In addition to the core skills offered by applied psychologists, in terms of assessment, intervention, supervision, consultation, and research in relation to clinical input, managers are asking applied psychologists to adopt stronger leadership roles. Applied psychologists are seen as important sources of knowledge concerning the 'normal' psychological processes associated with change and transition and how these affects the individual, groups and systems.

Future Challenges

The future landscape of work within health and care services will be much broader, more diverse, and continually changing. The task for all professions will be to adapt to these changes. The delivery of the reform agenda will see continued and expanded use of multidisciplinary team-based working. Teams need to take a lifespan approach, seamless across community and hospital settings and across specialties. Team integration of all professional groups needs to be balanced with sufficient professional and governance support. Strong leadership is required to help staff deliver increasingly sophisticated psychological services in a complex and perpetually changing environment. Three of the major challenges for psychological services will be:

- service organisation and delivery;
- workforce modernisation; and
- leadership.

These issues are interlinked and have implications for the role and function of applied psychologists, and other health professionals involved in the delivery of psychological services.

Service Organisation and Delivery

In the future, there will be a multiplicity of providers and this may lead to an increased desire or need for those currently employed in the public sector to consider employment opportunities in the independent or voluntary sector. As the use of a multi-disciplinary, team-based approach to organising services increases, the need for departmentally organised Psychological Services may reduce. To facilitate the governance of psychological services, promote standardised practice, and allow equal access to appropriate interventions, psychological therapies networks, operating as virtual teams across an organisation could offer a way of organising psychological services in the future.

Leadership and management of such services would not necessarily need to be from an applied psychologist, but those involved will need to demonstrate a high level of understanding about psychological services as well as complex organisational leadership skills. Organisations delivering psychological services need to have individuals at Board level to lead on the strategic development and operation of these services. This will become increasingly important as services are provided in multi-

disciplinary based settings with complex management arrangements and the need to respond creatively to changing contexts. Despite the general decreased need for departmentally organised psychological services, there may continue to be a small niche market need in some areas such as Specialist Psychotherapies and Personality Disorders.

The NHS has stated clearly its wish to welcome new providers. This ambition is echoed in Government policy across all sectors, and the White Paper, *Our health, Our care, Our say*, makes a commitment to support and promote better use of third sector providers. Contestability, social enterprise, breakout groups from the NHS and private providers will present threats to traditional third sector (voluntary and community sector) providers unless they adapt. It may well be advisable for public sector agencies to support, manage and/or fund programmes to foster a healthy third sector in their area, in order to support public services, and to ensure a wide variety of opportunities are available to local populations. Such programmes might include engagement with the development of regional 'hubs' of expertise to support third sector development, and the development of regional and sub-regional Infrastructure Development Plans.

Workforce Modernisation

To support the vision of a patient-led NHS a key area of development is workforce modernisation. This aims to provide innovative, flexible, productive working practices and deliver the changes in practice and culture needed to support the reform agenda. In light of changes and developments in the provision of health care, there has been a need to clarify the roles of applied psychologists. This task has been undertaken by the NWWAP Career Pathways project group and is detailed in the two documents produced by the group, *Career Pathways & Roles for Applied Psychologists*, and the new *Guidance for National Assessors*.

Applied psychologists are a scarce resource and their skills need to be targeted to where they will be used most efficiently. It is essential that applied psychologists actively and innovatively contribute to the development of services. Part of this will inevitably involve considering which aspects of their current role could be carried out by others with less training.

Investment has been made in new contracts for almost all NHS staff to support greater flexibility and the need to move away from traditional occupational roles towards defined competencies. *The Ten Essential Shared Capabilities: A Framework for the Whole Mental Health Workforce* (ESC), published in 2004, sets out the minimum requirements or capabilities that all staff working in mental health services across all sectors should possess (DoH, 2004d).

Supporting this, National Occupational Standards (NOS) set out the key roles for the delivery of mental health services; the standards to be achieved by way of performance criteria; and the knowledge and understanding required to deliver the key roles. They provide specific evidence in support of Knowledge and Skills Framework (KSF) skills escalator. The KSF (DoH, 2004c) is designed to help in the development and review of staff employed in the NHS and provides the basis of pay progression. For staff undertaking training, their focus should be on the ESC.

Linked to this, is the concept of capable teams and skills mix. Workforce planning will only be partly based on traditional methods of numbers per head of population. Managers and commissioners will look at the skill mix needed to deliver the service. This will be done in terms of competencies and costing to determine what mix of health professionals and bandings are best able to meet the needs of service users. If applied psychologists fail to clarify their role and articulate to managers and commissioners of services what they are getting for their money, in a way that is understandable and demonstrates positive outcomes, there is a risk that they will be viewed at best, a luxury and at worst as an expensive alternative.

New and innovative ways of working are essential because services are changing. Future service delivery will be through predominantly multi-disciplinary and multi-professional teams, which need to provide a clear pathway for the service user and carer. The demand for services and insufficient supply of professionally qualified staff mean that traditional practice must be reviewed to ensure that the best use is being made of highly trained professionals. It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered.

Leadership

Effective leadership at all levels across all agencies is crucial to facilitating the engagement of both staff and organisations in modernising health services. Systems of education, training, pay, workforce planning, and regulation are coming on line to support staff in the process of modernisation and reform.

The New Ways of Working for Psychiatrists report advocated a stronger clinical leadership role for applied psychologists. This stance is supported by interviews with psychiatrists, team co-ordinators, middle, and senior management who participated in the Leadership Project conducted in the development of this document. The invitation is clear. How the profession responds will in part determine the future role of applied psychologists in the public sector, but more importantly, it will have significant consequences to the way that psychological services are designed and delivered. This is the responsibility of all applied psychologists. The challenge is to ensure that applied psychologists have the qualities and skills to take up leadership roles in ways that inspire the trust and confidence of multi-professional staff groups.

In the DH 2004 document (DoH, 2004b), good leadership was described as '*essential to the delivery of effective psychological therapy*'. It also stated, '*psychological therapy services also need clear management*.' This was advocated to meet

'individual practitioners' needs for support, supervision, and training, can be balanced with service needs for more effective partnerships between providers, including CMHTs, acute wards, early intervention services, ethnic minority services, services for people with learning disabilities, for older adults, and others' (DoH, 2004b).

The importance of effective leadership is recognised as critical to the success of service development. In *Creating a Patient-led NHS – Delivering the NHS Improvement Plan (2005)* the Government stated that in addition to the system changes announced as part of the reform agenda, a change in culture was also needed if service provision was to become truly patient-led (DoH, 2005b).

Executive Level Leadership

The position of a Director of Psychological Therapies Services, at Board or Executive level in an organisation is vital to improving access and availability of psychological therapies and services (DoH, 2004b). The Project Group support the recommendation of specific representation at Board level for the delivery of Psychological Services. The role could include:

- A strategic and operational overview of the delivery of psychological therapies/services in the Trust, ensuring that only well-established treatment modalities based on sound clinical and research evidence are deployed.
- A strategic and operational overview of systems and processes to improve the psychological skills of the workforce, ensuring that practitioners have had accredited training, recognised by professional bodies with appropriate standards.
- Ensuring that psychotherapy practitioners have in place a system of regular supervision of their clinical work.
- Strategic development of systems and processes designed to improve the psychological health of the workforce.
- Leading and advising on organisational development initiatives within the Trust.
- Leadership development of others – including succession planning, mentoring and peer supervision/support.
- Ensure full integration with the Care Programme approach, where appropriate to ensure close collaboration with other staff and services for people with severe mental illness.

Commissioners need to have an overall picture of the place of psychological therapies in mental health work. Leaders of Psychological Services need to be able to set out clearly and convincingly the arguments for investing in staff and physical resources in psychological therapies. This will help commissioners to place psychological therapies at the forefront of treatments offered to service users.

Functionally driven services, which are socially inclusive, and accessible across the lifespan will form the basis of user-led services in the rapidly changing environment of the future. There will be competition for resources from the voluntary and independent sectors for the most efficient, effective, service provider. Current services cannot assume that their services will be purchased and leaders will need to become more business minded and skilled in their approach.

Leaders of psychological services will need to have accurate up-to-date information regarding local service provision and the gaps in provision, across all sectors. Mapping of psychological service provision will assist with this and the commissioning process. The need for business and marketing skills will also become increasingly important for all service providers as competition for resources increases. Currently, the voluntary and independent sectors may be better placed in this respect due to their history of being entrepreneurial.

