Norfolk and Suffolk NHS
NHS Foundation Trust

New Ways of Working Approved Clinician / Responsible Clinician: NSFT's Initial Pilot Site

17 Month Report

by Miles France, on 27.2.2015

Contents

Glossary

- AC: Approved Clinician.
- [non-medical] AC: an Approved Clinician who originally trained as a Psychologist, Nurse, Occupational Therapist or Social Worker.
- AO: Assertive Outreach.
- BPS: The British Psychological Society took advice from an eminent Barrister, when challenged about what constituted *"medical expertise,"* viz the Approved Clinicians competency framework.
- CTO: Community Treatment Order is a component of Supervised Community Treatment, which specifies the conditions attached to this formal treatment and care (in the community).
- DH: Department of Health.
- LD: Learning Disability.
- MHA: the Mental Health Act, 1983 (which was amended by the MHA 2007).
- NWW: New Ways of Working (a national agenda, to help shape future mental health services).
- SCT: Supervised Community Treatment arose as one of the changes brought about by the amendments to the Mental Health Act, 1983.

1. Executive Summary

1.1 The development of a more diverse Approved Clinician workforce is government policy.

1.2 Although enshrined in legislation in 2007, the development of New Ways of Working has been slow in our area; Northumberland are a notable exception, with a revised 5 year plan for 20% of their AC workforce to come from allied healthcare backgrounds by April 2015.

1.3 The first 3 [non-medical] ACs – from Cumbria & Northumberland - were approved in 2010.

1.4 Improvements in Northumberland include the discharge of all bar one patient from a low secure learning disability ward and the re-modelling of the rehabilitation and community LD services. Nursing staff also report an increased role in complex MDT decision making.

1.5 Other encouraging developments have occurred in Cumbria, where a Nurse Consultant is a [non-medical] AC for a dementia in-patient ward. There has been a reduced prescribing of anti-psychotics and benzodiazepines. Section 3 MHA applications, following admission, have been reduced. Autonomous decision making and an up skilling amongst front-line staff has occurred, in connection with various clinical initiatives. Re-admission rates have been reduced and there has been a subsequent reduction in in-patient bed numbers.

1.6 Nurse Consultants/ACs in Staffordshire reported a reduced level of re-admissions for CTO patients *and* a reduced level of seclusion and lesser restrictive practices on a LD ward.

1.7 Following interest from experienced NSFT clinicians, a local working party entitled 'Approved Clinician / Responsible Clinician: New Ways of Working' was set up in 2012.

1.8 Miles France gained AC Approval in February 2013 and Annette Duff, a Nurse Consultant within Secure Services, was approved in June 2014.

1.9 There are now 32 [non-medical] ACs within England and Wales (see *Appendix 8*).

1.10 An initial pilot was started on 1.10.2013; Miles France is the Responsible Clinician for a group of CTO patients in central Norfolk Adult Service Line. Although patient numbers were originally set at 12, he now has responsibility for 22 patients and potentially a further 9 soon (4 further hospital discharges and 5 from re-aligned Norwich CCG surgeries).

1.11 The design of this pilot involves a naturalistic comparison, retrospectively and prospectively. Each period is for 18 months, prior to and from the point when the pilot post holder became the patient's Responsible Clinician. Each patient acts as their own control and most were automatically entered, other than for sound clinical reasons.

1.12 Consultants Psychiatrists' understandable concerns – about losing familiarity with the functions of being the Responsible Clinician for CTO patients – were accommodated. 3 South Central Consultants currently have one CTO patient each and one has 2 patients.

1.13 This reduces Consultant Psychiatrists' workloads, thus enabling colleagues to concentrate on other clinical duties and leadership functions.

1.14 Front line staff have developed an increased role in the complex decision making and risk management processes, viz other [non-medical] Approved Clinician sites in England. *Appendix 6* contains some very supportive feedback about the [non-medical] AC role.

1.15 The KPIs (see *Appendix 1*) reflect the statutory objectives of Supervised Community Treatment, towards maintaining and rehabilitating patients in the community:

- Re-admissions – including CTO recalls and CTO revocations – plus the number of mental health (MH) bed days used.
- SUIs and other adverse outcomes (involving healthcare and statutory agencies).
- Social engagement and meaningful activities.
- Harm minimisation & significant reductions in substance use, in the post pilot period.
- The number of patients discharged off CTOs, during the post-pilot period.
- The number of face-to-face Community Consultant hours, for CTO patients.

1.16 Quantitative KPIs (for the first 23 patients, up to 23.2.2015)

KPI Description (for the first 23 patients)	Pre-Pilot Numbers	Pre-Pilot Average	Post-Pilot Numbers	Post-Pilot Average
Total number of admissions to a MH hospital.	28		5	
Total number of MH hospital bed days used.	3855	167.7 *	160	7.0 *
Triangulated MH bed days (9 former CTO patients)	1711	190.1		
CTO Recalls.	12		4	
CTO Revocations.	5		2	
A&E attendance, for MH needs.	5		0	
MAU bed days, for MH needs.	2		0	
Total number of patients engaged in at least one meaningful activity.	2		13	
Total number of hours engaged in meaningful activities, by patients.	12.75	6.4 **	195.25	15.0 ***
Incidents of alleged physical or sexual violence, necessitating police involvement.	5		1 #	
The number of Serious Untoward Incidents, in line with Trust policy.	2		0	
The number of CTO patients discharged from compulsory treatment, during the pilot.			4	
The amount of Community Consultant face-to-face time required for CTO patients, in hours.			3.5	
CTO patients who have significantly reduced their use of substances.			5	
CTO patients engaging in harm minimisation measures, viz their use of substances.			9	

Some considerations when interpreting this quantitative data:

- * denotes the mean average for the first 23 patients within scope (one patient was discharged from CTO to a Consultant's care – the Lead Clinician subsequently agreed that follow-up care should continue, post CTO discharge - another was transferred, following threats of violence).
- ** denotes the mean average for 2 patients participating in 12.75 hours of activities.
- *** denotes the mean average for 13 patients participating in 195.25 hours of activities.
- # denotes a threat to physically harm the pilot post holder, within the context of CTO recall.
- At a review meeting on 23.2.2015 – which included Consultant colleagues, the Medical Director and the Director of Services for Norfolk – the following points were raised viz interpretation of the number of mental health bed days:
  - ☐ It is generally accepted that patients aged 50+ typically tend to be more settled in their overall presentation, than much younger patients with co-morbid needs. However, all five post-pilot admissions have involved patients aged 50+.
  - ☐ A core aim of SCT is to promote the effective rehabilitation and maintenance of patients being compulsorily treated and cared for in the community. However, some colleagues felt that these figures ought to adjusted, to exclude patients who had not had at least one previous episode of SCT prior to their last pre-pilot admission. The current triangulated figure of 1711 mental health bed days saved is still a significant achievement by the team.
  - ☐ Some colleagues suggested that another variable might be the knowledge, experience and skills set of the pilot post holder. However, the portolfio requirements for [non-medical] ACs is extensive, in order to demonstrate a commensurate level of skills and competence.
  - ☐ One North Central Consultant was enthusiastic about the pilot results; he supports this model being applied to other NSFT areas which have significant CTO numbers (see *2.10*).
  - ☐ See 2.1 – 2.14 viz future consistency of care, which helps inform the patient pathway.
- Should the pilot post holder's role be regularised, there would need to be further monitoring of all the KPIs, to cover the full 18 months post-pilot for more recent patients. This would allow for an external audit from an eminent colleague within the field, such as Prof. John Taylor.