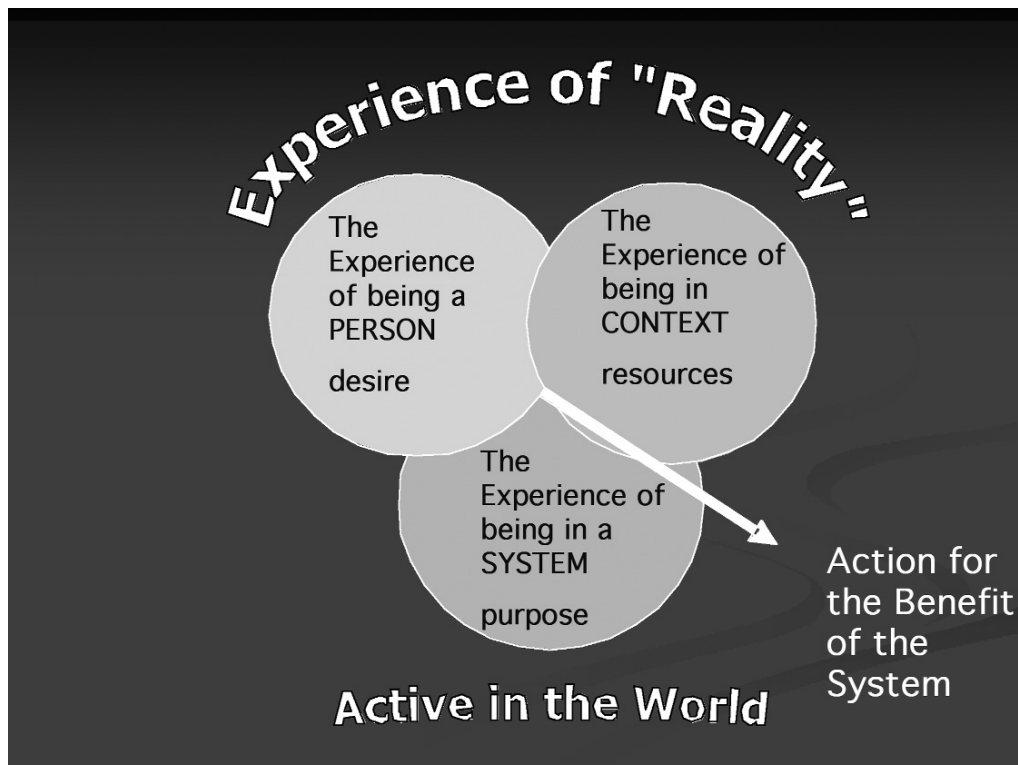
The need for effective leadership is not restricted to the top-level leaders of psychological services. The need for senior level applied psychologists, who can think and operate psychologically at a strategic level and are able to apply this across new larger mental health trusts will increase. Currently, there is a lack of potential candidates coming through the profession and there is no framework and limited awareness of the need for succession planning and developing the leadership skills of others. There will be increased expectation that applied psychologists who are the equivalent to Advanced level practitioners (AFC Bands 7, 8a and b) and consultant AFC 8c and d and 9) in the Department of Health's new Career Framework (DoH, 2005e) will adopt greater leadership roles in delivering psychological therapies. This is earlier than is currently assumed in the applied psychologists' career path. This will have a cascading effect for applied psychologists, with greater leadership skills development needed across all grades from doctorate training to consultant levels. The reform agenda will lead to an increase in demand for psychological services through improved access, the choice agenda, and workforce modernisation. In Appendix C and D, some of the current challenges facing applied psychologists, managers, commissioners, and all staff that provide psychological services are presented. The external landscape is constantly evolving, and will continue to do so; the challenges presented in the appendices are, therefore, time-limited and reflect the situation at this time.

Leadership and the Delivery of Psychological Services

In this section, the characteristics of the person as leader and the skills they need to be effective in leading the delivery of psychological services are considered. Each leader of or within an applied psychological service, brings personal characteristics and experience to bear on the task. An Applied Psychologist consciously brings together an understanding of themselves, and their impact on relationships in order to carry out the interpersonal and systemic psychological leadership task. Personal experience in life, and the experience developed from within the profession provide context and the sense of how available resources are distributed according to rules (not always fairly), to link their conscious and unconscious experience of the wider system, its purpose, and what can be done to make a difference (see Figure 1).

Applied Psychology is a relatively new profession. Historically, it has struggled to get recognition for its contribution to health care. A new era has begun, in which the evidence for psychological understanding and the contribution of applied psychologists is available and being rapidly accepted. The leadership task has, therefore, changed dramatically from campaigning to implementation. Existing leaders will need to reflect on the way the change should affect their style and objectives as leaders. In addition, junior members of the profession will need to develop and exercise certain forms of leadership much earlier in their careers, both clinically and as senior members of multi-disciplinary health care teams. At the same time, there will be competition from members of other professions, such as Psychotherapy and Nursing, for the Leadership of Psychological Therapy services. Applied psychologists with broad doctoral level academic and practice-based training will be strong contenders for these roles. The successful candidates will need to demonstrate a commitment to valuing workforce diversity in a multi-disciplinary psychological therapies future. They will need to be able to sustain the workforce through a major programme of changing practice and skill mix. A commitment to think widely about evidence and embrace person centred care is essential. Leaders who are willing to pursue clinical governance and safe and effective practice using different models and new ways of working will be the key to the future of the profession. Professional protectionism, which might dictate a more conservative approach, needs to be avoided.

Figure 1: Leadership: Making a Difference: The Person, Context and System.



Leadership: A note on terms

Leadership involves the ability to guide, direct, or influence others in order to achieve a goal or set of goals. All interpersonal relationships involve efforts to lead or influence. How influence is used to achieve goals is, however, a complex and multifaceted process. The ability to influence others has been looked at from different perspectives, including 'leadership', 'management', 'authority', and 'power'. It can be complicated further because the premises or assumptions underlying attempts to influence remain implicit and often deliberately concealed. This can lead to the use of negative influence terms such as 'manipulation' or 'coercion'. In 1988, Edgar Schein offered clear and simple definitions of these the key terms and concepts. These are provided in Appendix D .

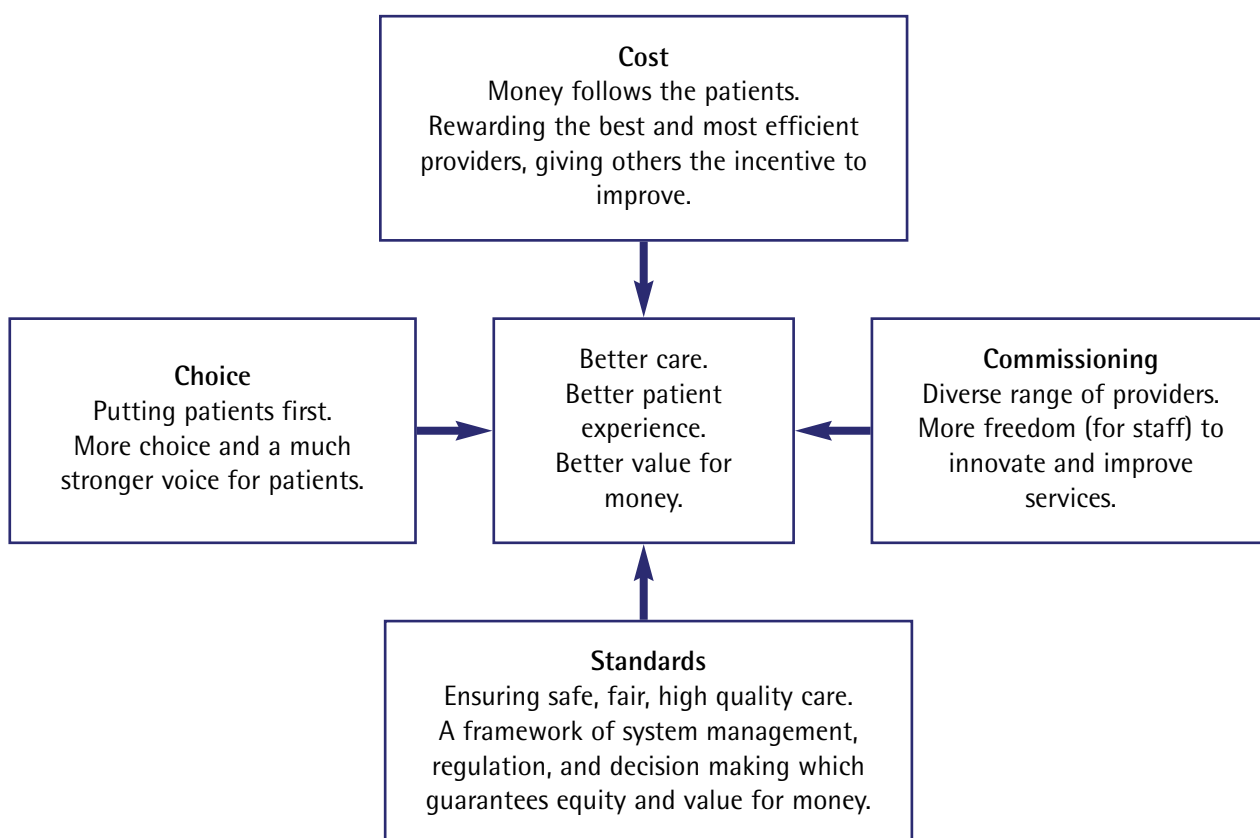
Over the past 10 years, there has been increased investment in the NHS as a whole. This has included unprecedented investment in mental health services, resulting in reported improvements for patients, such as faster access to treatment and better care (Mental Health Strategies, 2005; SCMh (Sainsbury Centre for Mental Health), 2003). According to the Government the increased investment was needed to rectify years of under funding. The ensuing reform agenda and modernisation programme has meant radical reorganisation of services, practice, and workforce. The aim of the reform and modernisation process is to improve the health and well-being of the nation. After six years of the 10-year programme some indicators show this has been achieved. However, patient satisfaction in terms of the quality of service received has fallen (DoH, 2006a; Healthcare Commission, 2004). Further changes, will need to be made to improve patient satisfaction and to align service delivery with the future vision of a patient-led NHS.

The programme of reform started with the *NHS Plan* (DoH, 2000a) and the *Wanless Report* (Wanless, 2002). These identified the need for investment and reform of the NHS if the core aim of the organisation is to be met: the provision of high quality care for every patient, according to their individual need, not their ability to pay. These two reports also highlighted the importance of value for money and the need to make best use of taxpayers' money, which funds the service. Following the *NHS Plan*, there were annual increases in investment in mental health. This increased funding is unlikely to continue past the Government's comprehensive spending review due for publication in 2007. The period of continual increasing investment will end and the emphasis will be predominantly on the reform of services.

People Who Commission Psychological Services

The organising framework for health reform initially described in the *NHS Plan* (DoH, 2000a) was laid out again in *Health Reform in England: update and next steps* (DoH, 2005d). The framework is a set of supporting reforms, intended to provide systems and incentives, which drive improvements in health and health services, increased responsiveness to patients, and reduce inequalities in health. The reform agenda is made up of four strands (see Figure 2 below) that are dynamically related and interdependent. This means that if one area of reform fails, the whole agenda will fail. A brief description of the four strands is located in Appendix E.

Figure 2: Organising Framework for Health Reform (DoH, 2005c).



The Government's current vision for future health and care provision emphasises well-being and recovery, social inclusion, independence, equality and diversity, choice, and working in partnership (between services and service users/carers).