1.17 There is no discernible difference in face-to-face time between consultant colleagues and the pilot's post holder (mean average time is 39.5 minutes, per contact).

However, the increased frequency and consistency of AC/RC input has enabled the team to focus upon a range of vital psycho-social issues (see *Appendix 4).*

1.18 Independent qualitative feedback was sought from patients, hospital managers and staff.

1.19 Some notable differences appear to be promoting effective changes in working practices:

- The frequency and consistency of input from the [non-medical] Responsible Clinician.
- A clear understanding of the patient journey into mental health services, documenting progressive signs/symptoms of acuity, crisis management plans and recovery goals.
- Hospital Managers and the MHA Administrators have been very positive about the overall improvement in the quality of the written and oral evidence presented to them.
- *Appendix 6* also provides independent feedback from patients and front line staff.
- There has been a significant reduction in substance abuse (5 patients), minimisation of harm (9 other patients) and support to minimise a partner's use of alcohol (1 patient).
- Where it is safe enough to do so – and with other additional strategies designed to augment treatment – it has been possible to reduce some patients medication levels.
- 13 patients are actively engaged in meaningful activities. The total number of hours is 195.25, at a mean average of 15.0 hours for each of the 13 patients involved.
- Agreeing clear pathways for discharging patients off CTOs, with closer collaboration with the Recovery College, in order to sustain an increased level of insight pro-term.
- CTO Training has been undertaken with several different constituent groups. This includes Hospital Managers, ward staff at Hellesdon Hospital, ward staff at the Julian Hospital and the DCLL team at Gateway House.
- Subject to the role continuing beyond 31.3.2015, it has been requested that further CTO training be undertaken with GYAS, Justin Gardner House, the AMHP service and the police control room at Wymondham. This should help to augment a greater baseline level of understanding about the needs of CTO patients, across Norfolk.
- Further involvement in reviewing/refining NSFTs policy for Supervised Community Treatment would be anticipated.
- Similarly, a positive reflection of NSFTs commitment to New Ways of Working would continue, via established links with the Regional Approved Clinicians Panel and colleagues at the Department of Health.
- Although not formally part of the pilot's remit, some gradual work is being undertaken with several patients, GPs and the NNUH viz physical health care improvements. This partnership approach includes:
  - ☐ Liaising with GPs, viz the frequency/necessity of routine blood tests, monitoring of individual's blood pressure and the possible necessity of further ECGs.
  - ☐ Assisting patients to attend GP/practice appointments, in connection with this.
  - ☐ Following a discussion with Sarah Fletcher, encouraging weight loss and healthier lifestyles, in conjunction with the recent use of the Lester Tool (DH, 2014a)
  - ☐ Ensuring that the Mental Capacity Act is given due consideration, within a very complex case involving ongoing cardiac treatment and cancer investigations/treatment.
- This report has primarily focussed upon the development of a [non-medical] Approved Clinician pilot for CTO patients. It is envisaged that further support would be provided with embedding a similar role within Secure Services. Some mentoring was provided towards enabling the Nurse Consultant to submit a successful portolfio to the Regional AC Panel; this support could readily be made available to future AC candidates.

2. Tentative Conclusions and Recommendations

2.1 The CTO Pilot Project has been very successful in the first 17 months, in terms of the independently sourced feedback (*Appendix 6*) and meeting the KPIs (*Appendices 1 & 7*).

2.2 It is likely that a further small number of patients will need to be recalled, given the relapsing nature of their condition and well documented engagement difficulties.

2.3 Good progress has been made with regards to changes in working practices, which have helped to promote the consistency and continuity of care (see point 1.19).

2.4 A review meeting on 23.2.2015 acknowledged that medical input for the CTO patients is relatively small. Clarification of medical input and clinical supervision arrangements would be needed beyond 31.3.2015, should the pilot post-holder's role be regularised.

2.5 A Consultant made a positive recommendation that all CTO patients who lack capacity to consent to treatment – or are disconsenting – should have an annual medical review. Other patients would need a medical review according to their prevailing clinical need(s).

2.6. Clarificatory legal advice is vital, viz the legality of [non-medical] ACs formally assessing whether patients have the Capacity to Consent to Treatment or not, or are disconsenting. In the absence of the DH taking a national lead, NSFT should seek legal advice from an eminent barrister; Richard Gordon, QC assisted the BPS with a similar issue.

2.7 The need for Consultant Psychiatrists involvement in medication reviews could be complimented by involving Non-medical Prescribers, as integral members of the team.

2.8 This adoption of Non-Medical Prescribers within CMHTs would help augment New Ways of Working. The NWW working party is currently planning a Spring 2015 conference, in order to consider this and other developments (such as Advanced Nurse Practitioners).

2.9 The development of the [non-medical] AC/RC's role aligns itself closely with the underpinning philosophy of the senior clinician's role envisaged within the FACT model.

This is because the FACT model is – amongst other factors - underpinned by:

- Developing a clearer understanding of a range of psycho-social needs; the promotion of accurate psycho-social histories has been vitally important (see *Appendix 4)*.
- A commitment to addressing meaningful activities/occupation, substance misuse, security of housing tenure and physical health care issues in a consistent fashion.
- The efficacy of overall patient outcomes, in relation to psychologically informed interventions.
- A change in service delivery from clinical environments to home visits, in the main.
- Future FACT model revisions could include employing a non-medical AC/Prescribers.

2.10 Consideration should be given to developing [non-medical] AC/RC roles in West Suffolk and East Suffolk, where there are currently 20 and 33 CTO patients (respectively).

2.11 IPM lists CTO patient numbers within the central Norfolk ASL as being 21. There are currently 37, with 3 CTO discharges due soon from Glaven and an additional 2 from PICU.

2.12 Regularising this AC post would promote consistency of care for 27 CTO patients, plus 4 discharged off CTOs. It is envisaged that the smooth discharge processes off Glaven / Waveney/PICU could equally apply to discharge planning processes off Thurne Ward.

2.13 The above measures should also enable Consultant colleagues to give an enhanced focus upon other clinical and leadership roles within the service.

2.14 Given current strategic concerns about safe, lesser restrictive (*DH, 2014b)*, effective and responsive services within our Trust, the NWW AC role should be commended as a model of good practice. It also positively reinforces a commitment to pro-actively develop NWW.

3. Early Origins – and Definition - of Assertive Outreach (AO)

3.1 Building upon the *Programs in Assertive Community Treatment Model* or PACT Model (*Marx et al, 1973*), further attempts were made to identify how so called 'revolving door' patients could be more effectively supported in the USA *(Stein, L. & Test, M., 1980)*.

3.2 The *Training in Community Living* Model developed by Stein, L. & Test, M. was able to demonstrate a dramatic fall in re-admission rates – from 56% to 6% in the control group – *(Kent, A. & Burns, T., 1996)*. Within this model, 10 FTE staff were expected to care for approximately 100 patients, with the team sharing the patient caseload.

3.3 This was followed by the development of Assertive Outreach Teams (AOTs) in Australia and New Zealand in the early 1980s *(Hoult, J. et al, 1981; Hoult, J et al, 1983),* Canada in the late 1980s *(Higenbottam, J. et al, 1992; Lafave, H. et al, 1996)* and within the United Kingdom from the late 1990s onwards *(Sainsbury's Centre for Mental Health, 1998; Fiander, M. et al, 2003).*

3.4 A UK definition for Assertive Outreach can be summarised as addressing the needs of a:

" small but significant group of severely mentally ill people who have multiple, long-term needs and who cannot or do not wish to engage with services.

Unless engagement is achieved and people in the group are provided with safe and effective services, they will continue to face social exclusion."

(Sainsbury's Centre for Mental Health: Keys to Engagement, 1998: 6)

3.5 Highlighting the need for a strengths based practice approach with Assertive Outreach patients, a national authority within this area of practice recognises some criticisms of the work undertaken by AOTs, including:

- Difficulties in matching the findings from international research, within relatively short timescales.
- Difficulties with maintaining the fidelity of the model and achieving the necessary savings over the short–term, rather than the medium to longer–term.
- Concerns about local service development, given the potential to form a narrow focus when addressing expectations arising from national policy directives or targets.
- A lack of clarity about staff to patient ratios and the impact of the travelling time involved, when working within rural - or semi-rural - locations.

(Morgan, S., 2008)

3.6 Other criticisms included the perception that the benefits of AOTs – viz engagement and reduced admission to hospital rates - plateaus out after the first few years, without an additional focus on physical health, housing and employment issues.

(Rana, T. & Commander, M., 2010)

3.7 Whilst AO patients expressed increased satisfaction levels with AO services per se and the overall level of contact *(Marshal, M. & Lockwood, A., 1998; Killaspy et al, 2006),* mental health services have been refocusing their service delivery for AO patients, including reviewing patients away from clinical environments or offices *(Killaspy, 2007)*.

3.8 The aforementioned views should *not* be construed as being critical of Assertive Outreach Teams per se – or local colleagues who had, until recently, worked within NSFT AOTs – but, rather on a national level, some Trusts are moving away from dedicated Assertive Outreach Teams.

This shift in emphasis was recognised at the National Assertive Outreach Conference, during the Autumn of 2013.

Accordingly, what other alternative model of practice might be adopted, in order to address the unmet needs for AO patients?

4. Flexible Assertive Community Treatment (FACT) Model

4.1 Following the development of Assertive Community Treatment from the 1970s onwards, Flexible Assertive Community Treatment (FACT) was subsequently developed in Holland from 2003 onwards *(van Veldhuizen, J. 2007)*.

4.2 Since 2010, Assertive Outreach Teams have been converting to FACT teams; it offers a more flexible option to step-up and step-down the level of support for patients with a higher level of overall need – using a fidelity model - within one team *(Bahler et al, 2007; van Veldhuizen, J. et al, 2008)*.

4.3 FACT teams place a greater overall emphasis upon physical health, meaningful activities/occupation and housing than traditional AOTs, which is felt to generate improved psychiatric, social and economic benefits *(van Veldhuizen, J. & Bahler, M., 2013)*.

4.4 van Veldhuizen, J. & Bahler, M. (2013) list structural differences between ACT and FACT:

- Assertive Community Treatment (ACT) teams target the 20% of the most severe and enduring patients – including so called requiring 'revolving door' hospital admissions – whereas FACT is available to all patients with a severe mental illness in a given area.
- ACT tends to have 60 – 100 patients per 250 000 residents. FACT teams ideally provide support to 180 – 220 patients within a rural population of 50 000 residents or 180 – 200 patients within a metropolitan population of 35 000 – 40 000 residents.
- The multi-disciplinary staffing mix if felt to be of crucial importance, towards pursuing a recovery plan which includes a focus upon physical health needs, reduced substance misuse, security of housing tenure and employment options. It is anticipated that 11 – 12 FTE staff should work in such FACT teams, with integral specialist substance misuse and employment rehabilitation workers.
- The caseload numbers in ACT teams are 1: 10 for most team members and 1: 100 for Psychiatrists. Within FACT teams, the corresponding numbers are 1: 20 and 0.8: 200.
- Typically, all 100 ACT team patients are discussed daily, whereas FACT teams concentrate upon the 20 – 30 patients who need daily care at that juncture.
- ACT patients tend to be seen 3 – 4 times per week; FACT teams will see patients less often, unless they are 'stepped-up' for additional support. Finite patient numbers is crucial, towards having sufficient flexibly to customise patient care within FACT teams.
- The FACT model allows for patients to be 'stepped-up' or 'stepped-down' at any juncture – rather than be re-referred to another CMHT team, when a sustained decreased level of need is identified with the ACT model – based upon the assumption that 10% to 20% of FACT patients will have fluctuating needs at any given time.
- If a patient relapses after being discharged from an ACT team, s/he may have to wait for a future AO service; FACT teams would simply step-up the level of care required and list the patient on the FACT board as needing greater input.
- Given the continuity of care for patients who may fluctuate between being acutely unwell and being relatively well – with a central emphasis placed upon preventing further relapses and enhancing recovery – the FACT model is felt to provide greater continuity of care overall.