The integrated community health and social care White Paper, *Our health, Our care, Our say* (DoH, 2006a) covers all aspects of care that people need in the community. This document was produced following extensive public consultations, carried out by the government to find out people want from health and social care services. They found that the public want:

- More choice about services.
- More care available outside hospital and closer to home.
- To take personal responsibility for their own well-being and to be supported in caring for themselves.
- Better care for those with long-term conditions.

All NHS Trusts are likely to eventually achieve Foundation Trust status under which they will have distinct governance arrangements to make them more accountable to local people and increased financial freedoms to invest in new services. The freedom and flexibilities proposed to accompany Foundation Trust status aim to give front-line health care professionals and local managers' incentives to improve services and innovate in response to the needs of their patients and local populations. It will also provide people who use services with the opportunity to become members of the Foundation Trust providing their services and some may decide to use the option to become Governors to lobby for improved access to psychological services.

A further consideration for commissioning will be the future role of local government and other central commissioning agencies, and the potential organisational mechanisms of Children's Trusts, Older People's Trusts. Health and social care organisations could lead or work together, as a consortium, developing strategies to commission services on a functional (i.e. adult, older adult, children, etc.) rather than organisational basis.

There will also be a greater emphasis on well-being rather than illness, which will lead to a growth in preventative interventions and health promotion. Social inclusion, equality, and diversity will also receive increased attention and will need to be incorporated into future strategies to improve the health and well-being of the population. Following the publication of *Delivering Race Equality in Mental Health Care* (DoH, 2005c), the Government committed to reduce the disproportionate rates of hospital admissions and compulsory detentions of people from Black and Ethnic Minority backgrounds by 2010.

People Providing Training in Psychological Therapies

As part of their contribution to future service delivery, applied psychologists are being invited to adopt greater clinical and strategic leadership roles. This is with the aim of improving service delivery and the experience of service users and carers, and as a way to make best use of this scarce resource (DoH, 2005a; Layard, 2005).

The NHS Leadership Centre (2005) published a summary of a literature review, which had investigated the evidence relating to the contribution that leadership development for professional groups makes in driving organisations forward. They concluded that there is considerable evidence that leadership development does contribute to enabling professional groups to drive their organisations forward (NHS Leadership Centre, 2005b). All organisations and the professional groups within them are subject to broad external pressures, social, economic, technological, and political. It is this wider environment that stimulates the necessity for change. With this in mind, leaders are needed who can respond to the challenge of change. Leadership development can be effective in helping them to understand and manage change and to lead their organisations forward. The review acknowledged that different professions may have different needs, but the overall need to be able to manage and promote change is cross professional. They found that development needs to be located in the professional and work-based context for it to be effective.

The New Ways of Working for Applied Psychologists (NWWAP) Group found that issues relating to leadership and leadership development were repeating themes in the discussions of all project groups. In relation to leadership development, the major challenges identified within the NWWAP project group were:

- Succession planning – A lack of suitable applicants for the most senior posts nationally in Psychological Services.
- Current capacity – Recognition that there are applied psychologists already demonstrating effective leadership behaviours which need to be utilised.
- Strengthening leadership skills of all applied psychologists – Consideration of the need, viability, and appropriateness of focusing on this aspect of professional practise.
- Leadership development needs – Identification of development needs across all grades of applied psychologists.

These challenges were investigated as part of the leadership project. Participants shared their perceptions of applied psychologists in leadership roles, and factors, which enable and inhibit effective leadership and leadership development.

Leadership Development in the Third Sector

The UK Workforce Hub has created the Third Sector Leadership Development Centre to raise the profile of leadership and leadership development across the sector. Based on the responses of a stratified, randomly-selected telephone survey of 1000 UK voluntary organisations, *Future skills* (2003) identified a number of key trends and issues for discussion. The most significant shortages in general skills that were identified included problem solving, customer handling and team working. Voluntary organisations' priority for skills needs for the future include, management skills such as planning and organising, project management and strategic planning. Other skills in high demand include team working and partnership working skills, leadership, and fundraising skills. The contents of this document and the leadership development framework presented above may also be of interest to those working in this sector. For the purposes of this document, the framework is focused on the development of leadership skills for applied psychologists but it may also be applicable to third sector organisations.

Approaches to Leadership Development

Leadership development approaches are influenced by the model (explicit or implicit) of leadership, which underlies the development framework. Unless there is a clear, agreed, shared understanding on the concept of leadership and an agreed framework, then leadership practices may be inappropriate for

the kind of leaders which the organisation or service needs (e.g. developing transactional leaders when transformational leaders are needed).

Significant leadership models being used in leadership development currently include the transformational leadership model and the charismatic model. The findings of the process used in developing the current document suggest that leadership development needs of applied psychologists are not encapsulated within one leadership model. This indicates that leadership development approaches, which are based on a single model, are unlikely to meet the leadership skills gap for delivering psychological services.

An important distinction is whether the need is to develop leaders or leadership. If the focus becomes solely on the individual person as leader this tends to be restricted to the skills, personality, style of engagement and behaviours of individual leaders. Clearly, individuals have a role in shaping events and circumstances at certain times. The disadvantage with this is that it assumes the capacity and power to influence lies in the individual. It ignores the influence of 'followers' and the impact of organisational and community constraints. It places too much emphasis on personal development at the expense of leadership development as a collective capacity. The findings of the Leadership Project suggest that effective leadership by individuals was heavily influenced by the interaction between the individual and the context, which indicates the need for situational leadership development. In terms of designing a framework for leading psychological services, leader and leadership development based on a range of underlying approaches are needed. Effective leadership will depend on the practitioner's ability to apply assessment and formulation skills to the leadership aspect of their role.

Some approaches to leadership development are aimed at leadership associated with the formal position of an individual within an organisation. For example, the NHS Leadership Qualities Framework is aimed at chief executives, medical directors, nurse managers. The leadership role of applied psychologists is not always connected to their position in a particular office or role and it can be formal or informal in how it is defined. Effective formal and informal leadership may be achieved using different processes – for example, informal leaders may work through influence rather than authority or direct control. The leadership development needs of applied psychologists are diverse and attention to all these aspects of leadership development. Applied psychologists need to be aware of their own leadership characteristics, how these are affected by other factors, such as the requirements of their position, and the formal or informal nature of their role.

In addition to the above, leadership development for applied psychologists needs to cover leadership as a set processes or dynamics occurring among and between individuals, groups and organisations. This set of processes or dynamics is concerned with motivating and influencing people, and shaping and achieving outcomes. As in the earlier example, the underlying leadership model will determine the focus of the approach (i.e. transformational, transactional).

Evaluation of Leadership Development

In the NHS Leadership Centre (2004), the evaluation of leadership development is reported to have subjective and objective elements (NHS Leadership Centre, 2004). The objective elements may come from organisational performance measures, while the subjective type comes from the perceptions and mental models that individuals and groups hold about leadership and leadership development. Measuring pre- and post-change can be a valuable approach in terms of objective measures but the change process itself may cause alterations to fundamental perceptions. This suggests that subjective assessment of leadership development using 360° feedback and objective assessment through performance indicators and organisational outcomes are needed. The review also found that there are 'illusions' in leadership that can make evaluating outcomes a challenge. The contribution of leaders is often exaggerated. A characteristic of good leadership is that the leader will always fail the expectations of their followers, at some point. This discourages dependency patterns but also but also indicates the need for qualitative measures of leadership as well as quantitative.

Enablers of Leadership Development

The gender stratification of the profession and preference or need to work part-time has historically excluded some applied psychologists from adopting leadership roles (DCP Membership Survey, 2005). However, where equal opportunities and joint leadership roles have been developed, post holders report the benefits of this arrangement, i.e. mutual support regarding the emotional implications of being in a leadership role, not as isolated as being a single post holder.

Respondents highlighted the following were ways by which they had developed leadership skills or factors that helped develop the leadership skills of others. Mentoring was the major process highlighted as a useful during participants own development and in the development of others leadership skills. Mentoring, role modelling, teaching and learning were all reported as critical for developing leadership skills, developing into a leadership role, and in managing the personal impact and emotional consequences of leadership. To facilitate leadership development, access to resources was viewed as essential, i.e. a mentor, training, and funding. Some local Trust leadership courses were seen as particularly helpful for learning the practical side of leadership and increasing knowledge of important management skills. However, it was acknowledged that a mix of formal and informal processes was the most beneficial means of development.

Outside of the processes described above, participants also reported that if leadership skills are part of career development it was important that this be supported by others, i.e. peers, team members, line manager, and the wider system. Having the time to take on tasks related to development of leadership skills and any training this entails was a common theme. Most applied psychologists that took part in the project, and who had successfully developed this aspect of their role had done so in addition to their usual roles and responsibilities.

Inhibitors of Leadership Development

It must be acknowledged that in some settings and contexts applied psychologists have not felt entitled or empowered to develop this aspect of role. There are managers and peers from other professions that would still prefer applied psychologists to spend their time solely seeing patients, delivering direct clinical contact. In addition to this, the individual practitioner's reasons for joining the profession and the perception of what it means to be a 'leader' or in a leadership role were cited by some of the participants as reasons for being less keen to develop this area of their practise. The preference for some is to work as a therapist providing one-to-one or small group therapy.

It was highlighted by those in leadership roles and by those being led that the leader may not have been chosen by those being led. It was possible that the preferred leader may be amongst those being led and that this had important implications. The different parties, stakeholders, objectives, interests, demands of those being led, and the person the leader is responsible to, could also make leadership and leadership development difficult.

Leadership Development Framework

For applied psychologists, there is currently no framework for leadership development at any stage of the career path outside of that provided by the NHS. The leadership development programme provided by the NHS was reported by participants in the leadership project to be useful in learning the practical aspects and logistics of leadership. However, the complexity of leading psychological services and the emotional impact of working psychologically in a leadership role are not being consistently met. Historically, there has also been systemic stripping of power, and limited opportunities for applied psychologists to adopt leadership roles, but now managers are increasingly requesting this type of input and role from applied psychologists. The leadership roles and development needs for applied psychologists can be categorised into the following domains:

■ **Tripartite Leadership Role**

- Strategic Leadership
- Professional Leadership
- Clinical Leadership

■ **Leadership – Development Needs**

- Pre-Doctorate level requirements
- Leadership skills required to work in multi-disciplinary teams
- Career-grade leadership skills
- Executive/Director level requirements

This document has so far considered the need, viability, and appropriateness of strengthening the leadership skills of applied psychologists. The leadership development framework, presented in Table 1, is intended to help identify the leadership development needs of applied psychologists, support the subsequent development of leadership skills for all grades of applied psychologist, and offer a structure to assist those preparing for professional, strategic or executive level positions as leaders. It is also offered as a way of making better use of a scarce resource through the strengthening of leadership skills and provides a process for meeting the need for improved succession planning. The framework may also be applicable to other professional groups who delivery psychological therapies, or as a general leadership development framework.