4.5 A comparative study – between ACT teams and replacement FACT teams, in two west London boroughs – demonstrated that the FACT model is cost effective *(Firn et al, 2012).*

4.6 Given the scope for improved outcomes, the Dutch Council for Public Health and Care plans to expand the number of FACT teams from circa 200 (in 2013) to 400 – 500 teams. It was also labelled as best practice for Dutch patients with schizophrenia, in 2012.

4.7 Nationally and locally, how have [non-medical] Approved Clinician roles developed? Why might they be relevant with FACT teams, supported by Non-Medical Prescribers?

5. The National Development of [non-medical] Approved Clinicians

5.1 Changes in Legislation

The Mental Health Act, 1983 (MHA) was amended by the Mental Health Act, 2007. These amendments were enacted in November 2008.

5.2 National Discussions, Which Shaped the Development of Approved Clinicians

During various extensive discussions with key stakeholders prior to legislative changes, clarification was provided about new ways of working which should result in developing and sustaining a more flexible workforce within mental health services (*DH, 2007a*). Following the amendment to the Mental Health Act, 1983, clinicians have been permitted to carry out a broader range of functions under this legislation (*DH, 2007b)*.

Extensive consultations with service-user groups, families and carers have highlighted their desire for *"timely and coordinated interventions .. based on their capabilities and competences" (NIMHE, 2008: 3)*. Whilst reviewing some of practicalities behind the successful implementation of the Approved Clinician role, it was noted that applicants *"were based in a range of services"* and *"in some cases, those preparing for the role were working in units with minimal involvement from a psychiatrist or [where there were] difficulties in recruiting psychiatrists" (NIMHE, 2009: 5).*

Part of their qualitative findings for redesigning services – which included the implementation of the [non-medical] Approved Clinician role – suggests that Consultant Psychiatrists should focus upon very complex cases and that the 'Creating Capable Teams Framework' leads to "*bringing the decision making closer to the patient ... and working to develop thinking much more strategically and systematically (p.11)."* This mirrors another review concerned with the freeing up time to care agenda: *"the Leading Better Care initiative, is resulting in benefits for patients in terms of enhanced safety, better experience of services and improved outcomes" (Scottish Government, 2010: 3).*

5.3 Definition of an Approved Clinician and Responsible Clinician

Section 145(1) MHA defines the Approved Clinician as being

" *A person approved by the Secretary of State or by the Welsh Ministers, to act as an Approved Clinician for the purposes of this [Mental Health] Act" (Jones, v.16: p. 578)*.

All Responsible Clinicians must be Approved Clinicians.

A Responsible Clinician is an Approved Clinician who has been given overall responsibility for the detained patient's care and treatment.

5.4 Which Body has Responsibility for Approving Approved Clinicians?

Changes were made to the national structure of the NHS on 1.4.2013. Prior to this, the NHS Midlands & East had overall responsibility for initial and subsequent approval of all Approved Clinicians, including [non-medical] Approved Clinicians.

This function is now being performed by the Department of Health (DH).

5.5 How are [non-medical] Approved Clinicians Appointed within NSFT?

Line management supervision and the appraisal process – together with a dedicated procedure and working party - provides the supportive framework for mentoring prospective candidate(s) towards applying for approval to the DH. Subsequent support ensures that this newly acquired knowledge and skills is transferred into the workplace, post-appointment by NSFT.

See *Appendix 2* (nationally agreed Approved Clinician competencies) and *Appendix 3* (flowchart) which provides a snapshot of this process.

5.6 The Development and Applicability of the 'Cumbria Model'

In February 2012, three NSFT staff – a Psychiatrist, a Nurse Consultant and a Senior Social Worker - visited the Cumbria Partnership NHS Foundation Trust (the Cumbrian Trust). The purpose was to discuss an innovative Nurse Consultant led in-patient service; the Nurse Consultant is a [non-medical] Approved Clinician, has day-to-day clinical responsibility for the unit and has an AfC banding of 8c. Discussions were held with the [non-medical] Approved Clinician, her Consultant Psychiatrist, the Head of Staff Development and a [non-medical] Approved Clinician candidate / AMHP Lead.

In setting the context, Cumbria has total population of 500 000, with 20% aged 65+. The Cumbrian Trust has had historical difficulties in recruiting and retaining Consultant Psychiatrists. As part of their workforce planning, consideration was given to maximising the development of clinical staff at each stage of their career and to address recruitment/retention issues. In terms of the former, emphasis is being placed upon mentoring newly qualified staff, encouraging further post-qualifying training, encouraging the take up of BIA and AMHP Training and - where the service need exists – encouraging very experienced and highly skilled staff to consider applying to become a [non-medical] Approved Clinician. In helping to overcome organisation resistance - including previous concerns about a loss of role amongst medical staff - the Cumbrian Trust's Medical Director and Head of Staff Development were instrumental in addressing change management issues. This role has subsequently attracted universal support.

5.7 The benefits of the late 2010 introduction of the 'Cumbria Model'

- Closer working relationships with patients and carers, who are central to the care planning, risk assessment and risk management decision making processes.
- Detentions under Section 2 MHA are tending to be rescinded and there are understood to be fewer 'conversions' to Section 3 MHA. Where appropriate, effective representations are being made to tribunals about the continued need for detention, based upon a more intimate knowledge of clinical and risk management factors.
- There has been a reduced use of anti-psychotics - both during the in-patient stay and post-discharge - and less subsequent use of benzodiazepines by residential homes.
- Medical colleagues recognise the added value of this service, simultaneously allowing them to develop their clinical and other leadership roles within the service.
- There also appears to have been a significant up skilling - and increased confidence/competence - amongst front-line staff. This has resulted in staff taking an increased responsibility for various clinical initiatives, such as the basic patient observations, risk management, discharge planning and gate-keeping.
- Conterminously, consideration was given to a phased reduction in in-patient beds. There has been accompanied by a substantial improvement in patients, carers and partner agencies' satisfaction levels.

5.8 Local Rationale for Change within NSFT

The Trust Service Strategy helped introduce the new role of the [non-medical] Approved Clinician, within a safe, sound and supportive framework. The three key aims are:

- Maximising improved patient care and outcomes, whilst maintaining patient safety.
- Increasing the diversity of Approved Clinicians, according to patient need and the appropriate knowledge, skills and experiential base.
- Maximising the overall flexibility of the workforce.

6. NSFT Approved Clinicians 1st Pilot Site: with SCT Patients

6.1 International Development of Compulsory Community Treatment.

Compulsory community mental health treatment has occurred within a number of countries over the past 30 – 40 years, in order to try to reduce the re-admission to hospital rates (*Churchill et al, 2007; Dawson J., 1995*). The earliest introduction was in some states of the USA (*Burns, T. & Mododynski, M, 2014*). The USA rate of re-admission, within six months of hospital discharge, varies between 20% and 50% (*Casper, 1995; Lidz, Mulvey and Gardner, 1993 and Schoenbaum, Cookson and Stevlovich, 1995*). Compulsory community treatment was subsequently introduced in Australia and New Zealand – where their usage is highest – and latterly Scotland (2005) and England and Wales (2008) (*Burns, T. & Mododynski, M, 2014*).

6.2 Compulsory Community Treatment, as a concept

Burns and Mododynski succinctly state that compulsory community treatment is designed for:

"Patients who have been compulsorily detained in the past, have limited insight into their illness and who are judged to be at high risk of relapse. The typical patient is most often male, diagnosed with schizophrenia, with a number of previous admissions, often under compulsion. The presentation is frequently one of self-neglect and isolation, rather than risk to others. Community Treatment Orders rely upon the provision for rapid recall to hospital for their enforcement. The most common requirements are adherence to medication and regular contact with the clinical team" (2014: 3).

Referring to the framework for Supervised Community Treatment (SCT) within the UK, the above criteria is adapted to include patients with serious affective disorders and male aged approximately 40 years of age (*Smith, M. et al, 2014*). It is interesting that, with this specifically vulnerable group of patients in mind, the UK Government under-estimated the use of SCT by 10 fold, having based it predictions upon the Kings Fund paper (*Rawala, M. and Gupta, S. 2014*; *Kings Fund, 2005*).

6.3 Why NSFT Choose a 1st Pilot Site Involving CTO Patients

As previously stated, New Ways of Working envisaged Approved Clinicians being chosen according to the knowledge, skills and experiential mix most befitting for patients. As indicated above, the diagnosis of this distinct group of community patients is well known and empirical evidence suggests that medication changes tend to be of a more minor nature, in comparison to the complexity of the prevailing psycho-social needs. Social deprivation is a significant factor in general admissions to hospital within the UK (*Kings Fund, 2010*) and within mental health services (*Burns, T. et al, 2007*). The latter echos earlier research which sought to draw a distinction between psychiatric emergencies and psycho-social crises within mental health services (*Segal, 1990; Rosen, 1997*).

Given the above complex needs, *McNicol, A.* quotes Miles France in stating the choice of the NSFT pilot site involved

"the belief that we could provide services at least equally well as medical colleagues in certain areas of mental health practice. The evidence base shows that people who present in crisis to mental health services often do so because of psycho-social emergencies" (2013).

It is contended that some allied health professionals have an appropriate knowledge, skills and experiential mix suited to meeting such needs and, potentially, within other service areas. See points 1.19 and 2.1 – 2.14 inclusive, for further details.

Appendix 1: Key Performance Indicators for the initial CTO Pilot Site

This pilot is not a formal research project.

This service evaluation will be performed using KPI measures for the group. The design of this pilot involves a naturalistic comparison, retrospectively and prospectively. Each period is for 18 months, prior to and from the point where Miles France became the patients' Responsible Clinician. Each patient acts as their own control and most were automatically entered, other than for sound clinical reasons.

Qualitative measures – the Commercial Development Officer independently sought feedback from patients, front line staff and Hospital Managers – has been included in a separate appendix, for the CTO pilot site. Qualitative measures will form a key component of the evaluation of a second pilot site, within secure services.

The MHA Administrators have been helpful in providing some statistical data. Further data – obtained by auditing patient files - has been gleaned and cross referenced:

- The number of CTO recalls.
- The number of CTO revocations.
- The total number of re-admissions to a MH hospital (for CTO patients).
- The total number of days spent as an in-patient within a MH hospital (for CTO patients).
- Mean average number of days spent as an in-patient within a MH hospital, including the duration of formal treatment (highlighting when the CTO was revoked).

Individual patient's medical notes were audited, in order to ascertain the following:

- The total number of CTO patients who were attending – and their individual frequency of attendance - A&E within a general hospital, for their mental health needs.
- The total number of MAU bed days used within a general hospital by CTO patients, for their mental health needs.
- The number of CTO patients who were engaged in at least one regular meaningful activity.
- The total number of hours per week that each CTO patient was engaged in regular meaningful activities (the number of activities participated in was also recorded).
- Incidents of physical or sexual violence, allegedly perpetrated by CTO patients, necessitating police involvement.
- The number of serious untoward incidents, identified in line with Trust policy.

Four further additional measures were also included, for the post pilot period only:

- The number of patients discharged from their CTO.
- The amount of Community Consultant face-to-face time required for CTO patients, in hours.
- The number of CTO patients with a co-morbid substance misuse problem, who have significantly reduced their consumption.
- The number of CTO patients with a co-morbid substance misuse problem, who have been engaging in harm minimisation measures.

Appendix 2: NHS England (2014) Approved Clinician Competencies

1. The role of the Approved Clinician and Responsible Clinician

1.1 A comprehensive understanding of the role, legal responsibilities and key functions of the Approved Clinician and the Responsible Clinician.

2. Legal and Policy Framework

2.1(a) Applied knowledge of the Mental Health Act 1983, related Codes of Practice and national and local policy and guidelines

2.1(b) Applied knowledge of other relevant legislation, Codes of Practice, national and local policy guidance, in particular, relevant parts of the Human Rights Act 1998, the Mental Capacity Act 2005, and the Children Acts 1989 & 2004.

2.1(c) Applied knowledge of relevant guidance issued by the National Institute for Health and Clinical Excellence (NICE).

2.2 Within 2.1, 'relevant' means relevant to the decisions likely to be taken by an Approved Clinician or a Responsible Clinician.

3. Assessment

3.1 Demonstrates an ability to:

3.1(a) Identify the presence of mental disorder;

3.1(b) Identify the severity of the disorder; and

3.1(c) Determine whether the disorder is of the kind or degree warranting compulsory confinement.

3.2 Assess all levels of clinical risk, including risks to the safety of the patient and others within an evidence-based framework for risk assessment and management.

3.3 Undertake mental health assessments incorporating biological, psychological, cultural and social perspectives.

4. Treatment

4.1 Demonstrates an understanding of:

4.1(a) Mental health related treatments, i.e. physical, psychological and social interventions;

4.1(b) Different treatment approaches and their applicability to different patients.

4.2 Demonstrates a high level of skill in determining whether a patient has capacity to consent to treatment.

4.3 The ability to formulate, review appropriately and lead on treatment for which the clinician is appropriately qualified in the context of a multi-disciplinary team.