Table 1: Leadership Development Framework.

Leadership Development Tasks	
Executive Band 8(d)–9	<ul style="list-style-type: none"> ● Leadership development of others ● Mentoring – including peer mentoring and mentoring to others ● Succession planning ● Policy Leadership ● Strategic Planning
Consultant Band 8(c)–(d)	<ul style="list-style-type: none"> ● Mentoring – including peer mentoring and mentoring to others ● Differentiation into tripartite role – clinical, professional, managerial ● Application of skills, lead for psychology at organisational level ● Support leadership role and function of executive leadership ● Identification of leadership skills and needs at speciality/service level ● Leadership development, with attention being given to potential successors from 8(a)–(b) banded staff, supporting equal opportunities ● Setting future direction for specialty/niche market/professional subgroup/team ● Policy Leadership
Principal Band 8(a)–(b)	<ul style="list-style-type: none"> ● Mentoring – including peer mentoring and mentoring to others ● Identification of leadership skills in others (individuals) ● Support leadership development of others ● Align learning experience to future leadership needs ● Leadership consultation across one or more settings
Clinical Psychologist Band 7	<ul style="list-style-type: none"> ● Mentoring – including peer mentoring and mentoring to others ● Consolidate skills ● Broaden repertoire and extend application of leadership skills ● Future career planning ● Wider range of practical experience (across settings) ● Role model to others ● Longer term projects ● Proactive identification of opportunities
Pre-Qualification Band 6	<ul style="list-style-type: none"> ● Personal leadership profile ● Increase awareness of impact on others and system ● Develop strengths and strengthen areas of need ● Scenario discussions with mentor ● Experiential learning on placement ● Feedback from multiple perspectives ● Develop political and organisational awareness ● Knowledge of other professional groups
Selection Stage	Selection criteria to include section on leadership potential

Recommendations

The recommendations from the Project Group are intended to ensure that high quality psychological therapies and services are made more readily available to users and carers. To this end, they have been made in the form of recommendations to the major parties involved in the commissioning and delivery of psychological services, those concerned with commissioning and delivering the training of applied psychologists and people who use services.

People Organising and Leading Psychological Services

- There is a need to ensure there is Board level strategic and systemic clinical leadership for psychological services.
- Leaders of psychological services should ensure that service users and carers are involved in the design, delivery and evaluation of services.
- There is a need to ensure succession-planning and mentoring processes are in place to develop future key leaders.
- In all continuing professional development of applied psychologists, the development of leadership qualities and competencies should be addressed.

People Commissioning Psychological Services

- There is a need to ensure that there is a high level of understanding about psychological therapies/services in those involved in commissioning such services.
- There is a need to ensure that commissioned psychological services are well led and that governance arrangements are in place to ensure staff providing psychological services are appropriately trained, supervised and regulated.
- Service commissioning should be based on an assessment of the psychological health needs of the population including physical health.
- Service users and carers should be involved in the commissioning as well as design, delivery and evaluation of psychological services.

People Providing Training in Psychological Therapies

- There is a need for pre-qualification programmes to select people with leadership potential as part of the programme.
- Pre-qualification Doctoral programmes should include the development of leadership and team-working competencies.
- Multi-professional leadership development programmes that incorporate action learning sets, mentorship arrangements, exposure to innovative leaders, as well as theoretical inputs, should be developed and commissioned.

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Appendix A – Leadership Project

When considering issues relating to leadership and leadership development, the concept of leadership and the chosen definition need to be clarified. For any discussion to be meaningful the parties involved need to have a shared understanding of the meaning of leadership in the given context. Key questions to assist clarification are:

- **Leadership of whom or what?**
- **Leadership to where and why?**

There also needs to be clarity regarding the similarities and differences between leadership and management. These concepts are distinct but complimentary processes that overlap in practical terms although each has its own unique characteristics.

When considering leadership and leadership development it can also be useful to differentiate between the formal position of leader, individual characteristics of the person, and leadership as a set of processes. Leadership in relation to the formal position of leader emphasises the role of designated leaders within an organisation. When considering characteristics of the person associated with leadership this focuses on the skills, personality, and leadership style of the individual. Leadership as a set of processes relates to dynamics that operate between individuals, groups, and organisations. Common to all three is the idea that leadership is concerned with motivating and influencing people with the aim of shaping events (Hartley & Hinksman, 2003).

There are many ways to define leadership. In the Modernisation Agency's series of *Improvement Leader's Guides* (NHS Modernisation Agency, 2005), leadership is described as being about:

- Challenging the process, inspiring a shared vision, enabling others to act and modelling the way (Clark, 1997).
- Transforming followers into leaders themselves (Gill, 2002).
- Creating an environment that supports individual team members in being maximally effective in achieving those outcomes that are valued by users and their supporters (Onyett, 2002).

The concept of leadership has been the topic of much debate, the literature on this topic spans over 100 years of research. The literature emphasises 'leadership style' and what constitutes a good leader. There have been many different proposals made, each with an associated agenda of how organisations should be led. This has been based on the assumption that leader behaviour can be described as either task-oriented or people-oriented, or as either authoritarian or democratic and that the effective leader is a democratic one, but one who is able to deploy either a task- or people-oriented style to suit the occasion (Millward & Bryan, 2005). This is the basic proposition of the contingency theory of leadership – see (Northouse, 2001) for a review – which has stimulated decades of research on when one or other style is effective. This has led to a list of 'conditions' under which one or other style is advocated as most appropriate. Few have tried to explain why this might be the case, or more importantly, how effective leadership is possible (Millward & Bryan, 2005).

Leadership is associated with, although not exclusively, an individual's position within the organisation. However, it is fundamental to the concept of leadership that anyone, at any level, can in principle, be a leader without necessarily being formally accredited with this role (Faugier & Woolnough, 2002). It is often the 'best person' for the task that takes on the leadership role within a multi-disciplinary/multi-professional team. At this point, it is important to highlight that although the focus tends to be upon the 'leader' rather than those who follow; the phenomenon may not be simply a result of the leader influencing and encouraging others to follow. Rather, it is the result of the dynamic between leader and followers (Goffee & Jones, 2006).

Clinical Leadership

The importance of front-line, 'clinical leadership' has been highlighted as critically important for developing integrated team work, which is reflective and actively manages team processes to improve effectiveness (Millward & Bryan, 2005). This acknowledges the need for leadership to be meaningful locally and clinically responsive. Therefore, Clinical Leadership is defined as '*facilitating evidenced-based practice and improved patient outcomes through local care*' (Millward & Bryan, 2005).

The idea of clinical leadership has been misunderstood by some as meaning this will lead to a situation of having 'too many chiefs' (Russell, 2001), which will then negatively impact on inter-professional working and the delivery of services (Curtess, 2001). These fears appear to be based on a restricted definition of leadership. One that is synonymous only with the formal position of leader, this is not clinical leadership, which is about effective delivery of health care at the front-line.

Recent leadership research has been dominated by the concept of transformational leadership introduced by (Bass & Avolio, 1993). The 'transformational' leader concept emphasises the importance of interpersonal and influencing skills (Clegg, 2000). By doing so, it starts to tackle the question of what makes effective leadership possible. An effective leader is able to motivate, inspire, stimulate, and facilitate others, irrespective of the circumstances – although clearly, the circumstances need to be taken into consideration (Kouzes & Posner, 1997). This proposes that personal skill is more important than formal status and rank. Evidence is beginning to accumulate that suggests transformational leadership skills are superior in fostering improved performance across a range of work settings, business and service alike (Northouse, 2001), and in health care in particular (Clegg, 2000; Outhwaite, 2003)

One leadership theory that has been attracting support is authentic leadership. This approach partly reflects a reaction to the now unpopular heroic leadership and trait theory approaches. Advocates of authentic leadership argue that the most effective leaders operate by making the most of the qualities they already possess. They utilise their strengths and understand their weaknesses. Authentic leadership involves introspection and heightened self-awareness. To be effective these qualities must be valid, perceived by others, and significant. According to this approach, leadership is not about adopting the style or traits of other successful leaders (Nicholson, 2005). Leaders who adopt 'false' personas that are not true to their own values and beliefs can be damaging to their organisations.

NHS Leadership Qualities Framework

The key characteristics, attitudes, and behaviours expected of leaders in the NHS, now and in the future, have been described in the NHS leadership qualities framework. It presents 15 qualities, arranged around three clusters: personal qualities, setting direction and delivering the service. This framework can be used to review general leadership abilities on individual basis, with a team, or colleagues to establish leadership capability and capacity. It can also be used as a focus for personal development, board development, leadership development, leadership profiling for recruitment and selection, career mapping and succession planning. The framework can be found in full at www.nhsleadershipqualities.co.uk. The personal qualities are presented in Table 2.

Table 2: NHS Personal Leadership Qualities.

Personal Qualities	Setting Direction	Delivering the Service
Self-belief	Seizing the future	Holding to account
Self-awareness	Intellectual flexibility	Empowering others
Self-management	Political astuteness	Collaborative working
Drive for improvement	Drive for results	Broad scanning
Personal integrity	Leading change through people	Effective and strategic influencing

However, when focussing specifically on the delivery of psychological services, effective leadership requires more than this. The combination of factors and processes that result in effective leadership (or at least the perception of it) is context bound, transient, dynamic, and often complex. It requires the ability to draw on a range of psychological theories and styles to assess and formulate the situation and then act accordingly. What makes this possible is the ability to apply analytical skills to critically appraise the situation on several levels, in both technical (e.g. immediate clinical imperatives and requirements) and people terms (e.g. harnessing appropriate and co-ordinated action as necessary to a high standard). In this way, effective leadership is 'knowing how to use the right styles in each situation' (Moiden, 2002).