4.4 The ability to communicate clearly the aims of the treatment, to patients, carers and the team.

5. Care Planning

5.1 Demonstrates the ability to manage and develop care plans which combine health, social services, and other resources, ideally, but not essentially, within the context of the Care Programme Approach.

6. Leadership and Multi-Disciplinary Team Working

6.1 The ability to effectively lead a multi-disciplinary team.

6.2 The ability to assimilate the (potentially diverse) views and opinions of other professionals, patients and carers, whilst maintaining an independent view.

6.3 The ability to manage and take responsibility for making decisions in complex cases without the need to refer to supervision in each individual case.

6.4 An understanding and recognition of the limits of their own skills ***and*** when to seek other professional views, to inform a decision.

7. Equality and Cultural Diversity

7.1 An up to date knowledge and understanding of equality issues, including those concerning race, disability, sexual orientation and gender.

7.2 An ability to identify, challenge and - where possible - redress discrimination and inequality in all its forms in relation to approved clinician practice.

7.3 An understanding the need to sensitively and actively promote equality and diversity.

7.4 An understanding of how cultural factors and personal values can affect practitioner's judgments and decisions in the application of mental health legislation and policy.

8. Communication

8.1 An ability to communicate effectively with professionals, patients, carers and others, particularly in relation to decisions taken and the underlying reasons for these.

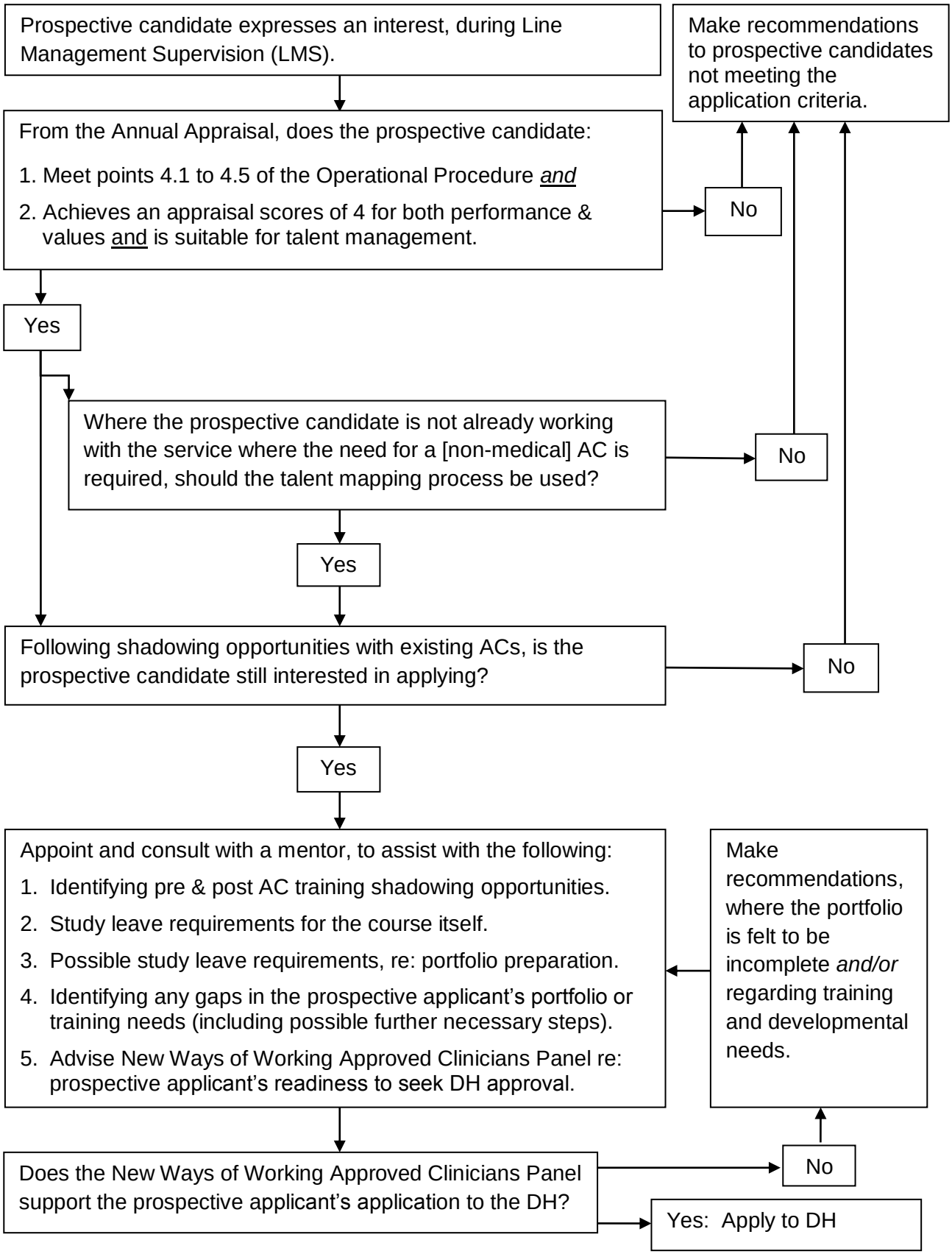
8.2 An ability to keep appropriate records and an awareness of the legal requirements with respect to record keeping.

8.3 Demonstrates an understanding of and has the ability to manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other stakeholders.

8.4 An ability to compile and complete statutory documentation and to provide written reports as required of an approved clinician.

8.5 An ability to present evidence to courts and tribunals.

Appendix 3: Expressions of Interest and Applying for AC Approval



Appendix 4: Relevance of Accurate Psycho-Social Histories

In addition to promoting the wider adoption of New Ways of Working, another key aim of this pilot has been to address a range of psycho-social issues, which a disproportionate number of mental health patients experience. This includes:

- Minimising the risk of homelessness *(Social Exclusion Unit, 2004, St. Mungos, 2009; Rees, S. 2009).*
- Addressing a lack of meaningful occupation *(Social Exclusion Unit, 2004; Rethink, 2010).*
- Conterminously addressing co-morbid substance misuse in a discrete/collaborative fashion (*Abou-Saleh, T. 2004; Cleary, M. et al, 2008; Crome, I. et al, 2009).*
- Enabling physical health care needs to be met (*Payne James et al, 2007; Academy of Royal Medical Colleges, 2009)*.

Placing an emphasis upon understanding psycho-social needs is crucial towards gaining a more holistic overview of patient need (*Royal College of Psychiatrists & Royal College of Physicians, 2003; MSF, 2011*). Although initially a very sensitive process, engagement can be improved by enabling patients to challenge past recordings and also become more informed about the efficacy of their previous treatment and care. Simultaneously, plans are devised for their future needs, incorporating headings for '*signs and symptoms of progressively becoming unwell'*, '*risk*s,' a '*crisis plan*' and '*recovery focussed goals*.' An emphasis upon core social work values is recognised as being beneficial in this respect (*Skills for Care, 2014; Dr. Ruth Allen, 2014).*

Additionally, an element of forward planning has been helpful towards completing Hospital Managers and First Tier Tribunal reports, plus a range of letters to other governmental and voluntary sector organisations. This is why psycho-social histories are such a priority to complete for every CTO patient. A commitment to open and systematic working has also engendered a degree of trust and mutual respect – and collaboration - with most patients.

Some anecdotal examples of the benefits of developing psycho-social histories have included:

- In a psychologically informed manner, enabling a woman with paranoid schizophrenia to develop a greater understand the situational context of previous substantial losses and subsequent attachment problems, in adulthood; the team has been able to simultaneously minimise the distress associated with meeting her very complex physical health needs.
- Enabling a man with paranoid schizophrenia to understand the impact of his previous propensity to self-medicate with alcohol – and the associated risk of eviction, when he became unwell – towards subsequently promoting a return to meaningful activities and some collaboration with the Recovery College. He has spoken with a great deal of passion and integrity - to a small audience which included NSFT's Chief Executive – about how much he values the rediscovery of his creative talents. He is exhibiting his art work in a local cafe.
- Enabling the team to understand the full impact of multiple past losses – whilst also helping to assist her physically disabled partner to minimise his harmful drinking - for a woman with paranoid schizophrenia who has a propensity to live a chaotic lifestyle.
- Enabling a young man with paranoid schizophrenia to openly address significant public safety issues and risk management concerns, whilst working towards addressing his physical health and meaningful activity needs.
- Working with a shy man with schizoaffective disorder, in order to help him understand the impact of his previous acute episodes, severe self-neglect and resulting social isolation. The validation of an alternative spiritual value base and a psychologically informed care plan has resulted in a diminution of the intensely distressing paranoid referential ideas. Moreover, he has become more meaningfully occupied within - and feels very supported and accepted by – his local church. It is pleasing to note that he has recently started (independently) attending social functions at other parishioner's homes, which is maximising his recovery.

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Appendix 6

Norfolk and Suffolk NHS
NHS Foundation Trust

Commercial Development
Hellesdon Hospital
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NR6 5BE

Tel: 01603 421502

1st October 2014

Re: Evidence Collected for NHS Leadership Recognition Award – Miles France

Please find below a summary of feedback from staff and service users, collected to support Miles' nomination by Dr. Jane Sayer (NSFT's Director of Nursing, Quality and Patient Safety) for the NHS Leadership Recognition Award for Development Champion. This in relation to his work in the [non-medical] Approved Clinician role.

I would add to the comments below, to say that the overall impression I got from everyone I spoke to was that not only is Miles highly regarded by his team and colleagues but they all feel that the role he is doing is extremely important and is starting to show a real impact with our service users.

- I have worked with Miles in a variety of professional settings over the past 20 years, and have always known him to be a practitioner of immense integrity and someone who always works with service users in the most collaborative way possible, even at times of greatest challenge for the individual in relation to Mental Health Act work. In his current position he is considered invaluable, leading the way not only within NSFT but within mental health. He is championing the role of non-medical ACs, tirelessly working with colleagues to promote the benefits and disseminating information to help others develop their own models of care. He is also incredibly supportive of other professionals and inclusive in the way he works.

- Within NSFT, he has successfully engaged consultant psychiatrists (through attendance at the Medical Advice Committee and collaborative discussions), worked closely with care coordinators and front line staff to engage them in working more holistically with patients and understanding the functions of CTOs and - by attending conferences and local groups - ensured that carers are fully informed and engaged in the process; individual family members have also been involved in dialogues about patient's personalised care and treatment.

- Miles has put himself forward for the role of Non-Medical Approved Clinician in NSFT and recently having witnessed the work he is doing in that role and the way in which he is working with an individual, to help that person achieve recovery goals that previously would not have been encouraged by a more traditional approach, gives me hope that we are moving towards a more optimistic approach to people who use our service for a life beyond mental illness. He is setting a standard that others will want to follow.

- He is standing up and being counted, and by leading the way in this role for the Trust, where others have feared to tread. This dedication is changing the way staff think about their work and inspiring others to follow his path. Miles has fast become a resource that makes the role feel achievable and allows patients to remain active and involved in their care.

- On Thursday 14th August 2014, the Hospital Managers held a very complex discussion for a female CTO patient, who is being treated with clozapine and is facing possible chemotherapy treatment. The Managers were particularly impressed with a number of facets of Miles France's presentation to the panel, including:

    - A deep understanding of the case, in terms of the high quality report and oral evidence.

    - A passionate, patient centred approach, balancing rights and responsibilities.

- Comments from various panels have also been highly complementary and it was thought that this ought to brought to your attention.

- Miles current role within the team is vitally important for the team to work efficiently with service users who are under a community treatment order.

- Miles has acted correctly and very professionally when working with service users, informing a service user of their rights regarding appealing against their CTO - Miles liaised with the Mental Health Act Administrator to inform them of the service user's wishes, aware that the service user lacks motivation to do this.

- Miles keeps all relevant members of the team updated regarding service users' progress, any issues etc.

- Miles kindly offered to do a presentation for the DCLL team on CTOs, in September 2014 – we recently had to recall a patient and as we don't often have CTO patients, staff struggled. Miles used this lady as the example and gave some background. This was very well received by the team and he has also given us his contact details in case we need advice in the future.

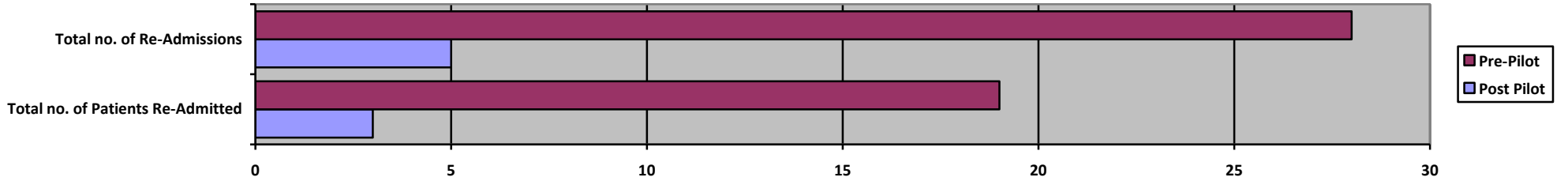
- Not only is Miles is to be commended for his achievement but for using it to challenge the established procedures and working towards a way to bring better outcomes and quality of life for our service users and acting as an inspiration to others who might want to step up and challenge the norm for the good of individuals in our care.