It has been proposed that this requires the ability to 'see' (or anticipate or predict) what is required (using evidence, theory and informed judgement) and to act accordingly (selecting from a wide repertoire of well-developed interpersonal as well as clinical skills). By building trust within a team, the effective leader acquires the licence to be 'tough' when required, because of a belief in his or her credibility and influence, but will also empower others to take clinical responsibility within a framework of coordinated action, mutual respect, guidance and support (Millward & Bryan, 2005).

Leaders need to help others to see the big picture with the underlying trends, forces, and potential surprises. They need to think systemically and be able to foresee how internal and external factors might benefit or destroy the organisation. Patience and persistence is needed to decipher and analyse large amounts of complicated and sometimes contradictory information. Marquardt (2000) identified key elements to this way of thinking including:

- Focussing on underlying causes rather than symptomatic solutions.
- Distinguishing between complex details (i.e. many variables) and dynamic complexity (when cause and effect are distant in time and space, and the consequences over time are subtle).
- Seeing processes and interrelationships.

Leadership Clarity and Team Innovation

Recent research published by the NHS Leadership Centre (2005) investigated the contribution of leadership to promoting team innovation in multi-disciplinary health care teams. The authors of the research argue that innovation, new treatment methods, and patient services can mean the difference between life and death. They can also mean that patients recover from illness or have a better quality of life. The results revealed that leadership clarity (including in this conflict over leadership) predicts team innovation, because leadership is needed to ensure that a team is able to persist in applying an idea for a new service or way of working over time. The effects of clear leadership occur at least partly because of the influence of leaders on team processes. Lack of clarity or conflict over leadership leaves team members uncertain about the direction in which they should be targeting their efforts (which in turn undermines innovation attempts) and less likely to participate effectively in team decision-making or working. Lack of clarity or conflict over leadership is also likely to produce different interpretations among team members regarding the meaning of excellence of service and appropriate innovation. Clear leadership and supportive team processes are vital for sustained and effective innovation. In the area of health care in particular, such insight is important (NHS Leadership Centre, 2005a).

In addition, the tendency to focus on style of leadership may be premature. There is a strong case to be made for exploring leadership clarity and conflict first. These factors may well be more important in understanding team innovation than issues of style, not least because team tasks and contexts vary considerably and this may require concomitant variation in styles (NHS Leadership Centre, 2005a). This supports the proposition that the appropriate style may be contingent on team context. Clarity of leadership and conflict over leadership are almost certainly not. The research carried out by the NHS Leadership Centre (2005) implies that those responsible for developing team-based organisations should focus on developing clarity of leadership and avoiding conflict over leadership, especially in newly formed teams. Often, the focus is on developing teams via teambuilding rather than on settling leadership issues.

Leadership Project – Background and Findings

It can be useful to consider the combination of individual characteristics and processes that are effective within a specific context by looking at it from the perspective of leadership styles and models. This and the propositions made above are supported by the findings of the Leadership Project, conducted on behalf of the NWWAP Project Group for Organising, Leading, and Managing Psychological Services. Participants in this project provided details of what they felt is involved in the effective leadership of psychological services. From the responses provided by participants it was evident that transformational, transactional, servant, adaptive and situational leadership styles are all effective in this context (a brief description of each is located in Appendix F). The themes that came out of the interviews are presented under the following subheadings:

- **The person as leader.**
- **Leadership skills.**

In relation to the delivery of psychological services, the responses of participants in the Leadership Project (Coak, 2006) supported the propositions that it is important to clarify what leadership means and that leadership is a multi-faceted concept not solely related to senior level leadership positions. The responses of participants indicated that leadership could be in terms of psychological thinking, psychological therapies, strategic direction, and the application of psychology to service user experience. In addition, it can relate to the leadership of one's own professional group, cross-professional leadership as a representative of the psychological perspective, or multi-professional leadership generally.

Furthermore, some participants reported that in a team the leadership role is not always made explicit and does not have to be, to be effective. It can be subtle, transitory, and depending on the context and skilful application, it can be more effective this way. This may be in part due to a reduction in the tension and anxieties on the part of both the psychologist and other team members about the meaning associated with taking a leadership role and the application of psychology to influence others. This area is again dependent on the surrounding context as others reported difficulties when there was a lack of clarity regarding the leadership role or position of an individual.

Leadership in relation to psychological services was also found to include encouraging and supporting psychological thinking within staff groups and teams, and applying psychological knowledge and skills to improve one's own leadership skills and support others in their leadership role or position. This involved developing an awareness of one's own preferred leadership style and adapting this after considering what skills to apply and when according to the context. The individual characteristics of leaders and the leadership processes offered by participants suggest effective leadership of psychological services cannot be reduced to a single model or approach. Furthermore, participants did not feel that all leaders or those with leadership roles would possess the same leadership profile.

The person as leader

In recent times, research has moved away from focussing upon the individual characteristics of the leader when attempting to understand leadership. Nonetheless, a consistent theme in the responses of participants during the Leadership Project indicated that individual characteristics are at least perceived to be important by both leaders and those who follow. In Table 3 the qualities of the individual, which were associated with effective leadership in psychological services are presented. This list is consistent with those presented earlier in Table 1.

Table 3: Personality Characteristics and Style.

Self-aware	Energetic	Consistent	Balanced
Personable	Approachable	Integrity	Credible
Creative	Focussed	Reflexive	Inspiring
Enthusiastic	Confident	Considerate	Realistic
Reflective	Flexible	Genuine	Honest

Leadership skills

Alongside individual characteristics, participants reported examples of the range of skills they felt were associated with effective leadership. Participants viewed political awareness, strategic thinking, and business alignment with the organisational values as being paramount. This was linked with an ability to translate organisational values into the professional language and then match these to the personal values of those being led. Fundamental to this is having an awareness of one's own value base and how this impacts upon oneself, others, and the surrounding system. In addition, some participants had found that it was important to have an awareness of the relationship between personal standpoint, aims/goals, and those of the organisation, and an ability to tolerate incongruence in these. The interplay between personality and beliefs can be important and participants reported that the person's values and beliefs support other leadership qualities and can provide a personal source of strength.

An ability to set-up and use sophisticated networks, connecting with influential people to keep informed, was viewed as an essential skill, as was the dissemination of information to others in a careful, timely, sensitive manner. Excellent interpersonal and communication skills are essential to achieving this, as is the ability to form and maintain relationships with a wide range of people. It was also considered useful to be aware of the importance of timing in relation to interactions and decision-making. Individuals who were effective in a leadership role were considered to have a clear vision of where they are going and why. They view change as normal and are seen as being willing to challenge the status quo. Always being prepared for change, they tend to see, seek, and take opportunities, and are good at identifying and using available resources. They are prepared to take calculated risks, make some mistakes, but learn from them. They are able to communicate their vision to others, set the direction and through an awareness of what drives co-workers enable those around them to move in the desired direction. To achieve this, it was considered essential that they have an ability to motivate self and others. In their everyday interactions, they tend to show interest in others, generally conveying a sense of hope, having a positive attitude, whilst demonstrating sensitivity to others' feelings and concerns.

It was also considered important to have knowledge of and be prepared to do management tasks. There is a need to know pure management, but also be able to adapt this knowledge. Having good problem-solving and decision-making skills along with a tendency to surround themselves with the best people they can find, then delegate authority, and then not interfere, were also reported to be useful abilities in this domain. Leadership also means dealing with difficult issues on behalf of others, balancing the need to protect with the process of empowering others to bring about change themselves. It is often how situations are handled when things are not going well, that defines a person's leadership ability.

Leadership was also reported to involve managing multiple accountability, which required a high awareness of others and consideration of different professions, together with an awareness of the role and influence of power – who has it, how and when it is used, and if it actually exists. To be effective in achieving this, a leader or those in a leadership role were reported as being able to work systemically, drawing together many viewpoints, and integrating complex information. It was also considered important to have the capacity to stand back and see the whole area as a process, situated within a wider immediate and historical context. Factors associated with the 'The Shadow-Side of the Organisation' were posed as potential reasons for some being less keen to adopt leadership roles.

Perception of Applied Psychologists in leadership role

In terms of skills and competencies, applied psychologists are perceived as well placed to take on leadership roles and positions. However, uptake of such roles and positions was seen to be lower than the potential capacity. The particular skills offered by applied psychologists included their ability to bring people together, their knowledge of human behaviour, relationships and group behaviour, their ability to integrate a range of viewpoints and bridge gaps between different stakeholders. They were seen as well suited to leadership roles because of their skills in formulating and reframing situations, their tendency to be good listeners and empathic concerning the needs and concerns of others. Applied psychologists reported using their core skills of assessment, formulation, intervention, and evaluation in their fulfilment of leadership responsibilities.

Participants in the leadership project indicated that a proportion of the profession have developed leadership skills over the course of their career and are already demonstrating effective leadership behaviours. Participants in the leadership project highlighted the presence of applied psychologists who already possess characteristics associated with effective leadership, or who have leadership potential. This clearly shows the leadership capability and capacity of the profession and forms the basis of further development and the expansion of this aspect of the professional role.

Participants reported positive perceptions of applied psychologists as leaders and psychologists in leadership roles. There was a general theme evident in the responses of managers and other professionals, which suggested that effective leadership from applied psychologists was not a universal phenomenon but was very much desired. Applied psychologists were perceived to be most effective in their leadership capacity when they demonstrated business and political awareness, enabling them to take the lead on areas of service delivery. It was also better received when they clearly articulated and demonstrated what they offered. This was best achieved by being transparent and understandable regarding their contribution. Their leadership skills were also seen as positive when their contribution was aligned to the service strategy, service-user centred, perceived as useful by others, and when it complimented the rest of the work performed by a team.