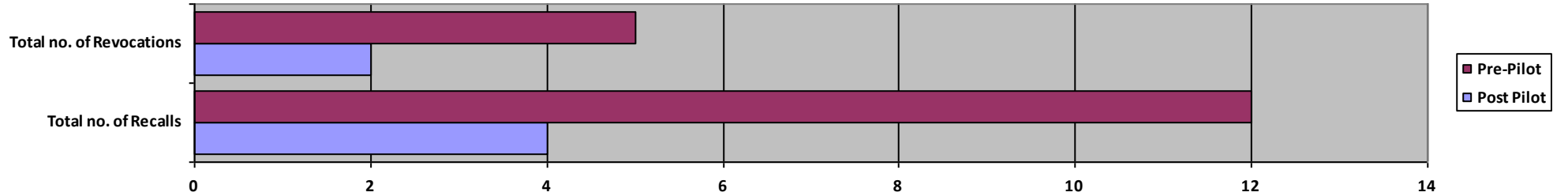
  I'm happy to provide further details of the award and the feedback received, if required.

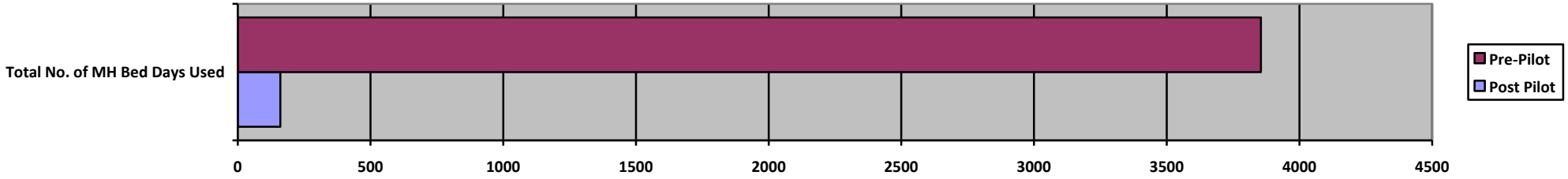
Emma-Louise Clayton
Commercial Development Officer

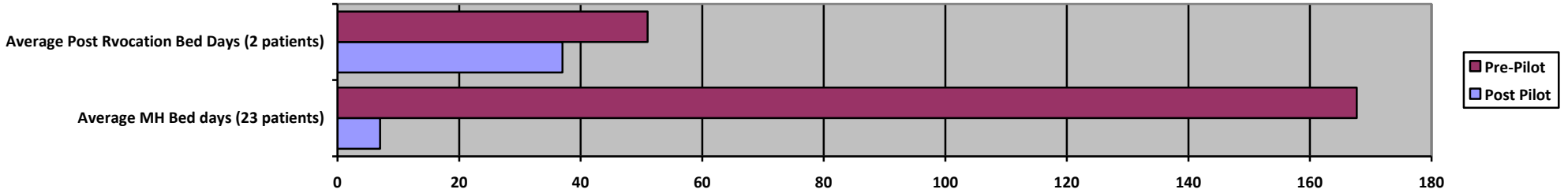
Appendix 7: KPIs Data Charts for the first 23 Patients (data analysis finalised for the period up to 23.2.2015)

Re-Admissions to MH Hospital

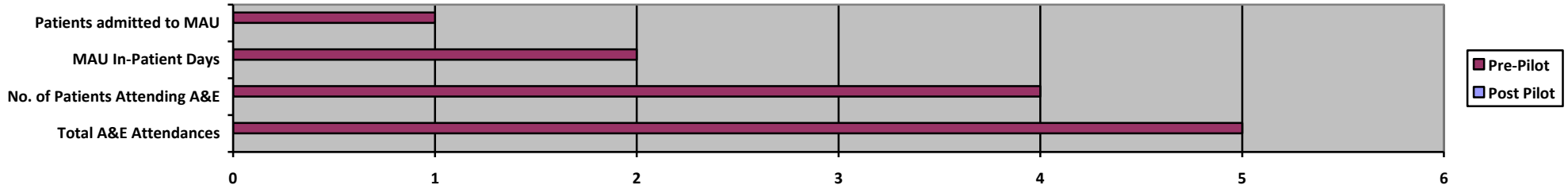




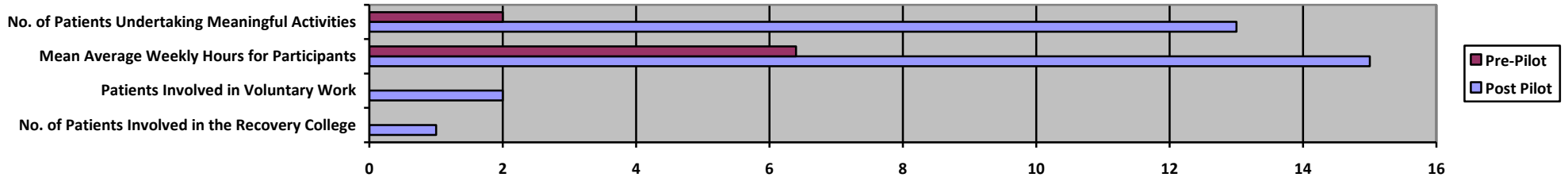




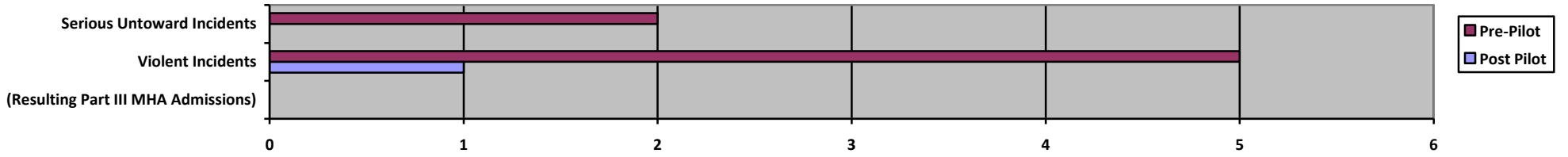
A&E Treatment and Admissions to the Medical Admission Unit (MAU) at the General Hospital



Meaningful Activities



SUIs and Incidents of Physical or Sexual Violence – allegedly perpetrated by CTO Patients – necessitating Police Involvement



NB: The sole violent incident in the post-pilot period – involving threats made by a patient towards his RC – occurred within the context of CTO recall.

Appendix 8: Geographical Spread of the 32 [non-medical] Approved Clinicians, within England and Wales