Positive accounts of applied psychologists' leadership capabilities were also reported where they were visible and accessible. A number of participants highlighted the positive influence in terms of enhancing the psychological mindedness of others which could be achieved just by 'being around'. A more visible presence also contributed to participants feeling that this led to the practitioner being perceived as less intimidating to other professions and a more integrated member of the team. Participants were keen for applied psychologists to proactively take the expert lead in areas of expertise, i.e. psychological research and practice, research, audit, psychometric assessments, psychological thinking, teaching/training others in psychological approaches but were also keen that they applied their skills to lead on areas such as service improvement and development.

In summary, leadership of psychological services involves understanding and facilitating change, with an awareness of both how this is influenced by the organisational context, culture, characteristics of those involved, and how change and transition impacts on those involved. Effective change management through the application of leadership skills will need to draw on multiple models of leadership and change.

Organisation, Management and Delivery of Psychological Services

Leadership Project – Background, Aims, and Methodology

Alison Coak (2006). PsychD Trainee: Specialist Placement Report.

In the light of current changes and developments within Health and Social Care, the role of Applied Psychologists needs to be considered and clarified. Major changes are currently being made in the way that services are delivered and the roles of all health professionals working in Health and Social Care will be redefined in accordance with these. Applied Psychologists are a scarce resource and it is essential that they clarify their position in relation to these changes and actively contribute to the change process.

New and innovative ways of working are essential because services are changing. Predominantly multi-disciplinary team based in their approach, they need to provide a clear pathway for the service user and carer. The pressure from demand for services and insufficient supply of professionally qualified staff mean that traditional practice must be reviewed to ensure that the best use is being made of highly trained professionals. It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered. Having effective leadership in place at all levels across all agencies is crucial to facilitating the engagement of both staff and organisations in modernising health services.

Role of Applied Psychologists in Health and Social Care

Current and future changes indicate that demand for psychological therapies will continue to increase. Applied Psychologists are a scarce but invaluable resource due to their limited numbers, broad knowledge base, and extensive training in psychological theory and practice. Therefore, Applied Psychologists need to clarify their contribution to service delivery, and how this fits into future services, in order to meet the needs of services users. Nationally, the BPS and NIMHE has set up a working group to look at NWW for Applied Psychologists and is taking a cross-professional approach to the issue. Locally, the need to consider and clarify the role of Applied Psychologists, and develop new and innovative ways of working formed the basis and impetus for the leadership project to be undertaken.

Leadership

Innovation, new treatment methods, and patient services can mean the difference between life and death. They can also mean that patients recover from illness or have a better quality of life. In a relentlessly evolving health care environment, the use of work groups or teams can allow flexibility in working and the generation and implementation of innovative services. Leaders who wish to promote team innovation need to develop teams in which there are clear, shared objectives, high levels of participation, a commitment to excellence and support for innovation. In specialist health care teams, there is a strong relationship between leadership clarity and team processes, and team processes in turn are strongly associated with team innovation. The implications of this are important for understanding how people function most effectively in teams.

Conflict or lack of clarity over leadership leaves team members uncertain about the direction in which they should be targeting their efforts (which in turn undermines innovation attempts) and less likely to participate effectively in team decision-making or working. Conflict or lack of clarity over leadership is also likely to produce different interpretations among team members of what excellence of service means, unresolved differences, and what appropriate innovation consists of. Clear leadership leads to clear objectives and higher levels of participation than would otherwise be the case, together with a greater likelihood of commitment to excellence, and to innovation.

Good leadership is essential to the delivery of effective psychological therapy. Indeed, much development and innovation in the organisation of psychological therapy services in the past owes to the vision of individual leaders. However, psychological therapy services also need clear management. In this way, individual practitioners' needs for support, supervision, and training, can be balanced with service needs for more effective partnerships between providers, including CMHTs, acute wards, early intervention services, ethnic minority services, services for people with learning disabilities, for older adults, and others.

Clinical Leadership Project

The aim of the project was to strengthen leadership skills and improve the outcomes and experience of care for service users and carers by making best use of this scarce resource and to improve the quality, effectiveness, and efficacy of clinical practice. The participants were major stakeholders of local psychological therapies & services, attendees at the NWWAP workshops, and leading experts in the field of leadership in psychological services. The findings and subsequent recommendations have been disseminated locally and nationally (i.e. by feeding into the BPS – NWW for Applied Psychologists) offering guidance on the role of Applied Psychologists in the organisation, delivery, management, of psychological services and therapies.

Methodology

An action research approach was taken for this project as it provided a means of developing responsible and reflective practice, whilst taking into account the view of different stakeholders. It is a critically reflexive model of research, being both practice-based and patient-centred in its philosophical approach. It is useful when wanting to help practitioners critically reflect on and examine their work practices and social interactions, and arrive at a consensus of what kind of services should be provided and why they should be provided in a particular way. Action research is a cyclical process, which begins by asking a group of people to examine a problem within their culture and to find ways of solving or reducing that problem. The members of NWWAP Project Organising, Leading and Managing Psychological Services in Trusts, were the reference group for study. This was an opportunity for their views to be incorporated into the study and assist in determining whether the study was feasible, necessary, likely to sustain everybody's interest, ethical, desirable, and likely to add to current research and experience.

Data Collection

Semi-structured interviews, lasting approximately 30–45 minutes, were used to explore the values and meanings attributed to the role of Applied Psychologists, working in Health and Social Care, in relation to the organisation, management, and delivery of psychological therapies and services.

Participants

Local Applied Psychologists (Bands 6–9) and a range of key staff members and stakeholders they work alongside (i.e. clinical leads, service managers, senior/specialist nurses, etc.).

Interview Questions

What does leadership involve?

How do you perceive Psychologists in this role? Give examples.

Issue of Mental Health Act – What is view of Psychologist as Professional Responsible Officer?

Develop a critical incident scenario – What would the role of a Psychologist be?

How can Psychologists contribute to service delivery?

Appendix B – Increasing Demand for Psychological Therapies

Drivers	Challenges	Considerations for individuals and services
<p>Choice</p> <p>Improving Access to Psychological Therapies (IAPT)</p> <p>Layard Hypothesis</p> <p>NICE Guidelines Care Pathways (18wk referral care pathway)</p> <p>Social Inclusion, Equality and Diversity</p> <p>Payment by Results</p> <p>Practice-based commissioning</p>	<ul style="list-style-type: none"> ● Assessment; Treatment; Range of therapies; Settings; Advance Directives; Mainstreaming Services ● Organisation and delivery of services – stepped care model ● Increasing demand for direct clinical work ● Increase in psychological therapies workforce ● Interpretation and implementation of standards ● Joined-up seamless working across whole of system and lifespan ● Mental Health Promotion ● Accessibility ● Services sensitive to ethnicity, race, culture ● Increase in capacity assessments ● Improve efficiency and workforce productivity, reduce waste ● Accurate information regarding workforce activity ● Competition between providers ● Service provision restricted to narrow range of therapeutic approaches 	<ul style="list-style-type: none"> ● Design and organisation needs to include broad range of therapies not only CBT, IPT. ● Seamless working across settings ● Need high quality, accessible information for informed choices ● Service user/carer/family involvement in service design and evaluation ● Clinical Governance – Quality ● Role of Applied Psychologists – design, implementation, training, supervision, consultation, direct clinical work ● Social Inclusion, Equality & Diversity ● Involvement in design and organisation of service delivery ● Engaging and communicating with commissioners and managers ● Service design needs to reflect the values, needs, and characteristics of the population it serves ● Training others in issues related to capacity to make decisions and how to adapt information to meet service-users needs and characteristics ● Skill mix and new and innovative ways of working ● Demonstrating benefits to patients - efficacy, effectiveness, high quality, safe ● Clear, accessible, understandable information to facilitate informed decision making ● Engaging and communicating with commissioners and service users

Appendix C – Workforce Modernisation and Applied Psychologist's Contribution to Service Delivery

Drivers	Challenges	Considerations for individuals and services
<p>Workforce modernisation programme AFC, KSF, ESC, NOS, Skill Mix</p>	<ul style="list-style-type: none"> ● Value for money ● Clarification of role ● New and innovative ways of working 	<ul style="list-style-type: none"> ● How to make best use of scarce resources such as applied psychologists ● Essential skills across all staff groups (i.e. team working, business, and political alignment) ● Unique contributions across staff groups ● Increasing service user, family, carer, public involvement ● Giving patients more choice and control
<p>Mental Health Act (Amended)</p>	<ul style="list-style-type: none"> ● Clinical Supervisor role ● Community-based treatment orders ● Increase number of mental health tribunals 	<ul style="list-style-type: none"> ● Development needs of applied psychologists to be able to take on this role ● Impact on therapeutic relationship ● Potential for greater number of capacity assessments
<p>NWW for Psychiatry</p>	<ul style="list-style-type: none"> ● Applied Psychologists to take stronger clinical and strategic leadership role 	<ul style="list-style-type: none"> ● What are the leadership development needs of applied psychologists (all grades)
<p>NWW for other professions</p>	<ul style="list-style-type: none"> ● Introduction of Associate Practitioners ● Increased training in psychological approaches, thinking, and formal therapies of others 	<ul style="list-style-type: none"> ● Governance of services delivering psychological therapies ● Role of applied psychologists in relation to other psychological therapists ● Role in relation to teaching, training, consultation and supervision

Appendix D – Key Terms and Concepts (Schein, 1988)

Leadership

Behaviour on the part of some members of the group or organisation that creates or changes basic assumptions and values in the group.

Management

Behaviour on the part of some members of the group or organisation that helps the group to achieve some goals, but within the assumptions or values previously agreed by the group.

Power

The ability to control/influence the behaviour of others because of: (a) the possession of resources that others need; (b) personal characteristics that make one influential; and/or (c) the perception that one controls resources that others need.

Authority

The amount of influence that is legitimately granted to an organisational position or to a person; if others do not consent to the basis of legitimacy (promotion, election, and so on), the person may have formal authority but no influence.

Coercion

The ability to influence others whether or not they consent because of actual control of resources, such as freedom, food, or safety that those others need.

Manipulation

Influencing others without making visible the motivation behind attempts to influence the legitimacy of the manipulation is a function of how the motivation is evaluated.

Appendix E – Four Strands of the Reform Agenda

Choice

Patient choice is one of the key elements at the heart of the reform agenda and the new patient-led NHS. The aim of the choice agenda is to provide patients with more choice and control over treatment and services. For choice to be meaningful there is a need for high quality, accessible information that can be tailored to individual needs. The Government's vision for choice in mental health is set out in *Our Choices in Mental Health* (CSIP, 2005). An outline of the issue of choice for people with learning disabilities is contained in *Valuing People* (DoH, 2001b).

Cost

In conjunction with patient choice, payment by results (PbR) is proposed to bring greater transparency concerning the financial element of the system. Under PbR, the money follows patient choices via practice-based and PCT-led commissioning, although there is also the potential for money to follow an individual service user via individual budgets. The aim of PbR is to reward the best and most efficient providers, whilst giving those providers struggling on quality or cost control the incentive to improve.

There will be increased pressure to improve effectiveness, reduce waste, and provide safe, efficient, value for money services. These will be the major driving forces of change for services, practice, and the workforce. It will increase the emphasis on improving workforce productivity and will have implications for workforce planners in terms of workforce activity information, costing requirements and skill mix solutions. The workforce costs of the NHS represent 70 per cent of all NHS costs and value for money represented by the different professional groups is likely to come under increasing scrutiny.

This will mean that more than ever, information will be needed regarding: who is doing what, with whom; where, when and how they provide it; how much it costs; how it compares with others; and what the outcomes are for patients. One of the primary concerns for commissioners will be output, whilst the primary concern for managers will be efficiency.

Standards

To ensure safety, quality, fairness, equity, and value for money of services a framework of system management, regulation, and decision-making is being implemented. This aim is to address the governance of organisations, standards of service provision, licensing of and competition between providers, performance systems to identify problem areas, and setting prices that create incentives for improving services, outcomes, and productivity.

Commissioning

Commissioning of health and social services is changing, with responsibility for day-to-day commissioning gradually transferred to individual GP practices through the 'practice-based commissioning' system. A GP practice can be commission all services, except those identified as 'tertiary services' in *Guidance on Commissioning Arrangements* (2003). These are to be commissioned by consortia of PCTs, as they are highly complex, low volume, frequently high cost services. By devolving commissioning power, the Department of Health believes this will give GPs more say in what services they buy for patients, consequently improving patient care. It is, therefore, critical to have good, clear communication between service users, commissioners, GP practices, and service providers.

If patient choice is to be meaningful, there must be enough good quality services from which to choose. To facilitate this, provision of services is being opened up to a wider range of providers, including NHS social enterprises and those from both the independent and voluntary sectors. By increasing overall capacity, staff in existing services will be freed up, encouraging innovation and new ways of working to develop. This will contribute to meeting the 18-week target from referral to treatment.

Appendix F – Leadership Styles and Models (Mind Tools, 2006)

The main leadership models and approaches reflected in this paper are transformational, transactional, servant, adaptive and situational leadership.

Transformational Leadership

A person with this leadership style inspires others constantly with a shared vision of the future. Transformational leaders are highly visible, and spend a lot of time communicating. They do not necessarily lead from the front, as they tend to delegate responsibility to others. While their enthusiasm is often infectious, they generally need support from ‘details people’. In many organisations, transactional and transformational leadership are needed. The transactional leaders (or managers) ensure that routine work is done reliably, while the transformational leaders look after initiatives that add value.

Transactional Leadership

This style of leadership starts with the idea that those being led agree to obey their leader when they take on a job: the ‘transaction’ is (usually) that the organisation pays those being led in return for their effort and compliance. Those who are following can do little to improve their job satisfaction under transactional leadership. The leader can give them some control of the income/reward by using incentives that encourage even higher standards or greater productivity.

Alternatively a transactional leader can practice ‘management by exception’, whereby, rather than rewarding better work, they take corrective action if the required standards were not met. Transactional leadership is really just a way of managing rather a true leadership style, as the focus is on short-term tasks. This style of leadership has serious limitations for knowledge-based or creative work, but remains a common style in many organisations.

Servant Leadership

This term, coined by Robert Greenleaf in the 1970s, describes a leader who is often not formally recognised as such. When someone, at any level within an organisation, leads simply by virtue of meeting the needs of their team, they are described as a ‘servant leader’. In many ways, servant leadership is a form of democratic leadership, as the whole team tends to be involved in decision-making.

Supporters of the servant leadership model suggest it is an important way ahead in a world where values are increasingly important, in which servant leaders achieve power based on their values and ideals. Others believe that in competitive leadership situations, people practicing servant leadership will often find themselves left behind by leaders using other leadership styles.

Adaptive Leadership

Adaptation is a dynamic process of mutual influence. Adaptive leadership affects and is affected by the environment. It addresses a very active form of leadership, not a passive effort taken merely to adjust to circumstances as found. In the same way that biological relationships between living entities are circular and interactive. According to the adaptive leadership model, organisations are like living systems, being composed not just of services and technology, but also of people.

Organisations are capable of intelligent, purposeful collective action, actions taken to influence their environments in desired directions. Like all living organisms, organisations can learn, adapt, and grow. They also have life cycles of birth, growth, maturity, and eventual decline. Adaptive leaders think and act to exert influence over their environments. They act to ensure that their organisations are well positioned competitively. They are proactive, foresee opportunities, and put the resources in place to go

after them. They employ a broad-based style of leadership that enables them to be personally more flexible and adaptive. When possible, adaptive leaders will entertain diverse and divergent views before making a decision. They can admit when they are wrong about a course of action and alter or abandon a non-productive course of action. They work by building capacity to learn, transform structure, change culture, and adapt technology. They keep themselves informed regarding what their stakeholders want and are willing to take risks. They are lifelong learners who strive to stay open to new ideas and encourage innovation from the ranks of their organisation.

Situational Leadership

While the above leadership approaches can often be individually effective, there is no 'right' way to lead or manage that suits all situations.

To choose the most effective approach the leader must consider:

- The culture, skills, and experience of those being led.
- The work involved (routine or new and creative).
- The organisational environment (stable or radically changing, conservative or adventurous)
- The leader's own preferred or natural leadership style.
- This type of leader will switch instinctively between styles according to the people and work they are dealing with. This is often referred to as 'situational leadership'.

Appendix G – Additional Themes from Leadership Project Interviews with Applied Psychologists

Team working

- Knowledgeable within team regarding own profession.
- Awareness of characteristics of other professions.
- Awareness of the characteristics of the overall team and the team members.
- Important to build relationships and have good rapport.
- Knowing where the allegiances lie within the team and with others outside of the team.
- Gap bridge gaps and differences between different working parties.
- ‘Working from within’.
- Being transparent about the work you do, i.e. ‘de-mystify-psychology’ and being consistent.
- How your role is perceived, in terms of legitimacy and permission to lead and how you were appointed could all have an impact. Need to take an active role in managing perceptions of how the profession and its actual or inferred knowledge base is perceived.
- Clarity of the role to other team members.

Applied Psychologists in Leadership Roles

Views of Managers, Team Co-ordinators, and Psychiatrists

A theme evident in the views of almost all participants that contributed to the information in this section concerned the changes they had seen and experienced in their interactions with applied psychologists over the course of their careers. They all provided positive and negative examples of how they either perceived leadership skills of applied psychologists or applied psychologists in leadership positions.

Examples from the past were almost all negative whereas now they experienced more and more either positive examples of applied psychologists demonstrating good leadership skills or positive examples of applied psychologists in leadership positions.

Participants had **negative** perceptions of applied psychologists when psychologists:

- were more focussed on their own professional agenda rather than the organisation’s agenda. For some this was a current area of frustration in relation to leadership activities, i.e. contributing to the development of service policies, strategy, guidelines, and care pathways;
- organised themselves in ways that led to perception that they were separate from the rest of the team;
- appeared elitist, precious, choose what they would do, ‘cherry picked’ cases;
- demonstrated a lack of political and business awareness in their interactions with others; and
- contribution involved the need for on-going responsibility, decisions between equally unsavoury options, rapid decision-making, and action during a critical incident.

Participants had **positive** perceptions when applied psychologists:

- demonstrated business and political awareness, enabling them to take the lead on areas of service delivery;
- clearly articulated and demonstrated what they can offer. In addition, when their contribution was perceived as useful; service-user centred; complimented the rest of the team; aligned to service strategy;
- were transparent and understandable regarding their contribution;
- were visible and accessible – positive influence just by ‘being around’, and less intimidating to other professions; and
- proactively took the lead in areas of expertise, i.e. psychological research and practice, research, audit, psychometric assessments, psychological thinking, teaching/training others in psychological approaches.

Pre-Doctorate Leadership Development

The need for leadership development is relevant to applied psychologists of all grades. This also applies to psychologists at the pre-doctorate level. This will require a fundamental change in the training of applied psychologists. When this issue was raised in the Leadership Project, it led to a variety of responses encapsulated in the following themes (see Tables 4 and 5).

Table 4: Leadership development of pre-doctorate psychologists – Concerns.

<p>How much can be fitted into the training process.</p> <p>Concern that profession may put 'all eggs in one basket' with focus Clinical Psychology focussing on Organisation and Counselling focussing on therapy.</p> <p>No point doing developing leadership skills during training, as will not be able to apply on day one following qualification and concerned that course is too influenced by increasing focus on advanced roles aspect of training.</p> <p>Need to keep training broad so to keep flexibility and adaptability.</p> <p>How much of leadership can be taught, if at all?</p>

Table 5: Leadership development of pre-doctorate psychologists – Needs.

<p>Identification of inherent qualities.</p> <p>Remembering the usefulness of our undergraduate training in 'normal' psychology.</p> <p>A mentor could usefully assist a trainee to identify which area of leadership they would like to develop, i.e. clinical, professional, management.</p> <p>If prospective trainees want to train as therapists should train as psychotherapists.</p> <p>As part of training, trainees should learn about their own leadership style, strengths, and needs.</p> <p>Fostering leadership skills – knowing self, self-reflection, others, what you want, task, how do you work in relationships, and how leadership is effected by context and position.</p> <p>Need to provide good role models.</p>

Appendix H – Useful Websites

Amicus Trade Union: www.amicustheunion.org.uk

British Psychological Society: www.bps.org.uk

Care Services Improvement Partnership: www.csip.org.uk

Chartered Management Institute: www.managers.org.uk

Dedicated KSF website: www.e-ksfnw.org

Department of Health: www.doh.gov.uk

Directors of Social Services: www.adss.org.uk

Health and Social Care Change Agent Team: www.changeagentteam.org.uk

Health Professions Council: www.hpc.org.uk

Healthcare Commission: www.healthcarecommission.org.uk

Kings Fund: www.kingsfund.org.uk

Leadership Qualities Framework: www.executive.modern.nhs.uk/framework/

Leadership Skills in the modern NHS: www.nhsleadershipqualities.nhs.uk/

National Electronic Library for Health: www.nelh.nhs.uk/

National Institute for Health and Clinical Excellence: www.nice.org.uk

National Library for Health: www.library.nhs.uk/Default.aspx

NHS Employers: www.wise.nhs.uk

NHS Institute for Innovation: www.institute.nhs.uk

NIMHE: www.nimhe.org.uk

Royal College of Psychiatry: www.rcpsych.ac.uk

Sainsbury Centre for Mental Health: www.scmh.org.uk

Management Standards Centre (MSC): www.management-standards.org

NHS Institute for Innovation and Improvement: www.nhs.leadershipqualities.nhs.uk

Appendix I – A Brief Description of Action Learning

Action learning was pioneered by Reg Revans (Revans, 1980) and has since been increasingly used in leadership development (Dotlich & Noel, 1998). A brief description of action learning is provided here by Howard Naylor. Action learning hinges on the proposition that learning is enhanced through problem solving of real issues, with reflection on what happened and why. It also encourages collaboration before decision-making and action, with potential benefits for joint working within, and across, organisations.

According to research, the most effective conditions for leadership development using action learning include ensuring the selection of appropriate peers for the learning set, and ensuring that the group addresses the most appropriate organisational issues, which enhance learning (Hartley & Hinksman, 2003). Action learning derives its power from the fact that it does not isolate any dimension from the context in which the leader works. It develops the whole leader for the whole organisation. It also recognises that what and how leaders learn are interconnected in that what a leader learns is influenced by how they learn.

Marquardt (2000) described how the elements of action learning (i.e. real problems, fellow leaders in the action learning team, a reflective inquiry process, commitment to action, and focusing on learning) contribute to the building of critical leadership skills. Marquardt (2000) cites seven leadership attributes and skills as being essential for the leading in the 21st century and then examines how action learning can be used to develop them. Effective problem solving is essential part of leadership and requires the ability to be a systems thinker. Action learning is built around a diverse group of people (whole systems) asking new and fresh questions in order to gain a full picture of the problem and its context before attempting to solve it. The core questions in action learning sets focus on examining underlying causes and far reaching solutions that recognise the importance of relationships. During action learning sessions, group members learn how to think in a systematic way and how to handle complex, seemingly unconnected, and sometimes contradictory aspects of organisational challenges (Marquardt, 1999).

What is action learning? (Howard Naylor, 2006)

Action learning is a way of helping organisations, and the people within them, to learn, develop, and make improvements to services and performance. The action learning approach starts from the viewpoint that people, as a result their organisations, learn and develop very effectively when they discuss, plan and take action on their real-life work issues and problems, and then reflect on the action, working in small groups (action learning sets) in partnership with other people and other organisations.

How does action learning work?

Action learning works by asking people to:

- Meet on a regular basis with other people (usually about once every four to eight weeks, for anything from a couple of hours to a full day) in a small group (usually between four and nine people) called an 'Action Learning Set'.
- In these 'set meetings', they discuss, and plan what action to take to tackle various work and personal development issues and problems which are brought to the set by the set members themselves. Action learning sets encourage people to engage with real-life 'here and now' challenges as well as future developments and improvements. Sets also work on the basis that set members are actually the real experts about their own work situations – but they learn, develop, and make improvements when they subject their expertise, views, thinking, opinions, and actions to discussion with and the questioning of others in the set.

Then, in between set meetings set members:

- Take action back in the workplace to tackle their work and personal development issues.
- Gather any relevant and useful information about the issues to share with others in the set.

Then, they come back to each set meeting to:

- Report back and review what has happened with their issues since the previous set meeting.
- Share any new information gathered.
- Reflect with others in the set on what has been learnt as a result of the action taken.
- Discuss and plan further action to take back in the workplace.

Then they continue this learning cycle of discussion – planning – action – reflection for as long as it is useful in creating learning, personal and professional development, and service and performance improvement.

What makes action-learning sets work effectively?

Action Learning Sets work well when:

- Set members commit to and do attend regular set meetings. A key factor is that all those involved are committed to supporting the set to work, because nothing kills an action learning set off more than indifference.
- Set members join the set voluntarily.
- Set members understand that the ‘set meeting’ is different from a ‘business meeting’. Sometimes, in day-to-day business meetings, we are forced into being ‘economical with the truth’ for organisational or political reasons, often with the result that nothing really changes or something is never really achieved as well as it could be. Action learning requires a willingness to admit what you don’t know (and what you do know) to set colleagues in order to resolve shared work problems
- Set members understand that they are not coming to ‘a training course’ with a ‘teacher, trainer, or expert’, who has ‘the right answer’.
- Set members recognise all other set members as equals in the action learning process.
- Set members bring to the set meeting their own real life work and personal development issues and problems for discussion and action.
- Set members are able to challenge and question each other’s views, thinking, opinions, and how they are taking action, giving constructive feedback about how work issues could be moved forward in a more effective way.
- Set members are able to support and help each other, sharing experiences, providing advice, and giving positive feedback.
- Set members feel safe enough within the set to honestly disclose worries about work issues, and to admit to not knowing what to do next with a particular work issue or problem.
- Set members know that discussions will be kept confidential to create honest and open discussion, questioning, and reflection.
- Set members go back to their workplace in between meetings and actually take action on their real life work issues.
- Set members come back to the set meetings willing to report back on what has happened, to reflect on and share their learning and development with others, and to discuss and plan further action to make improvements to services and performance.
- Set members accept it is their own responsibility to go around the four parts of the learning cycle. Action learning is more than just taking action or doing. Discussing, planning, and reflecting on an experience are just as important to learning as having the experience itself. A danger is that the set just becomes an unreflective, task-focused project group, or at the other extreme, a forum for discussion without any action.

What is the role of the action learning facilitator?

Action learning sets usually work with a set facilitator, who is there to help the set in developing this learning cycle of discussion – planning – action – reflection. The set facilitator helps the set to get started, and works with the set to develop a group environment that promotes discussion, planning, questioning, listening, challenge, support, reflection, and evaluation. However, the facilitator should not be seen as an ‘expert’ on all the various work issues that the set might discuss.

At the first set meeting, the facilitator's role is to:

- Help the set to get started by reminding set members how action learning works, and what makes it work.
- Agree 'ground rules' with the set members. Ground rules for a set will include commitment to regular attendance; equality of set membership; equality of 'air time' in the set; recognising the appropriate balance between challenge and support; honest and open communication; confidentiality; recognising the appropriate balance in a set meeting between being 'business-like' and 'a therapy session'.
- Ask set members to introduce themselves, talk about their job and their organisation, and to identify what they hope to achieve by being in this action learning set.
- Ask set members to identify the sort of work and personal development issues that they would like to discuss and take action on over the next few months.
- Agree practical issues like set meeting dates and venues.

At the second and subsequent set meetings, the facilitator's role is to:

- Ask each set member to describe the work/personal development issues that they wish to discuss with the set; or to report back on the action taken in the workplace since the last set meeting.
- Encourage other set members to listen and ask questions to ensure understanding, before having a set discussion on the issue, and reflecting on what has been learnt.

Some examples of the sort of questions that might be asked are:

- *What are you really trying to do, and why?*
 - *What action has been taken since the last set meeting, and what has it achieved?*
 - *Why do you think this has happened?*
 - *What might you have done differently?*
 - *What is stopping you from doing something, and why?*
 - *Why are people behaving in the way they are?*
 - *How do you feel about what is going on?*
 - *What can we learn from what has happened?*
 - *What can you do after today's set meeting?*
 - *Who can help you?*
 - *What have we learnt from discussing and reflecting on this issue at this set meeting?*
- Ask each set member to agree with the set the action they are now going to take back in the workplace to move this work/personal development issue forward.

In set meetings, the set should try to use the sort of behaviours that work well in a set – questioning rather than offering advice or immediate solutions; listening rather than interrupting or speaking over one another; encouraging the planning of action; getting the balance right between challenge and support; encouraging reflection and evaluation of actions to complete a learning cycle. The role of the facilitator is to help and encourage set members to develop these behaviours.

How is an action learning set established?

The first step in using an action learning approach is the forming of an action learning set, which is created when a group of people agree to meet to take action on and to share learning from real life work issues and problems. The action learning set is likely to be one of two types of set:

- The set could be made up of people from different areas, who bring to the set their own individual work issues.
- The set could be made up of people working together on a particular topic or theme, and who use the action learning process to research, take action on and learn about issues within this particular work topic or theme.

Why bother to get involved in an action learning set?

People joining an action learning set will probably want to achieve the following broad objectives:

- Changing and improving their service, or part of their service, by working with colleagues in the set, developing understanding about real-life work issues, and taking action on these real-life work issues in order to provide better and more effective services.
- Sharing and spreading learning and good practice from this change with others within their own organisation, and with partners in other organisations.
- Continuing personal and professional development and learning, for example: learning more about the effective management and implementation of change; developing a greater understanding of their own and others' behaviour in particular situations; learning about how to change behaviour at work in order to become more effective; developing more effective inter-personal skills such as working effectively in groups; learning about how to learn.

A BRIEF DESCRIPTION OF ACTION LEARNING

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